

The Electroshock Quotationary

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Dedicated to everyone committed to
ending forever the use of
electroshock everywhere

The Campaign for the Abolition of Electroshock in Texas (CAEST) was founded in Austin during the summer of 2005. *The Electroshock Quotationary* (ECTQ) was created to support the organization's mission by informing the public, through CAEST's website, about the nature of electroshock, its history, why and how it's used, and its effects on people. The editor will regularly update ECTQ with suitable materials when he finds them or when they are brought to his attention. In this regard he invites readers to submit original and/or published materials for consideration (e-mail address: lfrank@igc.org).

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INTRODUCTION: THE ESSENTIALS

I. THE CONTROVERSY

Electroshock (also known as electroconvulsive treatment, ECT, EST, ECS, and convulsive therapy) is a psychiatric procedure involving the induction of a grand mal seizure, or convulsion, by passing electricity through the brain. It is the most controversial “treatment” in psychiatry, and perhaps in all of medicine.

Proponents call it a safe and highly effective way to address various kinds of “mental illness” and certain medical conditions.

Opponents charge that it causes brain damage and is an instrument of social control, sometimes administered by means of coercion or outright force and seldom with genuine informed consent.

II. BACKGROUND

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

Today, an estimated 100,000 people in the United States undergo ECT every year. Two-thirds are women, and half are elderly. Age is not a disqualifying factor: there are published reports of individuals as young as 34½ months and as old as 102 undergoing the procedure (*see* in the text Bender’s entry in 1950 and the American Psychiatric Association’s second entry in 1990).

A typical electroshock series for a hospitalized “patient” in the United States costs between \$50,000 and \$75,000. An ECT series may also be administered on an outpatient basis — in a hospital or in a psychiatrist’s office — at considerably less expense: \$1,500 to \$2,000 per session. Government or private insurance usually covers most, if not all, of the cost. Psychiatrists who specialize in electroshock often earn \$300,000 to \$500,000 a year, considerably higher than the annual mean income for all psychiatrists (\$150,000).

The figures in the above two paragraphs suggest that in the United States alone electroshock is a multi-billion-dollar-a-year industry.

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

III. DIAGNOSES

The most common indication for electroshock is a diagnosis of clinical, or severe, depression. An ECT series for depression typically consists of 6 to 12 sessions. People diagnosed with schizophrenia or bipolar disorder (manic depression) may also be subjected to electroshock, but this is less common; for such patients, a series of 15 to 25 sessions is standard. ECT is usually administered in the early morning, three times a week (Mondays, Wednesdays, and Fridays).

Electroshock has also been administered to people with the following psychiatric diagnoses: alcoholism, anorexia, anxiety disorder, catatonia, drug withdrawal syndrome, homosexuality (no longer a psychiatric diagnosis), hysteria (ditto), narcotic addiction, neurosis, obsessive-compulsive disorder, personality disorder, postpartum depression, postpartum psychosis, pseudodementia, and psychosis. ECT has also been used to treat these medical conditions: Alzheimer's disease, backache, chronic pain, delirium tremens, dementia, epilepsy, neuroleptic malignant syndrome, Parkinson's disease, and psoriasis.

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

IV. METHOD OF ADMINISTRATION

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

A routine is followed for each session. The patient is asked to avoid food and drink for 8 to 12 hours beforehand. During this period, tranquilizers or sedatives may be used to reduce the patient's fear of and/or resistance to electroshock. Bladder and bowels are emptied just before the session, and dentures, hairpins, earrings, and the like are removed.

About 30 minutes beforehand, a conventional preanesthetic medication called atropine is administered to dry secretions in the mouth and air passages, thus reducing the risk of suffocation and other complications of swallowing one's own saliva.

Shortly afterward, the patient is taken to the treatment room and put on a bed, padded table, or gurney. Electrolyte jelly is applied to the two areas of the head, usually the

temporal areas, where the electrodes are to be placed. The jelly increases conductivity and prevents burns. An intravenous line is started, and sensors are placed on the head and chest to monitor brain and heart activity. A cuff is wrapped around the patient's upper arm to record blood pressure.

The patient is then anesthetized for 10 to 15 minutes with a short-acting barbiturate, commonly Brevital (methohexital). Once the patient is unconscious, the muscle relaxant Anectine (succinylcholine) is injected to reduce the risk of fractures, joint dislocations, and damage to skeletal muscle, tendons, and ligaments, which were very common before this modification became routine during the 1950s. Anectine causes an almost complete paralysis of the body, including the respiratory system, so that the patient must be supplied oxygen through a mask (oxygenation) until the Anectine wears off and the patient is able to resume breathing on his or her own.

The anesthetic is not used to spare the patient pain because the shock itself, if large enough, produces instant unconsciousness and is therefore painless. Instead, the anesthetic's purpose is to eliminate the sensation of suffocation that the patient, without an anesthetic, would experience as the muscle relaxant gradually took effect.

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

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

The preparations having been completed, the psychiatrist presses a button on the shock machine, releasing 70 to 500 volts (or more) of electricity for .02 second to 8 seconds. The electric current penetrates the patient's skull and passes through the brain, causing a grand mal convulsion that lasts for 30 seconds to a minute and sometimes longer.

The patient then is taken to the recovery room in a comatose state, from which she or he usually revives in 10 to 20 minutes. Ordinarily, the patient is able to leave the recovery room 30 to 60 minutes later.

V. EFFECTS

Once conscious, the patient experiences one or more of the following adverse effects: headache, dizziness, nausea, confusion, disorientation (not knowing who or where one is or what time or day it is), muscle ache and soreness, physical weakness, memory loss, euphoria, increased or irregular heartbeat (especially among the elderly), brief or prolonged apnea (inability to breathe), and brief or prolonged cyanosis (blue skin from loss of oxygen). Some of these effects may be so severe, even life-threatening, that

emergency treatment is necessary. For this reason, ECT is typically given in a hospital, where such equipment is readily available.

After an electroshock session, patients may become “agitated,” or furious, when they realize what has happened to them. Others become delirious or actively hostile, prompting the use of mechanical and/or chemical restraints. Within a few hours, most of the immediate adverse effects dissipate. Those that don’t may continue throughout the day, for several days, or longer. During the recovery period, patients are often prevented from or asked to refrain from driving, conducting legal or business transactions, and engaging in other activities requiring alertness and memory.

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

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

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

Physicians usually regard memory impairment, particularly when pronounced, as a sign of brain damage (*see* in the text Sterling’s entry in 2001, and the cross-references following his citation for more information about brain damage and ECT). Memory loss may be accompanied by apathy, emotional dullness (blunted emotion, flat affect), spontaneous seizures, amenorrhea, demoralization, dependency, and hopelessness; reduced ability to think, problem-solve, concentrate, and connect with others; loss of personality; and loss of creativity, energy, enthusiasm, moral awareness, and other elements that contribute to the individual’s sense of well-being and worth. The patient’s age and physical condition, together with the intensity, duration, number, and spacing of the individual convulsive procedures, determine the severity and persistence of these effects.

Electroshock can also be fatal. Estimates of ECT-related death rates vary widely. The lower estimates include:

- 1 in 10,000 (*see in the text* Boodman's first entry in 1996)
- 1 in 1,000 (Impastato's first entry in 1957)
- 1 in 200, among the elderly, over 60 (Impastato's in 1957)

Higher estimates include:

- 1 in 102 (*see in the text* Martin's entry in 1949)
- 1 in 95 (Boodman's first entry in 1996)
- 1 in 92 (Freeman and Kendell's entry in 1976)
- 1 in 89 (Sagebiel's in 1961)
- 1 in 69 (Gralnick's in 1946)
- 1 in 63, among a group undergoing intensive ECT (Perry's in 1963-1979)
- 1 in 38 (Ehrenberg's in 1955)
- 1 in 30 (Kurland's in 1959)
- 1 in 9, among a group undergoing intensive ECT (Weil's in 1949)
- 1 in 4, among the very elderly, over 80 (Kroessler and Fogel's in 1974-1986)

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

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

VI. DOES ELECTROSHOCK WORK?

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

- Patients may feel better because of the well-known placebo effect. Any treatment offered by a doctor, along with the suggestion that it will work, may have the effect of making a patient feel better, at least for a while.
- Patients may say they feel better (even when they don't) for a variety of reasons: because it's expected of them, because they want to please their psychiatrists or relatives, or because they fear that speaking truthfully would result in further ECT.
- Due to ECT-induced memory loss, patients may forget what had been bothering them; as a consequence, they may feel less troubled and complain less to others.
- Due to ECT-induced memory loss, patients may forget their ideas, beliefs, and forms of conduct that others had found objectionable, including resistance to being confined in a psychiatric facility and subjected to electroshock treatment. This phenomenon may be called the brainwashing effect.
- Family, friends, psychiatrists, and hospital staff may feel sympathy for ECT patients and give them more consideration and better care.
- Patients who believe the claims of psychiatrists and agree to undergo ECT may give up so much self-respect, health, memory, intelligence, money, skills, or faith they refuse admit to themselves or others that they are worse off after ECT.
- ECT-induced brain damage may be so severe that patients are unaware of their losses.
- ECT-induced brain damage may result in a brief period of euphoria during which the depression seems to lift, so for a time patients may indeed feel better.
- ECT patients typically become dependent on others and more docile, more cooperative, and easier to get along with as they recover from the treatment.
- Because ECT deadens the emotions, patients whose everyday lives are filled with tension, anger, sadness, and misery may experience temporary relief.

VII. WELL-KNOWN ELECTROSHOCK PATIENTS

Some of the better-known people who have undergone electroshock treatment include French poet Antonin Artaud, poet Richard Garry Brautigan, television personality Dick Cavett, Kitty Dukakis (Massachusetts governor Michael Dukakis's wife), Missouri senator and (briefly) 1972 Democratic Party vice presidential nominee Thomas Eagleton, writer Ralph Ellison, actor Frances Farmer, New Zealand writer Janet Frame, singer Connie Francis, singer and actor Judy Garland, Naomi Ginsberg (Allen Ginsberg's mother), Australian pianist David Helfgott, writer Ernest Hemingway, Russian-born U.S. pianist Vladimir Horowitz, poet Bob Kaufman, musician Roland Kohloff, Olga Koklova (Pablo Picasso's first wife), writer Seymour Krim, British actor Vivien Leigh, pianist and actor Oscar Levant, poet Robert Lowell, British humorist Spike Milligan, composer Paul Moravec, physician and writer Sherwin Nuland, actor Jennifer O'Neill, baseball player Jimmy Pearsall, writer Robert Pirsig, poet Sylvia Plath, songwriter and performer Lou Reed, singer/actor and human rights leader Paul Robeson, French fashion designer Yves Saint-Laurent, writer Andrew Solomon, writer William Styron, actor Gene Tierney, songwriter and performer Townes Van Zandt, physician Mark Vonnegut (Kurt Vonnegut's son), poet John Wieners, Rose Williams

(Tennessee Williams' sister), British writer Simon Winchester, CIA official Frank Wisner, and singer Tammy Wynette.

VIII. OVERVIEW

While media reports suggest that electroshock use in the United States is increasing, there is a growing grassroots movement demanding that the procedure be abandoned or abolished.

TEXT : CHRONOLOGICALLY ARRANGED QUOTATIONS

(Multiple entries for any given year are arranged alphabetically by author.)

A.D. 47? — The use of nonconvulsive electrotherapy as a method for alleviating symptoms through suggestion dates back to Scribonius Largus (c. A.D. 47), who treated the headaches of the Roman emperor with an electric eel.

FRANZ G. ALEXANDER (Hungarian-born U.S. psychoanalyst) and **SHELDON T. SELESNICK** (U.S. psychiatrist), *The History of Psychiatry*, ch. 18, 1966.

1200-1500 — Far from recognizing their plight for what it was, the witch hunters and exorcists fought the witches' delusions on the level of the deluded, and whenever the patient failed to respond to exorcism by persuasion, prayer or the sacraments, they saw no choice but to resort to their own brand of shock treatment: burning at the stake.

JAN EHRENWALD (U.S. psychiatrist), ed., *From Medicine Man to Freud*, ch. 7, 1956.

1400-1600 — Already towards the end of the Middle Ages and the beginning of the new period an interest developed in attempting to treat schizophrenics by some form of shock. In Switzerland, schizophrenics were put into nets and lowered into lakes until they were almost drowned and then pulled out again. Sometimes short-lasting remissions were witnessed. In other countries patients were hit with chains and whips. Some of these patients died. But again there were some very impressive recoveries and remissions. This kind of primitive shock treatment was considered to be of a magic [*sic*] nature. It was believed that the devil had possession of the human body and mind, and the only logical consequence of such ideas seemed to be the attempt to make the devil's stay in these strange places of residence as miserable as possible.

HANS HOFF (Austrian electroshock psychiatrist), "History of Organic Treatment of Schizophrenia," published in Max Rinkel and Harold E. Himwich, eds., *Insulin Treatment in Psychiatry*, 1959. The term schizophrenia was coined by the Swiss psychiatrist Eugen Bleuler in the early 1900s.

1755 — Probably the first electroconvulsive treatment for mental illness was administered by the French physician J. B. LeRoy in 1755 on a patient with a psychogenic blindness.

FRANZ G. ALEXANDER (Hungarian-born U.S. psychoanalyst) and **SHELDON T. SELESNICK** (U.S. psychiatrist), *The History of Psychiatry*, ch. 18, 1966.

1756 — Having procured an apparatus on purpose, I ordered several persons to be electrified who were ill of various disorders; some of whom found an immediate, some a gradual, cure. From this time I appointed, first some hours in every week and afterward an hour in every day, wherein any that desired it might try the virtue of this surprising medicine.... To this day, while hundreds, perhaps thousands, have received unspeakable good, I have not known one man, woman, or child, who has received any hurt thereby; so when I hear any talk of the danger of being electrified (especially if they are medical men who talk so), I cannot but impute it to great want either of sense or honesty.

JOHN WESLEY (English evangelist and founder of Methodism), journal, 9 November 1756. Comment: "*The desideratum[^f: or, electricity made plain and useful. By a lover of*

mankind, and of common sense] was written to popularize what he considered the cheapest, safest, and most successful treatment for ‘nervous Cases of every Kind,’ namely electricity” (Richard Hunter and Ida Macalpine, eds., “John Wesley,” *Three Hundred Years of Psychiatry (1535-1860)*, 1963). *The desideratum* was published in 1760.

1787 — In the month of November, 1787, a porter of the India warehouses was sent to me by a lady of great humanity for advice, being in a state of melancholy [for almost a year], induced by the death of one of his children....

He was quiet, would suffer his wife to lead him about the house, but he never spoke to her; he sighed frequently, and was inattentive to everything that passed....

I covered his head with a flannel, and rubbed the electric sparks all over the cranium; he seemed to feel it disagreeable, but said nothing. On the second visit, finding no inconvenience had ensued, I passed six small shocks through the brain in different directions. As soon as he got into an adjoining room, and saw his wife, he spoke to her, and in the evening was cheerful, expressing himself, as if he thought he should soon go to his work again. I repeated the shock in like manner on the third and fourth day, after which he went to work: I desired to see him every Sunday, which I did for three months after, and he remained perfectly well.

JOHN BIRCH (English surgeon), “John Birch,” published in Richard Hunter and Ida Macalpine, eds., *Three Hundred Years of Psychiatry (1535-1860)*, 1963.

1804, 1872 — Aldini was reported to have cured two cases of melancholia by passing galvanic current through the brain in 1804. In England, Clifford Allbutt in 1872 used the passage of electric current through the head for treatment of mania, brain-wasting, dementia and melancholia.

PETER SKRABANEK, “Convulsive Therapy — A Critical Appraisal of Its Origins and Value,” *Irish Medical Journal*, June 1986.

1881 — [In cases of enuresis, or bedwetting] I apply usually [in the region of the boy’s sexual organ] a tolerably strong current for one to two minutes; at the close, a wire electrode is introduced about two centimeters into the urethra — in girls I apply “small” sponge electrode between the labia close to the meatus urethrae — and the faradic current passed for one to two minutes with such a strength that a distinct, somewhat painful sensation is produced.

WILHELM ERB (German physician), *Handbook of Electrotherapy*, 1881, quoted in Thomas S. Szasz, *The Myth of Psychotherapy: Mental Healing as Religion, Rhetoric, and Repression*, ch. 6, sect. 1, 1978.

1893-1895 — [For a woman diagnosed with hysteria and a muscle disorder] we recommended the continuation of systematic kneading and faradization of the sensitive muscles, regardless of resulting pain, and I reserved to myself treatment of her legs with high tension electric currents, in order to be able to keep in touch with her....

In this way we brought about a slight improvement. In particular, she seemed to take quite a liking to the painful shocks produced by the high tension apparatus, and the stronger these were the more they seemed to push her own pains into the background. In the meantime my colleague was preparing the ground for psychical treatment, and

when, after four weeks of my pretense treatment, I proposed the other method and gave her some account of its procedure and mode of operation, I met with quick understanding and little resistance.

SIGMUND FREUD (Austrian neurologist and founder of psychoanalysis), *Studies in Hysteria*, ch. 2, sect. 5, 1893-1895, tr. James and Alix Strachey, 1955. Thirty years later, Freud commented on this practice, “My knowledge of electrotherapy was derived from W. Erb’s textbook, which provided detailed instructions for the treatment of all the symptoms of nervous diseases. Unluckily, I was soon driven to see that following these instructions was of no help whatever and that what I had taken for an epitome of exact observations was merely the construction of fantasy.... The successes of electric treatment in nervous disorder (in so far as there were any) were the effect of suggestion on the part of the physician” (*An Autobiographical Study*, ch. 1, 1925, tr. James Strachey, 1927).

1914-1918 — During the First World War, among the persons responsible for torturing soldiers with painful electric shocks and disguising the brutality as therapy was the foremost neuropsychiatrist of Austria-Hungary and perhaps of Europe, Julius Wagner-Jauregg.

THOMAS S. SZASZ (Hungarian-born U.S. psychiatrist), *The Myth of Psychotherapy: Mental Healing as Religion, Rhetoric, and Repression*, ch. 6, sect. 1, 1978.

1930s — Psychiatrists had used a variety of aggressive measures to control mental patients during the three centuries of the [asylum] system, but the 1930s saw a new approach in technology. In previous years assaults on the patients had been largely directed at the whole body rather than the brain. Patients were whipped, strapped into spinning chairs, dunked into cold water, poisoned with toxic agents, bled, placed in straitjackets, and thrown into solitary confinement. But with the third decade of the twentieth century, psychiatrists discovered it was more efficient to attack the brain directly. The major breakthrough took place in 1928, when Sakel, the inventor of insulin coma therapy, first discovered that addicts accidentally overdosed with insulin became more docile and manageable. The widespread acceptance of insulin coma therapy in the 1930s paved the way for a variety of brain-damaging convulsive therapies [including electroshock], and ultimately for direct surgical destruction of the highest centers of the brain (lobotomy).

PETER R. BREGGIN (U.S. psychiatrist), *Electroshock: Its Brain-Disabling Effects*, ch. 10, 1979.

1938 — Italian psychiatrists Ugo Cerletti (1877-1963) and Lucio Bini (1908-1964) introduced electroshock, Cerletti’s coinage, at the University of Rome in 1938.

The first experimental subject was identified only as “S. E.” He had been picked up by the police who had found him wandering about in a railway station. The Police Commissioner of Rome sent him to Cerletti’s institute for observation with a note reading that “he does not appear to be in full possession of his mental faculties.” Cerletti described what happened next:

“A diagnosis of schizophrenic syndrome was made based on his passive behavior, incoherence, low affective reserves, hallucinations, deliriant ideas of being influenced,

neologisms. This subject was chosen for the first experiment of induced electric convulsions in man.

“Two large electrodes were applied to the frontoparietal regions, and I decided to start cautiously with a low-intensity current of 80 volts for 0.2 seconds. As soon as the current was introduced, the patient reacted with a jolt and his body muscles stiffened: then he fell back on the bed without loss of consciousness. He started to sing abruptly at the top of his voice, then he quieted down. Naturally, we, who were conducting the experiment, were under great emotional strain and felt that we had already taken quite a risk.

“Nevertheless, it was quite evident to all of us that we had been using a too low voltage. It was proposed that we should allow the patient to have some rest and repeat the experiment the next day. All at once, the patient, who evidently had been following the conversation, said clearly and solemnly, without his usual gibberish: ‘Not another one! It’s deadly!’”

The next day, despite the subject’s plea, Cerletti administered a stronger shock which caused a seizure. Thus “the first experiment of induced electric convulsions in man” (Cerletti’s words) was carried out against the will of the subject.

Earlier in Rome, Cerletti had experimented with pigs and later wrote, “Having obtained authorization for experimenting from the director of the slaughterhouse, Professor Torti, I carried out tests, not only subjecting the pigs to the current for ever-increasing periods of time, but also applying the current in various ways across the head, across the neck, and across the chest.”

Referring to the first electroshock experiment on a human being, Cerletti wrote, “When I saw the patient’s reaction, I thought to myself: ‘This ought to be abolished.’ Ever since I have looked forward to the time when another treatment would replace electroshock.”

LEONARD ROY FRANK (U.S. electroshock survivor and editor), summary based on articles by Cerletti, “Electroshock Therapy,” published in Arthur M. Sackler et al., eds., *The Great Physiodynamic Therapies in Psychiatry: An Historical Appraisal*, 1956; Cerletti, “Old and New Information about Electroshock,” *American Journal of Psychiatry*, August 1950; and Frank J. Ayd Jr., “Guest Editorial: Ugo Cerletti (1877-1963),” *Psychosomatics*, November-December 1963.

See Lothar Kalinowsky’s entry immediately below, Cerletti’s in 1959, Ferruccio di Cori’s in 1963, and George Mora’s in 1963 below.

1938 — Cerletti had been worried that something might go wrong with the first treatment, and it was given in secret.... When the first treatment went well, we were allowed to attend the second treatment. We were called together for the treatment with a trumpet!...

According to my wife — because I don’t remember it exactly — she claims that when I came home I was very pale and said, “I saw something terrible today — I never want to see that again!”

LOTHAR B. KALINOWSKY (German-born U.S. electroshock psychiatrist and for many years the world’s leading authority on ECT, 1900-1992), quoted in Richard Abrams, “Interview with Lothar Kalinowsky, M.D.,” *Convulsive Therapy*, vol. 4, 1988. In 1933, Kalinowsky fled Germany for Italy where, between 1936 and 1939, he was associated with Cerletti. After arriving in the United States in 1940, he wrote hundreds

of journal articles and co-authored several influential books on psychiatry's physical treatments.

1940 — It seems very clear that the first documented treatment of ECT in this country [at 27 West 55th Street, New York City] was administered by Dr. David Impastato on January 7, 1940....

The first patient was a 29-year-old woman of Italian descent suffering from severe schizophrenia. The apparatus used by Dr. Impastato was made in Italy and brought to the United States in 1939 by Dr. Renato Almansi, who had been associated with Dr. Ugo Cerletti in Rome.

ZIGMOND M. LEBENSOHN (U.S. electroshock psychiatrist), "The History of Electroconvulsive Therapy in the United States and Its Place in American Psychiatry: A Personal Memoir," *Comprehensive Psychiatry*, May-June 1999.

1940 — These sundry procedures produce "beneficial" results by reducing the patient's capacity for being human. The philosophy is something to the effect that it is better to be a contented imbecile than a schizophrenic.

HARRY STACK SULLIVAN (U.S. psychiatrist), referring to lobotomy and shock treatment (in his phrase, psychiatry's "decortication treatments"), "Conceptions of Modern Psychiatry," *Psychiatry*, February 1940.

1941 — In a 1941 U.S. Public Health Service survey, 42 percent of [305 public and private] institutions surveyed had electroshock machines just three years after the first human electroshock trial.

JOEL BRASLOW (U.S. psychiatrist), slightly modified, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century*, ch. 5, 1997.

1941 — What then of... our vitamin capsules, our electric therapies, our ultra-violet lamps, our shortwave treatments and our shock therapy — in particular our shock therapy, whether it be insulin or metrazol or electric! Do we use these as empirically as our predecessors did their leeches and their bleedings?... I ask the question, are we, in the light of others who come after us, going to be accused of being users of stupid, bizarre or crude methods? Will they think us no better than quacks? Will they read our shock therapy methods with horror and say, "Why, they should have used baseball bats — it would have been just as productive of results."

C. C. BURLINGAME (psychiatrist), 1941, quoted in David Herman and Jim Green, "What Treatment?" *Madness: A Study Guide*, 1991.

1941 — All of the above-mentioned methods [i.e., various forms of shock and drug treatments] are damaging to the brain, but for the most part, the damage is either slight or temporary. The apparent paradox develops, however, that the greater the damage, the more likely the remission of psychotic symptoms....

It has been said that if we don't think correctly, it is because we haven't "brains enough." Maybe it will be shown that a mentally ill patient can think more clearly and more constructively with less brain in actual operation.

WALTER FREEMAN (U.S. neurologist and psychosurgeon who, in 1936, introduced lobotomy in the United States and became its leading proponent, 1895-1972), "Editorial

Comment: Brain-Damaging Therapeutics," *Diseases of the Nervous System* ("A Practical Journal of Psychiatry and Neurology"), March 1941. In 1935, Portuguese neurologist and neurosurgeon Egas Moniz introduced psychosurgery, the first method of which was called leucotomy or leukotomy (in Europe) and lobotomy (in the U.S.). In 1949, Moniz won the Nobel Prize in Physiology or Medicine for his "discovery of the therapeutic value of prefrontal leucotomy in certain psychoses."

See Abraham Myerson's entry in 1942 below.

1942 — *Case 1*. M.C. Philadelphia State Hospital. Reg. No. 51103. Paranoid dementia praecox in a woman of 45. Electrical convulsion treatments, 62 [in 16 of which no convulsion was produced], over a period of 5½ months. Numerous punctate hemorrhages in the cerebral cortex, medulla, cerebellum and basal ganglia. Areas of perivascular edema and necrosis....

Comment. The foregoing case is the first reported instance, so far as we know, of hemorrhages in the brain attributable to electrical convulsion treatment....

The importance of the case lies in that it offers a clear demonstration of the fact that electrical convulsion treatment is followed at times by structural damage of the brain.

BERNARD J. ALPERS and **JOSEPH HUGHES** (U.S. neurologists), "The Brain Changes in Electrically Induced Convulsions in the Human," *Journal of Neuropathology and Experimental Neurology*, April 1942.

See Peter Sterling's entry in 2001 below.

1942 — I do not believe shock therapy offers us any lasting benefit. It certainly is not specific. It does not in any way help the patient to understand his own problems or to change his attitude towards his problems. It certainly in no way assists the psychiatrist in understanding the patient, his problems or his makeup.... To put it bluntly, I do not believe that we can scramble brains and expect to have anything left but scrambled brains.

ANONYMOUS (psychiatrist), quoted in Lawrence Kolb and Victor H. Vogel, "The Use of Shock Therapy in 305 Mental Hospitals," *American Journal of Psychiatry*, July 1942.

1942 — Bini in 1942 suggested the repetition of ECT many times a day for certain patients, naming the method "annihilation."

UGO CERLETTI (Italian electroshock psychiatrist), "Old and New Information about Electroshock," *American Journal of Psychiatry*, August 1950.

1942 — A generalized convulsion leaves a human being in a state in which all that is called personality has been extinguished.

HANS LÖWENBACH (German-born U.S. electroshock psychiatrist) and **EDWARD J. STAINBROOK** (U.S. electroshock psychiatrist), opening sentence, "Observations on Mental Patients after Electro-shock," *American Journal of Psychiatry*, May 1942.

1942 — I believe there have to be organic changes or organic disturbances in the physiology of the brain for the cure [with electric convulsive therapy] to take place. I think the disturbance in memory is probably an integral part of the recovery process. I think it may be true that these people have for the time being at any rate more intelligence than they can handle and that the reduction of intelligence is an important

factor in the curative process. I say this without cynicism. The fact is that some of the very best cures that one gets are in those individuals whom one reduces almost to amentia.

ABRAHAM MYERSON (U.S. electroshock psychiatrist), discussion following Franklin G. Ebaugh et al., "Fatalities Following Electric Convulsive Therapy: A Report of 2 Cases with Autopsy Findings," *Transactions of the American Neurological Association*, June 1942.

See Walter Freeman's entry in 1941 above.

1942 — Since October 1940 my associates and I [at Trenton State Hospital, New Jersey] have employed electric shock therapy in 1,133 cases, in 448 of which electric shock was combined with insulin.... Chronic Psychoses: By far the largest number of patients to receive electric shock therapy alone were the dirty, denuded, deteriorated and disturbed schizophrenic patients. These patients made a remarkable change in their institutional adjustment, and the majority improved to the point of remaining clothed, going to the cafeteria and working in occupational therapy groups in the wards. We found, however, that if the treatments were discontinued, the patients soon returned to their previous level; therefore we maintain these patients on a regimen of one or two treatments a week for an indefinite period.

JOHN H. TAYLOR JR. (U.S. electroshock psychiatrist), remarks at a symposium, 13 November 1942, quoted in Philadelphia Psychiatric Society, "Symposium: Complications of and Contraindications to Electric Shock Therapy," *Archives of Neurology and Psychiatry*, May 1943.

1943 — In the fall of 1942 I brought an electric shock apparatus overseas as part of hospital equipment. The [military] hospital where I was stationed rapidly filled with psychotic patients. The shipmasters refused to accept disturbed patients for return to the States.... In late February or early March of 1943, after much deliberation, I began the use of electric shock treatment, which was contrary to Army regulations. It was amazing to see how rapidly the acute schizophrenic states underwent remissions.

BENJAMIN BOSHES (U.S. electroshock psychiatrist), discussion following Matthew T. Moore, "Electrocerebral Shock Therapy: A Reconsideration of Former Contraindications," *Archives of Neurology and Psychiatry*, June 1947.

1943 — Perhaps we are doing the right thing but in a very crude way just as if one were trying to right a watch with a hammer.

HAROLD E. HIMWICH (U.S. electroshock psychiatrist), "Electroshock: A Round Table Discussion," *American Journal of Psychiatry*, November 1943.

1943 — The mechanism of improvement and recovery [with electric shock] seems to be to knock out the brain and reduce the higher activities, to impair the memory, and thus the newer acquisition of the mind, namely, the pathological state, is forgotten.

ABRAHAM MYERSON (U.S. electroshock psychiatrist), "Borderline Cases Treated by Electric Shock," *American Journal of Psychiatry*, November 1943.

1943 — A subconvulsive shock, especially when the current passes through the head, is a very disagreeable and painful experience. Such shocks cause fear and terror. Many

patients believe that they are about to be electrocuted. A shock which ends in instantaneous unconsciousness with convulsions is not felt, for the speed of the current far surpasses the speed of the action currents of the nervous system and does not allow the patient time to think. After [electroconvulsive] treatment there is always a period of retrograde amnesia.

We, therefore, treated 10 patients with 3 subconvulsive shocks daily for a period of ten days. All of them became more and more terrified as these treatments were continued from day to day. Some developed more intense psychoses, others remained as psychotic as in the beginning. They had to be dragged into the treatment room. None of them improved or recovered. These same patients were then given the regular [electro]convulsive treatments.

In the beginning the patients were told that they were being taken into a room for the purpose of studying their brain waves. They were then shocked into unconsciousness. None of them remembered anything about the procedure. When they recovered from their confusion, many demanded to be informed as to just what had been done with them. Those who recovered and developed insight stated that all memory of the first weeks spent in the hospital was gone. In some this retrograde amnesia extended back for several months before they entered the institution.

CLARENCE A. NEYMAN, V. G. URSE (U.S. electroshock psychiatrists) et al., “Electric Shock Therapy in the Treatment of Schizophrenia, Manic Depressive Psychoses and Chronic Alcoholism,” *Journal of Nervous and Mental Disease* (“the world’s oldest independent scientific monthly in the field of human behavior”), December 1943.

1944 — [Film actress Frances Farmer arrived at Western Washington State Hospital at Fort Steilacoom on March 14, 1944.] She was taken from the padded van and led to the main receiving area. The straitjacket was removed and she was stripped. Standing nude before a large crowd of patients and orderlies that had assembled to see her, she was then numbered and fingerprinted....

Early the next morning, she was taken to another, smaller room, where she was to begin immediately an extensive program of ECT....

Frances had a reputation for being the most angry, rebellious inmate in the asylum. She refused to cooperate with the psychiatrists. She refused to admit she had a mental problem. She screamed that she was being unjustly incarcerated and demanded to be released. The stubborn independence and integrity that had made her a successful artist were here deemed “antisocial” behavior and she was treated for it with massive weekly doses of electroshock. When even this failed to get a response, she was given hydrotherapy [forced baths], a primitive form of shock treatment....

Months of such treatment went by and Frances’ resistance gradually melted. She became, she would write some time later, “like a bowl of jelly, agreeable and pliable.” She seemed to become almost another person. (“I’m sorry,” she supposedly told the doctors. “I was a rude and disrespectful. I was very, very sick.”) She flattered the nurses and orderlies. She admitted the error in her thinking. She became a model patient. The doctors immediately announced that she was completely cured. [She was then discharged from the hospital.]

WILLIAM ARNOLD, *Shadowland*, ch. 30, 1978. During the year before her time at Western Washington State Hospital, Farmer was subjected to insulin coma treatment at a sanitarium in La Crescenta, California. After WWSH, she was, for several years, in and

out of mental hospitals, where she was drugged and electroshocked repeatedly. Finally, in 1948, she was returned to WWSH where it is generally believed Walter Freeman lobotomized her. She was never institutionalized again, but the spark was gone. She died of cancer in 1970 at the age of 56.

See Gerald Clarke's entry on Judy Garland in 1949, Lawrence Olivier's on Vivien Leigh in 1953, and Gene Tierney's in 1955 below.

1944 — Even though the impairment of memory for the most part affects trivialities and is one to which an otherwise well patient can adjust, it necessarily imposes a mental strain. It also contra-indicates electro-therapy in those, for example teachers and transport workers, in whom an inability to remember names of persons and places may seriously impair working capacity. Finally, it implies permanent, or semi-permanent, damage to the brain which... may later have untoward consequences.

M. B. BRODY (British psychiatrist), closing sentences, "Prolonged Memory Defects Following Electro-Therapy," *Journal of Mental Science*, July 1944. The article presented the case notes of 5 patients who had undergone ECT at Runwell Hospital, Essex, England, where Brody was the Senior Resident Physician. In the opening paragraph, he wrote that to his knowledge his was only the second article which stated that "impairment of memory occurring during or after electro-therapy has any serious significance," adding that his case notes reveal "memory defects lasting a year or more."

1944 — I was six years old [in 1944]. My mother had been locked up in a mental hospital just before I was born, and I was a ward of the state. A psychiatrist at Bellevue Hospital in New York, Dr. Laretta Bender, had just begun her infamous series of experiments with shock treatment on children, and she needed more subjects. So I was diagnosed as a "childhood schizophrenic," torn away from my foster parents, and given 20 shock treatments....

I was dragged down the hallway crying, a handkerchief stuffed in my mouth so I wouldn't bite off my tongue. And I woke [after the shock treatment] not knowing where I was or who I was, but feeling as if I had undergone the experience of death.

After four months of this. I was returned to my foster home. Shock treatment had changed me from a shy little boy who liked to sit in a corner and read to a terrified child who would only cling to his foster mother and cry. I couldn't remember my teachers. I couldn't remember the little boy I was told had been my best friend. I couldn't even find my way around my own neighborhood. The social worker who visited every month told my foster parents that my memory loss was a symptom of my mental illness.

A few months later, I was shipped to a state hospital to spend the next 10 years of my life.

Was this [referring to the electroshock] the work of some isolated sadist, some mad scientist practicing in a closet? No, the psychiatrist who did this to me and several hundred other children is still a leader in her field, with many articles published in prestigious psychiatric journals; she still draws a salary from the New York State Department of Mental Hygiene. *And not one voice was ever raised within the entire psychiatric profession to protest what she had done.*

TED CHABASINSKI (U.S. electroshock survivor and attorney), "Electroshock: Medical Cure or Physical Torture?: Ex-patient Calls It 'Destructive,'" *Daily Californian* (Berkeley), 26 October 1982.

See Laretta Bender's entry in 1947 and Chabasinski's in 1982 below.

1944 — The evidence assembled from the various fields of investigation in regard to shock therapy points definitely to damage to the brain. Perhaps the majority of authors tend [*sic*] to minimize the significance of this and attempt to find some explanation more satisfying to their consciences. There is still a tendency to consider the brain as the “temple of the mind,” the “seat of the soul,” and the “greatest gift of God,” and to decry any suggestion that such a holy structure is being tampered with. The shackles of medieval thought are difficult to strike off.

WALTER FREEMAN and **JAMES W. WATTS** (U.S. psychosurgeons), “Physiological Psychology,” *Annual Review of Physiology*, 1944.

1944? — A [concentration-camp] prisoner who worked on a Birkenau hospital block later testified that “Dr. [Hans Wilhelm] König did electroshock experiments on women,” and added, “These women later talked about their treatment. I believe Dr. König carried out the electroshock experiments on sick women twice a week and that the women were later gassed.”

In other words, the electroshock treatments could be seen as a prelude to the gas chamber, and on the basis of such testimony and other investigations the International Committee of the Red Cross in Geneva (in association with the International Tracing Service in Arolsen in West Germany) placed these “electroshock experiments” on the list of “pseudo-medical experiments” for which victims could be compensated.

ROBERT JAY LIFTON (U.S. psychiatrist), *The Nazi Doctors: Medical Killing and the Psychology of Genocide*, ch. 15, 1985. In researching his book, Lifton conducted extensive interviews with concentration-camp doctors and psychiatrists.

1944 — During the spring of 1944, the SS officer in charge of the prison hospital [at Auschwitz] told me and one other male nurse [inmate] to report for a special assignment. We were told to be in front of the hospital compound barracks to take inmates from a truck to the barracks and return them later to the truck.

When the truck arrived, I found six to eight women in various states of despair....

We took the women into the barrack where a separate room had been fixed up. A number of SS officers were in the room. Since I went back and forth into the room several times, I saw the faces of the officers and recognized Dr. [Josef] Mengele.

After an hour, we were summoned back to remove the women. In the room where the “medical services” were performed, one woman was still connected to an electrical machine, presumably for electric-shock experimentation. We had been instructed to have a stretcher ready in order to carry the women out. We found two of them dead.... Two obviously were in a coma; the others were breathing hard and irregularly. None was conscious. I noticed that the teeth of those still alive were clenched and that wads of paper were placed in their mouths.

ERNEST W. MICHEL (chairman of a world gathering of Jewish Holocaust survivors in Jerusalem in 1981), “I Saw Him in Action” (op-ed column), *New York Times*, 6 March 1985. The column was adapted from Michel’s testimony at a Congressional hearing. Mengele was the war’s most infamous Nazi doctor. He conducted numerous medical experiments on Auschwitz inmates, many of them twins. He disappeared after the war.

1945 — [Shock] treatment is not without risks. A number of unexplained deaths have occurred, large numbers of patients with organic cardiovascular hypertensive disease have been successfully treated, yet some have died from coronary disease shortly after a treatment.... I have had a number of patients die suddenly from cardiovascular accidents, within a few weeks after full recovery from depressive psychoses, and am not fully convinced that the therapy may not have hastened their deaths.

A. E. BENNETT (U.S. electroshock psychiatrist), "An Evaluation of the Shock Therapies," *Diseases of the Nervous System*, January 1945.

1945 — But what is shock? Certainly it is something that afflicts the organism physically as well as mentally. The author of this book has no personal experience with shock treatment. He has, however, personal experience in analyzing doctors who apply shock treatment. The (conscious or unconscious) attitude of the doctors toward the treatment was regularly that of "killing and bringing alive again."... "Killing the sick person and creating the patient anew as a healthy person" is an ancient form of magical treatment.
OTTO FENICHEL (German-born U.S. psychoanalyst), *The Psychoanalytic Theory of Neurosis*, p. 508, 1945.

1945 — Smith, Hastings and Hughes reported only 10% improvement in the schizophrenics they treated [with electroshock therapy], while Kalinowsky showed improvement in 70% of his patients so diagnosed. The latter emphasized the importance of adequate treatment stating, "Discontinuation of treatment after the usually early clinical improvement leads almost invariably to relapse and is the most important reason for failure of this method in the treatment of schizophrenia.

EDWARD F. KERMAN (U.S. electroshock psychiatrist), "Electroshock Therapy: With Special Reference to Relapses and an Effort to prevent them," *Journal of Nervous and Mental Disease*, September 1945.

1945 — Of the 300 patients treated [with ECT], 201, or 67% are now out of the hospital, either paroled or discharged.... Eighty-eight, or 29% are still in the hospital, either in a state similar to that shown before treatment, or exhibiting various degrees of partial improvement.... Five patients are dead; one committed suicide following relapse from her former improved state; one developed tuberculosis several months after treatment and died from the tuberculous process; one stopped breathing with the application of the first shock and could not be resuscitated (autopsy was refused); one died suddenly three weeks after the last shock after a slight exertion; and one died 11 days after her last electric shock, during the course of ambulatory insulin therapy. Autopsies done on the last 2 patients showed some equivocal findings.... One is more impressed with the cerebral than the pulmonary factor in evaluating the cause of death.

EDWARD F. KERMAN, "Electroshock Therapy: With Special Reference to Relapses and an Effort to Prevent Them," *Journal of Nervous and Mental Disease*, September 1945.

1945 — In some hospitals, the shock machine is carried about the various wards and more or less brought to the patient; but, in this institution [Rochester State Hospital, New York] it has been found more convenient to bring the patient to the shock machine. Thus a series of rooms called the shock clinic was established.... While one patient is

being treated in the shock room, another is being adjusted on the second table and can then be wheeled in as soon as the first patient leaves the room. Thus a continuous stream of patients is maintained and by this method 30 patients can be treated in about one and one-half hours. Immediately after the treatment, each patient is placed in bed and a wide canvas strap is tied across his chest and abdomen. Men and women are treated the same day but in different groups....

The persistence of confusion varies considerably from case to case and is largely dependent on the treatment intervals. Formerly two treatments weekly were considerable advisable, but for some time all patients at [RSH] have been treated three times weekly. This regime has to some extent increased and maintained the confusion, which is evident particularly in memory loss for recent events. Patients seem to be more amused than alarmed by this circumstance.

WELLINGTON W. REYNOLDS (U.S. electroshock psychiatrist), "Electric Shock Treatment: Observations on 350 Cases," *Psychiatric Quarterly*, vol. 19, 1945.

1939-1945 — Terror stalked the halls of the euthanasia hospitals not only because patients feared being selected for killing at any time or because some of the staff beat and maltreated them but also because some medical procedures imposed unusual pain. At the Gugging and Mauer-Öhling Austrian state hospitals, physician Emil Gelny, who was not a psychiatrist, employed a machine designed to give electroshock treatments and thus inflict torture. Electroconvulsive therapy, common in psychiatric hospitals during that period, was an even more painful procedure before the postwar introduction of anesthesia and muscle relaxants. Gelny used these machines, with minor adjustments, to kill patients. After two trial executions by Erwin Jekelius at the Am Steinhof hospital in Vienna, Gelny installed these machines at Gugging and Mauer-Öhling and used them to kill hundreds of handicapped patients.

HENRY FRIEDLANDER (German-born U.S. professor of history), *The Origins of Nazi Genocide: From Euthanasia to the Final Solution*, ch. 9, 1995.

1946 — Anyone who has gone through the electric shock... never again rises out of its darkness and his life has been lowered a notch.

ANTONIN ARTAUD (French electroshock survivor, actor, and playwright), "Insanity and Black Magic," 1946, *Antonin Artaud: Selected Writings*, ed. Susan Sontag, 1973. Follow-up: "Gaston Ferdière, head doctor at the Rodez Asylum, told me he was there to reform my poetry" (Artaud, "Van Gogh: The Man Suicided by Society," 1947, *Antonin Artaud Anthology*, ed. Jack Hirschman, 1965). Later, Ferdière wrote about ECT's effects on Artaud and their significance: "[Artaud] asked the doctors, the nurses: 'What am I doing here? Where am I? Who am I?' That is absolutely normal, and this kind of sub-anxiety on waking is, on the psychopathological level, even a desirable phenomenon as it obliges the patient, who has been reduced to nothingness, who has been totally obliterated, to build himself up again, and to follow the process of reconstruction — which is precisely what we are aiming at" (**GASTON FERDIÈRE** [French electroshock psychiatrist], quoted in Charles Marowitz, "Artaud at Rodez," *Evergreen*, April 1968).

1946 — I grew up in Los Angeles in the 1940s. I was a "smart-mouth" kid who skipped school, had "bad" surfing friends, and stayed out some nights, even hitch-hiking around. My parents were angered and socially embarrassed by my behavior, and they consulted

the family doctor who advised electric shock treatments. He took me forcibly to his nursing home where they were administered, without anesthetic, and where I remained for 3-4 weeks of many treatments until I was thought "safe" enough to continue with outpatient treatments. It was 1946; I was 11 years old; and it happened again 2 years later. I can still recall some of what it was like:

The attendant tells me I've been here 3 weeks. I know I'm getting more and more shock treatments. They come into my room early in the morning. They wake me up and grab me and drag me to the treatment room. People push down on my arms and legs. The doctor puts the metal things on both sides of my head. Now he tells me to lift my head up and then puts a strap thing around my head over the metal things. It pulls on my hair. He says to open my mouth. I think I'm going to die each time. It's OK. I open my mouth and he sticks the black thing in it. Suddenly, I'm out. Nothing. Nothing till I wake up in my bed in the same dark room. Someone must carry me back to my room each time. I hate to wake up. Most of the time I sleep but when I wake up, I remember where I am because I hear the old ladies moaning, the same constant hum. I'm upset. When I look in the mirror I get more upset and want to cry. I don't even look like me! I can't remember what I'm doing! I never wash my hair. It's sticky and itchy. I'm so tired. I must be so bad. They just keep coming back and taking me to that room for more shocks. My arms have red blotches on them like finger marks. Why? They hold me down so hard on that black table. I guess that's why my back hurts. If I don't open my mouth fast enough they grab my face and pull my mouth open. I cry and cry. I want to die. I can't help it anymore. I can't think. I can't remember anything. The child I was is gone forever.

After the second shock series I ran away from home, and my parents disowned me. Now I had to make it on my own or die. I never looked back. To protect myself, I became very vigilant, very "normal" and quiet, and very adult. I was 14 years old. I got a job as a hospital attendant and eventually became a psychiatric nurse. I figured, "If you can't beat 'em, join 'em." Staying focused made it possible to hide my memory retention problems. In the mid-70s I developed symptoms of multiple sclerosis which was finally diagnosed in 1990. Recently I have had epileptic seizures. At least so far, they are only partial seizures. The consulting neurologists have told me that these conditions point to brain damage, in my case, caused by the ECT. Ironically, it is possible I survived as well as I have because I was given ECT when very young and my brain had some capacity to repair itself or compensate more easily.

I often wonder who I would have become and what my life would have been like had it not been for the electric shocks.

MARGO BOUER (U.S. electroshock survivor and nurse), personal communication, 16 January 2006. Bouer's has written about her life in *After Shock: A Memoir (Lost Childhood)*, 1997, xlibris.com

1946 — There were 4 deaths among 276 patients who underwent electroshock at Central Islip Hospital, New York over a three-year period ending in 1945 [editor's summary].

ALEXANDER GRALNICK (U.S. electroshock psychiatrist), "A Three-Year Survey of Electroshock Therapy: Report on 276 Cases," *American Journal of Psychiatry*, March 1946.

1946 — Evans reported an instance of pneumonia beginning 2 days after a shock treatment and ending fatally 36 hours later, although he did not charge this complication to the therapy. In an unreported case, symptoms of bronchopneumonia began 10 or 12 days after, and ended fatally 2½ weeks after a shock course, similarly this death was not ascribed to the therapy.

LOUIS LOWINGER and **JAMES H. HUDDLESON** (U.S. electroshock psychiatrist), “Complications in Electric Shock Therapy,” *American Journal of Psychiatry*, March 1946.

1946 — A large group of cases, most of which were those of chronic dementia praecox [schizophrenia], were treated [with electric convulsive therapy] mainly because of requests from the patient’s family, regardless of the duration of the illness and the type of onset....

Another group of chronic cases were [sic] selected for treatment because of the difficulties presented in their care, and the object was to modify symptoms to a point at which the patient would make a better hospital adjustment.

JACOB NORMAN and **JOHN T. SHEA** (U.S. electroshock psychiatrists), “Three Years’ Experience with Electric Convulsive Therapy,” *New England Journal of Medicine*, 27 June 1946. During this three-year period at Foxborough State Hospital in Massachusetts, “approximately 4000 treatments” were administered to 266 patients. “If no improvement was noted after the series of twenty treatments, no further treatment was given except that in 12 cases of chronic schizophrenia fifty treatments were given, regardless of the fact that the patients did not improve after the first twenty.” Some of these patients “showed symptoms pointing to the possibility of organic brain damage.”

1946 — [Psychiatrist D. Ewen Cameron proposed] that after the war each surviving German over the age of twelve should receive a short course of electroshock treatment to burn out any remaining vestige of Nazism.

GORDON THOMAS (British writer), *Journey into Madness: The True Story of Secret CIA Mind Control and Medical Abuse*, ch. 8, 1989.

See D. Ewen Cameron’s entry in 1957 below.

1946 — [Army] regulations prescribe that no more than 12 shock treatments be administered in any one course. In many cases 12 treatments are sufficient. In others, more treatments are required. In such instances we ordinarily terminate treatment after the 12th reaction and begin a new course of 12 treatments after a few days’ interval when such action is indicated.

MARK ZEIFERT (U.S. electroshock psychiatrist), “Convulsive Shock Therapy in an Army General Hospital,” *Diseases of the Nervous System*, April 1946.

1947 — It is the opinion of all observers in the hospital, in the school rooms, of the parents and other guardians that the children [a total of 100] were always somewhat improved by the [electric shock] treatment inasmuch as they were less disturbed, less excitable, less withdrawn, and less anxious. They were better controlled, seemed better integrated and more mature and were better able to meet social situations in a realistic fashion. They were more composed, happier, and were better able to accept teaching or psychotherapy in groups or individually.

LAURETTA BENDER (U.S. electroshock psychiatrist and co-originator of the Bender-Gestalt Scale Test, 1897-1987), "One Hundred Cases of Childhood Schizophrenia Treated with Electric Shock," *Transactions of the American Neurological Association* (72nd Annual Meeting), July 1947. Comment: In a 1954 follow-up study, two psychiatrists investigated 32 children who had been administered ECT by Bender. "In a number of cases, parents have told the writers that their children were definitely worse after EST. In fact, many of these children were regarded as so dangerous to themselves or others that hospitalization become imperative. Also, after a course of such treatment one nine-year-old boy made what was interpreted as an attempt at suicide." Soon afterwards, when being admitted to a state hospital, "he said that he had tried to hang himself because [referring to ECT] he was 'afraid of dying and wanted to get it over with fast'" (**E. R. CLARDY** and **ELIZABETH M. RUMPF** [U.S. psychiatrists], "The Effect of Electric Shock Treatment on Children Having Schizophrenic Manifestations," *Psychiatric Quarterly*, vol. 28 [supplement], 1954). Comment: "Children have been treated without harm as shown by the extensive experience of Bender" (**LOTHAR B. KALINOWSKY** [German-born U.S. electroshock psychiatrist], "Electric and Other Convulsive Treatments," published in Silvano Arieti, ed., *American Handbook of Psychiatry*, 2nd ed., vol. 5, 1975).

See Ted Chabasinski's entry in 1944 above; and Bender's entries in 1950 and 1942-1969 and Chabasinski's entry in 1982 below.

1947 — The most persistent impression obtained is that the shock patients show a picture resembling the post-lobotomy syndrome.

LEON SALZMAN (U.S. psychiatrist), "An Evaluation of Shock Therapy," *American Journal of Psychiatry*, March 1947.

1948 — She continued (to be) noisy, talkative, restless, into everything, throwing things out the windows and insisting that electricity came up through the floor to bother her. She was put on maintenance EST 7/6/48 and has had 6 treatments and none since July 20. She does not like the treatments which may account for some of her improvement in behavior.

ANONYMOUS (U.S. electroshock psychiatrist), "continuous notes," Stockton State Hospital (California), case 58214, 9 August 1948, quoted in Joel Braslow (U.S. psychiatrist), *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century*, ch. 5, 1997. In researching his book, Braslow had access to patients' psychiatric records in several California state hospitals for the period from the 1920s through the 1950s.

1948 — E.S.T. seems to keep her "under control" so to speak.

ANONYMOUS (U.S. electroshock psychiatrist), "continuous notes," Stockton State Hospital (California), case 53774, 14 December 1948, quoted in Joel Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century*, ch. 5, 1997.

1948 — Patients get a break at Brooklyn [State Hospital], both on the humane and medical end. Virtually every patient who is admitted gets an early chance at shock therapy, if suitable for such treatment....

It is a distinct pleasure to report, after the heartbreaking scenes witnessed in many other state hospitals, that Brooklyn State Hospital, while far from being a model mental hospital, is decidedly one that can be recommended. Would that there were many more like it.

ALBERT DEUTSCH (U.S. writer), *The Shame of the States*, ch. 18, 1948. In the book's introduction, psychiatrist **KARL A. MENNINGER** wrote that Deutsch "has probably done more than anyone else to keep before the eyes of the American people the abuses that are perpetrated in their name in public psychiatric hospitals.... He combines the skill of the reporter and the training of the scientist with the deep feeling of a man of compassion and vision."

1948 — By what mechanism do the shock therapies [i.e., insulin coma treatment, metrazol convulsive treatment and electroconvulsive treatment] obtain their phenomenal results? By what path does a stimulus given to the soma reach the domain of the psyche and rehabilitate it to follow patterns that we call normal or quasi normal?...

The following [are] 50 shock theories gleaned from American and foreign sources. Some of them are independent, others overlap, but all challenge our attention.

I. SOMATOGENIC THEORIES....

2. *Destructive*. Because prefrontal lobotomy improves the mentally ill by destruction, the improvement obtained by all the shock therapies must also involve some destructive processes....

8. *Circulation*. They help by way of a circulatory shake up....

18. *Capillary spasms*. It produces spasms in the brain capillaries and diseased nerve cells are eliminated....

20. *Cerebral function*. It decreases cerebral function....

24. *Cortex cells*. Irreversible changes in the cortex cells explain the change in the mental condition....

II. PSYCHOGENIC THEORIES....

2. *Dying and resurrection*. There is an unconscious experience of dying and resurrection....

4. *Preparation for psychotherapy*. It is only a preparation of the ground for psychotherapy....

5. *Catharsis*. Emotional catharsis is facilitated....

6. *Contact with physician*. The treatments bring patient and physician in close contact....

7. *Physician becomes "mother"*. Helpless and dependent, the patient sees in the physician a mother....

12. *Vital instincts*. Threat of death mobilizes all the vital instincts and forces a reestablishment of contacts with reality....

13. *Atonement*. The treatment is considered by patient as punishment for sins and gives feelings of relief....

14. *Fear*. Fear of the procedure causes remission....

15. *Victory and joy*. Victory over death and joy of rebirth produce the results....

16. *Ego*. The healthy ego reobtains dominion over pathological ego....

17. *Amnesia*. The resulting amnesia is healing....

18. *Eros*. Erotization is the therapeutic factor....

22. *Lower level.* The personality is brought down to a lower level and adjustment is obtained more easily in a primitive vegetative existence than in a highly developed personality. Imbecility replaces insanity.

HIRSCH L. GORDON (U.S. electroshock psychiatrist), "Fifty Shock Therapy Theories," *Military Surgeon*, November 1948.

1948 — This brings us for a moment to a discussion of the brain damage produced by electroshock.... Is a certain amount of brain damage not necessary in this type of treatment? Frontal lobotomy indicates that improvement takes place by a definite damage of certain parts of the brain.

PAUL H. HOCH (Hungarian-born U.S. electroshock psychiatrist and onetime commissioner of the New York State Department of Mental Hygiene), "Discussion and Concluding Remarks," *Journal of Personality*, vol. 17, 1948.

1948 — We started by inducing two to four grand mal convulsions daily until the desired degree of regression was reached.... We considered a patient had regressed sufficiently when he wet and soiled, or acted and talked like a child of four....

Sometimes the confusion passes rapidly and patients act as if they had awakened from dreaming; their minds seem like clean slates upon which we can write.

CYRIL J. C. KENNEDY and **DAVID ANCHEL** (U.S. electroshock psychiatrists), "Regressive Electric-Shock in Schizophrenics Refractory to Other Shock Therapies." *Psychiatric Quarterly*, vol. 22, 1948.

1948 — *Case 2.* Mrs. J. R. represents the group of patients who have, over a period of years, been ardent followers of a certain faith and who become depressed and confused when thoughts of previous sex practices recur. Her conflict arose because she could not reconcile her past conduct with her present religious beliefs. She was a woman of 65, short and stockily built, and had raised 4 children. Her sickness followed the death of her husband four years before and has persisted to date. She objects to any medication or shock treatment because of her faith but does show definite temporary improvement after shock therapy. This patient is not accessible to psychotherapy, owing to her age and her profound religious beliefs.

N. K. RICKELS and **CHARLES G. POLAN** (U.S. electroshock psychiatrists), "Causes of Failure in Treatment with Electric Shock: Analysis of Thirty-Eight Cases," *Archives of Neurology and Psychiatry*, March 1948.

1948 — The pre-treatment room, with its air of pleasant diversion, is equipped with a radio and recording machine with a large stack of records for listening and dancing. A librarian visits the unit daily with magazines, books, and newspapers. The Red Cross is represented by Grey Ladies who chat and play cards with patients awaiting their turn for [electric shock] treatment. The recreational aides and nurses also act as dancing partners for any patients so inclined. Although the space is limited, this entertainment is greatly enjoyed. Here the patient is induced to relax and is given an opportunity to forget his fear and anxiety in the pleasant atmosphere of a social gathering of friendly people.

CLINTON C. SHERMAN and **LEON O. CHARBONNEAU** (U.S. nurses), "Electric Shock Therapy," *American Journal of Nursing*, May 1948. Both nurses were staff

members at the U.S. Veterans Hospital in Northampton, Massachusetts while writing this article.

1949 — The number of patients treated [with electroconvulsive treatment at California's Stockton State Hospital] for the year ending June 30, 1949, increased over the previous year by nearly five times, to 2,997. Underscoring its status as the "foremost method of therapy in the state hospitals," doctors shocked 60 percent of the patients at Stockton that year.

JOEL BRASLOW (U.S. psychiatrist), *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century*, ch. 5, 1997.

1949 — [While filming *Annie Get Your Gun* in 1949, Judy Garland] began to arrive at the studio late or not at all, often staying home, unable to rise from her bed. Her weight dropped to 90 pounds, and her hair began to fall out, a side effect, most likely, of her profligate use of amphetamines. In an effort to lift her out of her depression, a new doctor, Fred Pobirs, persuaded her to undergo a series of six electroshock treatments. **GERALD CLARKE** (U.S. writer), *Get Happy: The Life of Judy Garland*, 2000. **JUDY GARLAND** returned to the set after finishing the electroshock series, but, as she recalled later, "I couldn't learn anything. I couldn't retain anything; I was just up there making strange noises. Here I was in the middle of a million-dollar property, with a million-dollar wardrobe, with a million eyes on me, and I was in a complete daze. I knew it, and everyone around me knew it." The studio soon suspended her from the film. See William Arnold's entry on Frances Farmer in 1944 above; and Lawrence Olivier's on Vivien Leigh in 1953 and Gene Tierney's in 1955 below.

1949 — Quite a number of psychiatrists object to shock treatment, or frontal lobotomy, because they say it is only a symptomatic treatment, like giving the patient a sleeping pill when he suffers from insomnia.... In most of our treatments what we actually are achieving is an emotional amputation, in a sense that we prevent a conflict from remaining dominant in the patient's mind.

PAUL H. HOCH (Hungarian-born U.S. electroshock psychiatrist), "Theoretical Aspects of Frontal Lobotomy and Similar Brain Operations," *American Journal of Psychiatry*, December 1949.

1949 — There were 5 deaths among 511 patients who underwent electroshock at Pontiac State Hospital, Michigan [editor's summary].

PETER A. MARTIN (U.S. electroshock psychiatrist), "Convulsive Therapies: Review of 511 Cases at Pontiac State Hospital," *Journal of Nervous and Mental Disease*, February 1949.

1949 — Two soft pads, which felt slightly moist, clamped themselves against Winston's temples. He quailed. There was pain coming, a new kind of pain. O'Brien laid a hand reassuringly, almost kindly, on his.

"This time it will not hurt," he said. "Keep your eyes fixed on mine."

At this moment there was a devastating explosion, or what seemed like an explosion, though it was not certain whether there was any noise. There was undoubtedly a blinding flash of light. Winston was not hurt, only prostrated.... A terrific painless, blow

had flattened him out. Also something had happened inside his head. As his eyes regained their focus, he remembered who he was, and where he was, and recognized the face that was gazing into his own; but somewhere or other there was a large patch of emptiness, as though a piece had been taken out of his brain.

GEORGE ORWELL (English writer), *Nineteen Eighty-Four* (a novel), ch. 3, sect. 2, 1949.

1949 — It should be understood that long-continued treatment with electroshock does no physical harm. Cases have been reported in which two hundred fifty and even one thousand convulsions have been induced over a period of years, with no organic damage to the patient.

PHILLIP POLATIN (U.S. electroshock psychiatrist) and **ELLEN C. PHILTINE**, *How Psychiatry Helps*, ch. 6, 1949.

1949 — There were 2 deaths among 18 patients who underwent intensive electroshock at Mapperley Hospital, Nottingham, England in 1949 [editor's summary].

PAUL L. WEIL (British electroshock psychiatrist), "Regressive' Electroplexy in Schizophrenics," *Journal of Mental Science*, April 1950.

Late 1940s–early 1950s — Every morning I woke in dread, waiting for the day nurse to go on her rounds and announce from the list of names in her hand whether or not I was for shock treatment, the new and fashionable means of quieting people and of making them realize that orders are to be obeyed and floors are to be polished without anyone protesting and faces are made to be fixed into smiles and weeping is a crime.

JANET FRAME (New Zealand electroshock survivor and writer), *Faces in the Water*, ch. 1, sect. 1, 1961. Frame was electroshocked more than 200 times over an eight-year period during her twenties. An acclaimed writer, Frame's autobiography was made into a 1990 film titled *An Angel at My Table*.

Late 1940s–early 1950s — Suddenly the inevitable cry or scream sounds from behind the closed doors which after a few minutes swing open and Molly or Goldie or Mrs. Gregg, convulsed and snorting, is wheeled out. I close my eyes tight as the bed passes me, yet I cannot escape seeing it, or the other beds where people are lying, perhaps heavily asleep, or whimperingly awake, their faces flushed, their eyes bloodshot. I can hear someone moaning and weeping; it is someone who has woken up in the wrong time and place, for I know that the treatment snatches these things from you, leaves you alone and blind in a nothingness of being, and you try to fumble your way like a newborn animal to the flowing of first comforts; then you wake, small and frightened, and tears keep falling in a grief that you cannot name.

JANET FRAME, *Faces in the Water*, ch. 1, sect. 1, 1961.

Late 1940s–early 1950s — I tried to forget my still-growing disquiet and dread and the haunting smell of the other ward, as I became to all appearances one of the gentle contented patients of Ward Seven, that the E.S.T. which happened three times a week, and the succession of screams heard as the machine advanced along the corridor, were a nightmare that one suffered for one's own "good." "For your own good" is a persuasive argument that will eventually make man agree to his own destruction.

JANET FRAME, *Faces in the Water*, ch. 2, sect. 1, 1961.

1950 — In April 1950, a “mute and autistic” 34½-month-old boy was administered 20 electric convulsions after being referred to the children’s ward of New York’s Bellevue Hospital. A month later he was discharged. The discharge note indicated “moderate improvement, since he was eating and sleeping better, was more friendly with the other children, and he was toilet trained” [editor’s summary].

LAURETTA BENDER (U.S. electroshock psychiatrist), “The Development of a Schizophrenic Child Treated with Electric Convulsions at Three Years of Age,” published in Gerald Caplan, ed., *Emotional Problems of Early Childhood*, 1955.

See Bender’s entry in 1947 above.

1950 — Some patients come to operation [lobotomy] at the end of a long and exasperating series of medical treatments, hospital treatments, shock treatments, including endocrines and vitamins mixed with their physiotherapy and psychotherapy. They are still desperate, and will go to any length to get rid of their distress. Other patients can’t be dragged into the hospital and have to be held down on a bed in a hotel room until sufficient shock treatment can be given to render them manageable.

WALTER FREEMAN and **JAMES W. WATTS** (U.S. psychosurgeons), *Psychosurgery in the Treatment of Mental Disorders and Intractable Pain*, 2nd ed., ch. 8, 1950. Pictured on the page facing the above excerpt is a naked, distraught woman in a standing position with a restraining belt around her waist struggling with 2 nurses; the complete caption reads, “Figure 44. Case 441. ‘Other patients have to be held...’” [ellipsis in original].

1950 — In 1950, [Yale psychologist Irving L.] Janis collected personal memories, from childhood to the present, from 30 people, 19 of whom later received ECT. Four weeks after ECT, all 19 suffered “profound, extensive recall failures” that “occurred so infrequently among the 11 patients in the control group as to be almost negligible.” Most of the gaps were for the period of 6 months before ECT, but in some cases the memory loss was for events more than 10 years previously. Surprisingly, retrograde amnesia was scarcely researched again until the 1970s [when] protests compelled ECT proponents to try and prove ECT is safe.

JOHN READ (New Zealand psychologist), “Electroconvulsive Therapy,” published in Read, Loren R. Mosher and Richard P. Bentall, eds., *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia*, 2004.

1950 — Within 2 weeks from the beginning of our intensive electric shock treatment the character of the ward [of 114 “psychotic women patients” at Stockton State Hospital in California] changed radically from that of a chronic disturbed ward to that of a quiet chronic ward. Combative behavior of the patients diminished dramatically. Physical labor of the attendants was cut in half. For example, individual tray service for 40 to 50 patients per meal was abolished. Soiling and smearing were also markedly reduced. Patients in general became better “ward citizens,” and in the words of one attendant “began to act like human beings.” There was a general heightening of the morale of both attendants and patients.

MERVYN SHOOR and **FREEMAN H. ADAMS** (U.S. electroshock psychiatrists), “The Intensive Electric Shock Therapy of Chronic Disturbed Psychotic Patients,” *American Journal of Psychiatry*, October 1950.

1951 — [On small hospital ships returning to the U.S. from the Pacific war zone during World War II] it was discovered that the usual electric shock therapy application, administered in the morning and afternoon of *two* successive days, worked nothing less than miracles in converting wildly disturbed patients into quiet, tractable, cooperative, and *often improved* individuals....

It was decided to try this intensive therapy at Willard [State Hospital in Willard, New York] — a modality which the employees concerned came to dub the “Blitz,” ultimately leading to the term “B.E.S.T.” (Blitz Electric Shock Therapy). The authors think time and results have justified this descriptive classification.

The first question was the matter of selection. In most research investigations two groups are chosen, one for control and one for experimentation. In the Willard case, one group could well stand for both, pre-treatment histories and recorded activities serving for control comparison. It was further decided to apply the traditional physiological concept of “all-or-none,” and 50 of the most disturbed female patients were selected.

JAMES A. BRUSSEL and **JACOB SCHNEIDER** (U.S. electroshock psychiatrists), “The B.E.S.T. in the Treatment and Control of Chronically Disturbed Mental Patients — A Preliminary Report,” *Psychiatric Quarterly*, vol. 1 (supplement), 1951. Early in World War II, the German Army developed *blitzkrieg* tactics, literally “lightning war.”

1951 — As in Victorian and ancient times, women in mid-twentieth-century America were liable to be seen as mentally disordered in the context of their reproductive functions (menstruation, childbirth, menopause), as well as their gender role “duties” as wives and mothers. Describing a married female patient who exhibited “marked improvement” after EST, Steinfeld and his colleagues commented that “the patient, for the first time since her marriage accepted her husband completely and did not reject his desire for impregnating her.”

TIMOTHY W. KNEELAND (U.S. political scientist) and **CAROL A. B. WARREN** (U.S. sociologist), *Pushbutton Psychiatry: A History of Electroshock in America*, ch. 3, 2002. The quoted material in the excerpt is from J. I. Steinfeld, *Therapeutic Studies on Psychotics*, 1951.

1951 — The CIA in 1951 apparently conducted human experiments using electroshock techniques despite warnings from an expert that they were “extremely painful and could reduce subjects to the vegetable level.”

The CIA carried out human-behavior and mind-control projects, including the use of unwitting subjects, from 1951 until they were ordered discontinued in 1973....

The documents included a Dec. 3, 1951, memo on the conversation a CIA officer had with a psychologist [*sic*] on the use of electroshock in interrogations and for other purposes.

Names were blacked out in copies of released material.

[The article concluded with a summary of the memo’s content.]

UNITED PRESS INTERNATIONAL, “CIA Once Tried Electroshock, Though It Created ‘Vegetables,’” *San Francisco Examiner*, 8 January 1979. The following excerpts are from a copy of an anonymous CIA agent’s memo cited in the article:

“Artichoke’ — [blacked out]....

2. “[Blacked out] is reported to be an authority on electric shock. He is a professor at the [blacked out] and, in addition, is a psychiatrist of considerable note. [Blacked out] is, in addition, a fully cleared Agency consultant.

3. “[Blacked out] explained that he felt that electric shock might be of considerable interest to the ‘artichoke’ type of work. He stated that the standard electric-shock machine (Reiter) could be used in two ways. One setting of this machine produced the normal electric-shock treatment (including convulsion) with amnesia after a number of treatments. He stated that using this machine as an electro-shock device with the convulsive treatment, he felt that he could guarantee amnesia for certain periods of time and particularly he could guarantee amnesia for any knowledge of use of the convulsive shock.

4. “[Blacked out] stated that the other or lower setting of the machine produced a different type of shock. He said he could not explain it, but knew that when this lower current type of shock was applied without convulsion, it had the effect of making a man talk. He said, however, that the use of this type of shock was prohibited because it produced in the individual excruciating pain and he stated that there would be no question in his mind that the individual would be quite willing to give information if threatened with the use of this machine. He stated that this was a third-degree method but, undoubtedly, would be effective. [Blacked out] stated that he had never had the device applied to himself, but had talked with people who had been shocked in this manner and stated that they complained that their whole head was on fire and it was much too painful a treatment for any medical practice. He stated that the only way it was ever used was in connection with sedatives and even then its use was extremely painful. The writer asked [blacked out] whether or not in the ‘groggy’ condition following the convulsion by the electric-shock machine anyone had attempted to obtain hypnotic control over the patient, since it occurred to the writer that it would be a good time to attempt to obtain hypnotic control. [Blacked out] stated that, to his knowledge, it had never been done, but he could make this attempt in the near future at the [blacked out] and he would see whether or not this could be done.

5. “[Blacked out] and [blacked out], as well as all others present, discussed the use of electro shock at considerable length and it was [blacked out] opinion that an individual could gradually be reduced through the use of electro-shock treatment to the vegetable level. He stated that, whereas amnesia could be guaranteed relative [to] the actual use of the shock and the time element surrounding it, he said it would obtain imperfect amnesia for periods further back. He stated several instances in which people who had been given the electro-shock treatment remembered some details of certain things and complete blanks in other ways.

6. “... [Blacked out] said that the standard electro-shock machine is a very common machine in medical offices and in the major cities there must be several hundred of them in use at all times....”

See D. Ewen Cameron’s entry in 1957 below.

1952 — Daniel Bovet (Swiss-born Italian pharmacologist) introduced succinylcholine (Anectine) as a muscle relaxant to prevent fractures and other bone injuries during the administration of electroshock. The new drug was a synthetic version of curare which had been used for the same purpose on a small minority of ECT patients since 1940. Deaths believed to have been caused by curare discouraged its broader use.

1952 — In my short experience with this patient, she has been a chronic disturbed, unmanageable patient on Unit 5 of Cottage E. I have attempted to give her daily shock in order to quiet her down and make her more manageable and less of a ward problem. After about 8 shock treatments in 10 days, patient continues the same as before. She obviously is in need of lobotomy.

ANONYMOUS (U.S. electroshock psychiatrist), “continuous notes,” Stockton State Hospital (California), case 59533, 27 February 1952, quoted in Joel Braslow (U.S. psychiatrist), *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century*, ch. 6, 1997.

1952 — An ancillary, nevertheless very helpful, role can be played by ECT in the treatment of narcotic addiction. It is highly to be recommended as a tool for the management of the withdrawal period. The so-called “annihilating” form of treatment should be used and we have found two to three treatments administered daily for a period of up to seven days to be of greatest help in overcoming the host of withdrawal symptoms.

ALFRED GALLINEK (U.S. electroshock psychiatrist), “Controversial Indications for Electric Shock Therapy,” *Confinia Neurologica*, vol. 12, 1952.

1952 — Price and Knouss describe three different types of music which should be played during the three stages of preparing the patient for the treatment [ECT], for his return to consciousness and for the rest period after the treatment. We are not opposed to such efforts, but the most important requirement is to avoid observation of the treatment by patients who are not only frightened themselves but through their reports contribute to the opposition against the treatment by others.

LOTHAR B. KALINOWSKY (German-born U.S. electroshock psychiatrist) and **PAUL H. HOCH** (Hungarian-born U.S. electroshock psychiatrist), *Shock Treatments, Psychosurgery and Other Somatic Treatments in Psychiatry*, 2nd ed., ch. 3, sect. B.9, 1952 (1946).

1952 — After several [electroconvulsive] treatments, when the patient is much better, he develops an increasing fear for which he is unable to account. This late and quite intense fear is not explained by any discomfort from the treatment, nor by the psychotic fears which have usually disappeared, at least temporarily, by this time.... “The agonizing experience of the shattered self” (Schildge) is the most convincing explanation for the late fear of the treatment.

LOTHAR B. KALINOWSKY and **PAUL H. HOCH**, *Shock Treatments, Psychosurgery and Other Somatic Treatments in Psychiatry*, 2nd ed., ch. 3, sect. B.11, 1952 (1946).

1952 — An unpleasant experience in ECT is the postconvulsive excitement immediately following the convulsion, which may last from a few minutes to one-half hour. Some patients, particularly males, become dangerously assaultive, develop enormous strength, try to escape, run around, and injure themselves, and may strike anyone who attempts to control them.

LOTHAR B. KALINOWSKY and **PAUL H. HOCH**, *Shock Treatments, Psychosurgery and Other Somatic Treatments in Psychiatry*, 2nd ed., ch. 3, sect. B.11, 1952 (1946).

1952 — All patients who remain unimproved after ECT are inclined to complain bitterly of their memory difficulties.

LOTHAR B. KALINOWSKY and **PAUL H. HOCH**, *Shock Treatments, Psychosurgery and Other Somatic Treatments in Psychiatry*, 2nd ed., ch. 3, sect. B.13, 1952 (1946). Compare: “Losses in intelligence, memory, and other measurable abilities [after lobotomy] are due to the psychosis, not to lobotomy” (**WALTER FREEMAN** [U.S. neurologist and psychosurgeon], “West Virginia Lobotomy Project: A Sequel.” *Journal of the American Medical Association*, 29 September 1962).

1952 — Physicians who treat their patients to the point of complete disorientation are highly satisfied with the value of ECT in schizophrenia. Such “confusional treatment” always uses intense therapy.

LOTHAR B. KALINOWSKY and **PAUL H. HOCH**, *Shock Treatments, Psychosurgery and Other Somatic Treatments in Psychiatry*, 2nd ed., ch. 3, sect. B.19, 1952 (1946).

1952 — At present, we can say only that we are treating empirically disorders whose etiology is unknown, with methods such as shock treatments whose action is also shrouded in mystery.

LOTHAR B. KALINOWSKY and **PAUL H. HOCH**, closing sentence, *Shock Treatments, Psychosurgery and Other Somatic Treatments in Psychiatry*, 2nd ed., 1952 (1946). Kalinowsky attributed this observation, well-known among electroshock psychiatrists, to Hoch (interview, *Psychiatric News*, 5 May 1978).

1952 — What counts alone with most shock therapists is the “adjustment” their fearful apparatus and its brain-searing explosion produces. In effect, there is little difference between the white-coated psychiatric shock specialist and his primitive forebear, the mud-daubed witch doctor, who also treated diseases of the mind by scaring out, shaking out, routing out, and exorcising by dire agony and inhuman ordeal the demons or devils — today disguised by scientific-sounding names — which they believed cause patients to behave in such deplorable, tactless, or irritating ways. In the name of this adjustment, and in order to bring about the desired quiet and submissiveness, the patient is put through a crucifixion of such torment as one would wish to spare the lowliest animal.

ROBERT LINDNER (U.S. psychoanalyst), *Prescription for Rebellion*, ch. 2, 1952.

1952 — Something has... happened to the patient: he has been pulverized into submission, thrashed and smashed into adjustment, granulized into cowed domesticity. If he can now meet the criteria of the “shockiatrist” who has attended him — if he can be

polite, keep himself tidy, respond with heartiness to his physician's cheery morning greeting, refrain from annoying people with his complaining and, above all, make no noise, everything will be well. If not — Quick, nurse, the little black box!

ROBERT LINDNER, *Prescription for Rebellion*, ch. 2, 1952.

1953 — I hope in due course to publish studies showing that the schizophrenic patient may be as dependent on ECT for a normal existence as a diabetic is on insulin.

HAROLD BOURNE (British electroshock psychiatrist), "The Insulin Myth," *Lancet*, 7 November 1953.

1953 — [The series of electroshock left her with] slight but noticeable personality changes.... She was not the same girl that I had fallen in love with [ellipsis in original].

LAWRENCE OLIVIER (British actor), referring to his former wife actress Vivien Leigh who had undergone ECT in 1953, quoted in "Health: Electric Shock Treatment," *Sunday Times* (London), 9 December 2001.

See William Arnold's entry on Frances Farmer in 1944 and Gerald Clarke's on Judy Garland in 1949 above; and Gene Tierney's entry in 1955 and Robert J. Grimm's in 1976 below.

1953 — Doctor Gordon [a pseudonym] was unlocking the closet. He dragged out a table on wheels with a machine on it and rolled it behind the head of the bed. The nurse started swabbing my temples with a smelly grease....

"Don't worry," the nurse grinned down at me. "Their first time everybody's scared to death."

I tried to smile, but my skin had gone stiff, like parchment.

Doctor Gordon was fitting two metal plates on either side of my head. He buckled them into place with a strap that dented my forehead, and gave me a wire to bite.

I shut my eyes.

There was a brief silence, like an indrawn breath.

Then something bent down, and took hold of me and shook me like the end of the world. Whee-ee-ee-ee-ee, it shrilled, through an air crackling with blue light, and with each flash a great jolt drubbed me till I thought my bones would break and the sap fly out of me like a split plant.

I wondered what terrible thing it was that I had done.

SYLVIA PLATH (U.S. electroshock survivor, writer, and poet), describing ECT as she experienced it in 1953, *The Bell Jar*, ch. 12, 1971.

See Plath's entries in 1960 and 1963 below.

1953 — D. H. White female, age 31, was admitted to the hospital April 27, 1953.... [After undergoing a series of 11 electroshocks, she was discharged "in good social remission."] As she still had a few psychotic residuals, it was arranged for her to return for out-patient treatments. She returned four days after the last hospital treatment and the decision was made to change the technique to the Reiter [ECT machine] and use Atropine, Anectine, and Sodium Pentothal. Patient was given treatment at 9:40 A.M. She apparently never took another breath nor was anyone sure that another heartbeat was felt or heard. She was pronounced dead at 10:40.

G. WILSE ROBINSON JR., and **JOHN D. DeMOTT** (U.S. electroshock psychiatrists), "How Important Is Liver Damage in the Use of Anectine Controlled Electroshock?" *Confinia Neurologica*, vol. 4, 1954.

1953 — During the past eleven years, in our work with electroshock therapy (EST) at Bellevue Psychiatric Hospital [New York City] and elsewhere, we have on numerous occasions observed that acutely disturbed patients become quiet and cooperative after a few shock treatments. In view of these observations, we decided to administer EST as a “sedative” to selected patients on the disturbed wards of Bellevue Hospital. The patients chosen for treatment were those who were grossly uncooperative, assaultive or refused food.... The treatment schedule followed was to administer one treatment in the morning and one in the afternoon until the patient became cooperative, and then to control him with one or two treatments daily if he relapsed.

LEWIS I. SHARP, ANTHONY R. GABRIEL (U.S. electroshock psychiatrists), and **DAVID J. IMPASTATO** (Italian-born U.S. electroshock psychiatrist), “Management of the Acutely Disturbed Patient by Sedative Electroshock Therapy,” *Diseases of the Nervous System*, January 1953.

1954 — Shock therapy never builds. It only destroys, and its work of destruction is beyond control. It is not new. The only new thing about it is the method of delivering the shock. A hundred and fifty years ago a well-recognized shock-treatment method was to flog or frighten the patient, and in some instances the results were excellent. Now we “do it electrically,” and we get about the same percentage of good results, but with some breaking of bones, and memory losses which frightening and flogging never produced.

Memory losses in modern shock therapy may be passed off as infrequent, limited, and temporary, but they are really frequent, they cannot be limited, and they are usually permanent. I have heard doctors laugh about them as they laugh about other things in mental patients, but the losses are serious to the patients themselves. And along with such losses go changes in general intelligence and personality, but when these changes are too obvious to be overlooked they are ascribed to the mental illness with no mention at all of the treatment.

JOHN MAURICE GRIMES (U.S. psychiatrist), *When Minds Go Wrong*, 2nd ed., ch. 20, 1954 (1951).

1954? — Although [the electric shock treatments] benefited schizophrenics infinitely more than psychotherapy or other environmental treatment, they had their disadvantages. In our unit at St. Thomas’s [a general hospital in London], for instance, patients might become so excited and upset in the early stages of treatment that we could not continue it under general hospital conditions, and had to send one out of every three on to mental hospitals. Largactil [the British brand name for the neuroleptic drug marketed as Thorazine in the United States], this French discovery, now allowed us to keep even the worst cases under sedation while electric shock and other treatments were being given.

WILLIAM SARGANT (British electroshock psychiatrist, 1907-1988), *The Unquiet Mind: The Autobiography of a Physician in Psychological Medicine*, ch. 21, 1967. Sargant was for many years Britain’s leading proponent of psychiatry’s physical treatments — psychosurgery, shock, and drugs. In an essay published in *The Times of London*, he wrote, “Conscience can now be eliminated surgically without any impairment of day-to-day working efficiency” (“The Movement in Psychiatry Away from

the Philosophical: New Chemical and Physical Methods of Freeing Tormented Minds,” 22 August 1974).

1946-1954 — When brain cells are killed, they’re dead forever, unlike skin cells that regenerate or nail and hair cells that continue growing posthumously.

At the Woman’s Medical College of Pennsylvania (1946-1950), one of my pathology professors told our class that ECT kills brain cells. Yet, early in my psychiatric residency at Kingsbridge Veterans Administration Hospital in the Bronx (1951-1954), I discovered that every resident was required to spend three months on its locked shock wards and that this meant I would have to participate directly in shocking some of the patients. With all my heart and whatever ingenuity I could muster, I pleaded to get out of this mandatory service. I knew deep in my innards that I’d never push the button that would run electricity through someone’s brain causing who knows how much brain-cell death. One morning in desperation, I hit upon the idea of an alternative to the shock wards: I would set up and conduct a research project! Later that day, I presented my idea to the chief of the neuropsychiatric service and — he agreed! I would not have to shock a single person!

The research involved interviewing insulin shock patients at the hospital, which had an insulin ward in addition to its ECT ward. My interviews resulted in an article titled “The Death Experience in Insulin Coma Treatment” that was published in the *American Journal of Psychiatry* (June 1956).

Another assignment I created for myself to avoid the electrocutions was conducting group therapy sessions for ECT patients. My most vivid memory from that experience was how furious these patients were at their doctors, other staff members, their families, or anyone they thought was responsible for their being shocked. It was only in these sessions that they could safely vent their rage. How they raged and raged! The title of a chapter from my book *Beyond the Couch* (1972) sums up the attitude I developed during my psychiatric training: “Medical Sadism: Shock and Electricity, Ice Pick and Lobotomy.”

If not in our era, in the future, people everywhere will look with as much horror on our lobotomies, our insulin comas and electric shocks, and our other methods of damaging the brain as we now look upon the cruelties — chains, purgatives, spinning chairs, wet packs, and the like — visited upon asylum inmates in an earlier age.

EILEEN WALKENSTEIN (U.S. psychiatrist), personal communication, 20 December 2005.

1955 — [The psychiatrist] is now ridiculed because of his propensity to treat certain of his patients with a gadget — an electroshock machine! He is now referred to as an “electrician” and a “push button practitioner” and other opprobrious and less printable terms.

GILBERT ADAMSON (Canadian electroshock psychiatrist), “Electroshock,” *Manitoba Medical Review*, 1955, quoted in Timothy W. Kneeland and Carol A. B. Warren, *Pushbutton Psychiatry: A History of Electroshock in America*, ch. 3 (epigraph), 2002.

1955 — There were 4 deaths among 112 patients who underwent electroshock at Boston State Hospital. “J. W., aged 72, is the only patient who died as an immediate result of

EST. Eight minutes after his 51st treatment he suddenly stopped breathing” [editor’s summary].

RUTH EHRENBERG and **MILES J. O. GULLILNGSRUD** (U.S. electroshock psychiatrists), “Electroconvulsive Therapy in Elderly Patients,” *American Journal of Psychiatry*, April 1955.

1955 — Over the next eight months I underwent nineteen more electric shock treatments, a grand total, I think, of thirty-two. Pieces of my life just disappeared. A mental patient once said it must have been [like] what Eve felt, having been created full grown out of somebody’s rib, born without a history. That is exactly how I felt.

GENE TIERNEY (U.S. electroshock survivor and actor), *Self-Portrait: Gene Tierney*, ch. 17, 1979. Tierney underwent ECT at the Institute for Living (also known as the Hartford Retreat) in Hartford, Connecticut in 1955.

See William Arnold’s entry on Frances Farmer in 1944, Gerald Clarke’s on Judy Garland in 1949, and Lawrence Olivier’s on Vivien Leigh in 1953 above.

1955 — The omnipotent attitude at its most blatant takes the form of a need to have the power of life and death over one’s subjects. With electroconvulsive treatment all the appearances of producing a death-dealing blow, followed by “rebirth,” is there.

The need to cure quickly, magically, ritualistically can be seen often in an intense “therapeutic ambitiousness.” Slow methods, devoid of special effects and allure, may be hard to tolerate. This zeal can cause an inability to tolerate plateaus or regressions in the patient’s condition with a consequent generation of anxiety and anger in the physician. He may react unconsciously with retaliatory punishment of the wayward or disappointing child. Electroconvulsive treatment could then become the convenient instrument to vent one’s wrath.

GEORGE J. WAYNE (U.S. electroshock psychiatrist), “Some Unconscious Determinants in Physicians Motivating the Use of Particular Treatment Methods — With Special Reference to Electroconvulsive Treatment,” *Psychoanalytic Review* (“The oldest continuously published psychoanalytic journal in the world”), January 1955.

1956 — One of us (J. A. E.) has collected these statements over a period of eight years in Britain and the United States. Most of them have been heard on many occasions. Colleagues who have seen the list of comments have confirmed our findings that many affect-laden colloquialisms are regularly used by shock therapists in referring to their therapy....

1. “Let’s give him the works.”
2. “Hit him with all we’ve got.”
3. “Why don’t you throw the book at him?”
4. “Knock him out with EST.”
5. “Let’s see if a few shocks will knock him out of it.”
6. “Why don’t you put him on the assembly line?”
7. “If he would not get better with one course, give him a double-sized course now.”
8. “The patient was noisy and resistive so I put him on intensive EST three times a day.”
9. One shock therapist told the husband of a woman who was about to be shocked that it would prove beneficial to her by virtue of its effect as “a mental spanking.”

10. "I'm going to gas him."
11. "Why don't you give him the gas?"
12. "I spend my entire mornings looking after the insulin therapy patients."
13. "I take my insulin therapy patients to the doors of death, and when they are knocking on the doors, I snatch them back."
14. "She's too nice a patient for us to give her EST."

DAVID WILFRED ABSE and **JOHN A. EWING** (British-born U.S. psychiatrists), "Transference and Countertransference in Somatic Therapies," *Journal of Nervous and Mental Disease*, January 1956.

1956 — The [ECT] case fatality rate is apt to increase as a higher proportion of poor-risk patients are treated. Failure to accept and make known this risk in treatment has unfortunately given rise to the impression that the treatment is practically devoid of such hazard; this in turn has led willy-nilly to the erroneous assumption that death associated with the treatment must in some manner be the fault of the psychiatrist giving the treatment or the institution involved or both. It is our plea that deaths in electroconvulsive and related forms of treatment be reported. It is only in this way that the actual case fatality rate can be established. This is, among other things, an important factor in the assessment of the relative merits of the several modifications of electroconvulsive therapy. In contrast to the American practice in which deaths associated with electrotherapy are reported only sporadically, if at all, the rule in England and Wales is that all unusual or unexpected deaths, including those in electrotherapy and other somatic treatments (such as leukotomy, insulin, and continuous narcosis) that occur in psychiatric hospitals, come within the purview of the board of control of the Ministry of Health. This procedure, according to the Hon. S. W. Maclay, medical commissioner of the board of control, gives "an overall picture difficult to achieve in any other way."

SAUNDERS P. ALEXANDER (Polish-born U.S. electroshock psychiatrist) and **LAWRENCE H. GAHAGAN** (U.S. electroshock psychiatrist), "Deaths Following Electrotherapy," *Journal of the American Medical Association*, 16 June 1956.

1956 — Attention must be called to the habit formed by certain psychiatrists [during the Algerian War] of flying to the aid of the police. There are, for instance, psychiatrists in Algiers, known to numerous prisoners, who have given electric shock treatments to the accused and have questioned them during the waking phase, which is characterized by a certain confusion, a relaxation of resistance, a disappearance of the person's defenses. When by chance these are liberated because the doctor, despite this barbarous treatment, was able to obtain no information, what is brought to us is a personality in shreds.

FRANTZ FANON (French West Indian psychiatrist), *A Dying Colonialism*, ch. 4, 1959, tr. Haskin Chevalier, 1965. Fanon, an anti-colonialist, headed the psychiatric department of a hospital near Algiers for several years during the Algerian War before resigning his post and fleeing the country in 1956.

1956 — Sir: Being in contact with many psychiatrists who give electric convulsive therapy, I am greatly alarmed by personal communications on fatalities which remain unpublished because of understandable fear of lawsuits....

Much more serious [than the risk of death from the use of muscle relaxants in combination with intravenous barbiturates] is the sharp rise of fatalities in patients who are under chlorpromazine [Thorazine] and reserpine [Serpasil] medication while given ECT. I received detailed reports on several such fatalities. One case each of death from ECT during chlorpromazine and reserpine medication. A man, age 55, suffering from a depression, had a blood pressure of 145/90 and a normal EKG. He took a first tablet of 50 mg. of Thorazine the evening before the first ECT and a second tablet of 50 mg. of Thorazine the morning of the treatment. After the convulsion he resumed normal respiration but expired a minute later. No autopsy.

LOTHAR B. KALINOWSKY (German-born U.S. electroshock psychiatrist), letter to *American Journal of Psychiatry*, March 1956.

1956 — In the amnesia caused by all electric shocks, the level of the whole intellect is lowered....

The stronger the amnesia, the more severe the underlying brain cell damage must be.

To complete the clinical picture, it should be mentioned that the “slap-happiness” or “punch-drunkenness” combined with [emotional] flatness, witnessed after too many “therapeutic” electroshocks remind one of the clinical pictures in cases of frontal lobe tumors, in the small group of paretics, or again in lobotomies [lobotomized persons]....

The aggravation set up by [ECT-caused “side effects, such as amnesia, temporary befuddlement or euphoria”] may result in a secondary reactive depression, which in some cases has led to suicide.

MANFRED SAKEL (Austrian-born U.S. psychiatrist who, in 1933, introduced insulin coma treatment as a treatment for schizophrenia, 1900-1957), commenting on ECT (a competing shock method), “Sakel Shock Treatment,” published in Arthur M. Sackler et al., eds., *The Great Physiological Therapies in Psychiatry: An Historical Perspective*, 1956.

See Sidney Sament’s entry in 1983 and Peter Sterling’s in 2001 below.

1948-1956 — [After experiencing ECT, patients] “tremble,” “sweat profusely,” and make “impassioned verbal pleas for help,” reported Harvard University’s Thelma Alper [1948]. Electroshock, patients told their doctors, was “like having a bomb fall on you,” “being in a fire and getting all burned up,” and “getting a crack in the puss” [1953].

Researchers reported that the mentally ill regularly viewed the treatment as a “punishment” and the doctors who administered it as “cruel and heartless” [1956].

ROBERT WHITAKER (U.S. writer), *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*, ch. 4, 2002.

1957 — We reported to the 2nd World Congress of Psychiatry in 1957 on the use of depatterning in the treatment of paranoid schizophrenic patients. By “depatterning” is meant the extensive breakup of the existing patterns of behavior, both normal and pathologic, by means of intensive electroshock therapy usually carried out in association with prolonged sleep. We have recently extended this method of treatment to other types of schizophrenia, to intractable alcoholic addiction and to some cases of chronic psychoneurosis impervious to psychotherapy....

[During the third stage of depatterning the patient’s] 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.

D. EWEN CAMERON (Scottish-born Canadian electroshock psychiatrist and onetime president of the American Psychiatric Association, the Canadian Psychiatric Association, the World Psychiatric Association, the Quebec Psychiatric Association, the American Psychopathological Association, and the Society of Biological Psychiatry), describing “depatterning treatment” which he developed during the 1950s at the Allan Memorial Institute (now closed) of McGill University in Montreal, “Production of Differential Amnesia as a Factor in the Treatment of Schizophrenia,” *Comprehensive Psychiatry*, February 1960. Cameron “found [his treatment for schizophrenia] to be more successful than any hitherto reported.” Along with the antipsychotic drug Thorazine (chlorpromazine) and prolonged sleep lasting 30 to 60 days, Cameron used the Page-Russell method of ECT administration in twice-daily sessions. Each session consisted of six 150-volt, closely-spaced electroshocks of one-second each. The third stage of depatterning occurred after 30-40 such sessions, between 180 and 240 electroshocks in all. This stage was followed by a “period of reorganization,” during which Cameron applied his “psychic driving” technique. According to writer **JOHN MARKS** (*The Search for the “Manchurian Candidate”: The CIA and Mind Control*, ch. 8, 1980), psychic driving entailed bombarding subjects with tape-recorded, emotionally loaded messages repeated 16 hours a day through speakers installed under the subjects’ pillows in “sleep rooms.” Several weeks of negative messages, intended to wipe out unwanted behavior, were followed by two to five weeks of positive messages, to induce the desired behavior. Cameron established the effect of the negative tapes by “running wires to [the subjects’] legs and shocking them at the end of the message.” Marks concluded, “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.” In 1978, previously secret documents revealed that the CIA partially funded Cameron’s brainwashing experiments as part of its MK-ULTRA (Mind Control) Project. The Canadian government was the chief funder of these experiments. Cameron was esteemed by colleagues and neighbors alike according to this tribute to him in 1967: “He had a deep love of wife and family, a pervasive humor, an innate sense of fairness, plus a deep resentment of political maneuvering. Listen to what his neighbors said of him in an editorial after his death:... ‘His world-wide success in his profession was, of course, due principally to his great knowledge and brilliance. But surely a great factor also was the softness — one is tempted to say loveliness — of his personality. Those who were privileged to know him, even briefly, will not soon forget the warmth and the kindness of this understanding man’” (**FRANCIS J. BRACELAND** [U.S. psychiatrist and onetime president of the American Psychiatric Association], “In Memoriam: D. Ewen Cameron, 1901-1967,” *American Journal of Psychiatry*, December 1967). See Gordon Thomas’s entry in 1946 and United Press International’s in 1951 above; and Cameron’s and Linda Macdonald’s entries in 1963 and Michael Perry’s entry in 1963-1979 below.

1957 — This report is based on the study of 214 electroshock fatalities reported in the literature and 40 fatalities heretofore unpublished, made available through the kindness of the members of the Eastern Psychiatric Research Association.

The death rate in electroshock therapy has been estimated to be approximately one in one thousand patients [of all ages] treated.... The death rate is approximately one in 200 patients, or 0.5 percent, in patients over 60 years of age....

[Of the 254 electroshock fatalities under review in this study], one hundred patients died from cardiovascular causes; 66 patients from cerebral, 43 patients from respiratory; and 26 patients from other causes. In 19 patients the cause of death was not stated.

DAVID J. IMPASTATO (Italian-born U.S. electroshock psychiatrist), “Prevention of Fatalities in Electroshock Therapy,” *Diseases of the Nervous System*, July 1957. Impastato’s 42-page article is the most comprehensive and detailed study of ECT deaths published in the professional literature. Contemporary electroshock psychiatrists and their supporters rarely, if ever, cite this article in their writings. Three-hundred and eighty-four deaths, including the 254 deaths reported in the Impastato study, were documented in Leonard Roy Frank’s *History of Shock Treatment*. The death reports were drawn from 109 English-language sources published between 1943 and 1977. The fully-cited sources are listed chronologically, with each entry specifying the number of deaths reported and, in some instances, other details (“ECT Death Chronology,” 1978). See Dennis Cauchon’s first entry (referring to the estimate of 1 death in 200 ECT patients over 60 years of age) in 1995 below. See also (referring to the 66 ECT deaths from “cerebral” causes) American Psychiatric Association’s first entry in 1990 and Peter Sterling’s entry in 2001 below.

1957 — The Eastern Psychiatric Research Association has recently debated the question whether the patient should be apprised of the [electroshock] treatment he is about to receive. Opinions were about equally divided. I feel that the patient should not be informed. Knowledge that he is going to receive the treatment could not possibly do the patient any good; on the contrary, it may do him irreparable harm. Most patients associate EST with severe insanity and if it is suggested, they will refuse it claiming that they are not insane and do not need the treatment. If these patients are left without treatment 10 percent (depressions) will commit suicide. Other patients may be fearful of the treatments due to information gathered in reading about it or from friends. These also will refuse to have the treatment. Still others will refuse it because they associate the treatment with ordinary shock or electric current and fear that they might be electrocuted. If these patients are forced to undertake the treatment, they may develop such fear anxiety as to lead to possible suicide. Upon consideration of the fact that it is the knowledge rather than the ignorance that he is going to receive EST that may lead to suicide, I recommended that patients be kept in ignorance of the planned treatment. Of course, the closest relative should know and sign consent for the treatment.

DAVID J. IMPASTATO, “Prevention of Fatalities in Electroshock Therapy,” *Diseases of the Nervous System*, July 1957.

1957 — While some therapists exceed the limits of ordinary prudence by overmedication with potent pharmacologic agents, a few seem to have an attraction for the shock machine itself with the result that the patient is exposed to what may be called an iatrogenic [doctor-caused] status epilepticus. An example: “After intravenous injection of 2.cc. of curare, the machine was set at 70 volts for .4 sec. and a stimulus administered. Immediately after the initial convulsion, the stimulus was repeated. This was done four times.” The patient, a 54 yr. old male, died after the fifth procedure....

Use of relaxant drugs unquestionably increases the risk of a fatal accident. In weighing the relative merits of shock therapy with or without relaxants, the therapist might well ask himself the question: How many vertebral compressions would he be willing to trade for one fatality traceable to a relaxant drug? On the subject of risks associated with cardio-vascular disease, it appears that if a patient can tolerate ECT combined with a barbiturate-relaxant cocktail, he can take it straight as well. A certain irreducible minimum of cardiac deaths will occur under any circumstances because the existing clinical and laboratory methods cannot predict accurately an impending coronary accident.

J. M. RADZINSKY (U.S. electroshock psychiatrist), "Electroshock Therapy without Muscle Relaxants," *Diseases of the Nervous System*, November 1957.

1958 — N. P. Lancaster and associates introduced unilateral ECT in the belief that it was safer and caused fewer memory problems than bilateral ECT, the standard method of administration. In bilateral ECT, the electrodes are placed on the patient's temples so that the current passes through the brain's frontal lobe area. In unilateral ECT one electrode is placed on a temple and the other just above the back of the neck on the same side of the head so that the current passes through only one, usually the nondominant, hemisphere of the brain. The advantages and disadvantages of both methods are still being disputed. Those psychiatrists favoring bilateral ECT seem to have won out, although some ECT psychiatrists use both methods. An estimated 70 to 80 percent of ECT today is administered bilaterally. **ARTHUR N. GABRIEL**, a proponent of bilateral ECT, wrote, "We have found that unilateral placement requires more treatments in the long run because we find it clinically less effective. We choose to spare the patient the additional anesthetic risk of more frequent treatments ("ECT as the Treatment of Choice," *World Medical News Review*, November 1974). Another ECT specialist, **HERVEY MILTON CLECKLEY**, said, "My thought about unilateral stimulation is that it fails to cure. I think this failure to cure is in direct proportion to the avoidance of memory loss" (quoted in Corbett H. Thigpen, letter to *Convulsive Therapy Bulletin*, October 1976).

1958 — Psychoanalysis is not alone in making use of regression in order to favor a new development. It was recommended by Jesus to Nicodemus, who was astounded by the recommendation that he be born again and really grow up. The same idea appears in other (especially Oriental) religions. In a technical sense hypnosis and the insulin therapy routine depend upon this device. (Footnote: Patients awakening from electroshock therapy frequently describe themselves as having been reborn.) Indeed, it occurs to some degree in all hospitalization, whether for psychiatric illnesses or for medical and surgical illnesses, and in anesthesia, shock therapies, insulin treatment, etc. (Footnote: The recent reports by scientific observers of various indoctrination programs by communist governments suggest that [this] important psychological principle has been employed in the induction of cognitive changes that vary in extent and duration.) **KARL A. MENNINGER** (U.S. psychiatrist and "dean of American psychiatry," 1893-1990), *Theory of Psychoanalytic Technique*, ch. 3, 1958. Psychiatrist **FRANCIS J. RIGNEY JR.** (of San Francisco) told the editor in 1975 that while he was training at the Menninger Clinic during the early 1950s the insulin ward was closed because insulin

patients were “dying off like flies.” No explanation for the ward’s closing appeared in the *Bulletin of the Menninger Clinic*, a respected and widely read psychiatric journal.

1958 — At work one day in August, [Deputy Director for Plans Frank Wisner, the Central Intelligence Agency’s third highest ranking official] broke down completely. An ambulance was called, and Wisner was subdued by hospital attendants and carried out of L Building by force, while DDP officials watched in shocked silence. Even then Wisner insisted there was nothing wrong with him — he did not need medical attention, a little rest would do the trick — but finally Desmond FitzGerald [his friend and a top DDP official] persuaded him that this was more than ordinary overwork, and Wisner consented to treatment in Shepherd Pratt hospital near Baltimore. The late 1950s were the great age of electroshock therapy, and Wisner’s six months at Shepherd Pratt were an ordeal. He never talked about it to his old CIA colleagues except once, when he said to FitzGerald: “Des, if knew what you’d done to me, you could never live with yourself.” **THOMAS POWERS** (U.S. writer), *The Man Who Kept the Secrets: Richard Helms and the CIA*, ch. 5, 1981. After being released from Shepherd Pratt in 1958, Wisner returned to the CIA, and a less important assignment, as chief of station in London, finally leaving the Agency in 1961. He committed suicide in 1965 at the age of 55.

1959 — This is the Psycho, the
home of the buzz and the prod,
Where the electric shock patients
speak only to the insulins
The insulins only to God.

ANONYMOUS (U.S. psychiatric patient), complete untitled poem, reprinted from a mental hospital newspaper in Max Rinkel and Harold E. Himwich, eds., *Insulin Treatment in Psychiatry*, ch. 10 (discussion), 1959.

1959 — To an attack like that in the electric convulsive treatment, the brain reacts with a defensive mechanism by producing some substance which I call acroagonine. (Acros in Greek means extreme; agon: struggle.) This acroagonine denotes a substance of extreme defense in struggle.

How did I prove the existence of this substance? I obtained a suspension of pigs’ brains which had been submitted to electric convulsive treatment and I injected 1 cc. of a suspension of this substance in mental patients in a series of 10 to 15. I observed that these patients first regained their normal sleep patterns, lost their anxiety and their feeling of guilt, and gradually, after 10 to 20 days, recovered. This treatment was called electric shock by proxy. Experiments on 300 patients have given positive results while the control patients injected with a suspension of cerebral substances of non-treated pigs did not show any improvement.

UGO CERLETTI (Italian electroshock psychiatrist), “An Address,” *Journal of Neuropsychiatry*, September-October 1959.

See Leonard Frank’s entry in 1938 above; and Ferruccio di Cori’s in 1963 below.

1959 — Once again I was on the human assembly line: electric shock clubbed my good brain into needless unconsciousness (and I walked to my several executions like a brave

little chappie instead of questioning them) and unquestioned Old Testament authority ruled our little club.

SEYMOUR KRIM (U.S. electroshock survivor and writer), “The Insanity Bit” (sect. 1), 1959, *Views of a Nearsighted Cannoneer*, 1968.

1959 — John C. Krantz Jr. introduced Indoklon, a convulsogenic drug, administered by inhalation or injection, to treat mental illness. Two years later, researchers (including Krantz) conducted a comparative study involving 90 patients treated with Indoklon and another 90 treated with ECT. They found that “the complications observed in both groups... seem to be about the same, except for the fact that there were three deaths in the ECT group” [editor’s summary].

ALBERT A. KURLAND, T. E. HANLON (U.S. electroshock psychiatrists) et al., “A Comparative Study of Hexafluorodiethyl Ether (Indoklon) and Electroconvulsive Therapy,” *Journal of Nervous and Mental Disease*, July 1959.

1959 — I would like to add to the testimony about the harm of electric shock. I got part of my medical records, so I know for a fact that I received about 18 shock treatments. I believe that I [may have] received about twice that many in 1959.

I can’t really testify too much to the terrors, the horrors, of shock treatment, that some of the people have mentioned here today, because frankly I can’t remember them. But it’s only been 23 years, and so I am still holding out with the faith that my memory will indeed return, as the psychiatrists assured my family it would. The psychiatrists at that time also assured my family, who were reluctant to let me have shock treatment, that the things they had heard about shock treatment, they could just forget, because shock treatment was now a much more thoroughly understood procedure. It was now much different from the things that they might have read or heard about. It was the new, improved shock treatment....

I have almost a total memory loss about my entire childhood. I was 16 years of age when I received shock treatment. I have very little memory of the two or three years following the shock treatment.

GREG REISNER (U.S. electroshock survivor), testimony at a hearing on electroshock conducted by the Berkeley Human Relations and Welfare Commission, 24 April 1982, published in “Electroshock Hearings in Berkeley,” *Madness Network News*, Spring 1983.

1940s-1950s — During the 1940s and 1950s, electroshock was frequently given in the office of the psychiatrist without the benefit of anesthesia, muscle relaxants, or emergency equipment. In certain cases, the psychiatrist would make a “house call” with his ECT machine, accompanied by a nurse or an assistant, and the treatment would be administered in the patient’s own bed.

ZIGMOND M. LEBENSOHN (U.S. electroshock psychiatrist), “The History of Electroconvulsive Therapy in the United States and Its Place in American Psychiatry: A Personal Memoir,” *Comprehensive Psychiatry*, May-June 1999.

1950s — Dr. Willard Pennell, who has used ECT since the 1950s, recalled when entire wards full of patients in state hospitals would be given shock treatment on the same morning.

“They didn’t have the Anectine then,” he said, “and they didn’t use an anesthetic. Patients could look up the row of beds and see other patients going into epileptic seizures, one by one, as the psychiatrists moved down the row. They knew their turn was coming, and it was no doubt terrifying.”

CHARLES PETIT (U.S. journalist), “Shudders over Shock Treatments,” *San Francisco Chronicle*, 30 December 1974.

1960 — I can still feel the cold, sticky linoleum beneath my bare feet as I shuffled my way to the bathroom on those freezing early mornings during the winter of 1960. The sensations and memories are as much a part of me now as they were then, perhaps even more vivid now, as I realize the shocking brutality of my treatment as an adolescent girl locked into a mental institution because of my overwhelming feelings of depression.

We were lined up side by side in our beds on those mornings, four girls, huddled beneath our cold, white sheets, petrified and silent. I can see the nurse in her starched white uniform. I can smell the alcohol she rubbed on my bottom, and I can feel the sting of the sharp needle as she injected the insulin into me: insulin coma therapy, five days a week for six weeks.

After we were groggy from the insulin, but often not yet in a coma, the second treatment would begin. I can still see him walking through the door to our bare hospital-green room, his face, gray-white in color, and his black suit and black shoes. He carried all his equipment in a small black suitcase in one hand, this man of death and destruction. He set up his machine behind our heads, one by one. Curled up beneath our sheets, heads covered, as though seeking womb-like protection, we were, as they peeled the sheets off us, one by one, forcing us onto our backs, bare and open and vulnerable. I was second in the line-up.

Before being turned, I would often peek out from a small, secret opening in my sheet to see what they were doing to Susan, the first to receive the treatment. I would make myself watch as if it might prepare me in some way. And when she would shake violently all over, my eyes would close. I could no longer watch. I would shiver beneath my sheet in fear. And then they would come to me. I can still feel the sticky, cold jelly they put on my temples. My arms and legs were held down. Each time, I expected I would die. I did not feel the current running through me. I did wake up with a violent headache and nausea every time. My mind was blurred. And I permanently lost eight months of my memory for events preceding the shock treatments. I also lost my self-esteem. I had been beaten down.

But I was lucky. I was very, very lucky. On one of those cold, winter mornings exactly thirty years ago, they injected my friend, Susan, in the bed next to me, with more insulin than her frail young body could tolerate. A few hours later, as the four of us were having our mandatory afternoon nap, still huddled beneath our sheets, my friend Susan went to sleep and never woke up. She had just turned seventeen. When she died, she became a part of me.

On the winter afternoons after Susan died, I can remember my “mental health care” continued by my being taken into that same shock room, where we also slept at night, by a mental health worker. He would lock the door, push me up against the wall, and sexually abuse me. My head foggy from the insulin, dazed from the drugs, I was petrified. I did not scream. I did not dare. I survived. And I did not tell anyone for a long, long time.

DOROTHY WASHBURN DUNDAS (U.S. electroshock survivor and writer), opening paragraphs, "The Shocking Truth" (For Susan Kelly), published in Jeanine Grobe, ed., *Beyond Bedlam: Contemporary Women Psychiatric Survivors Speak Out*, 1995. Dundas was institutionalized for three years during which time she was subjected to 40 insulin comas and 10 electroshocks at Baldpate Hospital in Georgetown, Massachusetts.

1960 — By the roots of my hair some god got hold of me.
I sizzled in his blue volts like a desert prophet.

SYLVIA PLATH (U.S. electroshock survivor, writer, and poet), "The Hanging Man," 1960, *Sylvia Plath: Collected Poems*, ed. Ted Hughes, 1981.
See Plath's entries in 1953 above and 1963 below.

1960 — In the present study, 33 women in the group reviewed were treated with electroshock therapy during gestation. Clinical states of severe agitation and/or catatonic withdrawal were considered indications for such treatment, as it was felt that potential hazards of malnutrition, dehydration, and violent injury existed for both mother and fetus. Thus, electroshock therapy was given as an emergency form of treatment. There were 2 infant deaths in the 33 cases treated.... [There was serious fetal damage in two other cases.]

DAVID E. SOBEL (U.S. electroshock psychiatrist), "Fetal Damage Due to ECT, Insulin Coma, Chlorpromazine, or Reserpine," *Archives of General Psychiatry*, June 1960. Compare: "Pregnancy is definitely no contraindication [for ECT] which is again in accordance with the known fact that pregnant epileptic women are not threatened by abortion or premature birth. Even in patients treated at termination of pregnancy convulsions do not produce labor pain or rupture of the membrane. Followups also did not show any damage to the child" (**LOTHAR B. KALINOWSKY** [German-born U.S. electroshock psychiatrist], "Electric and Other Convulsive Treatments," published in Silvano Arieti, ed., *American Handbook of Psychiatry*, vol. 5, ch. 27, 1975).

1961 — In some mental hospitals, it has been said, one way of dealing with female patients who became pregnant on the hospital grounds was to perform hysterectomies. Less common, perhaps, was the way of dealing with those patients, sometimes called "biters," who continued to bite persons around them: total extraction of teeth. The first of these medical acts was sometimes called "treatment for sexual promiscuity"; the second, "treatment for biting." Another example is the fashion, now sharply declining in American hospitals, of using lobotomy for a hospital's most incorrigible and troublesome patients. The use of electroshock, on the attendant's recommendation, as a means of threatening inmates into discipline and quieting those that won't be threatened, provides a somewhat milder but more widespread example of the same process. In all of these cases, the medical action is presented to the patient and his relatives as an individual service, but what is being serviced here is the institution.

ERVING GOFFMAN (U.S. sociologist), "The Medical Model and Mental Hospitalization," *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, 1961.

1961 — I think one should go to the extreme of always explaining to a patient if he is going to get electroshock why he is going to get it and what it is going to be like and so

forth and so on. But as far as getting permission from the patient is concerned, this is not necessary.

MANFRED GUTTMACHER (U.S. electroshock psychiatrist), testimony at hearings on the “Constitutional Rights of the Mentally Ill” before the Subcommittee on Constitutional Rights of the Committee on the Judiciary, United States Senate, 29 March 1961.

1961 — What these shock doctors don’t know is about writers and such things as remorse and contrition and what they do to them. They should make all psychiatrists take a course in creative writing so they’d know about writers....

Well, what is the sense of ruining my head and erasing my memory, which is my capital, and putting me out of business? It was a brilliant cure but we lost the patient. It’s a bum turn, Hotch, terrible.

ERNEST HEMINGWAY (U.S. electroshock patient and writer), remarks to the author who was visiting him at the Mayo Clinic in Rochester, Minnesota where Hemingway was being electroshocked in 1961, quoted in A. E. Hotchner, *Papa Hemingway*, ch. 14, 1967. During one of his stays at the Mayo Clinic, Hemingway had posted on the door of his room a notice, the first sentence of which read, “FORMER WRITER ENGAGED IN PREPARATION OF SCHEDULED FULL-SCALE NEWS CONFERENCE” (quoted in Frederick Busch, “Fear Was His Beat,” *New York Times Book Review*, 25 July 1999). A few days after being released from the Mayo Clinic following a second electroshock series, Hemingway killed himself with a shotgun blast to the head at the age of 61. Several years later, Howard P. Rome, his Mayo Clinic psychiatrist, was elected president of the American Psychiatric Association.

1961 — There were 3 deaths among 267 patients who underwent intensive electroshock between 1946 and 1960 [editor’s summary].

JAMES L. SAGEBIEL (U.S. electroshock psychiatrist), “Regressive Convulsive Therapy and Lobotomy in the Treatment of Mental Disorders,” *Diseases of the Nervous System*, April 1961.

1961 — On becoming king [of Morocco] in 1961, Hassan [II] had asked the [Central Intelligence] Agency to restructure and train his own security service. It had become one of the harshest in the Arab world, a rival in sheer cruelty to the shah’s SAVAK. The Moroccan security service was fully staffed with doctors who supervised a wide range of tortures of political detainees at a purpose-built detention center near Tazmarent. It included isolation chambers.... The center also had several Page-Russell electroshock machines, which were routinely used on prisoners. During the post-shock periods, Moroccan physicians questioned the detainees, seeking information about opponents to the king.

GORDON THOMAS (British writer), *Journey into Madness: The True Story of Secret CIA Mind Control and Medical Abuse*, ch. 19, 1989.

1957-1961 — Husbands might wish to have their wives forget the emotional troubles, including marital strife, which precipitated hospitalization. Mr. Karr [a pseudonym] commented on his wife’s long-term memory loss as proof of her successful cure by ECT, saying that her memory was still gone, especially for the period when she felt ill, and

that “they did a good job there.” These husbands used their wives’ memory loss to establish their own definitions of past situations in the marital relationship....

Mr. Karr... expressed pleasure to the research interviewer that electroshock therapy had made his wife forget her hostile outbursts against him in the pre-hospital period.

CAROL A. B. WARREN (U.S. sociologist), “Electroconvulsive Therapy, the Self, and Family Relations,” *Research in the Sociology of Health Care*, vol. 7, 1988. Warren’s study was based on interviews with 10 women (and their husbands) who had been institutionalized a total of 17 times at Napa State Hospital (California) between 1957 and 1961. In the “Discussion” section of the same article, Warren commented: “Treatments such as ECT intervene between the prehospital and posthospital reality-negotiations of marital partners. In the wake of hospital treatment, the couple ‘constructs not only present reality but reconstructs past reality as well, fabricating a common memory that integrates the recollections of the two individuals’ [Peter Berger and Hansfried Kellner]. When the recollections of one partner are to some degree erased, *the dynamic reconstruction of reality* shifts a little, or a lot” [editor’s emphasis].

1957-1961 — Rita Vick [a pseudonym] had forgotten, after ECT, the five of her seven children who had been removed from her custody. One day she found an album in the Vick house and asked her husband “who were all those children?” For fear of upsetting her with renewed thoughts of the custody loss, Mr. Vick told her that they were a neighbor’s children.

CAROL A. B. WARREN, “Electroconvulsive Therapy, the Self, and Family Relations,” *Research in the Sociology of Health Care*, vol. 7, 1988.

1962 — There are some of us Chronics that the staff made a couple of mistakes on years back, some of us who were Acutes when we came in, and got changed over. Ellis is a Chronic came in as an Acute and got fouled up bad when they overloaded him in that filthy brain-murdering room that the black boys call the “Shock Shop.” Now he’s nailed against the wall in the same condition they lifted him off the table for the last time in the same shape, arms out, palms cupped, with the same horror on his face. He’s nailed like that on the wall, like a stuffed trophy. They pull the nails when it’s time to eat or time to drive him in to bed or when they want him to move so’s I can mop the puddle where he stands.

KEN KESEY (U.S. writer), *One Flew over the Cuckoo’s Nest* (a novel), ch. 1, 1962. See first entry in 1975 below.

1962 — “The Shock Shop, Mr. McMurphy, is jargon for the EST machine, the Electro Shock Therapy. A device that might be said to do the work of the sleeping pill, the electric chair, *and* the torture rack. It’s a clever little procedure, simple, quick, nearly painless it happens so fast, but no one ever wants another one. Ever.”

“What’s this thing do?”

“You are strapped to a table, shaped, ironically, like a cross, with a crown of electric sparks in place of the thorns. You are touched on each side of the head with wires. Zap! Five cents’ worth of electricity through the brain and you are jointly administered therapy and a punishment for your hostile go-to-hell behavior, on top of being put out of everyone’s way for six hours to three days, depending on the individual.”

KEN KESEY, *One Flew over the Cuckoo’s Nest*, ch. 1, 1962.

1961-1962 — When I was young, I wanted to be a priest and I guess that was the dream of my childhood, and I went into a seminary at the age of 16 and later went to novitiate. And one day I woke up in a hospital. And on my medical records it said that I was a catatonic schizophrenic and that therefore they gave me electroshock treatment. The treatment itself was horrendous.

I remember two of them from my medical records which stated that I had 17 of them. I remember being strapped down, totally powerless, electrodes being applied to my head, injection of drugs, and a hum starting to appear inside my head, increasing in volume till my whole head vibrated, and finally at the last moment it was like a crack, like a gunshot, which blew me into nonexistence.

Coming to and not knowing who I was or where I was. An incredible fog. That was horrendous, and I remember the last treatment that I had. I told the psychiatrist when I was lying on the table, “I don’t want this treatment, I am afraid of it, it is horrendous, it kills me, it’s very painful.”

And he said, “There is no pain. We give you a drug and there is no pain. Don’t be so childish, don’t be a baby about it. Just relax and take the drug.” And that was such a [pause] demeaning... [ellipsis in original]. I was even denied the ability to say that my experience is that I feel pain in this treatment, that I am being a baby... [ellipsis in original]. He is the expert. He has this credential. He went to school and studied this. He has been certified by the state. But I am the person going through this, and I have no credibility....

I came home a vegetable. My mother took me home. I was a little child without the ability to do anything. I used to sit around in the front room and think about suicide. Now that’s pretty drastic for someone who has grown up a Catholic to think about suicide....

At some point I had to make the decision whether to kill myself or live and I made a decision to live, even though that seemed like a great leap into some unknown, whatever the world was, and it was a [pause] I took the leap. It is strange because, as a child, I had all these kinds of mystical experiences or whatever, experiences with God, and that was destroyed and that whole feeling of nature and that whole sense of being in tune with the universe somehow or with some relationship not only to nature, but to community, to people around me, it was destroyed.

It has taken years to regain that. And there are two years, and this is the thing that infuriates me, there are two years of my life that are just nothing, that are just like pain, jellied pain, that has no meaning.

STEVEN SEARS (U.S. electroshock survivor, human rights activist, and office manager), testimony at a hearing on electroshock conducted by the Berkeley Human Relations and Welfare Commission, 24 April 1982, published in “Electroshock Hearings in Berkeley,” *Madness Network News*, Spring 1983. In addition to the ECT, Sears underwent 19 subcoma insulin treatments at Merciville Sanitarium in Aurora, Illinois at the age of 19 in 1961-1962.

1963 — Intelligence may be the pride — the towering distinction of man; emotion gives color and force to his actions; but memory is the bastion of his being. Without memory, there is no personal identity, there is no continuity to the days of his life. Memory

provides the raw material for designs both small and great. Thus, governed and enriched by memory, all the enterprises of man go forward.

D. EWEN CAMERON (Scottish-born Canadian electroshock psychiatrist), “The Process of Remembering,” *British Journal of Psychiatry*, May 1963.

See Cameron’s entry in 1957 above; and Linda Macdonald’s in 1963 below.

1963 — Thousands of papers, scientific and otherwise, poured in to support this form of therapy [ECT] and assess its values. Countless lives, sufferings and tragedies had been spared. However, the undaunted spirit of [Hugo] Cerletti did not rest. He “wanted to know what was at the basis of electro-shock recovery.” He formulated a theory that the humoral and hormonal changes provoked in the brain by the epileptic attack led to the formation of substances which he called “acrogonines” — substances when injected into the patient would have therapeutic effects similar to those resulting from electro-shock.

Death found Cerletti still feverishly working to establish the validity of this brilliant hypothesis....

Cerletti was essentially an individualistic and liberalistic personality. His views on human rights led him, at the end of the Second World War, to clash with the Italian authorities because of his antifascist leanings.

He spent most of his life in Rome and loved “his city.” Whoever had the rare opportunity to assess his humanistic knowledge during his promenades throughout the city had a memory to cherish and to carry in his heart. Cerletti had the supreme gift of being a keen observer and a perceptive one. He knew the limitations of a human mind but he had the thirst for knowledge of eternal youth. He was a friend to many, a teacher to all, a born patrician.

To those who live in his sphere of influence, to those who have known and benefited from his work, his end does not signify disappearance but continuation of his superb leadership [closing paragraphs].

FERRUCCIO di CORI (Italian electroshock psychiatrist), “In Memoriam,” *Journal of Neuropsychiatry*, October 1963.

See Leonard Frank’s entry in 1938 and Hugo Cerletti’s in 1959 above; and George Mora’s in 1963 below.

1963 — The name on my admission chart at the Allan Memorial reads “Linda Helen Cowan (nee Macdonald).” It was March 28, 1963. A young wife and mother, I was to become one of the last victims of Dr. Ewen Cameron’s experiments [“depatterning treatment”] on the human brain. I am 49 years old today. I accept my age only because my birth certificate validates the time, day, and the place of my birth. In reality, *my* reality, I am 23. I have no memory of existing prior to October 1963, and the recollections I do have of events of the following years until 1966 are fuzzy and few....

Dr. Cameron’s “brainwashing” experiments wiped my brain clean of every experience I had ever known....

My parents were introduced to me that winter of 1963/64. Of course, I did not know them. The children came back from wherever they had been living. I had no idea who they were, and I certainly had no sense of what a “mother” was. They were all “older” than I; the oldest could read and write — their mother could not....

A woman robbed of her life. I had decided to share my life with you. If sharing my personal experience can help to educate the public so that such abusive experimentation

will not, for any reason, with or without consent, be performed on human beings ever again, indeed something positive will have emerged from a living hell.

LINDA MACDONALD (Canadian electroshock survivor), "Breakthrough" (1986), published in Bonnie Burstow and Don Weitz, eds., *Shrink Resistant: The Struggle Against Psychiatry in Canada*, 1988.

See D. Ewen Cameron's entries in 1957 and 1963 above.

1963 — In 1963 I had been discharged from Henderson General Hospital in Hamilton, Ontario half way through a series of about 15 electroshocks. I had dutifully gone back and had the rest of them as an outpatient. A month later I was back in the hospital again — this time in what was then called the Ontario Hospital (Hamilton) and later renamed Hamilton Psychiatric Hospital — because I wasn't any better. I was just as depressed as I had been to start with. This time the experience of the hospital was the reverse.

Now I actually got to see this person who happened to be called a psychologist and I talked. Eventually I dealt with my problem, got out of the hospital, and went home.

Up to that point, I really had not done a lot of thinking about ECT. I knew it hadn't worked but assumed that it must be me, that I was an exception, that they would not have this treatment unless it was a good treatment, and that I had been unlucky. I had been one of those rare people for whom this supposedly wonderful treatment didn't work.

Then over time I started noticing some very significant changes in myself. There were three things that stood out. The first one was that I wasn't as smart as I had been. I would still get to the same places, but it was a lot harder work. It took me longer. I had to think harder to do things that I could have done before much more easily.

The second thing I noticed was that there were chunks from my life that were missing. I kept waiting for them to come back and they didn't. There was just a sort of random missingness. There wasn't a pattern to it. It's just that bits and pieces were missing. These chunks were gone and they never came back.

There was also what you might call selective interference with my ability to remember things. I discovered, for instance, that I couldn't memorize music anymore. I played the piano. I would sit down and try to memorize a piece of music, which had never been difficult for me. I couldn't do it. I would spend eight hours trying to memorize one page of music. I still have exactly the same problem.

And the third thing that happened is that I was having these odd little sleeping spells that resembled narcolepsy. I would just sort of fade out. A couple of minutes later, I would fade back in again. That had never happened to me before. I started thinking that all of these things might have something to do with the shock treatment but in a very general sort of way. I didn't really put it together. I wondered. I speculated. But I didn't really start to put it together for fifteen years.

CARLA McKAGUE (Canadian electroshock survivor and attorney), Bonnie Burstow interview, in 1994, presented as written testimony at public hearings on electroshock (modified by McKague), Toronto, 9 April 2005, <http://capa.oise.utoronto.ca/personal.html>

1963 — In 1959 and in 1961, at the invitation of the American Psychiatric Association, [Ugo Cerletti, the discoverer of electroshock,] attended the annual conventions in Philadelphia and in Chicago, respectively. Although more than eighty, those who met

him there noticed an alert expression and inquisitive mind. His interests embraced many aspects of modern psychiatry as well as the progress achieved in this country. Those who saw him must have also been impressed by his kind and unassuming attitude. A true humanist, lover of art in all its expressions, and an excellent draughtsman, Cerletti will remain prominent among those who contributed to the greatest degree to the battle against mental illness.

GEORGE MORA (Italian-born U.S. psychiatrist), closing sentences, “In Memoriam: Ugo Cerletti, M.D. (1877-1963),” *American Journal of Psychiatry*, December 1963. See Leonard Frank’s entry in 1938 and Ferruccio di Cori’s in 1963 above.

1963 — At the head of the cot is a table on which sits a metal box covered with dials and gauges. The box seems to be eyeing me copperhead-ugly, from its coil of electric wires, the latest model in Johnny-Panic-Killers....

The white cot is ready. With a terrible gentleness Miss Milleravage takes the watch from my wrist, the rings from my fingers, the hairpins from my hair. She begins to undress me. When I am bare, I am anointed on the temples and robed in sheets virginal as the first snow. Then, from the four corners of the room and from the door behind me come five false priests in white surgical gowns and masks whose one life work is to unseat Johnny Panic from his own throne. They extend me full-length on my back on the cot. The crown of wire is placed on my head, the wafer of forgetfulness on my tongue. The masked priests move to their posts and take hold: one of my left leg, one of my right, one of my right arm, one of my left. One behind my head at the metal box where I can’t see.

From their cramped niches along the wall, the votaries raise their voices in protest. They begin the devotional chant:

The only thing to love is Fear itself.

Love of Fear is the beginning of wisdom.

The only thing to love is Fear itself.

May Fear and Fear and Fear be everywhere.

SYLVIA PLATH (U.S. electroshock survivor, writer, and poet), a thinly veiled account of what electroshock was like for her, “Johnny Panic and the Bible of Dreams,” *Atlantic*, September 1968. In her essay, Plath spoke of herself as “an unsordid collector of dreams for themselves alone. A lover of dreams for Johnny Panic’s sake, the Maker of them all.” She committed suicide at the age of 40 in 1963, two years before her acclaimed collection of poems, *Ariel*, was published.

See Plath’s entries in 1953 and 1960 above.

1963 — How different the world might be today if only a handful of people had been sent for psychiatric “treatments,” instead of being tried and sent to jail! Gandhi, Nehru, Sukarno, Castro, Hitler — and of course many others, for example the “freedom riders” in the South — have been sentenced to terms in prison. Surely, the social *status quo* could have been better preserved by finding each of these men mentally ill and subjecting them to enough electric shock treatments to quell their aspirations.

THOMAS S. SZASZ (Hungarian-born U.S. psychiatrist), *Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices*, ch. 13, 1963.

1964 — The average schizophrenic has no motivation for drug intake because he does not consider himself sick. He also finds out pretty soon that the drugs slow him down or give him other discomfort and that subjectively he feels better without medication. The rising readmission rate in our hospitals is probably not due to diminishing effectiveness of the drug, but to many patients' failure to take the prescribed amount or to take them at all. Therefore, maintenance ECT still has its indications as also, by the way, psychosurgery has in some selected cases.

LOTHAR B. KALINOWSKY (German-born U.S. electroshock psychiatrist), "Electric Convulsive Therapy after Ten Years of Pharmacotherapy," *American Journal of Psychiatry*, April 1964.

1964 — A person who does not have a memory is not able to perform as an actress. I'm still able to do things — that is, I'm able to do them in a very limited way as a kind of hobby. I have to work terribly hard to do it. Recently, I did a public theater appearance. I had to drive around with the tape on saying the lines over and over and over and over. Previously, I'd just do a couple of readings... and that would be enough. I don't have this quick ability anymore. I don't like to appeal to emotionalism, but I'm furious about the whole thing. I mean my life changed radically....

Since the shock treatment [in 1964] I'm missing between eight and fifteen years of memory and skills, and this includes most of my education. I was a trained classical pianist.... Well, the piano's in my house, but I mean it's mostly just a sentimental symbol. It just sits there. I don't have that kind of ability any longer....

I lost people by losing those eight to fifteen years. People come up to me and they speak to me and they know me and they tell me about things that we've done. I don't know who they are. I don't know what they're talking about although obviously I have been friendly with them....

[The shock treatment] diminished me.... I am certainly nothing like I was, and my life is nothing like it would have been.

CONNIE NEIL (Canadian electroshock survivor), testimony at electroshock hearings before the Toronto's Board of Health, January 1984, quoted in *Phoenix Rising* (Electroshock Supplement), April 1984.

1966 — Perhaps a plausible explanation for the efficacy of shock is that it produces a slight brain damage and thus erases the most recent neurohistological changes in the highest brain area, which stores as memories those experiences which precipitated the psychosis. In other words, as the result of shock treatment the patient completely forgets the events leading up to his symptoms and thus is put back into a predepression psychological state. The best-substantiated acts of electroshock therapy are that amnesia occurs during this period and that when the temporary memory defect based on the patient's reversible brain damage is restored, illness is apt to reoccur. The exceptions are those lucky patients whose external-life situations fortuitously improve after the shock therapy.

FRANZ G. ALEXANDER (Hungarian-born U.S. psychoanalyst) and **SHELDON T. SELESNICK** (U.S. psychiatrist), *The History of Psychiatry*, ch. 18, 1966.

1966 — Let me describe the most horrible experience of my life. I was injected with a muscle relaxant, while my mouth was plugged with a rubber tube to bite down on (so

that I wouldn't bite my tongue), and an oxygen mask covered my face. Dr. Ames Fischer fitted the pieces of metal to my temples, and then he said in a sterile voice, "Let him feel it this time!" As the current went through my brain along with the rest of my body, I wanted to scream, but because of the muscle relaxant, I was paralyzed — I couldn't even close my eyes. I remember the next time that I was to have a treatment. I begged and begged, "Please don't let me feel it this time!" I had fourteen of these treatments in the period of four months that I was detained on the fourth floor Acute Treatment Ward in Langley Porter [Neuropsychiatric Institute in San Francisco].

GARY BLACKBURN (U.S. electroshock survivor), "My Experience with Shock," *Madness Network News*, Spring 1977.

1966 — My parents, horrified [at the conditions at New York's Bellevue Hospital], pulled strings with money they didn't have and had me transferred to Gracie Square Hospital, a place where rich alcoholics dried out and rich psychotics were zapped at \$50 a shock. Terrified, having seen the price for disobedience (for I had defied the psychiatrists by not resuming my role), I tried hard now to be "good." The carpeted floors and pastel walls showed me one of my choices; the vacant stares and shuffling gaits of the patients returning each morning from the shock room showed the other. Again the lesson: conformity or punishment!

JUDI CHAMBERLIN (U.S. psychiatric survivor, activist, and writer), published in Dorothy E. Smith and Sara J. David, eds., *Women Look at Psychiatry*, 1975. Since 1971, Chamberlin has been a leading force in the psychiatric survivors movement. Her *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (1978) is the most highly regarded and influential book to have emerged from the survivors movement.

1966 — The [unmodified electroconvulsive] treatments were continued on a three-times-a-week schedule. Gradually there began to be evident improvement in the behavior of the patients, the appearance of the ward, and the number of patients volunteering for work. This latter was a result of the ECTs alleviating schizophrenic or depressive thinking and affect with some. With others it was simply a result of their dislike or fear of ECT. In either case our objective of motivating them to work was achieved.

LLOYD H. COTTER (U.S. electroshock psychiatrist), describing his use of electroshock on 120 male Vietnamese mental patients in a hospital near Bien Hoa in 1966, "Operant Conditioning in a Vietnamese Mental Hospital," *American Journal of Psychiatry*, July 1967. Later, as recounted in the same article, Cotter used a similar approach with 130 female work-refusers at the same hospital. The electroshock was less effective with them, he reported: after 20 ECTs only 15 women were working. He told the remaining women, "If you don't work, you don't eat." Twelve women immediately agreed to work, and by the end of three days without food, all the rest "volunteered" for work. Cotter concluded the report on his ECT-centered operant conditioning program with these words: "It would appear to be most indicated for long-term patients who have failed to respond to other treatment modalities. The use of effective reinforcements should not be neglected due to a misguided idea of what constitutes kindness" [editor's summary]. Comment: "The significance of the Cotter article is not that one psychiatrist so ingenuously reported on his use of violence — electroshock and starvation — to force mental patients to work. That is revealing only about the individual. The significance

lies, rather, in what is revealed about professional standards by the fact that the psychiatrist's work resulted not in censure or sanctions, but in publication of his article in the official journal of his professional association [the American Psychiatric Association]" (**EDWARD M. OPTON JR.** [U.S. attorney and psychologist], "Psychiatric Violence Against Prisoners: When Therapy Is Punishment," *Mississippi Law Journal*, vol. 3, 1974).

1964-1966 — A clear reference to the use of electric fish to produce shock and cure psychiatric cases is found in a 16th century Jesuit missionary account of Ethiopia: "The superstitious Abassines [Ethiopians] believe that it [the electric catfish] is good to expel Devils out of the human body, and it did torment Spirits no less than men." I find this reference especially interesting since during my stay in Ethiopia in 1964-1966, electric shock therapy was being widely promoted by a psychiatrist there as a new technique. Modern psychiatry, he said in effect, was coming to Ethiopia to expel the Devil out of the human body.

E. FULLER TORREY (U.S. psychiatrist), *The Mind Game: Witchdoctors and Psychiatrists*, ch. 5, 1972. The quotation in the excerpt is from P. Kellaway, "The Part Played by Electric Fish in the Early History of Bioelectricity and Electrotherapy," *Bulletin of the History of Medicine*, vol. 20, 1946

1967 — I was a victim of ECT when I was nineteen years old. I am now forty. The ECT was given to me against my will.... Before the ECT I was a college student studying art and a springboard diver in training for the Olympics. After the treatments I tried to resume these things, but I could not remember people who knew me at school and lost my nerve for diving. I feel the shock treatment was responsible.

My parents never would have consented to the treatment if they had been informed it might hurt my memory and damage my brain.

SUZA GAUDINO (U.S. electroshock survivor), letter to the Food and Drug Administration, 24 January 1988.

1967 — To explain ECT, I must first confront my shame. So I ask myself: What is the most shaming image of yourself from the hospital? It is the image I can never see. It is me on the shock table, writhing from the convulsion, drooling and twitching. That paralyzed, twitching image: That's me. There, I have just allowed you to envision my greatest mortification.

LAUREL J. HODKIN (U.S. electroshock survivor), on her ECT experience in 1967, *Biological Psychiatry and the Invention of the Asylum in Modern America. Organic Theories and Somatic Treatment: A History and Case Study* (unpublished dissertation, Saybrook Graduate School and Research Center), 1999.

1968 — [Electroconvulsive] treatment is not painful or otherwise unpleasant.

LOTHAR B. KALINOWSKY (German-born U.S. electroshock psychiatrist), "Thirty Years of Empiricism," *International Journal of Psychiatry*, February 1968.

1968 — In 1968 I had 19 shock treatments. I found out later that they were probably unnecessary and that I had severe thyroid and female hormone deficiencies. Needless to say the electric shocks didn't help my hormone deficiencies!

They did wreck my life however! I suffer severe memory loss which has never returned. It covers 8 to 10 years!

I also have a very deep inability to learn and comprehend things and this has led to problems with my own self understanding. It also has affected my relations with my own family and other people too.

DOROTHY OIMETTE (U.S. electroshock survivor), letter to the Food and Drug Administration, 29 January 1988.

1968 — When we are concerned with schizophrenic and paranoid psychoses, [electroconvulsive] treatment must usually be given more intensively, in spite of which, full freedom from symptoms is not attained. Instead, the symptoms become less marked at the same time as a general lowering of the mental level occurs.

JAN-OTTO OTTOSSON (Swedish electroshock psychiatrist), “Psychological or Physiological Theories of ECT,” *International Journal of Psychiatry*, February 1968.

1969 — A few patients may seem to feel worse after [an ECT] treatment and evidence more agitation than before. It may simply mean that the depression was far more intense than suspected. This is not uncommon, so do not lose heart if it happens. The only answer here is to persist with treatment in accordance with the doctor’s recommendation.

LEONARD CAMMER (U.S. electroshock psychiatrist), advice to relatives of ECT patients, *Up from Depression*, ch. 13, 1969.

1969 — As ill luck would have it, the term “electroshock” became a disquieting misnomer for an excellent and highly beneficial treatment method. More aptly, it should have been called a “stimulation” procedure. However, the word “shock” attained general usage through one of those quirks of language application....

I prefer electric-stimulation treatment, which says exactly what it is.

LEONARD CAMMER, *Up from Depression*, ch. 13, 1969. Comment: “Dr. Leonard Cammer, one of electric shock treatment’s most outspoken advocates, has tried to allay public fear concerning its use. He believes the word ‘shock’ scares a lot of people and calls the procedure ‘electric-stimulation treatment.’ I don’t believe the word ‘shock’ in this case scares people nearly enough, and propose that this technique be called ‘electric shock torture’” (**JOE KENNEDY ADAMS** [U.S. psychologist], “You’re in for the Shock of Your Life,” published in Sherry Hirsch et al., eds., *Madness Network News Reader*, p. 84, 1974).

1969 — In my department at the Vienna Polyclinic, we use drugs, and use electroconvulsive treatment. I have signed authorization for lobotomies without having cause to regret it. In a few cases, I have even carried out transorbital lobotomy. However, I promise you that the human dignity of our patients is not violated in this way.... What matters is not a technique or therapeutic approach as such, be it drug treatment or shock treatment, but the spirit in which it is being carried out.

VIKTOR E. FRANKL (Austrian Holocaust survivor and electroshock psychiatrist who introduced logotherapy, a method of psychotherapy), “‘Nothing But—’: On Reductionism and Nihilism,” *Encounter*, November 1969.

1969 — In more modern and progressive mental hospitals the aides are not allowed to beat up on the patients. It is necessary for the aide to report that the patient cannot control his hostility so that the doctor can bang the patient in the head with a shock machine.

JAY HALEY (U.S. psychotherapist), “The Art of Being Schizophrenic,” *The Power Tactics of Jesus Christ and Other Essays*, 1969.

1969 — During this period I was undergoing outpatient psychotherapy with Dr. Richard Bridburg, the Chief of Patient-Staff Services at the Institute of Living [where I had been electroshocked in 1969]. Once, when I tried to tell him about the enormous problems I was facing due to my lack of memory (I was going to ask his advice), he became downright hostile and said that such a thing was impossible. He said that shock treatments cause memory loss only right after they are administered. In no uncertain terms, he pompously informed me that anything else I had forgotten was due to normal forgetting. This is simply not true. In my own case, I lost years, not weeks, of time. Besides, the difference between normal forgetting and the total erasure caused by electroshock is like the difference between dunking your big toe in water and being drowned. I have never met anyone else who has “forgotten” where she went to college. But I realize that I was lucky. If I had been born ten years earlier, I might have had a lobotomy.

I had frequent nightmares about wandering into a hospital and not being able to find the exit door, about being burned by electrical wires, and paralyzed by injections of mind-altering drugs. It took a long, long time for me to accustom myself to the “real” world again. For many years I felt like there was a hole through the center of my existence and no one knew of it but me.

JEANNE LINDSAY (U.S. electroshock survivor and school counselor), closing paragraphs, “My Own Experience,” *Madness Network News*, Winter 1983-1984.

1942-1969 — Electric convulsive treatment was given to more than 500 children at Bellevue from 1942 to 1956, and at Creedmoor State Hospital Children’s service from 1956 to 1969. In the 1940s insulin therapy was sometimes combined with electric therapy.

LAURETTA BENDER (U.S. electroshock psychiatrist), “The Prescription of Treatment for Children,” published in Silvano Arieti, ed., *American Handbook of Psychiatry*, 2nd ed., vol. 5, 1975. Both hospitals are in New York City. See Bender’s entry in 1947 above.

Early 1970s — In the early 1970s, when Nixon was president and Vietnam was the visible war zone, I was going through some interesting life changes. I had many strange and intense experiences. I was occasionally euphoric and was sometimes overwhelmed as I tried to explore and examine the possibilities of my human potential in the fantastic realities of our existence.

In the course of events I was captured and incarcerated for my “thought crimes.” Thought crimes because I had broken no law, only spoken out, and acted out in response to my environment. I was locked up in a psychiatric prison. I was immediately forcibly injected with powerful mind-numbing and physically debilitating drugs, and rapidly descended into the typical state of clinically induced depression. I was

repeatedly reminded that I was sick, and was forced to admit to and accept this sudden illness.

Within three weeks, ECT was presented as a way to bring me out of this depression — a condition that would be necessary before I could be released from the “hospital.”

The only information I remember being told about was that the proposed treatment, ECT, was electroconvulsive treatment, and that it was not shock treatment.

So, I was persuaded to submit to the treatments. During the treatments I remember feeling very confused and disoriented, and especially sensing a loss of all memory of my past. I hoped that each new treatment would kill me so I would not have to endure any more suffering.

[The hospital] records indicate I received a series of 15 electroconvulsive treatments. Then, fortunately, my financial resources became exhausted. “Coincidentally,” I was pronounced well enough to be released. I was helped out of bed, given a three-day supply of pills, a prescription for more pills and helped out the door and dumped into a strange city — broke and broken.

In time, with the help and support of family and friends, I was able to reconstruct parts of my past.

There is no way of knowing what is missing from my memory. I do know I felt my spirit had been broken, that I no longer had skills and abilities I once enjoyed, and I know that it has taken many years to restore my spontaneity, creativity, and imagination.

GEORGE EBERT (U.S. electroshock survivor and founder and project coordinator of The Alliance, Syracuse), testimony at a hearing on ECT before the New York Assembly Standing Committee on Mental Health, Mental Retardation, and Developmental Disabilities, New York City, 18 May 2001. For more than 25 years Ebert has played a vital role in the campaign against electroshock and other psychiatric abuses.

1970? — The most terrible and damaging result of the [electroshock] treatment was that I lost all memories of the early childhood of my six children. I returned home and didn’t even know them. I was no longer the same mother because my memories were gone.

JEANNE CLAYTOR (U.S. electroshock survivor), quoted in Mark Smith, “Nightmare from ‘60s Haunts Mental Patients of ‘90s,” *Houston Chronicle*, 8 March 1992. Claytor, who was 66 in 1992, said that because of the severe memory loss from ECT she had to relearn basic arithmetic and was unable to navigate her native Amarillo, Texas without a map.

1970 — I received over 20 ECTs when I was 17 years old.... I was told the memories would come back in 6 weeks. I was told the shock treatments were no more powerful than the batteries in a flashlight. This was 30 years ago.

I lost 95% of all my memories before the treatment. They never came back. I went back to high school. I did not remember my fellow students. I could not find my classes. It was awful. To this day I look at the school year books hoping some of the pictures will spark a memory. I used to play the violin. I had won 2nd place in duets in the city of Cleveland. (The only reason I know this is because I have the medal in my drawer.) I could not remember how to play my violin after the first series of treatments. I was devastated.... My doctor kept saying that one more series would make me well....

I have trouble with my memory today. I have been told I have permanent brain damage due to the ECT treatment. My IQ was 120 before treatments and it is not anywhere near that now. I have trouble just trying to cook a meal. I do not work. I make lists so that I can try to remember what I need to do.

ECTs changed my life forever — and not for the better. I wish no one would be given ECTs.

SUE ANN KULCSAR (U.S. electroshock survivor), letter to the Food and Drug Administration, 9 November 2000.

1970 — The confusion, disorientation and amnesia... are desirable effects of the treatment.

JOSEPH PERLSON (U.S. electroshock psychiatrist), letter to *Playboy*, August 1970, quoted in Edward M. Opton Jr. and Alan W. Schefflin, *The Mind Manipulators*, ch. 9, 1978. Perlson reported his having administered ECT more than 50,000 times.

1970 — When I was nine, my mother's mind was murdered by an electroshock brainwashing course which psychiatry often used against unhappily married women whose husbands abused them, a real-life "Stepford wife" scenario. She became a total stranger: passive, emotionally distant and incapable of initiating or sustaining a conversation. Shortly afterwards, this mother of four young boys blew her brains out with my father's pistol. I didn't understand why she did it until 1970, when I myself, at the age of 15, was shocked six times for the same reason: I was suffering as a victim of aggravated domestic assault. Nothing could have prepared me for the horror and devastation I experienced as a result. Suddenly I was a refugee in my own mind, a hollow-eyed shadow of my former self, haunting a broken, smoldering landscape that used to be my life. A chasm opened up in my life, the boundary between before and after. Whoever I was before, that child died, and ever since I've been trying to make a life for myself while dragging around a lifeless child-corpse inside me, as if my Siamese twin had died. Now I understand why my mother killed herself and I don't blame her. I now know there is a fate worse than death: being half alive.

RICH WINKEL (U.S. electroshock survivor and computer programmer), personal communication, 21 September 2005. Winkel was shocked at St. Vincent's Hospital in St. Louis.

1971 — They put me through a series of shock treatments every time I am admitted to Austin State Hospital [Texas] and every time I get stupider and stupider.

ANONYMOUS (U.S. electroshock survivor), quoted in Doug Cameron, *How to Survive Being Committed to a Mental Hospital*, ch. 18, 1979.

1971 — Of course "Behaviorism works." So does torture. Give me a no-nonsense, down-to-earth behaviorist, a few drugs, and simple electrical appliances, and in six months I will have him reciting the Athanasian Creed in public.

W. H. AUDEN (English poet), "Behaviorism," *A Certain World: A Commonplace Book*, 1971.

1971 — As difficult as it may be for the reader to believe, I was now being shocked on the basis that I was not eating meat....

[My parents and the psychiatrist] were bound and determined to get me to stop denying myself meat. Evidently, I was supposed to forget about being a vegetarian and, over eighteen shock treatments, one would presume I would. I, after all, forgot nearly everything else, including how to spell correctly, my wife's name, my complete childhood, my college, my high school, all the books I ever read; you name it, I forgot it. With a little more effort, I could have become completely illiterate....

Vegetarianism was... a religious practice of mine.... There is supposed to be some sort of right in this country about religious freedom and the right to practice according to one's own beliefs, I guess, for that amount of time, everyone must have forgotten about it, at least while I was being shocked.

DOUG CAMERON (U.S. electroshock survivor and teacher), *How to Survive Being Committed to a Mental Hospital*, ch. 17, 1979. Cameron underwent a series of 18 electroshocks at Terrell State Hospital (Terrell, Texas). The number of ECTs for a standard series on his ward was 15 but three were added on, as related in ch. 25 of his book, because he persisted in his vegetarianism, "a practice most sacred to me." These last sessions were particularly hard for Cameron. The inability to breathe "worsened a hundredfold" during these electroshocks and during the last one he had the "feeling of almost dying of asphyxiation." He then realized the shocking would continue until he resumed eating meat. So he did: "I am only a man. I could only take so much" [editor's summary].

See Doug Cameron's entry in 1993 below.

1971 — Waiting for shock treatments was in many ways like waiting for execution. Each time we were put to sleep and shocked, it was like dying. In a kind of way, I was always surprised to wake up afterward and find that I was still alive and that it was all over, at least for another day and a half.

DOUG CAMERON, *How to Survive Being Committed to a Mental Hospital*, ch. 18, 1979.

1971 — Although most clinicians consider ECT's effect on mental functions reversible, we know of no systematic, long-term studies that demonstrate this conclusively, and almost every experienced clinician knows of a number of patients whose memory functions have in some measure remained impaired indefinitely.

THOMAS P. DETRE and **HENRY G. JARECKI** (U.S. psychiatrists), *Modern Psychiatric Treatment*, p. 642, 1971. Compare: Memory loss "is often distressing to the patient and may continue to some degree for several weeks or a few months following the termination of [ECT] treatment. Full return of memory finally occurs"

(**LAWRENCE C. KOLB** [U.S. psychiatrist and onetime president of the American Psychiatric Association], *Modern Clinical Psychiatry*, 8th ed., p. 642, 1973).

1971 — I was confined in a cold lonely room filled with fear and terror, wondering if I should fight the scheduled electroconvulsive "treatment" or give in to a hell that would rob me of part of my life. The first day I found out the hard way that fighting doesn't work. I was huddled in my bed holding tight to the little will power I had left. I heard the clicking of heels coming down the hallway. I thought to myself, "Maybe it will be someone else today," although deep inside, I wished that it wouldn't have to be anyone. But it's not someone else; it's me they have come for!

As I was being taken to what the victims called the “Shock Shop,” I knew there was no way out. I wondered what I had done to deserve this. I thought this was what it must feel like to walk down death row, except that I had committed no crime.

Later, I awoke in a daze, head aching, with patches of memory lost. Even knowing that by cooperating there would be fewer trips to the Shock Shop, I fought every treatment. At times I would try to hide, but the nightmare continued.

This all happened in a Houston hospital when I was in 24. There were three series of electroshock, 28 ECTs in all. And when it was all over, I was not able to remember my own child’s name. Some of the lost memories returned, but there were others that never did. I had to learn many things all over again; it took me 20 years to partially catch up to where I thought I had been before.

Sometime, after discharge, I started having small seizures that have become more severe. Judging by older people with similar experiences, I can expect increasingly worse seizures. The reality is that my brain was permanently damaged during ECT. The major seizures, which last for 5 to 10 minutes, cause my body and mind to remember and feel just as they did during the electroshocks.

Are we still living in the Stone Age? Isn’t this like the ancients who drilled holes in their neighbor’s skull to let out evil spirits? What has happened to the doctor’s creed, “First, do no harm?”

The pain of ECT is a never-ending pain. It has cost me my health, my memory, my child, my then husband, my chances of better employment, and portions of my education. It will continue until I take my last breath, but in the meantime, I use my every breath to work for the prohibition of all electroshock. But if this can’t be done, every psychiatrist should be required to have printed across his forehead a warning that states: “ELECTROCONVULSIVE THERAPY IS DANGEROUS TO YOUR HEALTH AND WILL CAUSE PERMANENT BRAIN DAMAGE.”

DIANN’A LOPER (U.S. electroshock survivor and legislative advocate), personal communication, 27 September 2005.

See Doug Cameron’s entry in 1993 below.

1971 — Electro-shock treatment was administered 433 times last year at the California Medical Facility in Vacaville.

Dr. L. J. Pope, superintendent of the correctional institution [prison], said the disputed therapy was not given as often in 1971 as in former years. It was supplanted by new drugs.

NORMAN MELNICK (U.S. journalist), “Shock Therapy at Vacaville,” *San Francisco Sunday Examiner & Chronicle*, 30 January 1972.

1971 — Based on force and fraud, and justified by “medical necessity,” the prime purpose of psychiatric treatments — whether utilizing drugs, electricity, surgery or confinement, especially if imposed on unconsenting clients — is to authenticate the subject as a “patient,” the psychiatrist as a “doctor,” and the intervention as a form of “treatment.” The cost of this fictionalization runs high: it requires the sacrifice of the patient as a person; of the psychiatrist as a critical thinker and moral agent; and of the legal system as a protector of the citizen from the abuse of state power.

THOMAS S. SZASZ (Hungarian-born U.S. psychiatrist), “From the Slaughterhouse to the Madhouse,” *Psychotherapy, Theory, Research and Practice*, Spring 1971.

1971 — Faculty in some medical centers teach that even skillfully administered ECT causes permanent, measurable brain damage, and that this is reason enough to avoid it. We have never been able to track down any evidence for such a conclusion: in some cases it comes down to an article of faith that “it just must” cause damage.

MORTON R. WEINSTEIN and **AMES FISCHER** (U.S. electroshock psychiatrists), “Combined Treatment with ECT and Antipsychotic Drugs in Schizophrenia,” *Diseases of the Nervous System*, December 1971.

See Peter Sterling’s entry in 2001 below.

1971 — I have suffered loss of jobs, family or friends’ respect as a result of ECT treatments (in 1971). I was administered 26 treatments with the ECT device for endocrine glands malfunction “nervous breakdown”. Five years later I realized I was brain damaged because of confused physiological functioning and continual depression on the job and in school (college). I am now 38 years old — and 3/4 of *every* day since those 26 ECT treatments I am bitter because I no longer feel vital and fit for life.

KAREN WHITEHEAD (U.S. electroshock survivor), letter to the Food and Drug Administration, 27 January 1988.

1972 — Soon after Missouri Senator Thomas F. Eagleton’s selection as the Democratic vice-presidential candidate in 1972, media reports disclosed that he had undergone ECT at Barnes Hospital (St. Louis) and the Mayo Clinic (Rochester, Minnesota) during 1960 and 1966 respectively. Initially, he had the support of the Democratic presidential candidate, South Dakota Senator **GEORGE S. McGOVERN**, who on hearing the news of his running mate’s psychiatric history famously said, “I am 1,000 percent for Tom Eagleton, and I have no intention of dropping him from the ticket.” But 3 days later, after consulting with psychiatrist Karl A. Menninger and others, McGovern changed his mind and forced Eagleton off the ticket.

1972 — There is an inherent wisdom in the brain as an organ of the body subject to wearing out. When it does, we have a depression. A depressed man or woman is like a car that can’t turn the motor over with a weak battery. It needs a recharge.

[According to the reporter, Dr. Cammer said that he was grateful to Sen. Thomas Eagleton for the publicity he gave to the value of ECT.] After the story appeared, I got calls from six professional people — two of them doctors — who had been denying depressions.

They said, “If it was good enough for Eagleton, it’s good enough for me.” One man was calling on behalf of his wife, who had been under treatment with drugs, without success, for months.

When she finally came in for treatments and began to improve, she said to her husband, “You SOB, why didn’t you tell me what to do before?”

A depressed person is grateful when someone takes over, because he can’t deal with anguish himself. The last thing a friend or relative should say to someone in depression is, “You can snap out of it if you try.” Would you say that to someone paralyzed by a stroke?”

LEONARD CAMMER (U.S. electroshock psychiatrist), quoted in Eloise Dungan, "Depression Is Needless," *San Francisco Sunday Examiner & Chronicle*, 12 November 1972.

1972 — *Carmen*: I got scared of the shock treatments. It's a very scary feeling, especially when you feel like the metal things of the electricity goes through you — it's like a hammer hitting your head. I was afraid of the third one.

Phyllis: Did you say you didn't want it?

Carmen: Oh, I fought against it. But they gave it to me by force.

Phyllis: Who signed for it?

Carmen: My husband did. He said the doctor said, "She's not doing any good so let's try shock treatments."

PHYLLIS CHESLER (U.S. psychotherapist and writer), *Women & Madness*, ch. 8 ("Third World Women"), 1972.

1972 — I was hired by Gladman Hospital (Oakland) in 1970 as a night nurse in spite of my open objection to electroshock. My tenure was for 2 and one-half years....

[One night in December of 1972], I found patient Zappane sitting in a chair, staring into space. He was a man in his late sixties, and I believe from his accent that he was an Italian immigrant. The patient of Doctor Adler would be receiving his very first electroshock treatment. I talked to him as I checked his blood pressure. He remained silent as I explained the procedure. As I was about to leave, he spoke: "I'm afraid. I don't want it. I don't want the shock treatment. I'll die from it. I don't want to die. I'm afraid. Will they know where to send my body? Will they know where to send my clothes? This is the worst Christmas I ever had."

I advised him to speak to his doctor and let him know of his fears and that he didn't want the treatment. I wrote his conversation with me in the nurse's observations and charted his vital signs. The EST nurse came to pick up the charts of those that would receive EST that day. I told her that patient Zappane was unusually frightened and believed that he would die from the treatment. She smiled and walked off with the charts. I closed the rest of my charts and signed out for the day.

That night I returned to my usual unit. Shortly after coming on duty I learned from a nurse on Station 1 that patient Zappane had died. I went to Station 1 to see if I could find his chart. It was still there. I read through his medical history and found that he had had a series of strokes and it was known that he had brain lesions (damaged tissue) from his EEG work-up.

That morning I questioned several members of the day staff. Yes, they told me, he fought, he screamed. Yes, he had to be carried to the EST room. He never recovered from the convulsion and the resuscitating equipment didn't function. He was taken by ambulance to Highland General Hospital, but he was dead in the EST room. We learned several days later that his autopsy determined that his death was caused by a massive cerebral hemorrhage from a "blown" lesion.

I was told by hospital administration that sometimes these things happen and that I should not feel bad about it. After all, I was not responsible for the man's death. And even though it was very risky sending a man in his physiological condition to receive EST, they felt it was worth the risk. After all, he was a depressive and could have committed suicide. And he had signed the consent form when he was admitted.

Patient Zappane did not live to see Christmas, and some of us called it murder. **SUSANNE A. CHRISTOU** (U.S. nurse), "Some of Us Called It Murder," *Madness Network News*, Summer 1983.

1972 — Today ECT is a relatively harmless treatment, not significantly more distasteful than having a tooth filled under Novocain, though it is usually done in a hospital. **DAVID ELKIND** and **J. HERBERT HAMSHER** (U.S. psychologists), "The Anatomy of Melancholy," *Saturday Review*, 30 September 1972.

1972 — One of my first assignments as a psychoanalyst-in-training in 1972 was to visit a mental hospital in Toronto. I spoke Spanish so I was asked to talk with a young South American who was about to receive ECT. He was terrified, and begged me to intervene on his behalf. Knowing nothing about ECT but believing his terror, I went to see the psychiatrist in charge. He was from Iran, and since my familial background is Central Asian and being a professor of Sanskrit at the University of Toronto at the time, we were able to converse easily. I told him about the man. He sighed and said, "Yes, most patients scheduled for ECT are terrified, and for good reason — that's why it is used as punishment." "What?" I asked in amazement, since I had never imagined any "medical" treatment doubling as punishment. He sighed again. "Knowing this," I asked, "how can you work here?" He said he had no other choice. But there is always a choice. He knew what he was doing and he could have chosen not to do it. He could have walked away. Even better: he could have fought it. I resolved then and there never to have anything to do with this method of psychiatric terrorism *or* with the people who administer it. In the years since, having come to know many people who have been given ECT and to know about many others who give it to them, I have had no reason to change my mind. I am categorically opposed to the use of ECT in any way whatever.

JEFFREY MOUSSAIEFF MASSON (U.S. psychoanalyst, former director of the Freud Archives, and writer), personal communication, 19 January 2006.

1972 — Memory is usually fully restored by 1 or 2 months after ECT. Much research has been done over the past 35 years to investigate the possibility of permanent memory changes occurring with ECT. Research now suggests that such changes do not occur, regardless of the number of treatments given.

NATIONAL INSTITUTE OF MENTAL HEALTH, *Facts about Electroshock Therapy* (pamphlet, 9470-547), 1972.

1972 — I was treated with electro-convulsive therapy in 1972, aged 37, when I became troubled and troubling after attending a 5-day experiential course on group dynamics. Our family doctor made an appointment for me to be assessed at a psychiatric hospital in York, which is not far from Leeds in northern England where I now live.

The psychiatrist diagnosed schizophrenia and told my husband that he needed permission to treat me with ECT if drug treatment did not help. After five days on the neuroleptic Haldol, I was treated with ECT seven times. After being released from hospital, I felt like an empty shell and gradually slipped into a depressed state. After some painfully numbed weeks in the summer feeling as if I was behind a plate glass window, cut off from everything, I went back to hospital.

On readmission I said that I did not want to be treated with ECT but despite that, three weeks later, when I was beginning to feel myself again, the psychiatrist, on finding me crying, pressured me into signing consent for more ECT. I was treated 8 times with ECT in the next three weeks, and I left hospital with prescriptions for the neuroleptic Stelazine and the antidepressant Prothiaden. I took these and some other drugs psychiatrists prescribed for me in ever smaller doses till 1975 when I stopped taking them altogether and returned to teaching. Since then (even though I had another 'psychotic' episode in 1978), I've done fine without them, which no doubt would surprise the psychiatrist who had told me I would need to take them indefinitely.

Once home, after the second hospitalization, I could not settle into doing anything and my husband got someone to help in the house two mornings a week so I would not be alone so much. I could not remember where some things were kept, particularly my sewing things. I had also forgotten names of plants in the garden, and sometimes did not recognise people I had known. I felt fragile and confused. There was a little slow improvement during the next 2 years.

Fortunately, in 1974 my husband came across a process, Re-evaluation Counselling (co-counselling), which involves two people agreeing to take equal turns talking and listening to each other without interruption, and allowing and encouraging the natural recovery that comes from tears, laughter and other safe ways of releasing feelings. Over the next months he and I did this for many hours. It was immensely helpful then, and I still find it useful to exchange time regularly with people who practise this way of listening and talking. With this approach I began to gain confidence in myself, and some memories from around the time of the ECT came back to me faintly. I am left with difficulty in concentrating (taking notes helps), and in recognising faces of people I meet only rarely. To help myself I now concentrate on linking aspects of their appearance to their name, which I repeat silently to myself.

Since 1974, I have spoken openly and sometimes publicly about my experience of ECT when it has seemed appropriate, but keeping anything I say brief. I joined a group called ECT Anonymous (all of whose members have had ECT), have taken part in demonstrations against ECT and am now contact person for ECT Anonymous (unaparker@aol.com). I have also made formal written comments on a draft mental health bill at each stage of its progress, particularly on sections referring to ECT. I talk to people about the continuing use of ECT in Britain and try to make them aware of its risks. I have led workshops on ECT for people training as social workers for mental health services.

As contact person for ECT Anonymous, I receive phone calls from people who need to talk about ECT they have had, or might be considering. I am also trying to set up a local support group in Leeds for people who might want to share ways to manage memory problems resulting from ECT, or who are trying to understand ECT and come to terms with the effects it has had on them.

UNA PARKER (English electroshock survivor, retired teacher, and activist), personal communication, 20 December 2005.

1972 — Psychiatrists may insist that ECT is safe, but they only administer the treatments. The patients know better....

In 1972 I received 19 shock treatments because I was depressed. Without going into details, I can say that my life has been altered because of them and there isn't a day that

goes by that I'm not aware of it.... I am convinced that electroshock treatment causes brain damage.

BARBARA RICHER (U.S. electroshock survivor), letter to the Food and Drug Administration, 9 February 1988.

1972 — The therapeutic aim is in every case to give the minimum number of fits which will produce the desired result. In elderly people and those suffering from arteriosclerosis these memory disturbances are likely to be of more noticeable degree and longer duration than in young people, and one should be particularly careful in their case. One should also be cautious with the man who uses a highly trained memory in the exercise of his profession.

WILLIAM SARGANT and **ELIOT SLATER** (British electroshock psychiatrists), *An Introduction to Physical Methods of Treatment in Psychiatry*, 5th ed., ch. 2, 1972.

1972 — Finding that the patient has insurance seemed like the most common indication for giving electroshock.

DAVID S. VISCOTT (U.S. psychiatrist), *The Making of a Psychiatrist*, ch. 26, 1972.

1973 — After being at Brockville Psychiatric Hospital [Brockville, Ontario] for three months, Dr. Louis Sipos told me he was going to give me electroshock therapy. I asked Dr. Sipos what that was. He told me they would put electricity through my brain. I was frightened as he told me that and I answered Dr. Louis, “hey, if you put electricity through my brain, it will fry my brain like an egg and scramble it.” Dr. Louis said electroshock therapy was safe, and I protested with him and said I did not want electroshock. He told me he was going to give me ECT and that was that.

So on the morning of my electroshock therapy, apparently a peer on my ward told me many years later as I forgot this part in my memory, as the staff tried to bring me down the hallway to the electroshock room, I yelled and screamed as loud as I could, I bit the staff and kicked them as I did not want to go to the ECT room. I yelled for someone to help me and not let me go into the ECT room, but no one came to my rescue, no one helped me.

Eventually the staff forced me into the ECT room. This I do remember, however. The room had white walls and next to the bed there was steel box with wires coming out of it. I was told to lay on my back while a nurse gave me a needle in my arm. I was looking around the room and wanted out, I wanted to escape. I yelled to the staff I did not want ECT. No one listened to me. I was frightened as I looked around the room and at the staff. It was a traumatizing experience for me that still haunts me to this day. A rubber band was wrapped around my forehead and a rubber mallet put between my teeth. Then the psychiatrist turned on the shock machine and zapped me with electricity through my brain.

SUE CLARK (Canadian electroshock survivor and antipsychiatry activist), presented as written testimony at public hearings on electroshock, Toronto, 9 April 2005, <http://capa.oise.utoronto.ca/personal.html>. Clark underwent 5 electroshocks at the age of 18 in 1973.

1973 — I came home from the office after that first day back feeling panicky. I didn't know where to turn. I didn't know what to do. I was terrified. I've never been a crying

person, but all my beloved knowledge, everything I had learned in my field during twenty years or more, was gone. I'd lost everything that professionals take for granted. I'd lost my experience, my knowing. But it was worse than that. I felt that I'd lost my self. I fell on the bed and cried and cried and cried.

MARILYN RICE (U.S. electroshock survivor, government economist, and founder of the Committee for Truth in Psychiatry, 1923-1992), describing her return to work following a series of 8 electroshocks in 1973, quoted in Berton Roueché, "Annals of Medicine: As Empty as Eve," *New Yorker*, 9 September 1974. In the article, Roueché identified Rice pseudonymously as Natalie Parker. After ECT, she worked briefly and then retired on disability. Her organization, whose purpose is to establish the right of ECT candidates to truthful information about ECT, eventually attained a membership of more than 500 electroshock survivors. An expert researcher, she was a dedicated and outspoken opponent of electroshock administered without genuine informed consent.

1973 — Even today, the fantasy persists of being required to expose the body, of being attacked, wiped out, obliterated, of dying from electrocution, and of suffering permanent memory loss or impaired intellectual functioning. Therefore, a most important aspect of preparing a patient for therapy is to correct his/her fantasies in order to reduce anxiety, and in some cases, even get them to willingly accept treatment.

JAMES STRAIN (U.S. electroshock psychiatrist), "ECT: A Classic Approach Takes New Forms," *Psychiatry*, 1973.

1973 — Psychiatry is the New Priesthood. Now, instead of stretching heretics on the rack, they are plugging people into the wall socket for shock "therapy."

MICHAEL WHITFIELD (Los Angeles), letter to *National Observer*, 16 June 1973.

1974 — The day after I was discharged, my hospital roommate, Ruth, escaped and jumped from the University of Texas tower. She died on impact — a heap of broken bones to go with her broken spirit. Only three days before she had told me that she was tired of walking around like a zombie. She blamed this zombiness on a series of shock treatments she had recently received.

JIMMIE BREWER (U.S. psychiatric survivor), quoted in "NAPA News," *Madness Network News*, June 1974.

1974 — *London*. For two years, patients in a mental hospital in the north of England were given electric shock treatments that — unknown to anyone — did not work.

This bizarre story is recounted in an article in the current issue of *World Medicine*, a magazine for doctors published here every two weeks. And its author, a doctor involved in the treatment with the nonworking machine, suggests the experience raises a further question whether electric shock treatment — "electrical convulsive therapy," and a controversial treatment anyhow — really does patients any good. For, he says, the patients seemed to benefit as much from being put to sleep in preparation for the shock treatment — with anesthetics — as other patients do from the shock treatment itself....

"All the patients had been getting for two years," the doctor concludes, "was thiopentone and a shot of scoline (anesthetic to put them to sleep) — and no one had noticed."

RAYMOND R. COFFEY (U.S. journalist), “Hospital Shocked by Finding No Sock in Its Shock Machine,” *Chicago Daily News*, 20 September 1974.

1974 — and you will learn to forget
you will forget your pain
you will forget your anger
you will forget to rebel
you will forget the confusion and the chaos of being lost inside
yourself
you will forget the journey that you were on
you will forget where you started and you will forget your
destination
you will forget that you had a problem — a very big problem of
trying to find yourself in a world where very little space has
been made for your inner journey

and you will learn to fit in
you will learn to keep the lid on
you will learn to control the intensity of your feelings
you will learn to accept the box you belong in
you will learn to accept the rigid confines of what “they”
consider normal
you will learn that to try to break out of that box is to leave
yourself vulnerable to currents of electricity surging through your brain.

MICKY DUXBURY, opening stanzas, “In Front of Langley Porter,” 3 July 1974, published in Leonard Roy Frank, ed., *The History of Shock Treatment*, 1978. Duxbury read her poem at San Francisco’s Langley Porter Neuropsychiatric Institute during a Network Against Psychiatric Assault demonstration protesting the institute’s use of electroshock on unwilling and misinformed persons.

1974 — The after-effects resulting from aspirin exceed the after-effects of ECT.
LEON EPSTEIN (U.S. psychiatrist), quoted in C. Jacobson, “Questions Raised on Electroshock Treatment,” *Synopsis* (University of California Medical School, San Francisco), 17 May 1974. At the time, Epstein was acting medical director of Langley Porter Neuropsychiatric Institute.

1974 — The Network Against Psychiatric Assault (NAPA) was founded in San Francisco in 1974 to oppose all forms of psychiatric abuse. The group focused on the injustice and inhumanity of such practices of involuntary commitment, forced drugging, electroshock, and psychosurgery. By conducting educational forums and seminars, publishing *Madness Network News* (a journal critiquing mainstream psychiatry), and prompting media attention, NAPA helped give voice to an emerging psychiatric survivors movement. To lend immediacy and import to these educational efforts, whenever feasible NAPA engaged in political activism.

In May 1974, upon discovering that psychiatrists at San Francisco’s Langley Porter Neuropsychiatric Institute, one of California’s best known psychiatric facilities, was using electroshock on non-consenting and misinformed persons, NAPA asked Langley

Porter for information about its practices and the opportunity to discuss them publicly with members of its staff. When Langley Porter failed to respond satisfactorily, NAPA carried out a series of protest demonstrations and rallies on the doorsteps of the institute for the remainder of the year. During this period media coverage intensified and 30 community-based organizations and several elected officials wrote letters supporting NAPA's demand for a public inquiry. In January 1975, the San Francisco Mental Health Advisory Board (appointed by the county's Board of Supervisors) held a public hearing on the practice of electroshock not just at Langley Porter but at other psychiatric facilities in the city as well. Wade Hudson, representing NAPA, and physicians, both opposed to and in favor of ECT, made presentations followed by statements, almost all strongly critical of ECT, from a large number of electroshock survivors who were in the audience.

The controversy caused by the hearing and the preceding events led directly to a suspension of ECT in the city and county of San Francisco which lasted several years.

LEONARD ROY FRANK (U.S. electroshock survivor and editor).

See Ted Chabasinski's entry in 1982 below.

1974 — In 1974 the Network Against Psychiatric Assault proposed to California Assemblyman John Vasconcellos that he introduce legislation affording all mental patients the right to refuse “chemotherapy” (drug treatment), “shock treatments,” and “psychosurgery.” Vasconcellos accepted the challenge but soon realized that resistance from the psychiatric profession would make passage of such a bill virtually impossible. He then modified the bill so that it would only regulate “convulsive treatment” (meaning “electroconvulsive treatment” and “insulin coma treatment”) and psychosurgery. Enacted in 1975, psychiatrists soon judicially challenged the law, which was enjoined by a superior court judge because parts of it, he said, unconstitutionally restricted the practice of medicine. After being revised, the law was passed in 1976 and took effect the next year, thus becoming the first state law to regulate ECT. Since then, more than 30 states have enacted legislation regulating the procedure. Regarding its provisions concerning ECT, the California law requires that:

- A board-certified or board-eligible psychiatrist or neurologist “other than the patient’s attending or treating physician” must verify that the voluntary patient “has the capacity to give and has given written informed consent.”
- The decision to administer convulsive treatment to an involuntary patient, including anyone under guardianship or conservatorship, be reviewed by a committee of two physicians who both agree with the treating physician that “all reasonable treatment modalities have been carefully considered and that the treatment is definitely indicated and is the least drastic alternative available for this patient at this time.”
- If an involuntary patient’s attorney (or public defender) believes that the patient does not have the capacity to give informed consent, a superior court shall be petitioned to decide the issue. If the court, at an evidentiary hearing, determines that the patient does not have the capacity to give informed consent, convulsive treatment may be performed after written informed consent is obtained from the patient’s responsible relative, guardian, or conservator.
- If a voluntary patient’s treating physician or verifying physician believes that the patient does not have the capacity to give informed consent, a superior court shall

be petitioned to decide the issue, following the same procedure used in the case of involuntary patients as described in the previous paragraph.

- “No convulsive treatment shall be performed if the patient, whether admitted to the facility as a voluntary or involuntary patient, is deemed to be able to give informed consent and refuses to do so.”
- “Under no circumstance shall convulsive treatment be performed on a minor under 12 years of age.”
- Any physician or facility which administers convulsive treatments shall report quarterly on the number of persons treated with ECT, the status of such individuals, the number of individuals treatments administered, age distribution, sex and race of the patients, number of cardiac arrests, fracture cases, deaths, patients reporting memory loss, and other related information. “The Director of Health shall annually submit to the Legislature the accumulation of such reports.”
- To constitute voluntary informed consent, certain detailed information about the nature, method, and effects of ECT (listed) must be given to the patient in a clear and explicit manner and that the State Department of Health shall promulgate a standard written consent form with all information listed in the law and further information deemed necessary.

A physician who violates any provision of the law concerning specified legal rights of mental patients is subject to “a civil penalty of not more than \$5,000.” Such violation is also “a grounds for revocation of license.”

LEONARD ROY FRANK. NAPA’s campaign for human rights in psychiatry riled more than a few professionals, including **ALEXANDER ROGAWSKI**, professor of psychiatry at the University of Southern California School of Medicine and president of the section on psychiatry of the Los Angeles County Medical Association. He told a reporter that NAPA was like “a dog that bites on your heels and hinders you in what is obviously a very important job.... We’ve got enough troubles from the regular sources of the community. We don’t need these bastards to complicate matters. NAPA is no more than a fringe organization that continues to hamper our efforts” (quoted in Joy Horowitz, “Ex-Mental Patients Unite to Help Those Still Held,” *Los Angeles Times*, 30 May 1976).

See Rusk and Read’s entry in 1975, Ted Chabasinski’s in 1982, and Peter Breggin’s in 1989 below.

1974 — silent too long
time now to speak truth

time now as pendulum crests to swing back
not with like for like
not with weapons used against us
but with conscience call to people
to reveal atrocities we have known
to demand accounting from false healers
in brown shirts under white jackets
conditioned to/thru brutality
having enstoned their hearts
damned us by inches by miles [opening stanzas]...

we see them on wards
and in isolation
and in treatment rooms
we see them strapped onto beds and tables
writhing and convulsing
in their agony
we hear their pleas for mercy
their gasps
their screams
we feel their pain
their humiliation
their tears
rolling
down
our
cheeks

and our souls rebel within us
this barbarism must cease [closing stanza].

LEONARD ROY FRANK, “An End to Silence,” *Madness Network News*, September 1974, published in Frank, ed., *The History of Shock Treatment*, 1978.

1974 — EST has been described as “... a bogus, barbaric, and destructive weapon...” (quoted from NAPA literature). This statement is arrogant because the people who write such things arrogate to themselves high principle, high morality, care and concern for the rights and welfare of the mentally ill, and infer that we professionals who daily spend our lives and our skills alleviating suffering are inhuman barbarians who get sadistic kicks out of punishing and torturing patients.

ALLAN M. GUNN-SMITH (U.S. electroshock psychiatrist), letter to Assemblyman Carmen Perino, 16 December 1974, quoted in Network Against Psychiatric Assault, “NAPA Notes,” *Madness Network News*, April 1975. Gunn-Smith, who was Project Director of the geriatric-psychiatric ward at Stockton State Hospital (California), acknowledged having administered, during the previous 6 years, more than 4,000 electroconvulsive treatments to about 200 persons mostly between the ages of “65 and 100.”

1974 — “You can feel nothing. We will give you a shot.”

Yes, grappling in those starched gowns,
pulling me past the sheet wall you’ve hung,
hauling, thrashing, begging don’t
oh, please, don’t it hurts I can feel it I do remember —
everything.

Shot. Unsmiling head, administrator,
administers the shock,
his face etched in me charge by charge.
“Stop that. It does not hurt. You will not feel it.
Stop fighting us.”

Through me
like a wave of spasms
ripples the shock.

GAIL LARRICK (U.S. electroshock survivor), "Shock," published in Sherry Hirsch, et al., eds., *Madness Network News Reader*, p. 85, 1974.

1974 — Already things have become clouded
And God how I fear the clouding!
The fearful maze is jumbled and confused
And broken by flashes of half-forgotten glimpses
And a feeling of horror whose source is forgotten

Our treatment is not enough
More trips down that fearful hall
Hard to say how many
And it may not work
The dejection and the agony may continue
Or get worse or return all too soon
There are so many risks
And I have been given no choice

The room is empty now,
But the fear is still there
It lingers there in hazy memories
For those who look at the room empty
And those who have experienced it full.

ANNE MUELLER (U.S. electroshock survivor), "The Room," *Berkeley Community Health Project Newsletter* (California), December 1974.

1974 — Richard H. Trapnell, M.D., chief of the psychiatric ward at San Francisco's St. Francis Memorial Hospital, where in 1974 alone 1,373 electroshock treatments were carried out, in a letter (dated November 21, 1974) to the entire St. Francis medical staff, found it "deplorable that a small group (referring to NAPA) of ill-informed fanatics appear to have influenced Assemblyman Vasconcellos in sponsoring AB 4481." The idea of ECT, one of the grossest, most violent, dehumanizing techniques ever devised by man, being used on a wholesale basis in a hospital named after the gentlest of saints is enough to make you vomit. We'd like to ask Dr. Trapnell if he would have administered ECT to Francis of Assisi, who at various times during his life manifested such "symptoms" as hallucinations, exhibitionism, hostility, grandiosity, depression, withdrawal, raptures, guilt, and delusions, which according to psychiatric ideology indicate severe "mental illness."

NETWORK AGAINST PSYCHIATRIC ASSAULT, "NAPA Notes," *Madness Network News*, April 1975.

1974 — When pain is a factor in certain other conditions of a chronic nature that have not responded to anything else, such as severe backaches, I have seen complete cures from shock treatment [ECT]. I have seen a miraculous result in a causalgia case treated

by another psychiatrist with shock treatment. Another psychiatrist friend of mine cured a life-threatening case of Stevens-Johnson syndrome.

In my own experience I have seen such psychosomatic disorders as ulcers, spastic and ulcerative colitis, asthma, psoriasis, trigonitis, all respond to shock treatment with remission.

ROBERT PECK (U.S. electroshock psychiatrist), *The Miracle of Shock Treatment*, ch. 4, 1974. Peck also found that ECT was “a good treatment for intractable pain such as is found in cancer patients.”

1974 — I do not know any formal use of [shock treatment] in brain washing [*sic*] but it seems possible it could be so used. One can conjure up an image of large groups of dissidents in a police state being kept in a contented state of apathy by shock treatment. **ROBERT PECK**, *The Miracle of Shock Treatment*, ch. 8, 1974.

1974 — There exists some feeling among psychiatrists, myself included, that best results in shock treatments correlate with greatest amount of organicity (memory defect). **ROBERT PECK**, *The Miracle of Shock Treatment*, ch. 9, 1974.

1974 — [The old personality] was dead. Destroyed by order of the court, enforced by the transmission of high-voltage alternating current through the lobes of his brain. Approximately 800 mills of amperage at durations of 0.5 to 1.5 seconds had been applied on twenty-eight consecutive occasions, in a process known technologically as “Annihilation ECS” [ECT]. A whole personality had been liquidated without a trace in a technologically faultless act that has defined our relationship ever since. I have never met him. Never will.

ROBERT M. PIRSIG (U.S. electroshock survivor and writer), *Zen and the Art of Motorcycle Maintenance*, ch. 7, 1974.

1974 — *Interviewer*: You say you’d rather have a lobotomy than electroconvulsive shock? Do you have some pretty solid ideas about what electroconvulsive shock does?
Pribram: No — I just know what the brain looks like after a series of shocks — and it’s not very pleasant to look at. Not that it can’t be effective as a treatment if carefully used. The same is true of psychosurgery.... I would try electrical stimulation of the brain [ECT] first, rather than cutting, because I think that the same results can be obtained.
KARL PRIBRAM (U.S. psychologist, psychiatrist, and psychosurgeon), “From Lobotomy to Physics to Freud... an Interview with Karl Pribram,” *APA Monitor* (“A Publication of the American Psychological Association”), September-October 1974. In the interview, Pribram described one of “the ethical problems” encountered when he was a researcher for “the Connecticut lobotomy project” at Yale during the 1940s: “We had a young lady whom we had studied very intensely prior to lobotomy. Of course, with all the attention and everything that we gave to this patient, she got well. And so the question was: What do we do now? So I said, ‘It’s very obvious. Now we send her home.’ But I was voted down, essentially. They decided to do the lobotomy anyway because all the studies had been done.”

1974 — All your two-bit psychiatrists
Are giving you electroshock

They said, they'd let you live at home with mom and dad
Instead of mental hospitals
But every time you tried to read a book
You couldn't get to page 17
'cause you forgot where you were
So you couldn't even read.

LOU REED (U.S. electroshock survivor, songwriter, and performer), "Kill Your Sons" (song), 1974. Reed was electroshocked in 1961 at the age of 17.

1974 — The central idea of ELT is the selective loosening and erasure of traumatic and bad memories of a given personality pattern for the purpose of immediate reprogramming so the patient can develop into a new personality.

H. C. TIEN (Chinese-born U.S. electroshock psychiatrist), "100 Questions and Answers on ELT: The Electrolytic Therapy of Psychosynthesis," *World Journal of Psychosynthesis*, February 1974. In the same article Tien, who introduced ELT in 1962, described the procedure as a form of "therapeutic programming" that combines ECT with psychotherapy, long-term family therapy, T.V. monitoring, bottle-feeding, and "transnomation" ("therapeutic name-change"). Following an ECT treatment, "The patient is prepared and transferred in the infant-like state for immediate reprogramming in the family session. The patient is usually transferred on cart to a private bedroom for the family session [in which] the patient is actually bottle-fed by a relative, parent or spouse in order to re-establish rapport and a new consciousness with significant others in the family.... Most patients accept best the formula of half-chocolate and half-white milk. Funny enough. One of the patients was said to be 'allergic to chocolate' milk by his mother, but his wife programmed him to like chocolate milk during ELT: he now drinks chocolate milk." Tien asserted that there was "no going back" to traditional ECT in treating "involutional depression," because "patients are often left alone and confused after shock treatment without the love of a relative or the personalized attention of the wife or husband or of a parent. Whereas in ELT, the patient and his family work together, such that E stands for Electricity, L stands for Love and E + L = T, therapy!" And there you have it — ELT, electrolove therapy!

1973-1974 — According to information that has been submitted to [Massachusetts's Mental Health Department] by the hospitals themselves, from April 1973 through April 1974, more than 28 percent of all patients admitted to private mental hospitals [in Massachusetts] were given shock therapy.

RICHARD GAINES (U.S. journalist), "Electric Shock 'Therapy' Still Used to Excess," *Boston Phoenix*, 3 June 1975.

1975 — The Academy Award winning film *One Flew over the Cuckoo's Nest* was released. Based on Ken Kesey's novel, one horrific scene shows Randle Patrick McMurphy, the film's heroic rebel played by Jack Nicholson, undergoing "unmodified" electroshock, i.e., without an anesthetic and muscle relaxant. The psychiatrists' basic response to the bad publicity generated by the film was to say, "we don't do it that way anymore."

See Ken Kesey's two entries in 1962 above.

1975 — Recent memory loss [caused by ECT] could be compared to erasing a tape recording.

ROBERT E. ARNOT (U.S. electroshock psychiatrist), “Observations on the Effects of Electric Convulsive Treatment in Man — Psychological,” *Diseases of the Nervous System*, September 1975. Arnot’s choice of metaphor may have been influenced by reports in the media around the time of his writing the article that 18 minutes of President Richard Nixon’s secretly recorded White House tapes had been mysteriously erased.

1975 — Obviously if one is committed exclusively to psychotherapy, then the memory loss produced by the E.C.T is undesirable, because the patient may not recall the symptoms or the problems and conflicts that theoretically may have been part of the cause of the illness.

Actually, in the author’s opinion, the recent memory loss is beneficial. The patient gains from not recalling the psychotic episode and delusional material. This material is, I believe, like a nightmare that hangs over the rest of the patient’s life if he remembers it. If the memory of the illness is erased, I personally think that the patient can attain a better level of adjustment and recovery than if E.C.T is not used and if he improves, for example, with psychotropic drugs where the memory of the psychotic episode is still with him....

The mood returns to normal and remains there even after the series of E.C.T. is completed so that the effect is not just transitory. For the treating psychiatrist the appearance of the smiling, happy patient, who was formerly sad and dejected, is a very satisfactory [*sic*] experience. Likewise, the removal of the excessive demands of the formerly manic patient is for the psychiatrist a relief....

During the course of E.C.T, particularly between the fourth and eighth [*sic*], the level of anxiety is often markedly increased and may sometimes be accompanied by an apparent state of confusion.... The patient may say that he is being made worse and insist that the treatments be discontinued. But, for a satisfactory result, it is important to continue the ECT through this phase until the excessive anxiety subsides. The concomitant use of major and minor tranquilizers also helps through this phase.

ROBERT E. ARNOT, “Observations on the Effects of Electric Convulsive Treatment in Man — Psychological,” *Diseases of the Nervous System*, September 1975.

1975 — In former times, “classical” shock treatments commonly caused bone fractures among those racked by the violent physical convulsions. Although roughly 10 percent of today’s patients still get such unmodified ECT, most now first receive a sleep-inducing barbiturate like sodium pentothal, and the muscle-paralyzing agent succinylcholine, or Anectine. While an electrical storm rages unabated in the brain, these drugs suppress its outward manifestations, sparing witnesses the terrifying spectacle the body’s violent spasms.

These “improvements” are like the flowers planted at Buchenwald. Besides, they create their own risks, and don’t always work. The muscle paralyzer can cause prolonged failure to breathe and cardiac shock. The paralysis may also intensify the horror of the patient’s experience....

While barbiturates make for a smoother trip into unconsciousness, they also increase the chances of death by choking. Although they do produce sleep, they do not bring a

complete loss of feeling. Among former ECT patients I interviewed, many could recall the instant of shock itself, even though unable to recall surrounding events. One young man reported: “That pain went right through your head. All you’re aware of is this jolting pain going through your mind like an electric crowbar.”

JOHN FRIEDBERG (U.S. neurologist), “Let’s Stop Blasting the Brain,” *Psychology Today*, August 1975.

1975 — I open my mouth and the scream surrounds me. My body a lurch and a scream of pain. I am impaled on a pain. A firecracker, pain and lights, burning, screaming, my bones and my flesh. I am on fire. Shorter than a second. The fragments of a bomb sear my body. Blue-white lights, fiercer than God, going through me, my body, poor body, a contortion, a convulsion of ripping, searing. Pain incarnate. Branded. I cannot comprehend. Burning, burning, my fingers and toes, my limbs rigid with pain, stretched longer than the night. Shooting, shooting again, my body is charred. No breath. Hiroshima. The living dead.

JANET GOTKIN (U.S. electroshock survivor, writer, and researcher), *Too Much Anger, Too Many Tears: A Personal Triumph Over Psychiatry*, pt. 1 (“Franklin Central Hospital”), 1975. Gotkin underwent 100 electroshocks in the early 1970s. See Gotkin’s entry in 1985 below.

1975 — That night I dreamed I was being electrocuted. Again I felt the white-hot shocks screech through my body and I woke up screaming.

“Why Janet, what is the matter with you?”

“They’re trying to kill me, Miss Jones.”...

I wondered when they would be over, these ritual burnings. The pain, I would never survive the searing pain.

“Paranoid delusions,” they wrote on my chart. “She thinks there is a conspiracy to kill her by electrocution.”

JANET GOTKIN, *Too Much Anger, Too Many Tears: A Personal Triumph Over Psychiatry*, pt. 1 (“Franklin Central Hospital”), 1975.

1975 — Multiple monitored electroconvulsive treatment [MMECT] appears to be a safe, effective procedure for use in patients with depressive psychosis and acute schizophrenia who do not respond to psychotropic drugs, Dr. Charles Goldfarb said at the Annual Meeting of the American Psychiatric Association.

The procedure, which consists of the administration of multiple grand mal seizures at one or more treatment sessions, monitored on EEG and ECG, should be used in more psychiatric facilities, said Dr. Goldfarb, Department of Psychiatry, New Jersey Medical School, Newark [opening paragraphs]...

As many as 18 MMECT treatments can be given at the same session “without deleterious effect,” he [said].

G. H. GROSSER (U.S. electroshock psychiatrist) et al., “The regulation of Electroconvulsive Treatment in Massachusetts: A Follow-Up,” *Massachusetts Journal of Mental Health*, vol. 5, 1975. Goldfarb said that “a total of 35 seizures were given in 60-minute periods on 2 consecutive days — 17 the first day and 18 the second — to” an “acute, catatonic schizophrenic patient” who was in a “hypokinetic, stuporous state.”

1975 — A way of administering electroconvulsive therapy so that the shock reaches a fully conscious patient at the same time his most disturbing thoughts are present in the “mind’s eye” has produced dramatic improvement in some previously hopeless cases, Dr. Richard D. Rubin said at the silver anniversary meeting of the Canadian Psychiatric Association....

“One case was that of a fireman whose particular hallucination was that he talked to Jesus Christ. I sat by his bed for 3 hours, waiting wired up throughout this time, a syringe of succinylcholine [a muscle relaxant] inserted in a vein, and my finger resting near the button.

“When his hallucination finally occurred, the 40 mg. of succinylcholine was injected to prevent risk of fracture and, at the very instant fasciculation [twitching] was observed, the ECT was administered.”

INTERNATIONAL MEDICAL NEWS SERVICE, “ECT Timed with Disturbing Thoughts,” *Clinical Psychiatry News*, December 1975.

1975 — The three Alabama physicians and the non-physician superintendent at Bryce Hospital who were cited for civil and criminal contempt in the *Wyatt* case for failure to follow court-ordered guidelines in the administration of ECT have been found not guilty of the charges. However, the court did find that “each instance in which ECT was administered to an involuntary patient at Bryce Hospital without that patient’s own express [*sic*] and informed consent constituted a clear and direct violation of Standard 9” of the court’s 1972 order.

Of the seven patients receiving ECT following the court’s decree, only one, according to the court’s findings on the contempt charges, possibly gave the proper consent. In all seven cases, the electroconvulsive therapy was administered by F. N. Codina, M.D., one of the named defendants. The other three named defendants were James C. Thompson, M.D., James E. Morris, M.D., and Rod Clelland [opening paragraphs]....

It was on the basis of relying on the hospital’s policy, rather than the court’s decree, that Codina, acting, according to the court’s opinion, “reasonably and in good faith” administered ECT to patients whose condition, in his judgment, warranted such treatment.

“Criminal contempt requires proof of both a contemptuous act and a wrongful, contumacious state of mind,” noted U.S. District Judge Frank Johnson, stating further that “a finding that the offending act was willfully performed does not necessarily indicate that the accused possessed the contumacious intent which is an element of criminal contempt.”...

Alan A. Stone, M.D., chairman of APA’s Commission on Judicial Action, felt that “we were extremely fortunate” in receiving such a lenient ruling from Judge Johnson. He said, “The judge’s opinion made it clear that he was concerned, in my opinion, about driving doctors out of the state institutions. He seemed to have bent over backward in emphasizing that there was neither the intent for criminal contempt nor any damages to anyone for civil contempt; this certainly was the most generous interpretation.”

PSYCHIATRIC NEWS, “Alabama MDs Acquitted of Contempt Charges,” 15 October 1975.

1975 — The abuses of ECT, as they exist now, seem to fall into two major categories; first is the financial abuse. ECT in California is extremely lucrative and this encourages its

overuse. In Canada, and especially in Quebec, where the amount of money paid the psychiatrist for giving ECT has dropped to somewhere between \$5 and \$10 a treatment as opposed to the \$40 or \$50 here, the use of ECT has dropped precipitously. It is no secret that psychiatrists who heavily use ECT and medications for that matter, treatments that can be exploited for maximum earnings per hour, frequently have incomes in excess of \$100,000 to \$200,000 per year. On the other hand, psychiatrists who restrict their practices to mild to moderate use of medication, avoidance of hospitalization and little or no use of ECT rarely have incomes in excess of \$60,000.... The other abuse of ECT, less frequent but still present, is its use as punishment for patients in hospitals. Although not as common as it was previously, ECT is often used as a threat to induce patients to change their behavior. If this were occurring in prisons, public outcry would definitely arise and yet the subtle means of control such as telling an unruly patient "you're very depressed today and will need some more shock treatment" must raise questions of cruel and unusual punishment.

THOMAS N. RUSK and **RANDOLPH A. READ** (U.S. psychiatrists), letter to California Assemblyman John Vasconcellos, 9 January 1975, "Dear John," *Madness Network News*, April 1975. Vasconcellos's introduction of legislation regulating the use of electroshock and psychosurgery (later enacted) had prompted many proponents and opponents of ECT to write him.

See Leonard Frank's entry in 1974 above.

1976 — There were 2 deaths among patients who underwent intensive electroshock, including "a paranoid schizophrenic who had been receiving 10 treatments daily for a few days" [editor's summary].

PAUL H. BLACHLY (U.S. electroshock psychiatrist), "Multiple Monitored ECT: (MMECT)," *Convulsive Therapy Bulletin*, July 1976.

1976 — Many husbands still beat up their wives.... Other husbands just sign consent for the "medical treatments" called shock, and let the experts do it for them.

OLLIE MAE BOZARTH (U.S. electroshock survivor), "Shock: The Gentleman's Way to Beat Up a Woman," *Madness Network News*, June 1976.

1976 — [Among the 183 patients who underwent ECT at the Royal Edinburgh Hospital in 1971 and 1976, 2 deaths] may have been related to ECT. A 69-year-old woman died 24 hours after her 13th treatment. Postmortem showed a myocardial infarction [heart attack]. A 76 year-old woman also died 48 hours after her 13th ECT. Postmortem showed a myocardial infarction 24-48 hours old. Both patients were taking a tricyclic [antidepressant] drug at the time.

C. P. L. FREEMAN and **R. E. KENDELL** (British electroshock psychiatrists), "ECT: I. Patients' Experiences and Attitudes," *British Journal of Psychiatry*, July 1980.

See Leonard Frank's entry in 1971-1982 below.

1976 — Arguments on practical grounds concerning the use of ECT are clear enough, but when made publicly, psychiatry becomes vulnerable to criticism as political and sociological aspects of the problem come into focus. Once in the public domain, professional control over the basic data asserting no or negligible brain damage is lost among these other questions and concerns. To the practicing neurologist as well as to

the civil libertarian — the question is not one of large damage, but small or subtle damage. It is not whether or not one can coffee-klatch or drive a car, but as in the famous case of Phineas Gage in the 19th century when he returned after the pike injury to his frontal lobe — the comment was “It’s not Gage.”

ROBERT J. GRIMM (U.S. neurologist), “Statement to APA [American Psychiatric Association] Task Force on ECT,” unpublished letter (modified by Grimm), 7 May 1976, published in Leonard Roy Frank, ed., *The History of Shock Treatment*, 1978. See Lawrence Olivier’s entry in 1953.

1976 — For many hundreds of years one of the favorite treatments in medicine was bloodletting. We now know that didn’t do anyone any good. It did the doctors good because they could collect money for it. Now, electroshock is very much like bloodletting. It is a kind of mindletting in the sense that the person who gets it ends up with less mind than he had before the treatment. That may seem to be a good effect if somebody wants him to think less and be less bright and less thoughtful and less reflective.

THOMAS S. SZASZ (Hungarian-born U.S. psychiatrist), interview in a 2-part series on ECT, news program anchored by Tom Snyder, NBC, 20 February 1976.

1975-1976 — During July 1, 1975 to July 1, 1976, 12 of the 42 patients (28%) who underwent modified ECT at New York Hospital developed an arrhythmia or ischemia following the procedure. In patients with known cardiac disease the complication rate rose to 70%. This rate may have been even higher had all 17 cardiac patients been monitored. The four cardiac patients with no complications were not monitored so arrhythmias could easily have been missed. The 12 patients who developed cardiac complications of ECT came entirely from this group of 17 cardiac patients....

Four patients developed severe complications following an ECT treatment. E.S. sustained a cardiopulmonary arrest 45 minutes after her fifth treatment. She expired despite an intensive resuscitative effort.

JOAN P. GERRING and **HELEN M. SHIELDS** (U.S. psychiatrists), “The Identification and Management of Patients with a High Risk for Cardiac Arrhythmias during Modified ECT,” *Journal of Clinical Psychiatry*, April 1982. Elsewhere in the article, the authors described the 4 patients’ “severe complications” as “life threatening events.” Of the 12 patients who developed an arrhythmia or ischemia following ECT, there were 8 women and 4 men. They ranged in age from 58 to 80; half were between the age of 65 and 69. The patient who died was 71. Both authors were residents in the Department of Psychiatry, Cornell University Medical College, New York City, when this study was conducted.

1977 — Controversies about the use of ECT for treating emotional or behavioral disorders are not new. Inducing grand mal seizures by passing across the head a current which would be fatal if applied to the chest, is startling. Thus, psychiatrists do not immediately view all ECT’s opponents simply as meddling cultists; psychiatrists recognize that the burden of proof properly rests with the proponents of so dramatic a treatment.

COLORADO PSYCHIATRIC SOCIETY, “I. Report and Recommendations of a Task Force of the Colorado Psychiatric Society” (introduction), *Electroconvulsive Therapy in*

Colorado, October 1977. The Task Force went on to recommend guidelines for ECT in line with standard psychiatric practice.

1977 — Many people would like to see the use of ECT quietly abandoned. But the momentum of habit and the inertia of interest rarely yield quietly. We are talking about a behavior with roots in the age of lobotomy, insulin coma, pentylentetrazol convulsions and the final solution; a behavior with powerful rewards of prestige and high incomes; a behavior invested with the fervor of faith.

JOHN FRIEDBERG (U.S. neurologist), “ECT As a Neurologic Injury,” *Psychiatric Opinion*, January/February, 1977.

1977? — A Corvallis psychiatrist intimidated me into receiving electroshock at the Oregon State Hospital in Salem, telling me it was the “up and coming treatment” for bipolar disorder. He threatened that if I didn’t go through with it I would be permanently institutionalized. And I was on court commitment so I didn’t have much choice.

They strapped me down, and when I woke up, I had the worst headache of my life. I wanted to tear down walls it hurt so bad. Well the “treatment” for that was to put me in restraints. And here I couldn’t remember my own name for a day, or where I was, why I was there. I was terrified and confused.

You come out of the blackness of anesthesia, and you have a complete blank in your brain. It’s probably like being born, except as an adult. I had eleven “treatments” over the course of five months. As far as helping, the electroshock had no therapeutic value at all. None. To this day, friends will share with me some of the great times we had together, and I just can’t remember.

JODY A. HARMON (U.S. electroshock survivor), Oryx Cohen interview, Summer 2001, Oral History Project, mindfreedom.org/histories.shtml

1978 — An extensive American Psychiatric Association membership survey reports that 41 percent of the respondents agreed with the statement, “It is likely that ECT produces slight or subtle brain damage”; 26 percent disagreed [editor’s summary].

AMERICAN PSYCHIATRIC ASSOCIATION, *Electroconvulsive Therapy* (Task Force Report 14), ch. 1, 1978.

See Peter Sterling’s entry in 2001 below.

1978 — The truth is... that electroshock “works” by a mechanism that is simple, straightforward, and understood by many of those who have undergone it and anyone else who has truly wanted to find out. Unfortunately, the advocates of electroshock (particularly those who administer it) refuse to recognize what it does, because to do so would make them feel bad.

Electroshock works by damaging the brain. Proponents insist that this damage is negligible and transient — a contention that is disputed by many who have been subjected to the procedure. Furthermore, its advocates want to see this damage as a “side effect.” In fact, the changes one sees when electroshock is administered are completely consistent with any acute brain injury, such as a blow to the head with a hammer.

LEE COLEMAN (U.S. psychiatrist), introduction to Leonard Roy Frank, ed., *The History of Shock Treatment*, 1978.

See Peter Sterling's entry in 2001 below.

1978 — The principal complications of EST are death, brain damage, memory impairment, and spontaneous seizures. These complications are similar to those seen after head trauma, with which EST has been compared.

MAX FINK (Austrian-born U.S. electroshock psychiatrist, founding editor, in 1985, of *Convulsive Therapy*, renamed *The Journal of ECT* ["Official Journal of the Association for Convulsive Therapy"], and currently the world's leading proponent of ECT, 1923-), "Efficacy and Safety of Induced Seizures (EST) in Man," *Comprehensive Psychiatry*, January-February 1978. Eleven years later, Fink was quoted in a magazine article as saying, "I can't prove there's no brain damage [from ECT]. I can't prove there are no other sentient beings in the universe, either. But scientists have been trying for thirty years to find both, and so far they haven't come up with a thing" (Russ Rymer, "Electroshock," *Hippocrates*, March-April 1989).

See Peter Sterling's entry in 2001 below.

1978 — Shock is what finally validates psychiatrists and makes them look and feel like real doctors. Shock is their big gun, their open-heart surgery.

JOHN FRIEDBERG (U.S. neurologist), quoted in Dean Katz and Rick Anderson, "Doctors Split over Use of Electroshock," *Seattle Times*, 8 October 1978.

1978 — In the whole of medicine, actually, there is nothing so predictable as the effect of ECT in a depressed patient — not in any other patient, but in a typical depressed patient. It is absolutely predictable that the patient will get better, that he can go back to work in three weeks.... Nothing is so predictable in medicine, not to talk about psychiatry [ellipsis in original].

LOTHAR B. KALINOWSKY (German-born U.S. electroshock psychiatrist), Margaret C. McDonald interview, "ECT: Lothar Kalinowsky Remembers," *Psychiatric News*, 5 May 1978.

1978 — Dr. [Albert] Hurley admitted that some patients have been forced to take E.C.T. at Providence [Medical Center in Seattle].

When a reporter said hospital personnel have told of patients being brought "kicking and screaming" to the shock room by nurses and attendants, Dr. Hurley responded: "I think patients have had to be brought to the room against their immediate will, but they already had indicated a willingness to have the treatment."

In those instances, he said, "we had informed consent from somebody — a responsible relative or somebody. If someone isn't able to sign their name, we have a responsible relative sign for them."

Providence's consent form states the agreement can be abrogated at any time by either party. State law provides that anyone shall have a right to refuse to consent to shock treatment and that only a court can order involuntary shock treatment.

Other inquiries about use of E.C.T. at Providence brought occasional outrage in Dr. Hurley's response.

"I think your informant's a goddamn liar," he said at one point to reporters.

DEAN KATZ and **RICK ANDERSON** (U.S. journalists), “Providence Hospital Is Shock-Treatment Center,” *Seattle Times*, 8 October 1978. Hurley was Providence’s psychiatric director. According to Katz and Anderson, 191 patients received “a total of 1,528 treatments in 1977 [making Providence Washington] state’s major E.C.T. treatment center. More than one-third of all state E.C.T. patients are treated there. And it has, in medical circles, earned Providence the unwanted title of ‘The Shock Shop.’ The hospital does not wear it proudly.”

1978 — [Providence’s Dr. Albert] Hurley was asked about a recent case at his psychiatric unit where a 64-year-old, psychotically depressed former Boeing employee entered the hospital and began receiving shock treatments within four days. He responded: “That would be pretty unusual, to come in and have shock that soon.”...

The man, he was told by reporters, was in good physical health, according to his personal doctor. The man’s widow said he never previously had psychiatric counseling or had taken drugs other than a mild tranquilizer.

He remained in Providence about 2 weeks, receiving 6 shock treatments and, 24 hours after the last treatment, on August 12, died.

Cause of death, according to the official death certificate citing an autopsy done at Providence, was listed as pulmonary embolus — or blood clot of the lungs.

“I think it’s very unlikely,” Dr. Hurley said, “that the death was connected with the man’s treatment. It’s a question I can’t even answer — it hasn’t come up for review, yet. But this would be the first case ever reported here, and it is up to the pathologist to say something if it was — and he hasn’t.”

Dr. Hurley added:

“There are, of course, complications with this treatment, mainly the drugs — the anesthetics — and sometimes the resuscitation involved in post-treatment. One guy almost died the other night.”

DEAN KATZ and **RICK ANDERSON**, “Providence Hospital Is Shock-Treatment Center,” *Seattle Times*, 8 October 1978.

1978 — I have been a registered nurse for 13 years and I’ve been a psychiatric nurse for the past five....

I have seen the shock doctor try out all kinds of drugs, mixing them and using them in such a way that the patient would get worse. Worse. And then the doctor [would have a case for using] ECT as “all else has failed.” Often, if a lot of anticholinergic drugs are given at once, the patient can go into a worse state and it’s called an anticholinergic psychosis. I have seen him do this several times with different patients. It can be made to look in the chart that ECT is the last resort.

I have seen consults with other psychiatrists which are required by law, signed and written up when the patient was in the process of being put under anesthesia. This is clearly illegal.

Patients are badgered to consent to another series after the first series is finished. At this point they are often confused and do not remember how many treatments they have had. Can this be legal informed consent?

Patients are often given a soft sell and not told of the possibilities of irreversible brain damage. Thus, they cannot truly make an informed consent.

CATHIE MEYER (U.S. nurse), testimony at a hearing on electroshock conducted by the Berkeley Human Relations and Welfare Commission, 24 April 1982, published in “Electroshock Hearings in Berkeley,” *Madness Network News*, Spring 1983.

1978 — [Some view ECT as] a club. Madhouse keepers once carried clubs — real clubs made of oak or maple — as they made their rounds. In modern American state hospitals the nurses no longer carry clubs, but they have at their call the hospital’s security police, who do. Those clubs are an intrinsic part of the institution’s social structure: they enforce the rule that orders shall be given by staff and obeyed by patients.

The thousands of physicians who use ECT understandably find the shock-as-club analogies offensive in the extreme. Physicians see themselves as healers, not bullies; their weapons are weapons against disease, not against individuality or autonomy. They look inward, observe that their intentions are honorable, and conclude that their critics are misguided or malicious.

EDWARD M. OPTON JR. (U.S. attorney and psychologist) and **ALAN W. SCHEFLIN** (U.S. professor of law), *The Mind Manipulators*, ch. 9, 1978.

1978 — ECT is a technique particularly susceptible to misuse for purposes of mind manipulation. It is cheap. It is quick. In many people it inspires terror. As Dr. [Mark] Zeifert says, “Anticipation of ECT could, of course, be used as an instrument of torture...” [ellipsis in original]. Whether shock therapy actually does damage the brain permanently or not is beside the point here: if it does not, so much the better. The mind manipulator’s usual intent is to control behavior, not to fry brains.

Electroconvulsive shock is only one way to inspire terror, but it is one that has advantages, from the user’s point of view, that are shared by few others. It is legitimized as a standard medical practice, a fact of tremendous importance in a society that condemns torture and terror under their own names....

And finally ECT leaves no visible marks.

EDWARD M. OPTON JR. and **ALAN W. SCHEFLIN**, *The Mind Manipulators*, ch. 9, 1978. Compare: “TERROR acts powerfully upon the body, through the medium of the mind, and should be employed in the cure of madness.... FEAR, accompanied with PAIN, and a sense of SHAME, has sometimes cured this disease. Bartholin speaks in high terms of what he calls ‘flagellation’ in certain diseases” [emphasis in original]. (**BENJAMIN RUSH** [U.S. physician; signer of the Declaration of Independence; author of the first U.S. textbook on mental diseases; inventor of the “tranquillizer” [a chair with straps and a wooden head box that “binds and confines every part of the body”]; and “the father of American psychiatry” whose likeness appears on the seal of the American Psychiatric Association], *Medical Inquiries and Observations, Upon the Diseases of the Mind*, ch. 7, 1812).

1978 — A Philadelphia judge, Lisa Richette, tells of her experience after she became depressed and voluntarily went into a New Jersey clinic. In the hospital she found many of the young women patients were receiving electric shock. They were all voluntary patients who had committed themselves, “but they were taking the shock treatments because if they didn’t they could be committed involuntarily.” That is the threat that doctors can hold over their patients.

Judge Richette said that she knew in the interest of her eventual cure she had to resist. “But the more I resisted, the sicker they told me I was.” Within a week she told the staff she wanted to leave. She was told that even though she was a voluntary patient, the law stated that she could and would be held for seventy-two hours. “I said I’d file a writ of habeas corpus.” Judge Richette said, “They allowed me to leave, and as I was leaving, they said I was psychotic.” (Judge Richette attributes her cure to getting out of her system the antidepressant drugs she had taken and to getting psychological treatment — verbal therapy and assertiveness training — at a university-affiliated hospital that was not shock-oriented.)

JONAS ROBITSCHER (U.S. psychiatrist), *The Powers of Psychiatry*, ch. 16, 1980. Richette’s account was based on an article by Dianne Gordon published in the *Philadelphia Bulletin*, 6 October 1978.

1979 — While there can be no doubt that [electroshock] frequently causes great harm, it is possible that many individuals escape with little or no bad aftereffects. Most important, experiences with personal friends have shown me that even individuals who feel they have been harmed by the treatment can nonetheless live fully responsible, worthwhile, and happy lives.

PETER R. BREGGIN (U.S. psychiatrist), preface to *Electroshock: Its Brain-Disabling Effects*, 1979.

1979 — [Electroconvulsive] treatments must be described and given with compassion. After all, patients are likely not to be stupid, insensitive, deaf, or blind. They fear the currents that will pass through their body; they fear pain and brain damage; they anticipate and dread the loss of memory. After the first treatment, they are concerned about their feelings of unreality, confusion, unsteadiness, headache, and nausea. A special concern may be for the feeling of being conscious and unable to breathe, of suffocation, particularly when the anesthesia has been ineptly administered. It is of little help to a waiting and anxious patient to hear the bustle and comments associated with the treatment of another patient or to see a patient in post-ECT confusion or delirium. Proper attention to the courtesies and considerations due patients will do much to relieve their anxiety and our preoccupation with consent procedures and malpractice suits.

MAX FINK (Austrian-born U.S. electroshock psychiatrist), advice to colleagues, *Convulsive Therapy: Theory and Practice*, ch. 16, 1979.

1963-1979 — For more than 10 years psychiatrist Dr. Harry Bailey turned Chelmsford [a private psychiatric hospital in Sydney, Australia] into a chamber of horrors. Many patients did not check out alive....

Bailey treated more than 3,000 patients as guinea pigs for his Deep Sleep Therapy (DST) — barbiturate-induced comas lasting up to three weeks — and Electro-Convulsive Therapy, according to the Royal Commission’s report.

Between 1963 and 1979 at least 24 patients died as a result of DST. Another 24 committed suicide after being discharged.

In all, 183 deep sleep patients died either in hospital or within a year of returning to the outside world, while 977 were diagnosed as brain damaged....

Chelmsford is now closed. Bailey killed himself with drugs in 1985.

MICHAEL PERRY (journalist), “Horror Tales Emerge from Australian Hospital,” *Jakarta Post* (Indonesia), 28 December 1990.
See D. Ewen Cameron’s entry in 1957 above.

1980 — Within hours of arriving at the hospital, I was very carefully treated with electric-shock therapy. ECT is horribly misunderstood. People have this ghastly image of someone standing in a tub of water and putting his finger in a socket. I knew better. I had done some shows about it. The hospital requires a release for ECT. I was so disoriented I couldn’t figure out what they were asking me to sign, but I signed anyway. In my case, ECT was miraculous. My wife was dubious, but when she came into my room afterward, I sat up and said, “Look who’s back among the living.” It was like a magic wand. ECT is used as a jump starter to get you back. From that point on — six weeks I was in the hospital and to this day — I’ve been treated with medication.

DICK CAVETT (U.S. electric-shock therapy patient and television personality), describing his experience with ECT during “my biggest depressive episode” in 1980, “Goodbye, Darkness,” *People*, 3 August 1992.

1980? — It’s been 7-8 years since I had [ECT], the long term damage is there and it’s not coming back. At one time I never minded filling out job applications, I loved to read, my goal was to finish high school G.E.D. [General Educational Development] and become somebody.

I can no longer fill out applications. I’m not able to retain anything I might learn, I read and the next minute it’s gone. I can’t follow written instructions, I become confused. Just the other day I had to fill out an application for Food Stamps. I couldn’t do it. I started to cry. Something so simple and it deals with current things, I just couldn’t handle it.

At one time I tried to file for Social Security. I could not remember places I worked or years. My mother tells me I was always good with dates, years, etc, not no more. I can’t do any math, I’ve been tutored and helped and it won’t sink in. I can read a page in a book and look up and not have any recollection of what I read. I have lost my ability to learn and better myself....

I’d also like to tell you that since the ECT I lost my first husband, I have hardly any memory of him, we were married 10 years.

I can no longer remember from day to day. When I’m lucky enough to find work, it’s mass confusion and I usually don’t last too long.

DORIS HEIKILA (U.S. electroshock survivor), letter to the Food and Drug Administration, 25 February 1987.

1980 — One advantage in the use of this treatment as far as hospital staff is concerned is that the effect of successive shock treatments makes the patient more and more confused, regressed, compliant, and — above all — forgetful, until the patient no longer remembers that he is fighting his hospitalization and the use of electroshock treatment. If there is any question whether the patient meets the criteria for commitment, several shocks later all doubts will have disappeared as the patient becomes increasingly more disoriented and confused.

JONAS ROBITSCHER (U.S. psychiatrist), *The Powers of Psychiatry*, ch. 16, 1980.

1981 — The brain- and mind-disabling hypothesis states that the more potent somatic therapies in psychiatry, that is, the major tranquilizers, lithium, ECT, and psychosurgery, produce brain damage and dysfunction, and that this damage and dysfunction is the primary, clinical or so-called beneficial effect. The individual subjected to the dysfunction becomes less able and more helpless, ultimately becoming more docile, tractable, and most importantly, more suggestible or easy to influence. As with any brain-damaged person, the post-ECT patient will tend to deny both his personal problems and his brain dysfunction; the cooperation between physician and patient in this mutual hoax I have labeled *iatrogenic denial*....

Individual reactions to brain damage and dysfunction may also determine whether or not the patient is considered to be improved. A reaction of apathy to the damage may lead to a judgment of “improved” if the individual has previously been hostile, rebellious, manic, uncooperative, or restless and overactive. A reaction of euphoria to the damage may be called an improvement if the individual has been previously depressed, sluggish, and uncommunicative. The memory loss characteristic of ECT may also be considered an improvement if the individual no longer “knows” or “reports” on his concerns or bad recollections.

PETER R. BREGGIN (U.S. psychiatrist), “Disabling the Brain with Electroshock,” published in Maurice Dongier and Eric D. Wittkower, eds., *Divergent Views in Psychiatry*, 1981.

See Peter Sterling’s entry in 2001 below.

1981 — The proper number of treatments is important.... But I believe a bare minimum of twelve treatments must be given. How many more are required is a day-to-day decision based on clinical experience. You have to be guided by the patient’s tolerance for the treatment and by how dangerously sick the patient was to start with. But the patient must be symptom free for at least two or three weeks before treatments are discontinued.

MARTIN TOWLER (U.S. electroshock psychiatrist), quoted in Joel Warren Barna, “Shocking: How Galveston’s Medical School Earned Its Reputation as the Shock Treatment Capital of Texas,” *Houston City Magazine*, December 1981.

1982 — The widow of a man who died after receiving electric shock therapy at Natchaug Hospital [Mansfield, Connecticut] six years ago has been awarded an out-of-court settlement.

The settlement came on the eve of the trial. The plaintiff, Natalie A. Monty, had sued the hospital, its former medical director, Dr. Olga A. G. Little [and others.]

Monty’s attorney, Leon M. Kaatz of Hartford, would not discuss particulars of the settlement, which is still being finalized, but he said the settlement is in the “the neighborhood” of \$300,000.

DEBRA HURLEY (U.S. journalist), “Shock Therapy Victim’s Widow Gets Settlement,” *Hartford Courant*, 1 November 1982.

1982 — To the astonishment of local psychiatrists, a proposal has been placed on [Berkeley’s] November ballot that would ban the psychiatric procedure commonly known as electroshock therapy [opening paragraph]....

Tensions have been building up between the protesters and the psychiatric establishment....

Dr. Malcolm Duncan, director of inpatient psychiatry at [Berkeley's] Herrick Hospital accused antishock activists of trying to deny patients the right to choose a valuable treatment.

"If they take away the advances psychiatry has made in recent years, we might as well go back to the Dark Ages," Dr. Duncan said. "In many cases this therapy can get people out of institutions who might otherwise remain hospitalized for life."

But Ted Chabasinski, who wrote the election initiative said, "Psychiatrists used to call lobotomy an advance because it got people out of hospitals. Today they call it barbaric." **NEW YORK TIMES**, "Bid to Ban Shock Therapy Put on Berkeley Ballot," 8 August 1982.

1982 — The proposed Ordinance [prohibiting electric shock treatment in Berkeley] reads as follow:

The people of the City of Berkeley do ordain as follows:

Section 1. Title: The title of this ordinance shall be "An Act to Protect the Human Rights of Psychiatric Patients by Prohibiting the Use of Electric Shock Treatment in Berkeley."

Section 2. Declaration of policy: It is hereby recognized and declared that all persons within the City of Berkeley, including all persons involuntarily confined, have a fundamental right against interference with their thought processes and states of mind through the use of electric shock treatment.

Section 3. Prohibition: The administration of electric shock treatment to any person within the City of Berkeley is hereby prohibited.

Section 4. Penalties: Any violation of this ordinance shall be a misdemeanor punishable by not more than six months imprisonment, a fine of not more than \$500, or both.

PETITION TO ENACT AN ORDINANCE, Berkeley, California, 1982.

1982 — The psychiatric survivors movement won an important victory in 1982 when the citizens of Berkeley, California, voted overwhelmingly for Measure T, a ban criminalizing the use of electroshock "treatment" in their community. It may have been the first time anywhere in the world that electroshock was outlawed.

A Bay Area group called the Network Against Psychiatric Assault (NAPA) had begun confronting the psychiatric establishment in 1974. Its activities, including demonstrations, forums, and lobbying, generated broad media attention and laid the groundwork for the Berkeley ban by raising public awareness about widespread abuse in the psychiatric field.

In early 1981 NAPA organized protest demonstrations at Herrick Hospital, Berkeley's only electroshock facility and one of the state's leading ECT centers. Florence McDonald, a highly regarded member of the Berkeley City Council, attended one of the demonstrations and later offered to get the council involved in the issue. As a result, in January 1982, the city's Human Relations and Welfare Commission held a hearing on electroshock that was well covered by the media. Dozens of people who had undergone electroshock testified, all of them opposed to the procedure. The only people who spoke for shock were the doctors that gave it, and a few relatives of shock victims, who were of

course not there to speak for themselves.

NAPA next decided to place an electroshock ban on the ballot while the issue was in the public eye. NAPA activists started collecting signatures, and scores of people suddenly offered to help. The Coalition to Stop Electroshock, a group of eight community organizations, was formed for the occasion. Although the signature gatherers had only a few weeks to meet the deadline, they turned in twice as many signatures as required.

Word of the ballot measure spread rapidly around the country. Soon a prominent article about it appeared in the *New York Times*, followed by serious and sympathetic stories by major U.S. television networks, *USA Today*, the *Los Angeles Times*, and European media outlets.

Enthusiasm built as campaign workers rang doorbells, talked to voters, and passed out leaflets at markets, at theaters, and on the street. It was democracy, in its truest sense, at work. And on Election Day, Measure T passed with more than 60 percent of the vote, the largest margin of victory attained by any measure on the Berkeley ballot that year.

Unfortunately, Herrick Hospital, with the support (financial and otherwise) of the American Psychiatric Association, was able to get the courts to strike down the ban on the grounds that a state law governing the use of ECT preempted the city's right to regulate the procedure.

But for 41 days, Herrick's ECT devices were shut down. The people of Berkeley, by voting to outlaw electroshock, had sent a message to the country and beyond that electroshock had no place in a civilized community. Anti-ECT activists hoped the episode anticipated a time when electroshock would be relegated to history's dust heap. **TED CHABASINSKI** (U.S. electroshock survivor and attorney), personal communication, 25 November 2005. Chabasinski, a leading activist in the struggle against electroshock and other harmful psychiatric methods since 1972, was instrumental in organizing the campaign that resulted in Measure T's victory at the polls.

See Chabasinski's entry in 1944 and Laretta Bender's in 1947 above; and Leonard Frank's in 1974-1983 below.

1982 — It is what I call pathological consumerism. The city of Berkeley has once again besmirched itself....

Essentially, the Berkeley electorate is practicing medicine without a license. It flies in the face of logic to ask voters what treatments patients should have.... It is a question of principle, of the inmates not being allowed to run the asylum, literally.

MARTIN RUBINSTEIN (U.S. electroshock psychiatrist), quoted in Steve Twomey, "In Berkeley, One Medical Practice Comes to an End," *Philadelphia Inquirer*, 3 December 1982. Rubinstein administered ECT at Herrick Hospital in Berkeley.

1971-1982 — Between February 1977 and October 1978 Freeman and Kendell interviewed 166 patients who had ECT during either 1971 or 1976 in Edinburgh. Of this group, 64 percent reported "memory impairment" (25 percent "thought symptom severe," 39 percent "thought symptom mild"). Twenty-eight percent agreed with the statement that "ECT causes permanent changes to memory." Squire reported findings of his three-year follow-up study of 35 people who had received an average of 11 bilateral

ECTs. Of the 31 people available for interview, 18 (58 percent) answered “no” to the question, “Do you think your memory now is as good as it is for most people your age?” All but one of the 18 attributed their memory difficulties to ECT.

LEONARD ROY FRANK (U.S. electroshock survivor and editor), “Electroshock: Death, Brain Damage, Memory Loss, and Brainwashing,” *Journal of Mind and Behavior*, Summer-Autumn 1990. British psychiatrists C. P. L. Freeman and R. E. Kendell published their findings in an article titled “ECT: I. Patients’ Experiences and Attitudes,” *British Journal of Psychiatry*, July 1980; research psychologist Larry Squire’s study was summarized in his letter to the *American Journal of Psychiatry*, September 1982.

See Freeman and Kendell’s entry in 1976 above.

1983 — “A rose by any other name....” A rose called “Shit” would not smell as sweet. The average card-carrying idiot can figure that out. Then, why, in the name of common sense, do psychiatrists insist on calling their most effective treatment “electroshock treatment” or, worse, “electroconvulsive treatment”? A public-relations blunder of such proportions goggles [sic] the mind [opening sentences]....

If none of the thousands of psychiatrists who believe in the value of electroshock treatment can think of a better term, perhaps we can get some counsel from Madison Avenue. Our patients deserve no less [closing paragraph].

ARTHUR W. ANDERSON JR. (U.S. electroshock psychiatrist), letter to *Psychiatric News*, 7 January 1983. Comment: “Dr. Arthur W. Anderson Jr. is quite correct.... The symbol is the thing, as eminent sociologists have pointed out in their theories that reality is in large measure socially constructed. That is why my patients have never received electroconvulsive therapy. Rather, they undergo cerebroversion” (**FRANK ADAMS** [U.S. electroshock psychiatrist], letter to *Psychiatric News*, 18 March 1983).

1983 — Before ECT, I studied math up through calculus. After ECT, I can just barely make change in a store. ECT gives a person a different brain from the one a person had. One never feels sure about this strange new head. Some things come back. A great deal of memory never returns. And one cannot retain new information, so one’s future is DEAD.

JUNE BASSETT (U.S. electroshock survivor), letter to the Food and Drug Administration, 2 May 1983.

1983 — With respect to shock therapy specifically, I support its use in a limited fashion — only as a last resort for the treatment of severe depression that cannot be effectively treated any other way. In such instances, shock therapy can be lifesaving by preventing suicide in a person who is severely depressed.

As I pointed out before in this column, shock therapy performed today is not the “chamber of horrors” many people imagine; it is far more humane and less disturbing to the patient and those who administer the treatment.

TIMOTHY JOHNSON (U.S. physician), “Shock Therapy Is Not So Bad Today,” *Monterey Peninsula Herald* (California), 14 January 1984. At the time Johnson had a syndicated question-and-answer column focused on medical issues. For many years he has been ABC television’s medical correspondent.

1983 — My personal experience as a patient, shock treatment is intrusive therapy.... Blue Cross, Blue Shield pays for a quick fix. I had no after-care follow-up in the community. The experience of going back to work was horrendous. I could not remember names of fellow employees; code numbers for the computer department was wiped out of my mind.

Before this hospitalization, I was going to business school for accounting. All that I learned was wiped out of my mind. My vocal studies were brought to an abrupt halt. My repertoire of music was wiped out of my mind.

ELIZABETH PLASICK (U.S. electroshock survivor), letter to the Food and Drug Administration, 20 May 1983.

1983 — After a few sessions of ECT the symptoms are those of moderate cerebral contusion, and further enthusiastic use of ECT may result in the patient functioning at a subhuman level.

Electroconvulsive therapy in effect may be defined as a controlled type of brain damage produced by electrical means....

In all cases the ECT “response” is due to the concussion-type, or more serious, effect of ECT. The patient “forgets” his symptoms because the brain damage destroys memory traces in the brain, and the patient has to pay for this by a reduction in mental capacity of varying degree.

SIDNEY SAMENT (U.S. neurologist), letter to *Clinical Psychiatry News*, March 1983. See Manfred Sakel’s entry in 1956 above; and Peter Sterling’s in 2001 below.

1974-1983 — Adopting the nonviolent methods of Henry David Thoreau (“Civil Disobedience”), Mohandas K. Gandhi (*An Autobiography: The Story of My Experiments with Truth*), and Martin Luther King Jr. (“Letter from Birmingham City Jail”), the Network Against Psychiatric Assault, between 1974 and 1983, carried out or joined with other groups in carrying out acts of civil disobedience to call attention to the cruel practices psychiatrists impose on people they label “mentally ill.” These acts of civil disobedience included:

- Demonstrating, in 1974, at St. Mary’s Hospital (San Francisco) and invading the locked wards which house its McAuley Neuropsychiatric Institute to protest the staff’s use of forced drugging, “sheeting” (wrapping resistive inmates in sheets like mummies for hours at a time), and “harassment therapy” (for example, forcing inmates to scrub the floor with toothbrushes). Once inside, the protesters engaged in straightforward talk with inmates and staff and distributed literature critical of certain psychiatric practices. After the police arrived, the protesters quietly left the premises.
- Conducting, in the summer of 1976, a month-long sleep-in demonstration at Governor Jerry Brown’s office in Sacramento to protest forced labor without pay (euphemized as “occupational therapy”) and forced drugging in California’s psychiatric facilities. During the sleep-in several NAPA members met with Governor Brown who later ordered an investigation of California’s state hospitals which led to several modest reforms.
- Demonstrating in San Francisco, with psychiatric survivors who were attending an annual gathering of the International Conference on Human Rights and Psychiatric Oppression, at the 1980 Annual Meeting of the American Psychiatric

Association and forming a human-chain to block one of the entranceways to a building where the APA was meeting. The demonstration and block-in, which protested involuntary commitment and the use of force and deception by psychiatrists, continued for several hours without interference from the authorities.

- Demonstrating on March 15, 1983, with the Coalition to Stop Electroshock, at Berkeley's Herrick Hospital where psychiatrists had resumed ECT after a court order prohibited the city from enforcing the ban on electroshock Berkeley voters had approved in a referendum the previous November. At one point, 19 protesters split off from the 150 or so who participated in the demonstration to sit in front of the doors of Herrick's administrative offices. This act of civil disobedience prompted police action, and the 19 blockaders were arrested. After about six hours in jail all of them were released on their own recognizance. At a court hearing held subsequently, the defendants pleaded no contest to "blocking traffic" and were sentenced to "time served."

LEONARD ROY FRANK (U.S. electroshock survivor and editor). During the early 1980s, NAPA members also participated, with other opponents of psychiatric abuse, in civil disobedience actions in Toronto, New York City, and Syracuse. See Ted Chabasinski's entry in 1982 above; and Don Weitz's in 1976-1984 below.

1984 — It's a matter of losing skills, losing learning that I had accumulated.... My entire college education has been completely wiped out and besides that all the reading and learning that I did on my own in the past three years.... I guess the doctors would consider [that electroshock] had beneficial effects because it has "cured my depression," but it's cured my depression by ruining my life, by taking away everything that made it worth having in the first place.... It's really important to point out what [ECT] does to the emotions. It's like I exist in this kind of nowhere world right now. I don't feel depressed. On the other hand I don't feel happy. I just kind of feel nothing at all.

LINDA ANDRE (U.S. electroshock survivor, director of the Committee for Truth in Psychiatry, and writer), radio interview, WBAI (New York City), 1985. Andre underwent 15 electroshocks at New York City's Payne Whitney Psychiatric Clinic in 1984 at the age of 24. She is today in the forefront of the movement opposing electroshock. See Andre's entry in 2005 below.

1984 — My behavior [following electroshock in 1984] was greatly changed; in a brain-damaged stupor, I smiled, cooperated, agreed that I had been a very sick girl and thanked the doctor for curing me. I was released from the hospital like a child just born. I knew where I lived, but I didn't recognize the person I lived with. I didn't know where I had gotten the unfamiliar clothes in the closet. I didn't know if I had any money or where it was. I didn't know the people calling me on the phone.... Very, very gradually — I realized that three years of my life were missing. Four years after shock, they are still missing.

LINDA ANDRE, "The Politics of Experience," testimony before the Quality of Care Conference, Albany (New York), 13 May 1988, quoted in Leonard Roy Frank, "Electroshock: Death, Brain Damage, Memory Loss, and Brainwashing," *Journal of Mind and Behavior*, Summer-Autumn 1990.

1984 — The psychiatrist who helped instigate the effort to overturn Berkeley's ban on electroshock therapy has pleaded guilty to two misdemeanor counts of filing false Medi-Cal claims.

Dr. Ronald Bortman, who has a practice on Carleton Street in Berkeley, was fined the maximum \$5,000 for each count, ordered to pay \$33,112.41 in restitution and given three years probation.

Judge Carol Brosnahan also ordered him to perform 300 hours of community service [opening paragraphs]....

Bortman was the president of the East Bay chapter of the Northern California Psychiatric Society when that group filed suit to overturn the city's ban on electroshock, which voters approved overwhelmingly in November 1982. He was the only named individual plaintiff in the suit.

BERKELEY GAZETTE, "Electroshock Figure Guilty," 24 January 1984.

See Ted Chabasinski's entry in 1982 above.

1984 — In 1984, Marilyn Rice founded The Committee for Truth in Psychiatry (CTIP), all of whose members are electroshock survivors. The group has successfully opposed the American Psychiatric Association's petition to have the Food and Drug Administration reclassify ECT devices from the dangerous, high-risk category (Class III) of medical devices to the low-risk category (Class II). The 1979 law governing medical devices requires the FDA to investigate Class III devices preliminary to reclassifying or banning them. However, CTIP's call for the FDA to fulfill its full investigative mandate has thus far gone unheeded. Excerpts from 11 letters (those with "letter to the Food and Drug Administration" in the citation) in *The Electroshock Quotationary* have been drawn from the more than 1,000 letters and comments sent to the FDA (Docket #82P-0316) since 1983. Like all dockets at the FDA, this docket is a matter of public record and may be seen by any citizen on request.

LEONARD ROY FRANK (U.S. electroshock survivor and editor). To date (2006), the FDA has still not investigated electroshock equipment as required by the 1979 law.

1984 — It is 5 and one-half years since my horrifying experience of awaking in a hospital after ECT, not knowing who I was, where I was, who my husband and children were, what were my likes and dislikes, what my family was all about, what classes my children excelled in, what the family liked and disliked, and where I stood in the life I was supposed to be living.... The fear is a reality that I would never want to experience again in any way.

The consent form, which states that there may be some temporary memory loss, is an understatement. It is an outright lie and I wish to bring this to your attention. The damage from ECT can be extreme and completely disabling, to a degree inconceivable except by those who have undergone this horror. A diagnosis of organic brain syndrome or senile dementia after ECT through neuropsychological testing is not taken lightly by a person who had once been an intelligent and fully functioning being....

The heartache and striving for health following brain damage is an illness itself after the damage from ECT.

PAT GABEL (U.S. electroshock survivor), letter to the Food and Drug Administration, 25 June 1990.

1984 — Electroconvulsive therapy has a shotgun effect on the brain.

ROBERT G. HEATH (U.S. psychosurgeon), “An Overdue Comprehensive Look at a Malignant Treatment: Electroconvulsive Therapy,” *Behavioral and Brain Sciences*, vol. 7, 1984. Heath’s comment appears among otherwise favorable reflections on ECT.

1976-1984 — Since the 1970s, anti-shock demonstrations and protests, including nonviolent civil disobedience (CD), have played major roles in the psychiatric survivor liberation movement’s struggle to ban electroshock and expose its use as a serious human-rights violation.

As a form of direct action, CD has been carried out in various cities including Berkeley, Haverford (Pennsylvania), New York City, Sacramento, San Francisco, Syracuse, and Toronto. The CD was usually directed against specific psychiatric hospitals that were known to frequently administer electroshock but also against psychiatric convention sites.

For example, in May 1982 during the 10th Annual International Conference on Human Rights and Psychiatric Oppression, sixteen activists staged a sit-in in a downtown hotel lobby in Toronto where the American Psychiatric Association was holding its annual meeting. They were protesting against electroshock and other harmful procedures including forced drugging. All were arrested but released the same day on bail.

During an APA convention in New York City in May 1983, the movement held a counter-conference and supported CD against Gracie Square Hospital, a well-known shock mill in Manhattan. Backed by a four-member support group, nine psychiatric survivors chained themselves to the front doors of Gracie Square. This action attracted the police who arrested, booked and quickly released the demonstrators who had put their bodies on the line.

Three weeks later, at the 11th Annual International Conference on Human Rights and Psychiatric Oppression in Syracuse, several survivors chained themselves to the front doors of Benjamin Rush Psychiatric Center to protest that institution’s frequent use of electroshock on both adults and children. That CD had considerable impact, since the Center stopped using electroshock about three years later.

In 1984 in Toronto, there was another CD action in the office of Ontario’s Minister of Health. Organized and carried out by three activists including two shock survivors, the sit-in was a tactic to pressure the Minister of Health to appoint a shock survivor to a doctor-dominated government panel charged with investigating the “medical, legal and ethical aspects” of electroshock in Ontario. Shock survivor and attorney Carla McKague was appointed to the panel a few months later.

Since that time, many acts of resistance against electroshock and other abusive psychiatric practices have been carried out by individuals and groups in the United States, Canada, Europe, and elsewhere.

DON WEITZ (U.S.-born insulin shock survivor and Canadian antipsychiatry activist), personal communication, 5 October 2005. For almost 30 years, Weitz has led the struggle against psychiatric abuse in Canada.

See Leonard Frank’s entry in 1974-1983 above.

1985 — Electroconvulsive therapy is the most controversial treatment in psychiatry....

The [conference] panel has found that ECT is demonstrably effective for a narrow range of severe psychiatric disorders in a limited number of diagnostic categories: delusional and severe endogenous depression and manic and certain schizophrenic syndromes. There are, however significant side effects, especially acute confusional states and persistent memory deficits for events during the months surrounding the ECT treatment.

CONSENSUS DEVELOPMENT CONFERENCE STATEMENT,

“Electroconvulsive Therapy,” *Journal of the American Medical Association*, 18 October 1985. The statement was produced by a panel of 14 professionals, mainly physicians, who had participated in a three-day conference on ECT (sponsored by the National Institutes of Health and the National Institute of Mental Health) in Bethesda, Maryland in June 1985.

1985 — Expert in public propaganda
They go to work on me — convinced
of euphemism. Sure of number,
determined both will burn the term
splashed upon my face.

they try out some occupational tricks... EXPERIMENT,
they think it clever to baptize torture with initials.
they think it subtle to call it TREATMENT
they talk of cures
reciting tales of miraculous salvation.

I don't buy it
I've seen the disasters, the mistakes
I call it ELECTROCUTION.

NIRA FLEISCHMAN (Canadian electroshock survivor), complete poem, “ECT,” 1985, published in Bonnie Burstow and Don Weitz, eds., *Shrink Resistant: The Struggle Against Psychiatry in Canada*, 1988.

1985 — I told my shrink I didn't want to be cured of being a lesbian. He said that just proved how sick I was. He said I needed shock treatment.

SHEILA GILHOOLY (Canadian electroshock survivor and writer), “Still Sane,” published in Persimmon Blackbridge and Gilhooly, *Still Sane*, 1985.

1985 — I've asked myself these things many times — and never found an answer — questions about the people who give ECT, the “shock doctors”: “Are these men evil?” I asked, using “men” since 95 percent of all shock doctors are male. “Are they stupid? Are they really heartless and sadistic and cruel? Are they morally deficient? Or, perhaps, do they suffer from a kind of self-induced blindness, and unwillingness to see what they are truly doing to the people they purport to help?” ...

I choose to be charitable and, rather than assuming malicious intent, assume a kind of benign but powerful avoidance on the part of these shock doctors of some painful truths about the nature of their chosen “therapy.” We must tell some of those truths, in the belief that all people are capable of change, that all people can be open to new ideas and long hidden truths, if they truly want to be....

What has been “proved”? I will tell you: that ECT destroys healthy brain tissue! That these “treatments” cause anguish and misery and permanent damage each and every time they are inflicted. That there are no consistent criteria for improvement, that patient accounts of memory loss and suffering are discounted — for elderly people, as signs of senility; for the rest of us, as indications that our so-called mental illnesses remain, unabated.

Who gets “well” from ECT? I will tell you: those whose confusion is so intense they can, for a while, forget their sufferings. Those who are incapacitated into a passive acceptance of their allotted roles. Those who are cowed into quietness, assaulted into a nether world of obedience. For a time, their wild, mad, annoying rambunctiousness is quelled — and the doctors marvel at their “improvement.”

They bloody us into quietude, terrorize us into acquiescence, and call it a cure.

For sure, the ECT doctors are engaged in a highly questionable activity, both medically and ethically. And a profoundly controversial one. There really is no getting away from that.... Do they tell their patients, ever, the price of the trade-off — permanent brain damage for possible temporary relief from pain? Do they say that they are systematically and methodically burning portions of their patients’ brains — for a moment’s surcease? *Do they tell themselves? Ever?* [closing paragraphs]

JANET GOTKIN (U.S. electroshock survivor, writer, and researcher), “Electroshock: A Modern Medical Atrocity” (a talk presented at a plenary session of electroshock psychiatrists during the First International Conference of Electroconvulsive Therapy [ECT]: Clinical and Basic Research Issues, sponsored by the New York Academy of Sciences and the National Institute of Mental Health in New York City, 18 January 1985), published in Jeanine Grobe, ed., *Beyond Bedlam: Contemporary Women Psychiatric Survivors Speak Out*, 1995. The excerpt from the talk published above has been slightly modified by Gotkin.

See Gotkin’s two entries in 1975 above.

1985 — The voluminous but seldom read scientific literature on electroconvulsive therapy warrants the conclusion that the procedure is one of considerable risk and unproven effectiveness [opening sentence]....

Medicine properly accepts greater risks if a treatment is proved effective. Conversely, even uncommon complications are intolerable if the therapeutic effect is speculative.

EDWARD M. OPTON JR. (U.S. attorney and psychologist), “ECT: Is It Unsafe and Ineffective?” *Consensus Development Conference Program & Abstracts (Electroconvulsive Therapy)*, National Institutes of Health, 1985.

1986 — If there is any erasure [of memory from ECT], it is for the events during the hospital. In many ways we’re very grateful that patients forget that. After all, it’s not a pleasant time of your life. For a depressed patient to be in the hospital, it’s not pleasant. And if they forget that, that’s fine.

MAX FINK (Austrian-born U.S. electroshock psychiatrist), *Informed Consent for Patients and Families with Max Fink, M.D.* (film), Somatics, Inc., 1986.

1974-1986 — [The 65 depressed patients in this study were 80 years of age or older upon admission to the Rhode Island Hospital in Providence between the years 1974 and 1983. Thirty-seven were treated with ECT and 28 with antidepressant drugs.] At 1 year

[following treatment] we established a 73.0% survival rate for the ECT group and a 96.4% survival rate for the non-ECT group. At 3 years, the survival rate of the ECT group was 51.4% compared with 75.0% survival rate for the non-ECT group.

DAVID KROESSLER and **BARRY S. FOGEL** (U.S. electroshock psychiatrists), “Electroconvulsive Therapy for Major Depression in the Oldest Old,” *American Journal of Geriatric Psychiatry*, Winter 1993. Put another way, the death rate after one year for the ECT group was 7.5 times higher than that of the non-ECT group: 10 deaths among the 37 ECT patients (27%) compared with 1 death among the 28 non-ECT patients (3.6%). The authors reported that “two patients had only 2 ECTs: one withdrew consent, and the other developed CHF [congestive heart failure] and died before ECT could be continued” and that there was “lasting recovery” for 22% in the ECT and 71% in the non-ECT group.” The authors attributed the poor outcomes of the ECT patients to “their advanced age and physical illness.”

1987 — I can write a pretty good letter, I think, but in this case it’s what I can’t do that counts. I am constantly reminded of what I can’t do... although I could do it once. And what is “it”? I can’t remember new information with the ease I could before ECT. Distractions and interruptions seriously interfere with information retention.... Any new bit of information may “cancel out” the bit that preceded it. My auditory and visual memory seems to function episodically... enough so I know they exist and how well they functioned before ECT.

How have these deficits, which developed immediately after ECT, affected my life?

1. When I returned to my 6th grade teaching job after ECT I could not remember how to teach. Therefore, 5 months after ECT, I attempted suicide.

2. For two and a half years I worked in a kitchen. The loss in income was dramatic but worse was the total loss of confidence and the perception that I was a complete failure.

3. When I dared to take a college course, even multiple readings of the same material yielded next to nothing.

4. In September of 1987, I matriculated. However, because the information was complex and largely theoretical and because I found it hard to remember instructions, I withdrew from school. I am very fortunate that I survived the subsequent depression.

5. Why am I not making the \$40,000 I would be making if I’d remained in teaching? Why am I praying that I’ll find a job that pays me \$16,000? Why am I likely to settle for less if it will make few demands on my memory? I’m sure I need not answer “why.”

PAM MACCABEE (U.S. electroshock survivor), letter to the Food and Drug Administration, 20 January 1987.

1988 — Dr. Max Fink of the State University of New York at Stony Brook, a leading proponent, believes ECT should be given to “all patients whose condition is severe enough to require hospitalization.”

EDWARD EDELSON (U.S. journalist), “ECT Elicits Controversy — And Results,” *Houston Chronicle*, 28 December 1988.

1988 — By 1988, the number of American private hospitals providing ECT had risen to 444, from only 48 in 1970.

TIMOTHY W. KNEELAND (U.S. political scientist) and **CAROL A. B. WARREN** (U.S. sociologist), *Pushbutton Psychiatry: A History of Electroshock in America*, ch. 5, 2002.

1988 — Why do psychiatrists torture people and call it electroshock therapy?

JEFFREY MOUSSAIEFF MASSON (U.S. psychoanalyst, former director of the Freud Archives, and writer), preface to *Against Therapy: Emotional Tyranny and the Myth of Psychological Healing*, 1988.

1988 — Added to the beatings and chainings and baths and massages came treatments that were even more ferocious: gouging out parts of the brain, producing convulsions with electric shocks, starving, surgical removal of teeth, tonsils, uteri, etc.

KARL A. MENNINGER (U.S. psychiatrist), comparing some of the older methods used by psychiatrists with some of the more recent ones, letter to Thomas S. Szasz, 1988, published in “Reading Notes,” *Bulletin of the Menninger Clinic*, 1989. Twenty-four years earlier, Menninger also expressed misgivings about the term “schizophrenia”: “I avoid using words like schizophrenia just as I avoid using words like “wop” and “nigger” (“Psychiatrists Use Dangerous Words,” *Saturday Evening Post*, 25 April 1964).

1988 — As a former recipient of ECT, I have ongoingly suffered from memory loss. In addition to destruction of entire blocks of pre-ECT memories, I have continued to have considerable difficulty in memory recall with regard to academic pursuits....

Currently, I am finding it extremely embarrassing and hurtful when fellow classmates (however innocent) refer to my struggles in grasping my study materials, thusly: “You are an AIR-BRAIN!” How can I explain that my struggles are due to ECT?

As far as the loss of my childhood memories, I often feel as though a very vital part of my life “died” as a result of these treatments. In particular, when my family refers to specific earlier experiences, I feel a great sense of loss and grief because I cannot share their memories, as an ongoing testament of “life”, in totality, as they can easily recall each vivid childhood happening.

In addition to feeling deeply grieved about my own memory loss, I am also grieved that countless other fellow citizens risk being needlessly victimized in a like manner due to ECT devices, and not being honestly apprised by medical practitioners about the risk of permanent memory loss.

FELICIA McCARTY WINTER (U.S. electroshock survivor), letter to the Food and Drug Administration, 23 May 1988.

1989 — We were unable to confirm earlier reports that treatment with ECT or adequate amounts of antidepressants are associated with lower mortality in depressed persons. In fact, neither general (all cause) mortality rates nor suicide rates varied significantly among treatment groups.

DONALD W. BLACK, GEORGE WINOKUR (U.S. electroshock psychiatrists) et al., “Does Treatment Influence Mortality in Depressives? A Follow-up of 1076 Patients with Major Affective Disorders,” *Annals of Clinical Psychiatry*, September 1989. This follow-up study conducted at the University of Iowa Psychiatric Hospital in Iowa City divided 1076 inpatients admitted between 1970 and 1981 into four “treatment groups”: ECT

(372 patients), adequate antidepressants (180), inadequate antidepressants (317), and neither ECT nor antidepressants (207).

1989 — [Gary] Aden was a founder and first President of the International Psychiatric Association for the Advancement of Electrotherapy (now the Association for Convulsive Therapy)... A newspaper account dated September 27, 1989, in the *San Diego Union* [reported]: “Dr. Gary Carl Aden, 53, of La Jolla gave up his medical license effective September 8 after allegations that he had sex with patients, beat them and branded two of the women with heated metal devices, including an iron that bore his initials.”

In another story a patient describes Aden as drugging her with a hypodermic before sexually abusing her and beating her with a riding crop [*San Diego Union*, 1 January 1989].

Aden was permitted to forfeit his license without admitting guilt. He was not subjected to being psychiatrically diagnosed or treated involuntarily, nor was he criminally charged.

PETER R. BREGGIN (U.S. psychiatrist), *Toxic Psychiatry*, ch. 9, 1991. Aden had been medical director of the San Diego Neuropsychiatric Clinic for Human Relations Center in addition to being the plaintiff in *Aden v. Younger*, a lawsuit that challenged the 1975 law introduced by Assemblyman John Vasconcellos regulating the use of ECT and psychosurgery in California.

See Leonard Frank's second entry in 1974 above.

1989 — It seems to me that ECT is an improved modality and relatively benign when compared to neuroleptics which can cause tardive dyskinesia and tardive dystonia. I do not understand why there is so much objection to ECT when neuroleptics are far more dangerous and often the practitioner will find himself involved in medical malpractice litigation.

RAY JEFFRIES (U.S. physician), complete letter to *American Medical News*, 5 May 1989. Tardive dyskinesia and tardive dystonia are neurological disorders affecting the muscles. The former is characterized by involuntary, rhythmic movements of the extremities, face, jaw, tongue, and mouth, such as lip pursing, chewing movements, and tongue thrusting; the latter is characterized by sustained spasms and twitching. These potentially severe and irreversible conditions are common among antipsychotic-drug users.

1989 — The possibility of brain damage is absolutely refuted by brain scans, by neuropsychological studies, by autopsies, by animal studies, and by analysis of cerebrospinal fluid and blood chemicals that leak from damaged cells that aren't detected in ECT patients.

GLEN PETERSON (U.S. electroshock psychiatrist and onetime executive director of the International Psychiatric Association for the Advancement of Electrotherapy), quoted in Russ Rymer, “Electroshock,” *Hippocrates*, March-April 1989.

See Peter Breggin's entry in 1998 and Peter Sterling's in 2001 below.

1989 — [At last month's meeting of the American Medical Association House of Delegates] the AMA endorsed the use of electroconvulsive therapy (ECT) “as an effective

treatment modality in selected patients, as outlined by the American Psychiatric Association.”

In a resolution introduced by the California delegation, the association recognized ECT as “a safe procedure in proper hands.”

PSYCHIATRIC NEWS, complete announcement on the subject, “ECT, Animal Rights among Topics Discussed at AMA’s Dallas Meeting,” 20 January 1989.

1990 — In light of the available evidence, “brain damage” need not be included [in the ECT consent form] as a potential risk.

AMERICAN PSYCHIATRIC ASSOCIATION, *The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging* (A Task Force Report), ch. 3, sect. 5, 1990. The 2nd edition of *Practice* (2001) was even more dismissive of the brain-damage risk from ECT. Electroshock psychiatrists were told they *should* not (instead of *need* not) include “brain damage” as an ECT risk in the consent form. The corresponding sentence in the 2nd edition (ch. 8, sect. 4) read as follows: “In light of the accumulated body of data dealing with structural effects of ECT, ‘brain damage’ should not be included [in the ECT consent form] as a potential risk of treatment.” The APA Task Force on Electroconvulsive Therapy charged with writing the 1990 report was composed of Richard D. Weiner, M.D., Ph.D. (Chairperson), Max Fink, M.D., Donald Hammersley, M.D., Iver F. Small, M.D., Louis A. Moench, M.D., and Harold Sackeim, Ph.D. (Consultant). Harold Alan Pincus, M.D. and Sandy Ferris represented the APA Staff. The Task Force for the 2001 2nd edition was composed of Weiner (Chairperson), C. Edward Coffey, M.D., Laura J. Fochtmann, M.D., Robert M. Greenberg, M.D., Keith E. Isenberg, M.D., Charles H. Kellner, M.D., Sackeim, and Moench (Assembly Liaison). Pincus and Laurie E. McQueen, M.S.S.W. represented the APA Staff.

See David Impastato’s first entry (citing 66 ECT deaths from “cerebral” causes) in 1957 above; and Peter Breggin’s entries in 1992 and 1998 and Peter Sterling’s entry in 2001 below.

1990 — Advanced age is not an impediment to the use of ECT. The efficacy of ECT among elderly depressed patients is high, and case reports attest to the safe use of ECT in patients up to the age of 102. But ECT in the elderly also presents certain age-related issues that must be considered. With increasing age, seizure threshold may rise, and effective seizures may be difficult to induce....

Some elderly patients may have an increased likelihood of appreciable memory deficits and confusion during the course of treatment.

AMERICAN PSYCHIATRIC ASSOCIATION, *The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging* (A Task Force Report), ch. 3, sect. 6, 1990.

1990 — Individuals vary considerably in the extent to which they experience confusion and memory problems during and shortly following treatment with ECT. However, in part because psychiatric conditions themselves produce impairments in learning and memory, many patients actually report that their learning and memory functioning is improved after ECT compared to their functioning prior to the treatment course. A small minority of patients, perhaps 1 in 200, report severe problems in memory that remain for months or even years.

AMERICAN PSYCHIATRIC ASSOCIATION, Appendix B (Sample ECT consent form), *The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging* (A Task Force Report), 1990. Comment: “[Psychologist] **HAROLD A. SACKEIM**, chief of biological psychiatry at the New York State Psychiatric Institute [in New York City] and a member of the APA’s six-member shock therapy task force, says that the 1 in 200 figure is not derived from any scientific studies [see Sackeim’s second entry in 2001 below]. It is, Sackeim said, ‘an impressionistic number’ provided by New York psychiatrist and ECT advocate Max Fink in 1979. The figure will likely be deleted from future APA reports, Sackeim said” (**SANDRA G. BOODMAN**, “Shock Therapy: It’s Back,” *Washington Post*, 24 September 1996). The 1 in 200 figure was removed from the 2nd edition of *Practice* (2001). The corresponding paragraph in the sample ECT consent form (Appendix B) was changed to read, “The majority of patients state that the benefits of ECT outweigh the problems with memory. Furthermore, most patients report that their memory is actually improved after ECT. Nonetheless, a minority of patients report problems in memory that remain for months or even years. The reasons for these reported long-lasting impairments are not fully understood. As with any medical treatment, people who receive ECT differ considerably in the extent to which they experience side effects.”

1990 — What shock does is throw a blanket over people’s problems. It would be no different than if you were troubled about something in your life and you got into a car accident and had a concussion. For a while you wouldn’t worry about what was bothering you because you would be so disoriented. That’s exactly what shock therapy does. But in a few weeks when the shock wears off, your problems come back. These patients need to deal directly with their lives, and make the changes that will help them feel better.

LEE COLEMAN (U.S. psychiatrist), quoted in Vince Bielski, “Electroshock’s Quiet Comeback,” *San Francisco Bay Guardian*, 18 April 1990.

1990 — In recent years, to allay growing public fears concerning the use of electroshock, proponents have launched a media campaign, claiming among other things that with the introduction of certain modifications in the administration of ECT the problems once associated with the procedure have been solved, or at least substantially reduced. These techniques center on the use of anesthetics and muscle relaxants, changes in electrode placement, and the use of brief-pulse electrical stimulation. However, investigation and common sense indicate that while these modifications may offer some advantages..., the basic facts underlying the administration of electroshock have not changed at all. The nature of the human brain and that of electricity are no different today than they were more than 50 years ago when ECT was introduced.... When a convulsogenic dose of electricity is applied to the brain, there is going to be a certain amount of brain damage, some of which will be permanent. There is even evidence that the drug modifications make ECT more destructive than ever, for, as central nervous system depressants, anesthetics and muscle relaxants raise the subject’s convulsive threshold, which in turn makes it necessary to apply a larger dose of electricity to set off the convulsion. And, the more current applied, the more amnesia and brain damage. As Reed noted, “The amnesia directly relating to ECT depends on the amount of current used to trigger the generalized convulsion.”

LEONARD ROY FRANK (U.S. electroshock survivor and editor), “Electroshock: Death, Brain Damage, Memory Loss, and Brainwashing,” *Journal of Mind and Behavior*, Summer-Autumn 1990. The quote in the last sentence is from K. Reed, “Electroconvulsive Therapy: A Clinical Discussion,” *Psychiatric Medicine*, vol. 6, 1988. See Peter Sterling’s entry in 2001 and Frank’s second entry in 2002 below.

1990 — Brainwashing means washing the brain of its contents. Electroshock destroys memories and ideas by destroying the brain cells in which [they] are stored. A more accurate name for what is now called electroconvulsive therapy (ECT) would be electroconvulsive brainwashing (ECB).

LEONARD ROY FRANK, “Electroshock: Death, Brain Damage, Memory Loss, and Brainwashing,” *Journal of Mind and Behavior*, Summer-Autumn 1990.

1990 — With “therapeutic” fury
search-and-destroy doctors
using instruments of infamy
conduct electrical lobotomies
in little Auschwitzes called mental hospitals

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

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

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

LEONARD ROY FRANK, complete poem, “Aftermath,” *Phoenix Rising*, July 1990, reprinted in Frank, “Shock Treatment IV: Resistance in the 1990s,” published in Robert F. Morgan, ed., *Electroshock: The Case Against*, 2nd ed., 1991 (1985).

1990 — There was a piano in my house, and Dan told me that I used to enjoy playing it. Now I didn’t have a clue how it worked. There was a bookshelf full of books that I must have read, but I didn’t remember anything about them. There were two little boys in my house who obviously were mine, yet I didn’t remember them.

WENDY FUNK (Canadian electroshock survivor), diary entry, 11 July 1990, “*What Difference Does It Make?*” (*The Journey of a Soul Survivor*), ch. 24, 1998. Funk wrote this in her diary after undergoing a series of 20 electroshocks at Medicine Hat General

Hospital in Medicine Hat, Alberta. A second series of 10 ECTs was administered soon after the first series.

1990 — A psychiatrist once told me that ECT specialists were practically “malpractice free” with elderly patients, because their memory complaints following ECT were easily attributed to senility or the aging process.

ROBERT F. MORGAN (U.S. psychologist), slightly modified, testimony at public hearings on ECT conducted by the City Services Committee of the San Francisco Board of Supervisors, 27 November 1990, quoted in Leonard Roy Frank, “San Francisco Puts Electroshock on Public Trial,” *The Rights Tenet* (publication of the National Association for Rights Protection and Advocacy), Winter 1991. In his testimony, Morgan called for reparations and free rehabilitative/vocational services for electroshock victims of all ages.

1991 — Table 24-7. Indications for Electroconvulsive Therapy (ECT)

- Medication-refractory depression
- Suicidal depression
- Depression accompanied by refusal to eat or take fluids
- Depression during pregnancy
- History of positive response to ECT
- Catatonic syndromes
- Acute forms of schizophrenia
- Mania unresponsive to medication
- Psychotic or melancholic depression unresponsive to medication.

NANCY C. ANDREASEN (U.S. psychiatrist and onetime president of the American Psychiatric Association) and **DONALD W. BLACK** (U.S. electroshock psychiatrist), *Introductory Textbook of Psychiatry*, ch. 24, 1991.

1991 — In Europe during the middle ages, the inquisitors burned bodies at the stake supposedly to save souls from damnation. Throughout the world in our age, psychiatrists — the inquisitors’ modern-day counterparts — burn brains with electroshock supposedly to save minds from insanity. Society now recognizes for what they were the body-burning atrocities committed centuries ago against many tens of thousands of people. But it doesn’t recognize for what they are the brain-burning atrocities being committed in our own time against millions of people.

LEONARD ROY FRANK (U.S. electroshock survivor and editor), testimony at public hearings on ECT conducted by the City Services Committee of the San Francisco Board of Supervisors, 5 February 1991. Compare: “Institutional Psychiatry is a continuation of the Inquisition. All that has really changed is the vocabulary and the social style” (**THOMAS S. SZASZ** [Hungarian-born U.S. psychiatrist], *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement*, ch. 1, 1970).

1991 — A psychiatrist who advocated ECT answered a question from the audience at a conference on the treatment of schizophrenia: “Of course, shock treatment causes brain damage, but what’s a little brain damage [in exchange] for clinical improvement.”

BERTRAM P. KARON (U.S. psychologist), introduction to Robert F. Morgan, ed., *Electroshock: The Case Against*, 2nd ed., 1991 (1985).

1991? — After 6 [ECT] treatments my brain felt so “scrambled.” The doctors assured me that this feeling would be temporary. I refused further treatments and was sent home. At home I was generally “confused.” My attention span was short, and my memory was poor.

Today is 8 years later. I have been in touch with persons who claim to have been good friends with me at one time — but I don't remember them....

When I am asked to describe my experience, my state of mind, this is what I tell people: Take a brand new jigsaw puzzle, shake the box vigorously to thoroughly mix all of the pieces, then remove a random handful of pieces and throw them away. Now try to put the puzzle back together.

G. CHRISTIANE STARKS (U.S. electroshock survivor), “1st Person Project,” ect.org. Starks was 24 when she underwent ECT at Beth Israel Hospital in Boston.

1992 — The report under review [referring to American Psychiatric Association, *The Practice of Electroconvulsive Therapy*, 1990] makes clear that organized psychiatry and leading electroshock advocates are determined not to tell patients about the risks of ECT. As long as those in control and authority paint so benign a picture of so dangerous a treatment, psychiatrists and mental health practitioners in general are not likely to feel obliged to warn potential patients about its hazards. This report provides a shield for those who administer ECT — an “official” APA report that maintains there is no serious risk of harm — behind which they can hide from all manner of personal responsibility.

PETER R. BREGGIN (U.S. psychiatrist), “The Return of ECT,” *Readings (A Journal of Reviews and Commentary in Mental Health, American Orthopsychiatric Society)*, March 1992.

See American Psychiatric Association's 3 entries in 1990 above.

1993 — Senate Bill 201, after being signed by Texas Governor Ann Richards, went into effect on June 20, 1993 and so became—and still is—the strongest law in the United States regulating and restricting electroshock often referred to as electroconvulsive “treatment.” The main provisions of the law are:

1. Electroshock is banned for anyone under the age of 16, which is the age of consent for mental health treatment in Texas.

2. Regardless of psychiatric diagnosis, every Texas citizen has the right to refuse this procedure unless adjudicated “legally incompetent,” which is an unrelated and far more involved process than being designated “mentally ill.” But even this chink in the legal armor against forced electroshock can be sealed with an “advanced directive” made prior to a competency hearing.

3. Informed consent must be obtained before each individual electroshock treatment is administered, not merely before the start of a series of treatments. In other words, the citizen can withdraw from being electroshocked at any time.

4. All deaths occurring within fourteen days of the procedure must be reported to the Department of State Health Services (DSHS), which annually publishes the total number of deaths reported.

5. Violation of this law is a misdemeanor punishable by a fine of not more than \$10,000 or confinement in jail for not more than six months, or both.

Because I had been forcibly shocked in 1971, the passage of S.B. 201 was very important to me. For 22 years I had actively opposed electroshock. However, my efforts bore little fruit until 1993 when a “miracle” happened: I met Diann’a Loper, a lobbyist who in 1987 *Texas Monthly* had named one of the top ten lobbyists in Texas. She had also experienced the horrors of electroshock firsthand and was equally determined to do whatever it took to end, or at least limit the use of this procedure with its devastating, often lifelong aftereffects [see Cameron’s and Loper’s entries in 1971 above].

Due to discussions I’d previously had with several senators, a bill regulating electroshock was pending in the Texas legislature. Loper and I lobbied together on behalf of the bill. We made a good team—she had the political skills and I had become a lay expert on electroshock, particularly the electroshock machines. My article in *The Journal of Mind and Behavior* (1990) was the first to offer scientific proof that the new, so-called “kinder and gentler” machines were actually much more powerful, and therefore much more destructive than their predecessors.

Diann’a and I devoted all our energy to having the anti-shock bill passed. In preparation for the hearings, we founded World Association of Electroshock Survivors, brought the issue to the public’s attention through the media, and lobbied legislators.

We also arranged for neurologist John Friedberg from Berkeley, California, to meet one-on-one with members of the Senate Public Health and Human Services Committee, which had jurisdiction over the bill. Another group brought in psychiatrist Lee Coleman, also from Berkeley, to talk with legislators. For the hearings themselves, we brought in psychiatrist Peter Breggin from Bethesda, Maryland, and neurologist Robert Grimm from Portland, Oregon. The participation of these four courageous physicians in our lobbying efforts was crucial to passing the bill.

We also organized electroshock survivors to testify at the hearings. For many, this was their first chance to tell their stories publicly. Most of them linked electroshock with drastic memory loss, epileptic seizures, disability, fear and humiliation. Opponents of the bill—mostly physicians who administered electroshock, manufacturers of the shock machines and a few shock survivors—testified about electroshock’s “wonders.” By the time both sides had finished, more than 100 witnesses had testified.

In the end our side made the better case. The bill was passed by both Houses and signed into law. This was a major victory, but as long as people are being electroshocked anywhere on the planet, we will persevere in our efforts to end this terrible abuse.

DOUG CAMERON (U.S. electroshock survivor and teacher), personal communication, 9 February 2006.

1993 — What I think [ECT] did was to act like a Roto-Rooter on the depression. It just reamed me clear and the depression was gone.

ROLAND KOHLOFF (U.S. ECT patient and musician), quoted in Lisa W. Foderaro, “With Reforms in Treatment, Shock Therapy Loses Shock,” *New York Times*, 19 July 1993. Kohloff, who “was prone to bouts of severe depression,” once told a *Newsday* reporter about how ECT benefited him, “Instead of two months in a hospital, I get a series of treatments for a week and a half and I’m back playing again” (Joshua Kosman, “Roland Kohloff — S.F. Symphony’s Timpanist 16 Years,” *San Francisco Chronicle*, 5 March 2006).

1993 — A vast medical literature provides strong evidence that electroconvulsive therapy causes permanent brain damage, including loss of memory and catastrophic deterioration of personality....

During my 20 years as a community psychiatrist I have treated many patients who have been subjected to shock therapy. My experience as a clinician corroborates the many empirical studies that conclude that electroconvulsive therapy is abusive and inhumane, and causes irreversible physical and emotional damage.

HUGH L. POLK (U.S. psychiatrist), letter to *New York Times*, 1 August 1993.

See Peter Sterling's entry in 2001 below.

1993 — Fifteen percent of ECT practitioners in the USA prescribe up to eight inductions of ECT during the first two anesthetics [i.e., treatment sessions] in severely ill patients.

HAROLD A. SACKEIM (U.S. electroshock psychologist), letter to (and paraphrased by) Allan I. F. Scott and Lawrence J. Whalley, "The Onset and Rate of the Antidepressant Effect of Electroconvulsive Therapy," *British Journal of Psychiatry*, June 1993.

1993 — ECT may effectively silence people about their problems, and even convince some people that they are cured by numbing their faculties and destroying their memories. It may fulfill a socially-valued function in reinforcing social norms and returning people to unhappy or abusive situations, or to isolation and poverty without any expenditure on better services or community development. It is easier to numb people and induce forgetfulness than to try to eradicate poverty, provide worthwhile jobs and deal with people's demands to be listened to, understood, loved and valued as part of the community.

JAN WALLCRAFT (British electroshock survivor and writer), "ECT: Effective, But for Whom?" *OPENMIND* (British journal), April-May 1993.

1994 — If the body is the temple of the spirit, the brain may be seen as the inner sanctum of the body, the holiest of holy places. To invade, violate, and injure the brain, as electroshock unfailingly does, is a crime against the spirit and a desecration of the soul.

LEONARD ROY FRANK (U.S. electroshock survivor and editor), "Should ECT Be Prohibited?" published in Stuart A. Kirk and Susan D. Einbinder, eds., *Controversial Issues in Mental Health*, 1994.

1994 — One may see in the faces of patients condemned to electroconvulsive therapy an expectation that they are scheduled for torture; the casual order — "No breakfast for you, you're getting shock this morning" can produce hysteria and panic. Even were it beneficial, which it is not, the patient's conviction that he or she is subjected to torture makes it such. As arms and legs are held down and the body thrashes under the force of the electrical charge, one is observing torture under the guise of "treatment."

KATE MILLETT (U.S. psychiatric survivor, activist, and writer), *The Politics of Cruelty: An Essay on the Literature of Political Imprisonment*, 1994.

1995 — After four [electroconvulsive] treatments, there is marked improvement. No more egregious highs or lows. But there are huge gaps in my memory. I avoid friends and neighbors because I don't know their names anymore. I can't remember the books I've read or the movies I've seen. I have trouble recalling simple vocabulary. I forget phone numbers. Sometimes I even forget what floor I live on. It's embarrassing. But I continue treatment because I'm getting better.

And I actually start to love ECT. I have 19 treatments over the course of a year. I look forward to them. It's like receiving a blessing in a sanctuary.... It's an oddly religious experience. It's my meditation, my yoga, my tai chi.

On the one-year anniversary of my first electroshock treatment, I'm clearheaded and even-keeled. I call my doctor to announce my "new and improved" status and ask to be excused from ECT that week. He agrees to suspend treatment temporarily. Surprisingly, I'm disappointed. ECT reassures me. Soon I miss the hospital and my "maintenance" regimen. But I never see the doctor again. Two and a half years later, I still miss ECT. But medication keeps my illness in check, and I'm more sane than I've ever been. If I could only remember the capital of Chile.

ANDY BEHRMAN (U.S. electroshock survivor and writer), closing paragraphs, "Electroboy: He Was Hooked up, Switched on, Blissed out," *New York Times Magazine*, 24 January 1999. At 32, Behrman was diagnosed with "bipolar disorder." After being "treated unsuccessfully with more than 30 medications" during the next year-and-a-half, he underwent outpatient ECT at New York City's Gracie Square Hospital in 1995. Behrman's *Electroboy: A Memoir of Mania* was published in 2003.

1995 — The writer, Dennis Cauchon, reviewed five studies of elderly patients who had undergone ECT during the 1980s. There were three deaths among the 372 patients involved in these studies (a death rate of 1 in 124). He mentioned David Impastato's 1-in-200 estimate of ECT deaths among elderly patients [see Impastato's first entry in 1957 above] to Duke University psychiatrist Richard Weiner, chairman of the 1990 APA Task Force on Electroconvulsive Therapy. Weiner, sticking with the Task Force's 1-in-10,000 ECT-mortality estimate, disputed Impastato's 1-in-200 figure — "If it were anywhere near that high, we wouldn't be doing it" [editor's summary].

DENNIS CAUCHON (U.S. journalist), "Shock Therapy," *USA Today*, 6 December 1995.

See Sandra Boodman's first entry in 1996 below.

1995 — [Doctors are expanding ECT's] reach — to high-risk patients, to children, to the elderly — altering the profile of who gets shock therapy so much that the typical patient now is a fully insured, elderly woman treated for depression at a private hospital or medical school.

Someone like Ocie Shirk.

Shirk, a widow coping with recurring depression, already had one heart attack and suffered from atrial fibrillation, a condition that causes rapid heart quivers.

On a Monday at 9:34 am, Oct. 10, 1994, she received shock therapy at Shoal Creek Hospital [now known as Seton Shoal Creek Hospital], a for-profit psychiatric hospital in Austin. She had a heart attack in the recovery room. Four days later, she died of heart failure.

Yet shock therapy isn't mentioned on Shirk's death certificate, despite repeated instructions on the form to include every event that may have played a role in the death....

In addition to Shirk, state records show two other patients died after shock therapy at Shoal Creek. Asked about these deaths, [the hospital's chief executive Gail] Oberta repeats "We could find no correlation between deaths of patients and receiving ECT at this facility."

DENNIS CAUCHON, "Shock Therapy," *USA Today*, 6 December 1995.

1995 — I've never, ever recommended ECT to a patient who didn't thank me in the end. Never.

ELLEN FRANK (U.S. electroshock psychiatrist), quoted in Kathleen Hirsch, "Shock Therapy Makes a Comeback," *Ms.*, November-December 1995.

1995 — The treatment [ECT] is admittedly mysterious. One of my colleagues, Dr. Stuart Yudofsky, once likened it to kicking the television set when the picture is fuzzy. We still haven't the slightest clue why it works.

JACK M. GORMAN (U.S. psychiatrist), *The Essential Guide to Psychiatric Drugs*, 1995.

1995 — It's more dangerous to drive to the hospital than to have the treatment. The unfair stigma against [ECT] is denying a remarkably effective medical treatment to patients who need it.

CHARLES H. KELLNER (U.S. electroshock psychiatrist and onetime editor of *The Journal of ECT*), quoted in Dennis Cauchon, "Shock Therapy," *USA Today*, 6 December 1995.

1995 — The death of a chronically ill 79-year-old woman in a mental hospital has focused new attention on the emotional debate over electroshock therapy as a treatment for depression. The woman, whose identity is protected by confidentiality laws, died 24 hours after a shock treatment Dec. 30, 1995. Medical records described her as confused and disoriented when she signed into The Pavilion [an 85-bed, private psychiatric hospital in Amarillo, Texas] on Dec. 27.

SCOTT PARKS (U.S. journalist), opening paragraph, "Shock Therapy Scrutinized in Wake of Woman's Death," *Dallas Morning News*, 24 May 1997.

1995 — Psychiatrists don't make much money, and by practicing ECT they can bring their income almost up to the level of the family practitioner or internist.

CONRAD SWARTZ (U.S. electroshock psychiatrist), quoted in Dennis Cauchon, "Shock Therapy," *USA Today*, 6 December 1995. Swartz is co-owner of Somatics, Inc., manufacturer of the Thymatron ECT device. Cauchon reported that psychiatrists, according to the American Medical Association, had an average annual income of \$131,300 in 1993.

See Sandra Boodman's second entry in 1996 below.

1996 — According to the 1990 APA [Task Force] report, one in 10,000 patients dies as a result of modern ECT. This figure is derived from a study of deaths within 24 hours of ECT reported to California officials between 1977 and 1983.

But more recent statistics suggest that the death rate may be higher. Three years ago, Texas became the only state to require doctors to report deaths of patients that occur within 14 days of shock treatment and one of four states to require any reporting of ECT. Officials at the Texas Department of Mental Health and Mental Retardation report that between June 1, 1993 and September 1, 1996, they received reports of 21 deaths among an estimated 2,000 patients.

SANDRA G. BOODMAN (U.S. journalist), “Shock Therapy: It’s Back,” *Washington Post*, 24 September 1996. Based on the Texas Department of Mental Health’s three-year study, which found that one in 95 patients had died within 14 days of undergoing ECT, the APA report, with its estimate of one death in 10,000 ECT patients, understated the ECT death rate by a factor of more than 100.

See Dennis Cauchon’s first entry in 1995 above.

1996 — Among the small fraternity of electroshock experts, psychiatrist Richard Abrams is widely regarded as one of the most prominent.

Abrams, 59, who retired recently as a professor at the University of Health Sciences/Chicago Medical School, is the author of psychiatry’s standard textbook on ECT. He is a member of the editorial board of several psychiatric journals. The American Psychiatric Association’s 1990 task force report on ECT is studded with references to more than 60 articles he has authored....

What is less well known is that Abrams owns Somatics, one of the world’s largest ECT machine companies. Based in Lake Bluff, Ill., Somatics manufactures at least half of the ECT machines sold worldwide, Abrams said....

Yet Abrams’s 340-page textbook [*Electroconvulsive Therapy*, 2nd ed., 1992] never mentions his financial interest in Somatics, the company he founded in 1983 with Conrad Melton Swartz, 49, a professor of psychiatry at East Carolina University at Greenville, N.C. [see Swartz’s entry in 1995 above]. Neither does the 1994 instruction manual for the device written by Abrams and Swartz, the company’s sole owners and directors, which contains extensive biographical information.

Financial ties between device manufacturers, drug companies and biotech firms “are a growing reality of health care and a growing problem,” said Arthur L. Caplan, director of the Center for Bioethics at the University of Pennsylvania School of Medicine.

For doctors “the questions that such financial conflicts of interest generate are, do patients get adequate full disclosure of options or are you skewing how you present the facts because you have a financial stake in the treatment and you personally profit from it every time it’s used?” Caplan asked.

“It’s especially disturbing with ECT because it’s so controversial” and public mistrust of the treatment is so great, he added....

Abrams declined to say how much he has earned from Somatics. Approximately 1,250 machines, priced at nearly \$10,000, have been sold to hospitals worldwide, he said. Between 150 and 200 machines are sold annually, according to Abrams. Somatics also sells reusable mouthguards for \$29, which are designed to minimize the risk of chipped teeth or a lacerated tongue.

SANDRA G. BOODMAN, “Shock Therapy: It’s Back,” *Washington Post*, 24 September 1996. Responding to the same failure-to-disclose issue raised in Dennis Cauchon’s two-part series on ECT (“Shock Therapy,” *USA Today*, 6-7 December 1995), **RICHARD ABRAMS** concluded his letter to the editor (11 December 1995) as follows: “If there is any shame attached to ECT, it is that it has too often been given by inexperienced and poorly trained doctors with unsafe and obsolete equipment. A copy of my book, and one of my ECT devices, placed in each hospital offering this treatment should go a long way toward correcting this problem.” Abrams, in the 3rd edition of *Electroconvulsive Therapy* (1997), disclosed that he is “President of Somatics, Inc., a firm that manufactures and distributes the Thymatron ECT device” not in the text but on the back flap of the book jacket.

See Dennis Cauchon’s first entry in 1995 above; and Richard Abrams’ five entries in 1997 below.

1996 — Max Fink, 73, a professor of psychiatry at the State University of New York at Stony Brook, whose passionate advocacy is widely credited with reviving interest in ECT, receives royalties from two videos he made a decade ago. Fink is one of six ECT experts who served on the APA’s 1990 ECT task force, which drafted guidelines for the treatment.

In 1986 he made two videos about ECT, one for patients and their families, the other for hospital staff. Each sells for \$350 and is used by hospitals that administer ECT. Fink said that Somatics paid him \$18,000 for the rights to the videotapes; he said he receives 8 percent of the royalties. He declined to disclose how much money he has earned from the videos.

SANDRA G. BOODMAN, “Shock Therapy: It’s Back,” *Washington Post*, 24 September 1996.

1996 — ECT is one of God’s gifts to mankind. There is nothing like it, nothing equal to it in efficacy or safety in all of psychiatry.

MAX FINK (Austrian-born U.S. electroshock psychiatrist), quoted in Sandra G. Boodman, “Shock Therapy: It’s Back,” *Washington Post*, 24 September 1996.
See Rich Winkel’s entry in 2005 below.

1996 — One of the most distressing things I find [about electroshock is]... that when I am trying to remember things, the memories I have are not necessarily my own memories because of all the research that I did, talking to people and looking through books and, you know, having big meetings with my friends about what's happened in the past and stuff. I am taking their word for things that have happened in my life. And then, you know, my memory isn't perfect so I am just remembering what they remember about things about my life. So someone asks me a question about something that's happened in my past and I am like: "Well I think I was told this. So that's the answer that I am giving you but honestly I have no idea whether or not that's true." It's a very, very upsetting feeling to not know yourself or your own life except through second hand experience.

JACQUELINE GUEST (Canadian electroshock survivor and employment counsellor), testimony at public hearings on electroshock, Toronto, 9 April 2005, <http://capa.oise.utoronto.ca/personal.html>. Guest underwent electroshock about 38 times at the Clarke Institute of Psychiatry, Toronto, in 1996.

1996 — Memory is often equated with the very essence of a person’s “being.” As such, discussions about ECT’s effects on memory deserve our most careful consideration.

CHARLES H. KELLNER (U.S. electroshock psychiatrist), “The Cognitive Effects of ECT: Bridging the Gap between Research and Clinical Practice,” *Convulsive Therapy*, June 1996.

1996 — One moment that I remember clearly from my hospital stay for ECT in 1996 is the horror I felt when after one of my treatments I couldn’t remember how old my children were. Not only did the ECT not work for me, but my suffering was compounded when I realized that approximately 2 years of my life prior to the ECT had been erased. My retention of new information is also severely impaired. If anyone had told me that this could happen, even a remote chance, I never would have consented to ECT. I would much rather have lost a limb or 2 than to have lost my memory — my “self.”

JACKIE MISHRA (U.S. electroshock survivor), quoted in Loren R. Mosher and David Cohen, “The Ethics of Electroconvulsive Therapy (ECT),” *Virtual Mentor* (“Ethics Journal of the American Medical Association”), October 2003.

1995, 1996 — My long-term memory deficits far exceed anything my doctors anticipated, I was advised about, or that are validated by research. To the contrary, either I am one in a thousand, a complete anomaly, to be able to document memory loss still remaining after 3 years and extending as far back as incidents eight to nine years ago, or the profession in general, after all these years of treatment with ECT, has still failed to identify and come to grips with the true potential risks.

While the more distant incidents may be random events, they are hardly insignificant ones: hosting and driving Mother Teresa for a full-day visit to Los Angeles in 1989; the dinner reception for my National Jefferson Award in Washington, D.C., in 1990, where I met and sat beside my co-honoree, General Colin Powell; my brother’s wedding in 1991 — the list goes on, and keeps growing as people bring up references to the past in casual conversations.

Human memory seems to me to be one of the most precious aspects of our personality, since our memories are so critical to who we are and how we see ourselves and others. The memories of our past give us an understanding of where we fit in the world. I have experienced more than a “cognitive deficit.” I have lost a part of myself. **ANNE B. DONAHUE** (U.S. electroshock survivor and attorney), referring to the memory loss she experienced following two series of ECT in 1995 and 1996, a total of 33 sessions, that she said saved her life, “Electroconvulsive Therapy and Memory Loss: A Personal Journey,” *Journal of ECT* (“Official Journal of the Association for Convulsive Therapy”), July 2000.

1997 — Because ECT is given in virtually every... country of the world — and not infrequently at much higher rates of usage than in the United States — it is likely that between 1 and 2 million patients per year receive ECT worldwide.

Will ECT... be replaced by a less intrusive, pharmacologic, therapy that alters brain function in the desired direction (e.g., via a hypothalamic neuropeptide) but without the auxiliary convulsion and its attendant risks and drama? Perhaps, but, I think, not soon.... Despite manufacturers’ claims, no significant progress in the pharmacological

treatment of major depression has occurred since the introduction of imipramine [an antidepressant drug whose trade name is Tofranil] in 1958.

RICHARD ABRAMS (U.S. electroshock psychiatrist), *Electroconvulsive Therapy*, 3rd ed., ch. 1, 1997 (1988).

See Sandra Boodman's first entry in 1996 above.

1997 — Any patient who has failed a course of adequate antidepressant therapy should be offered ECT in preference to another trial with a different compound. In practice, this covers many depressives who are admitted to the hospital after failing to respond to outpatient pharmacotherapy. Of course, any patient with a history of previous unresponsiveness to antidepressants should receive ECT as the initial treatment.

RICHARD ABRAMS, *Electroconvulsive Therapy*, 3rd ed., ch. 1, 1997 (1988).

1997 — There is little doubt that many patients diagnosed as having acute or schizoaffective schizophrenia respond remarkably well to ECT.... Every such patient deserves one full trial of ECT (preferably earlier rather than later in their illness course) to insure that no treatment will be overlooked that has a chance, however slim, of halting the otherwise relentless progression of this devastating illness.

RICHARD ABRAMS, *Electroconvulsive Therapy*, 3rd ed., ch. 2, 1997 (1988).

1997 — Considering the appropriately high social and individual value placed on intact memory function, it is readily understandable that fears of ECT-induced memory loss are paramount among a majority of candidates for and recipients of this treatment. The facile reassurance by generations of psychiatrists (including myself) that such memory loss was “only temporary” not only occasionally proved inaccurate but served to inculcate a deserved sense of distrust among patients whose personal experience proved otherwise.

RICHARD ABRAMS, *Electroconvulsive Therapy*, 3rd ed., ch. 12, 1997.

1997 — The death rate reported for ECT is an order of magnitude smaller than the spontaneous death rate in the general population.

RICHARD ABRAMS, 1997, quoted in John Read, “Electroconvulsive Therapy,” published in Read, Loren R. Mosher and Richard P. Bentall, eds., *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia*, 2004.

1997 — Researchers have found no evidence that ECT damages the brain....

The idea of ECT is frightening to many people. Some may not know that muscle relaxants and anesthesia make it a safe, practically painless procedure.

Some people who advocate legislative bans against ECT are former psychiatric patients who have undergone the procedure and believe they have been harmed by it and that the treatment is used to punish patients' misbehavior. This is untrue.

AMERICAN PSYCHIATRIC ASSOCIATION, *Fact Sheet: Electroconvulsive Therapy (ECT)*, 1997.

1997 — Refinements pioneered by [Harold] Sackeim's group and others... allow patients to recover quickly from ECT with fewer side effects. “I've had people star on Broadway the night after receiving treatment,” Sackeim said. (His patients included “people that

you see on TV every night,” he added.) He and his colleagues showed that the amount of electricity required to induce a seizure varies enormously — by a factor of fifty — from individual to individual....

The amount of electricity required to induce seizures in humans increases “in a *huge* way” from session to session. According to this view, depression is a kind of mild, long-term seizure that can be ameliorated by an intense, short-term seizure. Sackeim compared shock therapy to stepping on a car’s gas pedal when an idling engine is revving too fast. “We’re triggering a seizure in order to get the brain to stop a seizure.” This explanation is “probably the predominant theory right now,” Sackeim said. “God knows if it’s true.”

JOHN HORGAN (U.S. writer), *The Undiscovered Mind: How the Human Mind Defies Replication, Medication, and Explanation*, ch. 4, 1999. While writing his book, Horgan interviewed Sackeim, a psychologist specializing in ECT research at New York City’s New York Psychiatric Institute where Sackeim arranged for the author to observe two patients undergoing ECT.

1997 — As far as we know, ECT does not have any long term effects on your memory or intelligence.

ROYAL COLLEGE OF PSYCHIATRISTS, *ECT (Electroconvulsive Therapy)*, Patient Information Factsheet No. 7, London, 1997.

1998 — There is an extensive animal research literature confirming brain damage from ECT. The damage is demonstrated in many large animal studies, human autopsy studies, brain wave studies, and an occasional CT scan study. Animal and human autopsy studies show that ECT routinely causes widespread pinpoint hemorrhages and scattered cell death. While the damage can be found throughout the brain, it is often worst in the region beneath the electrodes. Since at least one electrode always lies over the frontal lobe, it is no exaggeration to call ECT an electrical lobotomy.

PETER R. BREGGIN (U.S. psychiatrist), “Electroshock: Scientific, Ethical, and Political Issues,” *International Journal of Risk & Safety in Medicine*, vol. 11, 1998. See Glen Peterson’s entry in 1989 and American Psychiatric Association’s first entry in 1990 above; and Peter Sterling’s entry in 2001 below.

1998 — Even taking into account that some memory loss can result from stress, depression, and aging, what I know for certain is that after thirty-six electroshock treatments, innumerable memories have been literally and permanently erased, with only occasional freeze-framed flashbacks....

I have discovered that I have totally forgotten persons I used to know well: a friend told me that after my ECT treatments, I telephoned her, mentioned that I had come across her name in my address book, and asked, “Who are you?” And I have also found my explicit, short-term memory debilitated, my IQ quantifiably diminished (attested to by extensive neuropsychological assessments), my abstract reasoning and learning facility (such as trying for an ungodly number of hours to figure out how to work a new phone-fax machine or how to accomplish simple computer tasks) seriously impaired, my ability to find the words I want and need reduced (such that I struggle to write more than four or five sentences at a time and have to compensate for the loss of words I mean with simpler and less precise ones), and my cognitive capabilities weakened to the

extent that I immediately forget what I've just read, even losing track of the meanings of the words.

JONATHAN COTT (U.S. electroshock survivor and writer), *On the Sea of Memory: A Journey from Forgetting to Remembering*, ch. 1, 2005. In 1998, Cott had 26 of his 36 ECTs at New York City's New York State Psychiatric Institute, a major center for ECT research.

1988, 1998 —I was shown a short video [about ECT] in the hospital. The video actually showed the person going through a course of being shocked. What I don't remember the video showing was that... [ellipsis in original]. The video did not show the person awakening in the recovery room alone and disoriented. I don't remember the video showing that individual shuffling back to the ward lounge, ashamed under the watchful gaze of fellow inmates. I am becoming fairly convinced that in psychiatric training, neurology must be offered as an early morning class because the psychiatrists are obviously missing something very important. That very obvious and important thing is that blunt force trauma to the brain is not healing. Blunt force trauma to the brain is damaging. I think that the next time psychiatrists hold a convention we should hand out some pamphlets in comic book form of course, so they can understand, Blunt Force Trauma and You.

CHRIS DOWLING (Canadian electroshock survivor and community mental health worker), testimony at public hearings on electroshock, Toronto, 9 April 2005, <http://capa.oise.utoronto.ca/personal.html>. Dowling underwent about 30 electroshocks at the Homewood Health Centre, Guelph, Ontario in 1988 and 1998.

1999 — My memory is terrible, absolutely terrible. I can't even remember Sarah's first steps, and that's really hurtful... losing the memory of the kids growing up was awful....

I can be reading a magazine and I get halfway through or nearly to the end and I can't remember what it's about, so I've got to read it all over again....

People would come up to me in the street that knew me and would tell me how they knew me and I had no recollection of them at all... very frightening....

It's a void, I can't describe it, and there's also a feeling of something fundamental that I don't even know what it is [that's] missing... just like an intrinsic part of me that I feel isn't there and it once was.... Part of me feels like there was a real death of something, something died during that time.

ANONYMOUS (four British electroshock survivors), quoted in Lucy Johnstone (British psychologist), "Adverse Psychological Effects of ECT," *Journal of Mental Health*, vol. 8, 1999.

1999 — Although a patient's symptoms often resolve dramatically after a few treatments, a sustained recovery requires a greater number. For decades we were so concerned about the possibility of detrimental effects on memory that we restricted the treatments to the least number needed to achieve a discernable improvement. As a consequence, benefits were not sustained and the relapse rate was painfully high. Illness can recur in up to 20 percent of depressed patients within one month and in up to 50 percent within six months of a short course of treatment, even though antidepressants drugs are continued. For those with delusional depression, the relapse rates are higher. Now we routinely prescribe longer courses of treatment, followed by continuation ECT or

continuation pharmacotherapy. A complete course of treatment usually takes at least six months.

MAX FINK (Austrian-born U.S. electroshock psychiatrist), *Electroshock: Restoring the Mind*, ch. 2, 1999. Fink dedicated his book “To Ladislav Meduna, originator of convulsive therapy; and to the patients and their families who participated freely in the studies that established this effective treatment for the mentally ill.” Meduna introduced metrazol convulsive treatment in Budapest in 1934. Patients’ reactions while being prepared for a metrazol session have been described and published: “One patient refused to undress. A second one complained that he ‘didn’t want to die.’ A third patient asked why we wanted to ‘kill her.’ Physical resistance is shown not only by the refusal of certain patients to go to bed, but in many instances by combativeness.... Such statements as, ‘These treatments scare me to death.’ ‘Please don’t do that to me,’ and other tearful and frightened protests are frequent” (**WILLIAM C. MENNINGER** [U.S. psychiatrist and onetime president of the American Psychiatric Association], “The Results with Metrazol as an Adjunct Therapy in Schizophrenia and Depression,” *Bulletin of the Menninger Clinic*, September 1938).

1999 — It is essential to note that halting ECT prematurely is the main cause of recurrence [relapse].

MAX FINK, *Electroshock: Restoring the Mind*, ch. 2, 1999.

1999 — Electroshock has fewer risks than does treatment with psychotropic drugs....

Almost all medications used to treat emotional disorders cause changes in brain chemistry and physiology that manifest themselves as an impairment of memory.

MAX FINK, *Electroshock: Restoring the Mind*, ch. 3, 1999.

1999 — Repetitive compulsive acts mark a number of abnormal mental states — the hand-washing by patients with obsessive-compulsive disorder, the symbolic slashing of wrists in patients with borderline personality disorder, and the repetitive face-scratching and head-banging of patients with mental retardation. These movement syndromes are occasionally responsive to electroshock.

MAX FINK, *Electroshock: Restoring the Mind*, ch. 8, 1999.

1999 — Although ECT and most other somatic therapies have been attacked by the antipsychiatry movement, it must be remembered that vigorous opponents of psychiatry existed in Europe and America for hundreds of years. The causes for such antagonisms are many. They include the ignorance, prejudice, and emotional bias of single-minded individuals obsessed with the idea of attacking psychiatry. The spokesmen for the antipsychiatry groups include writers, former patients (not all of whom have fully recovered), physicians, legislators, and several prominent antipsychiatry psychiatrists, most notably Thomas Szasz and R. D. Laing.

ZIGMOND M. LEBENSOHN (U.S. electroshock psychiatrist), “The History of Electroconvulsive Therapy in the United States and Its Place in American Psychiatry: A Personal Memoir,” *Comprehensive Psychiatry*, May-June 1999.

2000 — By participating with fellow residents in inhuman acts, such as ECT and forced drugging, psychiatrists become bonded in a way reminiscent of the Nazi practice of

sending young SS officers to concentration camps where they would collaborate in torturing prisoners. The Nazis called this bonding “blutkitt,” literally “blood cement.” Afterwards, the SS officers would be assigned to local police stations where they’d brutalize other prisoners without compunction and with the encouragement of officers with similar backgrounds. Dostoevsky put it this way in *The Possessed* (1871): “All that business of titles and sentimentalism is a very good cement, but there is something better; persuade four members of the circle to do [in] a fifth on the pretense that he is a traitor, and you’ll tie [the four of them] together with the blood they’ve shed as though it were a knot. They’ll be your slaves, they won’t dare to rebel or call you to account.”

JOHN BREEDING (U.S. psychologist), *The Necessity of Madness and Unproductivity: Psychiatric Oppression or Human Transformation*, ch. 6, 2000. Compare: “Psychiatric training, above all else, is the ritualized indoctrination of the young physician into the theory and practice of psychiatric violence” (**THOMAS S. SZASZ** [Hungarian-born U.S. psychiatrist], “Psychiatry,” *The Second Sin*, 1973).

As psychiatrists, [electroshock specialists] believe themselves to be helpers. Challengers to this belief are a threat. Countless psychiatric survivors will attest to the fact that psychiatrists are apt to feel resentful toward those patients who can't or are unwilling to be helped by them. Administering ECT to such patients, or referring them to someone who will, is a quick, easy, and often profitable way for psychiatrists to vent their anger on them. At the same time, punishing (with ECT) those patients who do not see them as helpers strengthens the psychiatrists' conviction that they are.

JOHN BREEDING, *The Necessity of Madness and Unproductivity: Psychiatric Oppression or Human Transformation*, ch. 6, 2000.

2000 — Individuals who have undergone ECT report horrific emotional distress resulting from this procedure. Physical and cognitive debilitation, together with intense fear, shame and hopelessness make life and recovery a tremendous challenge for many people who undergo this procedure. My own clients have reported years of fearful avoidance of medical doctors after undergoing electroshock. The fear is so great that they neglect their physical medical needs, rather than go to a doctor. Electroshock survivors often have recurrent nightmares about the electroshock or about symbolic forms of torture and death. One client recently shared with me that the reading of testimonials from Holocaust survivors was a key to her recovery; she finally found people whose depth of emotional pain and anguish was similar to her own. This helped her to overcome some of the shame and stigmatization, and to begin walking through the isolation that so many psychiatric survivors experience after their “treatment.”

JOHN BREEDING, *The Necessity of Madness and Unproductivity: Psychiatric Oppression or Human Transformation*, ch. 9, 2000.

2000 — Public policy should move toward the elimination of electroconvulsive therapy and psychosurgery as unproven and inherently inhumane procedures. Effective humane alternatives to these techniques exist now and should be promoted.

NATIONAL COUNCIL ON DISABILITY (an independent federal agency which advises the government on disability policy), recommendation in a report titled “From Privileges to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves,” 20 January 2000.

2001 — In her novel, *Beloved*, Toni Morrison describes the farm where her character grew up as a slave: “It never looked as terrible as it was and it made her wonder if Hell was a pretty place too. Fire and brimstone all right, but hidden in lacy groves. Boys hanging from the most beautiful sycamores in the world.”

Boys hanging dead from the most beautiful sycamores in the world. Unconscious, brain-damaged patients lying on electroshock tables in the most impressive psychiatric institutions doing electroshock research funded by the government of the United States through the most prestigious National Institute of Mental Health.

Boys hanging, dead. Victims of forced electroshock, brains damaged, memory lost, potential healing suppressed, sometimes dead.

At the dawn of the 20th century in the United States, a black Southerner died at the hands of a white mob more than once a week. Society accepted the practice; some newspapers not only covered lynchings, but even advertised them. At the dawn of the 21st century, psychiatrists electroshock about 2,000 United States citizens every week. Society accepts the practice; the media not only covers it, but even promotes it.

Just as brave leaders and activists won civil rights legislation that led to a massive decline in the dehumanizing and degrading practice of racism, activists are now challenging the brutal practice of electroshock. Through the good efforts of this committee, New York’s legislature now has the opportunity to enact a landmark law regulating and restricting the use of electroshock which hopefully will lead one day to the abolition of this procedure, and thereby the establishment of a more just and humane society.

JOHN BREEDING (U.S. psychologist), closing paragraphs, testimony at a hearing on ECT before the New York Assembly Standing Committee on Mental Health, Mental Retardation, and Developmental Disabilities, New York City, 18 May 2001. A bill regulating ECT eventually passed out of the Committee but the New York State legislature voted it down.

2001 — [There exists] a phenomenon that this writer has rarely seen addressed: neurologists’ virtual silence about the topic of ECT. Given that neurologists are the officially recognized experts on the nervous system and on the effects of brain injuries, this silence ranks as a most remarkable omission. Every year in the United States, at least 100,000 persons receive series of electrically-induced seizures prescribed by one medical discipline while another medical discipline — which recognizes seizures as one of the most significant traumas to the brain — does not comment on the practice.

DAVID COHEN (U.S. professor of social work), “Electroconvulsive Treatment, Neurology, and Psychiatry,” *Ethical Human Sciences and Services*, Summer 2001.

2001 — The results of ECT in treating severe depression are among the most positive treatment effects in all of medicine.... For the sake of the many patients with major depression and their families, it is time to bring ECT out of the shadows.

RICHARD GLASS (U.S. electroshock psychiatrist), “Electroconvulsive Therapy: Time to Bring It Out of the Shadows” (editorial), *Journal of the American Medical Association*, 14 March 2001.

2001 — Shock treatment may have contributed to the sudden death of a psychiatric patient at Graylands Hospital [near Perth, Western Australia]. Giovanni Mario Franco was a physically fit 30-year-old when he was admitted to Graylands in February 1998 to be treated for schizophrenia. But on March 10 he died suddenly in a locked ward under the constant watch of two nurses. Mr. Franco had undergone electroconvulsive therapy — known as ECT or shock therapy — a day before he died. At an inquest into the death this week, Deputy State Coroner Evelyn Vickers was told it was possible the shock treatment caused his heart to stop beating....

Forensic pathologist Dr. Gerard Cadden told the inquest Mr. Franco died from undetermined causes but the most likely explanation was cardiac dysrhythmia — a catastrophic interference to a normal heartbeat. Asked if the fatal heart failure could have resulted from the shock therapy, Dr. Cadden replied: “Yes, it could have caused dysrhythmia.” He said the cause could never be conclusively determined, though, because dysrhythmia left no medical traces. Mr. Franco had no history of heart problems and an autopsy revealed his heart was normal....

Electroconvulsive therapy is routinely used in [Western Australian] psychiatric institutions despite concerns about its safety. Treatment involves sending bursts of up to 460 volts into the patient’s brain. Australian and New Zealand College of Psychiatrists spokesman Dr. Paul Skerritt said ECT was a widely accepted treatment for depression and other conditions. “This is not a treatment from the dark ages,” he said. It does not do the brain any harm.

JIM KELLY (Australian journalist), “Shock Death Link,” *Sunday Times* (Western Australia), 21 January 2001.

2001 — Conclusions: Our study indicates that without active treatment, virtually all remitted patients [i.e., those patients whose symptoms diminished following ECT] relapse within 6 months of stopping ECT. Monotherapy with nortriptyline [an antidepressant drug whose trade name is Pamelor] has limited efficacy. The combination of nortriptyline and lithium is more effective, but the relapse rate is still high, particularly during the first month of continuation therapy.

HAROLD A. SACKEIM (U.S. electroshock psychologist) et al., abstract for “Continuation Pharmacotherapy in the Prevention of Relapse Following Electroconvulsive Therapy,” *Journal of the American Medical Association*, 14 March 2001. Of the 290 patients diagnosed with “major depression” who underwent ECT, 58 qualified for participation in the continuation study. They were placed in three groups: 84 percent of the group given sugar pills (placebos) relapsed within 6 months; as did 60 percent of the nortriptyline group and 39 percent of the nortriptyline-lithium group.

2001 — A very rare number of patients may experience marked retrograde amnesia as a result of ECT. There is no firm estimate on this incidence but my estimate would be on the order of 1 in 500 patients.

Careful scientific study has shown that ECT does not cause brain damage (cellular death). Indeed, the conditions under which seizures in humans cause brain damage are sufficiently described to know that this cannot occur with ECT. To the contrary, all antidepressant treatments promote the development of new neurons (brain cells), a recently discovered fact.

HAROLD A. SACKEIM, written testimony at a hearing on ECT before the New York Assembly Standing Committee on Mental Health, Mental Retardation, and Developmental Disabilities, New York City, 18 May 2001.

See Sackeim's comment in the citation of the American Psychiatric Association's third entry in 1990 above; and Peter Sterling's entry in 2001 below.

2001 — ECS (ECT) unquestionably damages the brain. The damage is due to a variety of known mechanisms:

1) ECS is designed to evoke a *grand mal* epileptic seizure involving massive excitation of cortical neurons that also deliver excitation to lower brain structures. The seizure causes an acute rise in blood pressure well into the hypertensive range, and this frequently causes small hemorrhages in the brain. Wherever a hemorrhage occurs in the brain, nerve cells die — and nerve cells are not replaced.

2) ECS ruptures the “blood-brain barrier.” This barrier normally prevents many substances in the blood from reaching the brain. This protects the brain, which is our most chemically sensitive organ, from a variety of potential insults. Where this barrier is breached, nerve cells are exposed to insult and may also die. Rupture of this barrier also leads to brain “edema” (swelling), which, since the brain is enclosed by the rigid skull, leads to local arrest of blood supply, anoxia [lack of oxygen], and neuron death.

3) ECS causes neurons to release large quantities of the neurotransmitter, glutamate. This chemical excites further neuronal activity which releases more glutamate, leading to “excito-toxicity” — neurons literally die due to overactivity. Such excito-toxicity has been recognized relatively recently and is now a major topic of research. It is known to accompany seizures and over repeated episodes of ECS may be a significant contributor to accumulated brain damage.

PETER STERLING (U.S. professor of neuroscience), written testimony for a hearing on ECT before the New York Assembly Standing Committee on Mental Health, Mental Retardation, and Developmental Disabilities, New York City, 18 May 2001. Sterling's testimony was dated 31 May 2001.

See Alpers and Hughes' entry in 1942, Manfred Sakel's in 1956, David Impastato's first entry (citing 66 ECT deaths from “cerebral” causes) in 1957, Weinstein and Fischer's entry in 1971, American Psychiatric Association's in 1978, Lee Coleman's in 1978, Max Fink's in 1978, Peter Breggin's in 1981, Sidney Sament's in 1983, Glen Peterson's in 1989, American Psychiatric Association's first entry in 1990, Leonard Frank's in 1990, Hugh Polk's entry in 1993, Breggin's in 1998, and Harold Sackeim's in 2001 above.

2002 — [Electroshock] is a brutal, dehumanizing, memory-destroying, intelligence-lowering, brain-damaging, brainwashing, life-threatening technique. ECT robs people of their memories, their personality and their humanity. It reduces their capacity to lead full, meaningful lives; it crushes their spirits. Put simply, electroshock is a method for gutting the brain in order to control and punish people who fall or step out of line, and intimidate others who are on the verge of doing so.

LEONARD ROY FRANK (U.S. electroshock survivor and editor), “Electroshock: A Crime against the Spirit,” *Ethical Human Sciences and Services: An International Journal of Critical Inquiry*, Spring 2002.

2002 — The federal government stands by passively as psychiatrists continue to electroshock American citizens in direct violation of some of their most fundamental

freedoms, including freedom of conscience, freedom of thought, freedom of religion, freedom of speech, freedom from assault, and freedom from cruel and unusual punishment. The government also actively supports ECT through the licensing and funding of hospitals where the procedure is used, by covering ECT costs in its insurance programs (including Medicare), and by financing ECT research, including some of the most damaging ECT techniques ever devised. One recent study provides an example of such research. This ECT experiment was conducted at Wake Forest University School of Medicine/North Carolina Baptist Hospital, Winston-Salem, between 1995 and 1998. It involved the use of electric current at up to 12 times the individual's convulsive threshold on 36 depressed patients.... This reckless disregard for the safety of ECT subjects was supported by grants from the National Institute of Mental Health.

LEONARD ROY FRANK, "Electroshock: A Crime against the Spirit," *Ethical Human Sciences and Services: An International Journal of Critical Inquiry*, Spring 2002. The Wake Forest ECT study was reported in W. Vaughn McCall, David M. Reboussin, Richard D. Weiner, and Harold A. Sackeim, "Titrated Moderately Suprathreshold vs Fixed High-Dose Right Unilateral Electroconvulsive Therapy," *Archives of General Psychiatry*, May 2000.

See Frank's first entry in 1990 above.

2002 — Electroshock could never have become a major psychiatric procedure without the active collusion and silent acquiescence of tens of thousands of psychiatrists and other health professionals. Many of them know better; all of them *should know* better. The active and passive cooperation of the media has also played an essential role in expanding the use of electroshock. Amidst a barrage of propaganda from the psychiatric profession, the media passes on the claims of ECT proponents almost without challenge. The occasional critical articles are one-shot affairs with no follow-up, which the public quickly forgets. With so much controversy surrounding this procedure, one would think that some investigative reporters would key on to the story, but until now this has been only a rare occurrence. And the silence continues to drown out the voices of those who need to be heard. I am reminded of Martin Luther King's 1963 "Letter from Birmingham City Jail," in which he wrote, "We shall have to repent in this generation not merely for the vitriolic words and actions of the bad people, but for the appalling silence of the good people."

LEONARD ROY FRANK, "Electroshock: A Crime against the Spirit," *Ethical Human Sciences and Services: An International Journal of Critical Inquiry*, Spring 2002.

2003 — Two years ago, Cao Maobing attempted to organize his fellow workers at a state-owned silk factory into a trade union. He was sent to the No. 4 psychiatric hospital in Yancheng [China] the day after he spoke to Western reporters. His fellow workers, according to an American who knows Cao, described him warmly: "Mr. Cao is an upright, kind, and law-abiding citizen. He is a brave and intelligent worker. He made a lot of personal sacrifice to help other workers to uphold their right to basic living." Cao's wife said he was being forcibly medicated. "He's absolutely not insane and refuses to take the medicine. But eventually they force him to take it." She said she was told to leave the hospital after her husband was medicated. According to other reports, he was also given electroshock treatment on several occasions. Cao was released after six months and has never returned to trade union activity.

JONATHAN MIRSKY (U.S. journalist), “China’s Psychiatric Terror,” *New York Review of Books*, 27 February 2003.

2003 — *Electroconvulsive Therapy (ECT)*. When depression is severe, the patient is suicidal and other therapies have not been effective, ECT can help. Electrical impulses are delivered to the brain via electrodes applied to the head. It sounds scary, but it is painless and a lot better than living the rest of your life seriously depressed.

ISADORE ROSENFELD (U.S. physician), “Come Out from Under Your Cloud,” *Parade Magazine*, 5 October 2003. This was Rosenfeld’s complete description of ECT in an article on the nature, causes and treatment of depression. His column on medical issues appears regularly in *Parade*.

2004 — Baghdad. Electric shock treatment is usually administered without anesthetic at Iraq’s biggest psychiatric hospital.

Only 16 doctors treat 900 patients. Mortar rounds land in the courtyard, traumatizing the unstable.

But there is still a glimmer of hope at Baghdad’s Al-Rashad Teaching Psychiatric Hospital, a sprawling facility caught between U.S. troops and guerrillas that is recovering from post-war looters who raped patients last year.

With clean facilities, workshops and job programs for patients, it hopes to ease the anguish of mental illness in a city plagued by violence that offers little sanity outside....

“We really need anesthetics. We have to conduct electric shock treatment two to three times a week and we hardly have anything for the pain,” said Dr. Yasser Abdullah.

MICHAEL GEORGY (British journalist), “Psychiatric Hospital Struggles to Heal in Iraq,” Reuters, www.reuters.co.uk/newsArticle.jhtml, 21 June 2004.

2005 — A South Carolina woman has become the first survivor of electroconvulsive therapy to win a jury verdict and a large money judgment in compensation for extensive permanent amnesia and cognitive disability caused by the procedure.

Peggy S. Salters, 60, sued Palmetto Baptist Medical Center in Columbia, as well as the three doctors responsible for her care. As the result of an intensive course of outpatient ECT in 2000, she lost all memories of the past 30 years of her life, including all memories of her husband of three decades, now deceased, and the births of her three children. Ms. Salters held a Masters of Science in nursing and had a long career as a psychiatric nurse, but lost her knowledge of nursing skills and was unable to return to work after ECT.

The jury awarded her \$635,177 in compensation for her inability to work. The malpractice verdict was against the referring doctor, Eric Lewkowiez. The jury could not return a verdict against the other two doctors because of one holdout vote for acquittal. The hospital settled its liability for an undisclosed sum early in the trial.

LINDA ANDRE (U.S. electroshock survivor and writer), ctip@erols.com, 7 July 2005. See Andre’s entries in 1984 above.

2005 — There is no official count, but in 1996 the estimate was that 100,000 patients per year were being treated with ECT in the United States.... If you take the 100,000

estimate per year and each patient gets an average of 10 treatments, that's about 1 million treatments in 1996....

It is reasonable for child psychiatrists who are not wedded to psychodynamic thinking to consider ECT in children and adolescents with the illnesses for which ECT is used in adults....

Over the 70-plus [sic] years that ECT has been around, we have learned to appreciate that something magical happens in the body when we produce an epileptic fit....

In 1991, I was invited to go on a lecture tour in Holland. I gave seven lectures in five days at different universities and hospitals, and they were all about ECT. At that time, ECT use in Holland was the lowest in Europe. It was almost impossible to get the treatment. In January of this year, I went to a meeting in Brussels. A Dutch speaker described a significant use of ECT in Holland. In fact, they got so interested that the Dutch have published numerous research articles and a handbook of ECT. The same has happened in Germany and Austria, where usage has increased and a new German text has been published.

MAX FINK (Austrian-born U.S. electroshock psychiatrist), quoted in Arline Kaplan, "Through the Times with Max Fink, M.D.," *Psychiatric Times*, September 2005. According to Kaplan, "Fink believes that now the numbers being treated in the United States are beyond 100,000 patients per year, and he sees a revival of ECT in Europe as well." Fink reported, in Kaplan's paraphrase, that the "American Academy of Child and Adolescent Psychiatry has published a practice parameter for the use of ECT with adolescents. The authors [of a 2004 article published in the Academy's journal] concluded it may be an effective treatment for adolescents with severe mood disorders and other Axis I psychiatric disorders when more conservative treatments have been unsuccessful."

2005 — Psychiatry's diagnostic system obscures the reality of the individual's problems. Psychiatry's use of involuntary commitment and forced "treatment" constitutes an attack on everyone's human rights. Electroshock is a particularly vicious psychiatric technique because it reaches into and explodes the very core of who we are.

Since the time of Hippocrates, more than 2,000 years ago, physicians have tried to discover methods for controlling or curing the disease of epilepsy, and along come the psychiatrists and setting reason on its head induce epileptic-like seizures as a fake treatment for fake diseases.

Solving life's problems, now given psychiatric labels, calls for compassion, understanding and support not psychiatric violence as epitomized by electroshock.

PETER LEHMANN (European psychiatric survivor and founder of Peter Lehmann Publishing and Mail-Order Bookstore at www.peter-lehmann-publishing.com), personal communication, 16 December 2005.

2005 — How much does an electroshock cost? Oh, about 50 cents for the meds, maybe a nickel for the electricity — and a lifetime of regret and disability for the victim.

GARY MOORE (U.S. electroshock survivor), email to John Breeding, 11 October 2005.

2005 — For the last 15 years or so, nobody has been speaking about electroshock in Switzerland. Even among professionals, except for the ECT psychiatrists themselves, there is hardly any knowledge about the current practice of this "treatment." During the

1970s, psychiatrists noisily declared that electroshock was a very effective treatment, especially for depressed people. This “beneficial treatment” then fell into disrepute and for a while there were in real terms fewer people being electroshocked. Psychiatrists attributed this to a dishonest press campaign carried out by critics of psychiatry. Starting around 1985, however, and with little public awareness, the number of people being electroshocked began to rise and has continued rising ever since. One might speak of the silent comeback of electroshock.

There are good reasons for this silence: most people think of cruelty, torture and electrocution when they hear the word electroshock. Nearly everyone feels horror and dread when they imagine someone being administered electroshocks. The same must be true for psychiatrists, at least before they begin their specialized training. It is during this training that they learn to suppress their feelings more and more. This results in the gap between themselves and their patients becoming larger and larger. This gap separates not only the sane and the insane, the normal and the abnormal, but also the powerful and the powerless. This gap enables psychiatrists (and other people) to project everything in themselves that is disturbing and frightening, everything they dislike about themselves, onto the so-called mad people where it can be dealt with by any means they choose, including deception and violence. This blaming of others prevents empathy, understanding, and appreciation of the truth that we are all creatures of value – equal value.

Violence has always been a remedy, a false remedy, against fear. The powerful are especially fearful of those they cannot control. In modern society, the “lunatic” is emblematic of all the uncontrollables. Psychiatrists have developed the tools of control, really weapons of violence passed off as medical treatments. With these tools they are able to control, manipulate and destroy to a greater or lesser extent the intellectual and emotional capacities of the uncontrollables, now fixed with stigmatizing psychiatric labels, and so reduce their own fears and at the same time satisfy their sadistic impulses.

The true nature of electroshock becomes obvious when one considers that outside of psychiatry applying electricity to any part of a human body is immediately perceived as a method of torture.

MARC RUFER (Swiss psychiatrist), personal communication, 24 December 2005.

2005 – Turkey’s psychiatric hospitals are riddled with horrific abuses, including the use of raw electroshock as a form of punishment, according to [a newly published report by Mental Disability Rights International, a Washington-based group]....

[Modified ECT] is normally administered with anesthesia and muscle relaxants.

Without them it can be painful, terrifying and dangerous. Patients can break jaws or crack vertebrae during the induced seizures. The report quotes a 28-year old patient at Bakirkoy Psychiatric Hospital in Istanbul as saying, “I felt like dying.”...

The human rights group estimated that unmodified shock treatment was used on nearly a third of patients undergoing psychiatric crises at the government hospitals, including children as young as 9....

“If we use anesthesia the ECT won’t be as effective, because they won’t feel punishment,” the report quotes the director of the electroconvulsive therapy center as saying.

CRAIG S. SMITH (U.S. journalist), “Abuse of Electroshock Found in Turkish Mental Hospitals,” *New York Times*, 29 September 2005. An editorial on the MDRI report in

The Times the next day disclosed that “The staff in one institution told investigators that children who cannot feed themselves are left to starve to death.”

2005 — The magnitude of the atrocity is too great to communicate. That’s why it’s the perfect crime.

RICH WINKEL (U.S. electroshock survivor and computer programmer), referring to electroshock, zapback@efn.org, 2 February 2005.

See Max Fink’s entry in 1996 above.

2006 — Roky [Erickson’s] biggest battle was not with “schizophrenia,” but with those who called him that and treated him accordingly. Schizophrenia is a psychiatric garbage term for disturbed or disturbing behavior that is considered beyond the pale. The label “schizophrenia” is a justification for actions which almost destroyed Roky. [The labeling led to his being subjected to forced treatment.]... For an estimated 1.5 million Americans each year, forced treatment means an immense violation of liberty — unwilling incarceration in a psychiatric hospital. For the vast majority, including Roky Erickson, it also means forced drugging. For so-called schizophrenia, that means with neuroleptic drugs, which are known to have caused the largest epidemic of neurological disease in the history of the world — tardive dyskinesia. In Roky’s case, another standard psychiatric treatment, electroshock (also known as electroconvulsive treatment) was forcibly administered, repeatedly. By all rights, Erickson should have been destroyed by psychiatry; his recovery truly is miraculous.

JOHN BREEDING (U.S. psychologist), letter to *Austin Chronicle*, 23 January 2006, <http://www.austinchronicle.com/gbase/Community/Postmarks>. Erickson, an Austin (Texas) musician, had his own band, the 13th Floor Elevators, in the early 1980s. After being sidelined for many years, he made a comeback in 2005. In his 11th appearance that year, he played to a packed house in Austin’s Shoal Creek Saloon.

2006 — *The March of the Damned*. In the last decade, I have had the opportunity to listen to the many voices of the electroshock experience. There exist several commonalities, including a thirst for information.

Usually, a sense of bewilderment accompanies this need to know more.

The movie title *Dazed and Confused* brings to mind teenagers experimenting with drugs, but the phrase perfectly describes the majority of the ECT patients who find their way to the discussion board at ect.org, the website I’ve run for more than ten years.

They are dazed and confused, wondering what has happened and why.

The medical industry continues to market a “new and improved” electroshock, selling an endless stream of new customers on the benefits of unilateral ECT, high-tech machines with impressive dials and buttons, and fewer side effects. But in the end, after the final treatment, the results are the same as they’ve always been. The hype of new technology, better science, and better training is exposed for the lie it is: the new ECT is the old ECT only in a prettier package.

Day after day, the dazed and confused knock on the door of ect.org, seeking answers, hungry for the information they were never given. I sit at my computer, a virtual door, and watch them continue to march in, one by one. It never stops and it never gets better; it’s my own viewing of the march of the damned.

Patients are not routinely given adequate information when making a decision to

have ECT (if indeed they are given a choice at all). Doctors recite their mantra, that today's ECT is safer, and that memory loss is a thing of the past. Some blatantly lie and tell patients it will cure their depression. Others simply lie by omission, failing to give patients full disclosure of what lies ahead.

And so they join the march of the damned and then find that not only did the ECT not fix their lives, it added to their litany of problems. A few weeks beyond the last ECT, as the fog lifts just enough to begin to comprehend that this might not be the miracle promised, the questions begin. Typically, the doctor's answer is more ECT: maintenance ECT, ongoing ECT, continuation therapy, almost always accompanied by powerful, mind-bending psychiatric drugs.

Rarely will a doctor confront the patient's basic question: what happened? Where's the miracle? The answer belongs to the patient: blame. The patient is misremembering; it's the mental illness; the depression is causing the problems — or, the patient is simply a troublemaker.

Contemporary ECT has more bells and whistles than the ECT of many decades ago, but the results remain the same and the complaints haven't changed.

Doctors are able to dazzle their patients with new vocabulary — “synapses,” “serotonin,” “neurotransmitters,” and the like. More than sixty years later, however, ECT doctors still find their dictionaries missing the words disclosure and honesty. The spin has changed, but the march of the damned continues forward.

JULI LAWRENCE (U.S. electroshock survivor and human rights activist), personal communication, 24 January 2006. Lawrence underwent ECT 12 times at St. Elizabeth's Hospital, Belleville, Illinois, in 1994. Her ect.org is the most important and heavily trafficked ECT website on the Internet.

2006 — MindFreedom International has a number of ongoing campaigns that challenge human rights violations involving the use of electroshock. The MindFreedom board of directors has a long-standing position opposing the medical use of electroshock because the practice is inherently a human rights violation.

Over the years, MindFreedom has focused on specific examples of these human rights violations, including the use of forced electroshock, fraudulent informed consent, and coercion by the withholding of humane and safe alternatives to shock.

Here is a brief summary of current campaign activities:

- **International:** For several years MindFreedom has brought up issues involving human rights in the mental health system with the World Health Organization (WHO). During this period there have been several personal meetings with Dr. Benedetto Saraceno, director, Department of Mental Health and Substance Abuse at WHO. MindFreedom also organized a campaign to have people write, fax and e-mail WHO headquarters about these issues.

As a result, staff at WHO have repeatedly credited MindFreedom with making several changes at WHO. At MindFreedom's request, WHO has publicly stated that human rights in mental health amount to a “global crisis” and that this problem stems from the mental health system itself, not just from a lack of mental health care.

MindFreedom then asked WHO to be more specific. WHO has stated in written materials and in public statements that it officially opposes all forced or involuntary electroshock against the expressed wishes of the subject. Dr. Saraceno has publicly credited MindFreedom with influencing WHO to take this firm public position.

This is the first major government or health authority we know of to take such a clear position, without exception, on forced shock. Of course, this is a small first step, and nowhere near enough: we need to alert all nations that the world's highest health authority favors banning forced electroshock and has put that position in writing.

- **Oregon:** MindFreedom is based in Eugene, Oregon, where we continue our 20-year local campaign of pressuring Sacred Heart Hospital, which is run by PeaceHealth, to modify its informed consent process for shock. While PeaceHealth has made three or four minor changes, MindFreedom is asking for more. For example, a MindFreedom member discovered a fraudulent videotape by Max Fink, a psychiatrist with financial links to the ECT-device manufacturing industry, is still being used by Sacred Heart, despite assurances to the contrary. MindFreedom has filed complaints with the appropriate Eugene and Oregon government agencies.

- **Internet:** MindFreedom continues to sponsor the ZapBack e-mail list. This is one of the main, long-standing, moderated places on the Internet to network those who are concerned about electroshock as a human rights violation. News of campaigns, articles, information, questions and answers are posted on this list for MindFreedom members and others to support their activism on this issue. Those interested are encouraged to join this list, and help support MindFreedom's Campaign to End Electroshock.

DAVID OAKS (U.S. psychiatric survivor and director of MindFreedom International which he founded in 1986), personal communication, 2 January 2006. Accredited by the United Nations as a nongovernmental organization (NGO), MindFreedom International, unites 100 grassroots groups (in 14 nations) and thousands of members to win, by nonviolent means, campaigns for human rights of people diagnosed with psychiatric disabilities. MindFreedom International is where mutual support meets human rights activism. MindFreedom International is ready to work with individuals and groups striving for justice everywhere. For more information, see: www.MindFreedom.org, e-mail office@mindfreedom.org, or phone toll free 1-877-MAD-PRIDE. Oaks has championed the cause for human rights in psychiatry for more than 25 years.

2006 — Electroconvulsive therapy (ECT) has been evaluated in randomized, prospective, double-blind, placebo-controlled trials. These studies [under review] vary in methodology but all involve the administration of real ECT versus sham ECT under double-blind conditions. In the sham ECT condition, the patients receive a general anesthetic, are hooked up to the ECT machine, and the button is pushed, but no current is delivered. The patients have no way of knowing whether real or sham ECT was delivered. The evaluations of the patients' responses using standardized measures of depression are done by psychiatrists who do not know whether a given individual received real or sham ECT.

The sham ECT studies provide definitive evidence that real ECT is no more effective than sham ECT. The cost-benefit of ECT is therefore negative. The negative side of the cost-benefit analysis is due to deaths, cardiovascular complications, and memory and cognitive impairment caused by ECT.

COLIN A. ROSS (U.S. psychiatrist), abstract, "The Sham ECT Literature: Implications for Consent to ECT," *Ethical Human Psychology and Psychiatry*, Spring 2006.

ABOUT THE EDITOR

Leonard Roy Frank was born in 1932 in Brooklyn. A graduate of the University of Pennsylvania's Wharton School (1954), he was drafted into the U.S. Army for two years and afterwards worked for several years as a real estate salesman in New York City, Florida, and San Francisco. In 1962, he was diagnosed as a "paranoid schizophrenic" and involuntarily institutionalized in California for more than seven months during which time he was forced to undergo combined insulincoma-electroshock treatment (50 insulincomas and 35 electroshocks). From 1970 through 1974 he managed his own art gallery in San Francisco. From 1972 to 1984 (with a 3-year break) he was a staff member of *Madness Network News*. In 1974 he co-founded the Network Against Psychiatric Assault (NAPA). In 1976 he edited and published *The History of Shock Treatment*. In 1996, Feral House published *Influencing Minds: A Reader in Quotations* which he edited. In 1998, he edited *The Random House Webster's Quotationary* (20,000 quotes in 1,000 categories). During the following five years, Random House published seven other smaller quote collections he edited. Since 1998, his column of quotes, "Poor Leonard's Almanack," has appeared regularly in the Oakland-based monthly *Street Spirit*. Since 2005, his "Frankly Quoted" column has been distributed monthly free of charge to anyone asking to be placed on its Listerv (lfrank@igc.org). Frank has lived in San Francisco since 1959.