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Through the fire



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EDITORIAL

We're celebrating our third birthday. *Phoenix Rising* was first published in March 1980 when we worked out of a collective member's apartment. A start-up grant of \$5600 from Ontario PLURA (a multidenominational church organization) helped us survive our first year and Health and Welfare Canada have partially funded us for the last two years. We greatly appreciate their financial support. Despite setbacks, we've not only survived but grown. New subscriptions come in every week, the magazine is sold in roughly 50 bookstores across Canada and copies are sent free to psychiatric inmates and prisoners.

We're also celebrating the generous support we've received from many On Our Own members and volunteers and from other self-help/antipsychiatry groups in Canada and the United States. Their help in writing and submitting articles or letters, gathering and sharing news, interviewing and being interviewed, soliciting ads, and spreading the word about the magazine has been invaluable. THANK YOU.

We're also celebrating our continuing commitment to several basic objectives: our commitment to working with other antipsychiatry magazines, newsletters and groups for the freedom and rights of all psychiatric inmates and ex-inmates; our commitment to all those in the International Psychiatric Inmates Liberation Movement; our commitment to supporting the growth of other self-help/ex-inmate controlled groups, particularly in Canada; our commitment to across-the-board alternatives to "mental health care"; and our commitment to freedom of the press and free speech — specifically the right to speak out against all forms of psychiatric oppression or forced treatment wherever they exist. We intend to keep and act on these commitments.

We are particularly indebted to you, our readers and subscribers, who have done so much to help us grow and keep us on target. Without you, there would be no *Phoenix Rising*. Your interest, your letters, your sharing of copies with other people as well as your financial support mean a lot to us and keep us going. THANK YOU.

So please join us in celebrating: in wishing *Phoenix Rising* a Happy Birthday, a long life and many rebirths.





write on

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



You ran a story on my psychiatric history in Vol. 2 No. 2 of *Phoenix Rising*.

At the time, I wasn't really impressed with your magazine because of all the negative stories about the horrors of psychiatric care in Canadian Psychiatric facilities. Well, upon reflection of the contents of your magazine, I can see that you are doing an excellent job of getting a message across which the average person isn't buying, but which may affect him someday. The message is that psychiatric treatment in all psychiatric facilities in Canada is cruel, useless, and expensive.

To back up this statement I will give choice treatment results from my psychiatric treatment in North Bay Psychiatric Hospital under Doctor Sauks and the results from my psychiatrist Dr. Joel Whitton, in Toronto.

In 13 years of treatment in North Bay, I received 120 shock treatments under the care of Dr. A.A. Sauks, during the years from 1967-1970. His methods included beatings from the staff on a regular basis, I was kicked, punched, my bible taken away, and part of my front teeth knocked out. The dry method of Electric Shock Treatment which Dr. Sauks was fond of was given awake and many patients were given this treatment. In fact I once saw a patient go up to Dr. Sauks after he hadn't spoken for six months and say: "Do you want to hear a joke?" Dr. Sauks pointed his finger at him and said, "30 Electrical Shock Treatments starting Monday." Beneficial to the health? I understand Dr. Sauks was paid bonus from O.H.I.P. about \$75.00 for each one he administered. Recently I went up to visit some friends

at the Hospital up there and Dr. Sauks is still giving my friends his choice treatment.

Well, to put it simply, Shock Treatments don't improve the quality of a person's life, in fact it only leads to a loss of attractiveness of appearance in the patient, although financially it lines the pockets of the doctors. If a person really puts two and two together this is the most crooked and cruel type of medical treatment since the Nazi's methods of World War II. They at least finished their cruelty in five years.

When I came to Toronto in 1972 I was lucky to get Dr. Joel Whitton as a doctor. He is prominent in psychiatric circles today, and he doesn't believe in E.C.T. or putting his patients in hospital. He says, "It is only a ripple on the lake."

I've only been hospitalized for two days in the past ten years with him, and today I experience an enjoyment and popularity in my life. I have worked in many offices and have excellent references for work on computers, typing, etc. After I came out from North Bay, in two years I missed 150 days work at a mine in Elliot Lake. So, compare the results!

A person reading this letter might say, "So what? How does that affect me personally?"

Well, in just this way: If you suddenly meet a crisis in your life which you can't meet with all your physical and intellectual resources and end up in a Canadian Psychiatric Hospital, after you are put on a few strong tranquilizers, or give a contrary opinion, or raise your voice, you will most likely experience something similar to what all the "gripe letters" are trying to say about what it is really like in psychiatric facilities.

If every single person who went through a government psychiatric facility says it is a horror factory, dehumanizing, robbing of self-worth, degrading, cruel, and that you are permanently stigmatized, let me tell you: That is just an understatement.

The message *Phoenix Rising* is trying to get across is 100% accurate.

David Petterson
Toronto, Ont.



In 1843, Daniel McNaughton shot and killed Edward Drummond, private secretary to Sir Robert Peel, whom McNaughton had intended to kill. The defence was insanity. Evidence was introduced showing that McNaughton "was labouring under the insane delusion" of being hounded by enemies, among them Peel. Lord Chief Justice Tindel was so impressed by this evidence that he practically directed a verdict for acquittal. The jury found McNaughton not guilty on the ground of insanity.

As usually told, this is where the story ends. But what happened to Daniel McNaughton? McNaughton was acquitted; *de facto*, he was sentenced to life imprisonment in an insane asylum. He died in 1865 at Bradmoor, an asylum for the criminally insane, having been incarcerated for the last twenty-two years of his life.

Today as always a judge recognizes the defendant as mentally competent to stand trial; he allows him to enter a plea and defend himself as best he can, and he considers the defendant sane enough to be sentenced to the penitentiary if found guilty. But should the defendant be found "not guilty by reason of insanity," that verdict immediately transforms him into a "truly incompetent" person, whom the judge feels justified in committing to a mental hospital. Even if the defendant does not elect to plead insanity, so long as the law empowers physicians to incarcerate people in mental hospitals, the law enforcement agencies of the province will be tempted to make use of them. Actually, where a successful insanity defense means commitment, the well informed defendant rarely feels that the insanity plea serves his best interests. He tends to avoid this plea preferring punishment in jail to "treatment" in the mental hospital. I venture to predict that if the defendant clearly understood the realities of an acquittal by reason of insanity, such pleas would become very infrequent and perhaps would disappear.

In the final analysis, the insanity plea and the insanity verdict, together with the prison sentences called "treatment" served in buildings called "hospitals" are all parts of the complex structure of institutional psychiatry. Those who value and wish to defend individual liberty can be satisfied with nothing less than the abolition of this crime against humanity.

Raymond T. Renaud
Ottawa, Ontario



There seems to be rising public opposition to government supported housing for ex-psychiatric inmates. The reintegration of ex-inmates in the community is an absolutely essential step in their deinstitutionalization, and the public has as much to learn from the participating ex-inmates as the ex-inmates from the public.

Objections raised to the half-way houses include the supposedly unpredictable nature of former mental patients and the belief that property values will depreciate. A greater consideration should be that the value of any community is determined by more than property values: the measure of acceptance and tolerance of difference are also important and add to the value of life in a community. Whereas if it is thought that the "community" can only survive if there exists a homogeneous *status quo* of people then it is understandable that residents respond to the proposed housing with fear and prejudice. Instead, it can be argued, the community can have much to learn and be strengthened by mutual sharing with the ex-inmates.

The obstacles facing the ex-inmates are almost insurmountable considering what they have experienced at the hands of institutional psychiatry and the already intolerable amount of prejudice these people confront when trying to become self-sufficient and employable. Many of them have existed in mental hospitals for years where the only attitude fostered in them was one of dependence on the hospital and the profession of psychiatry. If there were a higher level of public awareness of the atrocities of these places then the outcry would be not against community housing projects but against the psychiatric deadlock that they help to break.

Robert Newman
Toronto, Ontario

In any publication, "profile" articles on individuals are among the most sensitive topics to cover, yet in many ways they have the most immediate impact on readers. Such "community portrait" articles are an essential part of the creation of our own culture as mad people and ex-inmates. For this reason, it's especially necessary to be conscious of the values we're affirming in the way we write about each other.

Connie Neil's "Profile" article "David Oaks: Anti-Psychiatry Activist" struck me as affirming values that we need to move beyond in building a non-hierarchical society. The body of the article presented plenty of quotes revealing the down-to-earth, egalitarian attitudes that make David the excellent activist he is in the eyes of many people who know him. However, I felt Connie's introductory section perpetuated the mystique surrounding connections with power in the academic establishment. The first information the reader is given is: "David Oaks, at 26, has impressive credentials. He graduated in 1977 from Harvard, where he studied government and economics, but 'feels a little weird about having been at Harvard...'"

The introduction next mentions David's 100 wpm typing. Only then are personal growth and anti-psychiatry movement work mentioned, as things he does "aside from" the "impressive" accomplishments described earlier. What does this say to readers about our priorities in what we value about people — about each other? Perhaps Connie herself is impressed (awed and mystified) by types of power that are inaccessible to most people.

If having graduated from one of the most prestigious schools in the country is not the most important thing to know about someone, why mention it first? In referring to a person's credentials, why not identify them by what is truly of value about a person — for example, in David's case, his demonstrated respect for all people, the ability to think independently, hard work kept up over a six year period in the ex-inmate movement, etc. Unlike a degree from an Ivy League school, anyone can aspire to credentials like these.

I feel that what people need to read now is more articles reminding us in clear ways that a four-year college background, and its accompanying baggage of "articulatness," is *not* a credential for the often mystified role of political activist.

Margaret House
Berkeley, California

I really enjoy the magazine. I read everything including the ads. It is a comfort to know that I am not alone in my suffering from illness, drugs, shock treatment, and incarceration.

A letter from a psychiatrist in one of your issues really angered me. She stated that she was annoyed because government funds supports such a "biased publication." This is real nerve! Government funds have been supporting the doctors' biased opinions for years. It's time our side was heard.

You are right about the horrors of ECT. I would like to add the name of Dr. Roy P. Shoichet of Toronto Western Hospital to your list of offenders. He gave me treatment in 1972 against my wishes, and because I had signed forms when entering hospital, there was nothing I could do about it. The treatment only made me more delusional and has impaired my memory and thinking abilities. For instance I had to learn to read over again. From reading one book a day I went to taking three months to stumble through a book painfully word by word. My speed has improved with time, but I have never recovered my former ability.

In one of your articles you stated that piportel stays in your system for 4 weeks. This is an understatement. I was on piportel injections for an 8 month period, and when I couldn't stand the side effects any longer I went off it. It took 6 months for that evil potion to leave my system, and I still haven't returned to normal.

After my experiences with piportel — I feel that it should be banned. It made me like a zombie — I couldn't talk, laugh, feel music (feel anything for that matter). I was just like a board, and lay all day on the couch in a stupor. It impaired my mind, and I couldn't think. I had to force myself to go through the simplest tasks.

My mind is still clouded, I can't relax, I can't sew or paint any longer, and my sense of humour is gone. This latter has been really trying for me, because I write humour, and have had several short stories published, but can't write them any longer. I have become an old woman overnight.

Florence Denison
South Porcupine, Ontario



This is the first installment in a two-part series of Allen Markman's detailed study of eight deaths in New York State mental health facilities. The section in this issue relates three of the most suspicious stories and two of four carefully documented accounts of psychiatric torture leading to death in the South Beach Psychiatric Center on Staten Island.

DEATH BY PSYCHIATRY:



A Preliminary Review of Eight Deaths in the New York State Psychiatric System

There are 23 adult psychiatric facilities in New York State operated by the New York State Office of Mental Health. The annual budget for the operation of these facilities is approximately \$700 million. The system holds nearly 24,000 inmates. Of these, more than 1,700 die each year. About 350 cases each year are studied by the New York State Commission on Quality of Care for the Mentally Disabled, a state agency founded in 1978. Most of these will be dismissed after undergoing preliminary investigation. A one or two-page letter will be written to the administrator of the hospital where the inmate died, and the case will be closed.

Some cases, however, will require further study. Then the Commission, along with the Mental Health Hygiene Medical

Review Board, a body composed of volunteer physicians, will undertake a thorough investigation into the deaths. These investigations, and the death reports issued by the Commission on Quality of Care, form the basis for this account.⁽¹⁾

Most of the 1,700 deaths never make it to the last stage. These are deaths which can be readily explained by "natural causes." But they are psychiatric deaths nonetheless. Many of the 1,700 are elderly, frail, the debilitated veterans of institutional psychiatry — the back wards people. These are the casualties of the undeclared and inarticulated civil wars Thomas Szasz has spoken of.⁽²⁾ This article is dedicated to those unnamed dead.

FACTOR X AND THE DEATH EQUATION

Recent media reports of psychiatric deaths have tended to group them into categories. Most of these reports have relied heavily, some almost entirely, on information gleaned from Medical Examiners.

Frederick Zugibe,⁽³⁾ the Rockland County Medical Examiner, revealed to the press in July 1978 that many inmates at two of New York State's largest facilities, Rockland Psychiatric Center and Letchworth Village Development Center (the latter for the retarded), died after being tranquilized to the point where they could not complain of distress. Dr. Zugibe alleged that many of these deaths were attributable to aspiration of vomit or food particles into the lungs and subsequent pneumonia (some died immediately from aspiration alone). These deaths could be called drug/pneumonia-related.

A second media-reported category is the hot weather death. Dr. Elliot Gross,⁽⁴⁾ Chief Medical Examiner of New York City, reported in mid-July of 1981 on at least eleven deaths of state psychiatric inmates during a heat wave. The use of high doses of psychotropic drugs, especially phenothiazines and related compounds, is believed to reduce the organism's ability to regulate body temperature. Death was caused by hyperpyrexia, commonly known as heat stroke. These deaths could be called drug/heat related.

The third, and final, category of death is the most recently reported. It has been called the "sudden death syndrome." It involves the sudden, unexpected deaths of seemingly young inmates after heavy drugging and restraint. This is the type of death that has been associated by the press with South Beach Psychiatric Center. These deaths are drug/restraint related.

The three categories taken from media reports can be reduced to equations. The Zugibe formula is $DEATH = DRUGS + PNEUMONIA$. The Gross formula is $DEATH = DRUGS + HEAT$. And the Sudden Death formula is $DEATH = DRUGS + RESTRAINT$. Drugs are common to all three. $DEATH = DRUGS + X$. This is the psychiatric death equation.

Equations, however, don't tell us how hard and for how long a psychiatric inmate has suffered before the respite of death. Nor do the equations tell us that some of the victims are the ones who had struggled the hardest against their oppressors. These and other insights into psychiatric death can only be uncovered by carefully gathering the facts and meticulously assembling them into a coherent story. First, the story of the individual before psychiatry — their strengths and weaknesses, their struggles with life; second, their initial

encounter with psychiatry, and how it changed them; third, a death chronology — the events leading up to their death by psychiatry. Finally, a post-mortem: the official, and unofficial, causes of death.

These eight deaths have been chosen not because they are representative of the rest. Rather, they are some of the deaths that have been reported by the media. And they are among the most "suspicious." Some of them have been thoroughly investigated by official governmental agencies, or soon will be. In short, the following eight stories can be told only because they have already been made public. We will never know the details of most of the dead. They took their stories with them.

THREE SHORT STORIES

GERARD GANTHIER: The Abuse of Electricity

Gerard Ganthier was a victim of electricity or, rather, its abuse. A 64-year-old inmate at the Manhattan Psychiatric Center, Mr. Ganthier was subjected to electro-convulsive therapy — shock treatment — on March 10, 1980, and died during the procedure from cardiac arrest.⁽⁵⁾ A deputy chief Medical Examiner, Dr. Millard Hyland, also found bone marrow emboli.⁽⁶⁾ What led Mr. Ganthier's case to be examined at all by the State's Commission on Quality of Care for the Mentally Disabled was the fact that after his heart stopped, the doctors did not have a cardiac defibrillator at hand. They had to find one. And when they had it, they reported that it was broken. (Tested later, it was found to be working.) After the doctors shocked his heart into silence, they failed to shock it back to life.

Dr. Hyland insists that it was a "coincidence" that Ganthier died after shock. Even so, the New York Times reported on March 13, 1980⁽⁷⁾ that shock treatment had been temporarily halted at Manhattan Psychiatric Center.

JOSEPH TAGGART: Death by "Terminal Seizure"

On the morning of July 13, 1980, Joseph Taggart was found on the floor of his ward at Creedmoor Psychiatric Center in a pool of blood.⁽⁸⁾ The Medical Examiner delivered a verdict of "probable terminal seizure," but could find no hard evidence of this. There were no signs of gross brain pathology or lesions which could have caused such a seizure. Nor did Joseph have a history of seizure disorders. He did have one abnormal brain wave test a few years back, but this in itself was not sufficient to convince the Medical Examiner that he was epileptic. The blood on the floor was

"explained" by a bitten tongue. This last detail was what led the Examiner to guess that it was a "terminal seizure"⁽⁹⁾. But the matter was not pursued very far by any of the official agencies. A one-page letter was written by the Commission of Quality of Care to the director of Creedmoor, in effect dismissing the case. No one will ever know what really killed Joseph Taggart.

PABLO MARTINEZ: "Unmercifully Beaten"

Pablo Martinez, a 27-year-old inmate at Manhattan Psychiatric Center, died on December 26, 1981 of physical assault. As befits a highly suspicious death, Pablo's case has been examined by two state agencies, the Manhattan District Attorney's Office, and the New York City Police Department. The press⁽¹⁰⁾ reported that two security guards sat on Pablo while two others placed a straitjacket on him backward, so that his arms were folded behind him. They left him on the floor, and soon the nurse noticed blood coming out of his mouth. He died at Metropolitan Hospital after a doctor at Manhattan State refused to try to resuscitate him. The nurse tried, but failed. The hospital has attributed his death to "falling" and "struggling," while the death certificate described his injuries as "bleeding in the neck and spinal canal, contusions of the spinal cord and bruises of the head, chest, arms, and legs." Ernesto Martinez, Pablo's father, believes his son was "unmercifully beaten." The results of the investigation by the Commission on Quality of Care have only recently been made public.⁽¹¹⁾ They found that Pablo died from "undue force" consisting of "asphyxia by compression of the neck while being restrained." Dr. Michael Ford, head of the Manhattan Psychiatric Center, called the findings "overstated" and added that the Manhattan District Attorney's office found no reason to take criminal action.

The Ganthier and Taggart cases have been written off by the authorities as not "suspicious" enough to warrant further study. The Martinez case was studied so hard that when the Commission's report finally came out, the public forgot that Pablo had ever lived.

THE SOUTH BEACH FOUR

ANTHONY RUGGERI: This Way to the Shower

Anthony Ruggeri was the first of the South Beach Four. On August 7, 1979, he was picked up by the police while allegedly attempting to break into his parents' home in Brooklyn. They took him to Kings County Hospital, a municipal facility, and from there he was transferred to Coney Island Hospital, another city-run facility. On August 13, 1979, he was transferred to the Coney Island Unit of the South Beach Psychiatric Center on Staten Island.

The Coney Island Unit at South Beach services people from certain parts of Brooklyn. Anthony may have considered himself lucky. He was being taken to what some have called "the jewel of the state hospital system." South Beach was, and still is, the newest and the "best" the system has to offer. It has colourful furnishings and is air-conditioned. It also has an Intensive Care Unit. On August 16, 1979, three days after Anthony was admitted to South Beach and labelled "manic depressive, manic type," he was transferred to the Intensive Care Unit.

Three days prior, he had been given Haldol, 10 mg by mouth four times per day and lithium, 300 mg orally four times per day. But now, his new doctor, learning that

Anthony had a history of "drug abuse" since his 18th year, abruptly stopped all medication, ostensibly to rule out the possibility of a "drug-induced psychosis."

By August 20, hospital records indicate that Anthony, now free of psychiatric drugs, "appeared asymptomatic and free of any psychotic behavior." The psychiatrist even told his parents that they could visit him back at the old unit on the 27th, the day they were planning to transfer him back. But his parents never saw him alive again.

On August 22, the chief of service returned from vacation and decided that Anthony was still crazy after all. He ordered that 12.5 mg of Prolixin⁽¹²⁾ be given EVERY TWO HOURS FROM 9 AM TO 9 PM FOR TEN DAYS, starting on the 24th. And, sure enough, beginning on the 24th, two injections of Prolixin were given. But the treating psychiatrist decided to discontinue the chief's order, so Anthony received no more Prolixin. Later on, the chief of service told the investigators that Anthony was being readied for transfer and so no senior psychiatrists would be available on the weekend in the event that something went wrong.

At 10 PM that same day, Anthony was given a 10 cc injection of paraldehyde, a powerful sedative (the order for the drug had expired a day before) for "agitation." A day later, Saturday, August 25, Anthony Ruggeri was reported to have spent an uneventful day. He hadn't been given any drugs on Saturday, either.

On the day he died, Sunday, August 26, there were only eight inmates in the Intensive Care Unit. The ICU could hold 15 "comfortably," so it was well below capacity. There were four staff on the 8 AM to 4 PM shift, and three staff on the 4 PM to midnight shift. The psychiatric resident was on the grounds 24 hours Saturday and Sunday. The medical resident was on grounds from noon to 10 PM on Sunday, two more hours than required.

That morning, the staff found Anthony in bed sweating profusely and having trouble breathing. He appeared to be having a seizure, according to the two nurses on duty. The senior staff nurse examined him and found his pulse to be 88 and respiration 35 (both elevated). He was hyperventilating⁽¹³⁾. His blood pressure was 120/80, a reading within normal limits. The psychiatric resident on duty was called and within 10 to 20 minutes he arrived and examined Anthony. He concluded that Mr. Ruggeri was "agitated, hyperventilating, demanding, manipulative, verbally abusive at times." Further, he saw no evidence of a seizure disorder or any medical problem.

This same psychiatric resident then suggested that Anthony breathe into a brown paper bag to ease his hyperventilation, but he refused. Then the resident gave Anthony an injection of sterile water, 1 cc, a placebo he hoped would calm Anthony and make him complain less.

From noon to 4 PM Anthony was put in the seclusion room for "agitation." It isn't clear whether the door to the seclusion room was closed or left open for observation. At 4 PM, Anthony was put in a straitjacket while still in seclusion. He was not seen by a physician prior to restraint, and the authorization for seclusion was signed ten minutes before he was pronounced dead.

At 6:30 Anthony had dinner. While still in a straitjacket in the seclusion room, he drank two cans of Sustacal, a liquid nutrient containing water, sugar, vitamins and minerals. He drank the cans rapidly, and also consumed a good deal of water provided by a therapy aide. Anthony was very thirsty that day because of the weather. By 2:15 in the afternoon, the National Weather Service reported that the temperature had reached 85 degrees. What's more, the air conditioning was not working and the seclusion room had a southern exposure and no blinds or shades.

By 8 PM, Anthony was so soaked with sweat that the straitjacket was removed, and he was taken forcibly to the

shower by two male staff. He resisted, so he was carried. He refused to cooperate, so he was placed in a posey restraint⁽¹⁴⁾, which was then tied to a chair. Then the chair with Anthony in it was placed in the shower. The staff noted that his color became ashen. While the nurse went to get the blood pressure cuff, Anthony became unconscious and slumped down in the chair. Attempts at resuscitation were immediate but unsuccessful. The paramedics came at 8:45. By 9:10 the medical resident pronounced Anthony Ruggeri dead.

The Medical Examiner claimed that the death of Anthony Ruggeri was due to "cardiac and pulmonary arrest." The physicians of the Mental Hygiene Medical Review Board were critical of the lack of lab work done by the hospital, especially an electrolyte evaluation, a medical consultation, and a neurological consultation.

It's all too obvious what killed Anthony Ruggeri. He died from a combination of heat and restraint. He was baked to death. From August 16, 1979 to August 26, he spent a total of 72 hours in seclusion and/or restraint.

As we will see in the deaths that follow, the Medical Examiner's findings are composed in such a way that they do not implicate doctors. Professional ethics dictate that doctors do not inform on each other. So death is ascribed to physiological processes with scant mention of the real causes; e.g., forced drugging, restraint.

JUDITH SINGER: Drugged and Bound

Judith Singer died on October 16, 1980⁽¹⁵⁾ on the same unit as Anthony Ruggeri, the Intensive Care Unit (ICU) at South Beach. She was only 19. Judith did not have a very easy life. She had been psychiatrized as early as age 15 after she cut her wrists. After three weeks in the psychiatric ward of a general hospital, she returned home. Ten months later, in November 1976, she attempted suicide. She was put on the adolescent unit at South Beach and given lithium⁽¹⁶⁾ for four months. After being discharged in March 1977, she was readmitted for "mixed drug abuse" — alcohol and lithium — after being arrested on a charge of car theft.

Some time later she was transferred to Geller House, a residence run by the Jewish Board of Family and Children's Services. In June 1978, she was placed in Linden Hill, another program run by the same agency. A few days later she was put back in South Beach for two months, lived at home for a few more months, and was readmitted to the Linden Hill program in November 1978. At this time she was taking 600 mg of lithium three times per day and 5 mg of Haldol, an "antipsychotic" drug.

Judith seemed to do well at Linden Hill. She was valedictorian of her senior class there, and in the summer of 1980 she did volunteer work with retarded children. In September she started classes at New York Technical College. She was so successful, in fact, that arrangements were made to have her placed in a less restrictive setting, the Youth Residence Center.

At this time, Judith complained of feeling "toxic" and she refused to take her lithium. She was shipped to Kings County Medical Center and her lithium dose was raised to 2100 mg four times per day, a huge dose. (300 mg three times per day is a typical dose.)⁽¹⁷⁾ Her Haldol was raised to 20 mg four times per day.

On October 10, 1980 Judith was evaluated for admission to South Beach Psychiatric Center and given two shots of Haldol, 5 mg each. Then she was admitted to the BARS II unit at South Beach, an admissions unit, on a "voluntary" status.⁽¹⁸⁾ Later that night she was given Haldol, 10 mg by mouth.

Early in the morning of October 11, at 1:15 AM to be precise, Judith was put in a bednet restraint.⁽¹⁹⁾ At 2 AM, she broke out of the restraint and was given one gram of chloral

hydrate, a potent sedative. Over the next four and a half hours, she was given five shots of Haldol, 5 mg. Later in the morning she remained in bednet restraint; she got another shot of Haldol, 5 mg early in the afternoon. At 10:40 PM came another dose of chloral hydrate, 1 gram by mouth.

Early Sunday, October 12, the nurse observed that Judith was still in bednet restraint. From midnight to 2 AM she was given five shots of Haldol, 5 mg, and another dose at 7:15 AM. She remained in restraint, though no physician had ordered it.⁽²⁰⁾ Throughout the previous shift, then, Judith had received 30 mg of injectable Haldol.

That same morning, Dr. P. saw Judith and decided to discontinue the Haldol because he felt it was "not effective." Now she was to get sodium amytal (a powerful sedative), and Thorazine. At 9:15 AM she was given a shot of sodium amytal, 500 mg, and put back in bednet restraint. At 10 AM her blood pressure was recorded at 128/80, a reading within normal limits. At 11 AM she got another shot of Haldol, 10 mg despite the fact that the order had been discontinued by Dr. P. At 11:30 AM she was released from the bednet, and sent to a room where she fell asleep.

That evening, at 10 PM, a nurse gave her a shot of Thorazine, 50 mg, because she "broke windows." Judith was also placed back in bednet restraint, although no physician had written an order for it. Contrary to regulations, no incident report was ever written concerning the window-breaking episode.

Shortly after midnight, October 13, 1980 (Columbus Day), the nurse coming on duty found Judith still tied to her bed. Ten minutes later she got a shot of Thorazine, 50 mg, and her blood pressure was taken. It was low, so the next dose of Thorazine was skipped. At 3:45 in the morning, the nurse noted that, while her blood pressure was normal, she was now experiencing "dystonic reactions."⁽²¹⁾ Dr. K. was called and he ordered a shot of Cogentin, 2 mg, an anti-parkinsonian medication. In the next hour and a half, Judith received two injections of Thorazine, 50 mg. Dr. K. also ordered "restraints prn if agitated" even though such an order was illegal under both state law and Office of Mental Health guidelines.

While there were no day or evening shift progress notes for Columbus Day, it was noted on the restraint form sheet that Judith was released from restraint at 8:45 in the morning after having remained in restraint all night. Also on this day, Dr. H. ordered blood thyroid studies to be done.

Early in the morning of Tuesday, October 14, at 2:30 AM, Judith was placed in seclusion after being injected with Thorazine, 50 mg. Later, at 6:30 AM, she broke the glass in the seclusion room and was removed from seclusion an hour later. Over the next thirteen and a half hours, Judith received six injections of Thorazine and a shot of paraldehyde, 5 cc. Four doses of Thorazine were 75 mg; and another was 200 mg — in all, a total of 600 mg of injected Thorazine. Some time later on October 14, Dr. F. wrote an order for "bednet restraint."

Shortly after midnight on Wednesday, October 15, the night nurse noted that Judith was roaming the halls clad in a blanket and urinating. At 1:15 AM she was placed in bednet restraint in the seclusion room with the door open and on one-to-one.⁽²²⁾ She was given no drugs during this time. At 8:45 AM Dr. F. extended the restraint order. At 1:45 in the afternoon he extended it once again because she threw a cup at a staff person 15 minutes before. While the doctor's order was for "restraint," she was placed instead in seclusion.

At some time during the day, Dr. B. ordered Judith transferred from the BARS II unit to the Coney Island Inpatient Unit, or CIIP. Judith was seen briefly by the "psych MD" and weighed herself on his scale (208 pounds). Then she was locked in seclusion. She was given no drugs during this shift, but she complained of thirst and was given water.

She remained in seclusion at least until 5 PM. At 5 PM she refused Thorazine, and it was forced on her by injection. At 6 PM, she was put into a bednet restraint for "threatening behavior." At 8:45 PM she was removed from restraint, given "range of motion" exercises⁽²³⁾ and placed back in restraint. At 9 PM, she was again yelling for water. A half hour later she got a shot of sodium amytal, 50 mg. At 10 PM she requested water. At midnight she was released from bednet restraint and bathed. Her blood pressure was within normal range.

October 16, 1980 was the date of her death. Shortly after bathing, she was placed back in restraint. At 2:30 AM she was noted as "fighting restraint." Her blood pressure was 150/76 — elevated. At 3 AM she got an injection of sodium amytal, 50 mg. Judith remained in restraint the rest of the night but slept until 8 AM. At 9 AM, still in restraint, she was given Thorazine, 500 mg, by mouth and Cogentin, 2 mg, as well as 600 mg of lithium carbonate.

Finally, at 9:30 AM she was removed from restraint but was kept in seclusion. She ate breakfast, but by 10:30 was back in the bednet because she had been "verbally abusive" and had punched the window of the seclusion room door.

At 11 AM Judith Singer was placed in a straitjacket to be interviewed by the ICU team for possible transfer out of CIIP. She was put in a wheelchair. At noon she was returned to CIIP and put in seclusion while remaining in a straitjacket. She slept for two and a half hours.

At 2:30 PM Judith arrived at ICU still straitjacketed and tied to a wheelchair in a posey restraint. The wheelchair was tied to a pole in the ICU dayroom. Since Judith was in restraint, the ICU nurse had to defer checking her vital signs.

With the move came a change of drug orders. Judith's new drugs were to include lithium, Thorazine, and sodium amytal. In addition, Benadryl was added as a substitute for Cogentin, and Dalmane was added to help her sleep. At 5 PM she was given Thorazine, 500 mg and lithium, 600 mg, both by mouth, but the nurse noted that Judith spit out half of the medication. She also refused liquids.

At 5:30 PM it was noted that Judith "remained agitated." Fifteen minutes later, still wrapped in a straitjacket, it was noted that she was pale. She was removed from restraint immediately and a medical emergency was called. Dr. R. arrived before 6 PM and couldn't find a pulse. Cardiopulmonary resuscitation was begun, and Judith was transferred at once to the nearby Staten Island Hospital emergency room, where she was pronounced dead at 6:20 PM.

The autopsy, performed by the New York City Medical Examiner's office, listed the cause of death as "Manic Depressive Psychosis with Exhaustion." This is remarkable. "Manic depressive psychosis" is considered as "affective disorder" by the American Psychiatric Association's official diagnostic handbook, the DSM III⁽²⁴⁾ There is no mention of the disorder having fatal consequences, with the sole



exception of suicide in a "major depressive episode." There appears to be little or no scientific justification in listing "manic depressive psychosis with exhaustion" as a cause of death on an autopsy.

The reason for listing a mental disorder as a cause of death on an autopsy is to protect the psychiatrists from prosecution and the state from civil suits. From the death chronology, it is only too clear what killed Judith Singer. While the autopsy did not reveal any anatomical changes and the toxicological reports could find no lethal level of drugs in her tissues, her death is no mystery.

The commission found that South Beach "disregarded" state regulations.⁽²⁵⁾ Clarence Sundram, the Commissioner, added that "there were very clear deficiencies in the quality of care" at South Beach.⁽²⁶⁾

The Mental Hygiene Medical Review Board postulated that Judith may have died from the cumulative action of various drugs or a possible electrolyte imbalance. But since her tears weren't tested, no one will ever know this for sure. In reality, Judith Singer was mindlessly drugged and trussed until her overworked heart could no longer take the strain. The remarkable thing is that she lived as long as she did.

Postscript: The Chief of ICU was demoted to an outpatient clinic; he resigned. Three other doctors were lectured.

The stories of two other victims of South Beach's "care" will appear in the next issue of Phoenix Rising.

NOTES

(1) The following reports issued by the New York State Commission on Quality of Care for the Mentally Disabled were used as primary source material for this paper. The opinions expressed by this author are his own and not necessarily shared by the Commission, its Commissioner, or any person employed by the Commission. (Pseudonyms are indicated in quotation marks.)

—Gerard Ganthier — a 2-page letter addressed to Gabriel Koz, MD, Director of Manhattan Psychiatric Center from Janet Samson, Director of Investigations Bureau of Commission on Quality of Care, May 20, 1982.

—Joseph Taggart — a 1-page letter addressed to Yoosuf Haveliwala, MD, Director of Creedmoor Psychiatric Center, from Janet Samson, Sept. 2, 1981.

—Anthony Ruggeri — "In the Matter of 'Alphonse Rio'," March 1981.

—Judith Singer — "In the Matter of 'Alex Zolla,'" May 1982.

—Allen S. — "In the Matter of the Death of Allen S.," Nov. 1979.

(2) Thomas Szasz, *THE SECOND SIN*, Anchor Press, 1973, p 77. "Mental Hospitals are the POW camps of our undeclared and inarticulated civil wars."

(3) Pranay Gupte, "Tranquilizing Held A Factor in Deaths of Mental Patients: Overmedication is Alleged," *New York Times*, July 17, 1978, pp A1, D8; See also David Richman, MD ("Dr. Caligari"), "Psychiatric Drug Deaths," *On the Edge*, June 1981, pp 3-6.

(4) Ronald Sullivan, "Deaths of 3 Mental Patients Linked to Heat Wave," *New York Times*, July 16, 1981, pp B1, B5; "Patients' Deaths Tied to the Heat Are Investigated," *New York Times*, July 17, 1981, p B1; Hugh Wyatt, "Drugs & Heat Probed in 11 Hosp Deaths," *Daily News*, July 16, 1981, np.

(5) Donald Gentile, "Death Puts Spotlight on Wards," *Daily News*, March 13, 1980, p. 5.

(6) Bone Marrow Emboli — A condition where pieces of marrow leave the bone, enter the bloodstream, and eventually lodge in an artery, clogging it and thereby causing damage or destruction of the tissue. This condition can be fatal.

(7) Clyde Haberman, "A Death Halts Shock Treatments," *New York Times*, March 13, 1980, np.

(8) Gary Livingstone, "Re: The Death of Joseph Taggart, SSU, Bldg 1," Internal memo by ombudsman of Creedmoor Psychiatric Center dated 7/15/80; Personal communication with Mr. Livingston.

(9) Terminal Seizure — A seizure (electrical "short circuit" of the brain) which results in death.

(10) Ronald Smothers, "The Death of a Psychiatric Patient: The Gray Area of Restraint," *New York Times*, Feb. 17, 1982, pp B1, B4.

(11) Ronald Smothers, "Death of a Psychiatric Patient Is Attributed to Undue Force," *New York Times*, February 6, 1983, Sect 1, p 38.

(12) Prolixin — Brand name of fluphenazine hydrochloride, a powerful "antipsychotic" drug of the phenothiazine family, piperazine type. The drug schedule of the Anthony Ruggeri case is an example of a program of "rapid neuroleptization."

(13) Hyperventilation — Abnormally prolonged rapid and deep breathing which eventually results in alkalosis of the blood from too much carbon dioxide.

(14) Posey Restraint — A long piece of fabric used to tie inmates to beds and chairs. Also used to bind feet and legs to a bed while the upper body is restrained in a bednet. (see note 19)

(15) "Patient's Death Probed at Center," *Staten Island Advance*, Oct. 21, 1980, p A19

(16) Lithium Carbonate — A highly toxic, sometimes fatal, mineral salt used in psychiatry primarily as an "antimanic treatment."

(17) This dosage was reported without comment by the Commission in their death report on Judith Singer ("Janice Sherman"). It appears likely that the figure is either a typographical error or refers to the total daily dose instead of the amount of each quarterly dose.

(18) "Voluntary" Status — In New York State, a "voluntary" inmate must inform the director of a facility of their intent to leave; then the institution has three days to commit, or release them.

(19) Bednet Restraint — A netlike device used to secure an inmate's upper body to a bed, restricting motion of the upper body and arms. Often used in conjunction with a posey restraint.

(20) In New York State, there are regulations governing the use of restraints. They must be ordered by a physician, and the maximum length of such an order is four hours. The inmate must be examined every two hours and be released for exercise of the limbs.

(21) Dystonic Reactions — Sudden, abnormal, and involuntary muscle cramping that often leads to bizarre posturing. Caused by neuroleptic drugs.

(22) 1:1 — Constant supervision of an inmate by a staff person, ostensibly to prevent suicide or self-mutilation.

(23) ROM Exercise — A special exercise routine to relieve the muscular strain created by straitjacketing and bednetting.

(24) American Psychiatric Association, *Diagnostic and Statistical Manual (3rd Edition)*, 1980, pp 205-218.

(25) Bruce Alpert, "MDs Faulted in S. Beach Patient's Death," *Staten Island Advance*, Feb. 26, 1982, np

(26) Ronald Smothers, "Report on a Death Faults S.I. Mental Center," Feb. 28, 1982, np.

SOUTH BEACH — A Personal Account

On December 8, 1982 Allen Markman interviewed Frances Ruggeri, Anthony's mother, along with the mother of another South Beach victim. The following condensed version reveals the Ruggeris' trust and helplessness before the mental health bureaucracy, and Anthony's deepening confrontation.

A.M.: MRS. RUGGERI, WHEN DID YOUR SON FIRST BECOME INVOLVED WITH PSYCHIATRY?

F.R.: It was 1976. Andrew was almost 21.

A.M.: WHAT WERE THE CIRCUMSTANCES SURROUNDING IT? WAS HE IN ANY KIND OF TROUBLE?

F.R.: No, it wasn't . . . See, usually he worked with us in the pizza store. We were a little old-fashioned. At night when he stopped work he went out. He felt free with the other friend. So he smoked marijuana.

A.M.: YOU ORIGINALLY CAME HERE FROM SICILY WITH YOUR HUSBAND AND YOU OPENED UP A PIZZERIA. YOUR SON STARTED GETTING INVOLVED WITH DRUGS.

F.R.: No, I think he just started smoking marijuana.

A.M.: PRETTY MUCH MARIJUANA. NOTHING MORE SERIOUS THAN THAT. AND IT BECAME A PROBLEM.

F.R.: A little, because sometimes he felt guilty. He knew that as soon as he came inside at night I could smell something funny. So I said, What do you do? You smoke! Because we all know, we all heard about junk. So he said, No, no. I had a couple of beers. He told me he had a couple of beers. So, he goes on. As long as he was working, he stayed home. But then he started to go out and he no longer came home at night. So we were worried. And then it happened that his friend's father told us that they see something in their son like in my son. He doesn't come home, he looks a little different. He says, you know why I took my son to Kings County Hospital? I say, Why? He says, because they help him there. So they don't smoke that thing anymore.

A.M.: WHAT HAPPENED? HOW DID YOUR SON GET INTO KINGS COUNTY? DID YOU CALL THE POLICE?

F.R.: He came in late. He went in late, and he didn't want to come upstairs. The store is downstairs and we live upstairs. So he doesn't want to come upstairs to sleep. If we were afraid, maybe we say he go out again. You know, he had the key, and maybe he would go out again. And we were afraid because at that time, I don't know if it was at that time somebody killed somebody in the park. So we were afraid.

A.M.: YOU WERE WORRIED?

F.R.: We said, Don't go out. We had the idea of the other man who said he'd taken his son to Kings County. We thought that when they go there they come out a new person. We asked our private doctor. We said, What can we do? He said, Better take him to the hospital. He said the same thing so we got encouraged. We said maybe once he goes there they'll talk, they'll do something. Then it's okay.

A.M.: HOW LONG WAS HE AT KINGS COUNTY?

F.R.: Two weeks.

A.M.: HOW WAS HE WHEN HE CAME OUT?

F.R.: Pretty good. After that — that was about March or April. After that, in the summer, my husband and my other son went to Italy.

A.M.: THIS WAS IN MARCH OF . . .

F.R.: 1976.

A.M.: HOW DID ANTHONY GET INTO SOUTH BEACH?

F.R.: Before he was there, he was six weeks in Kingsboro, and he came out. They gave him some medication. For a couple of weeks he took the medication. He was okay. Then he didn't want to take it no more.

A.M.: KINGSBORO, I THINK, IS A STATE HOSPITAL?

F.R.: Yeah, so he was there. When he came out he was normal as long as he took that medicine that they gave to him.

A.M.: HE DIDN'T WORK? HE WASN'T ABLE TO WORK IN THE PIZZERIA?

F.R.: No, we were closed. He came out from the hospital. It was almost at the end of June. In July, August we close the store for two months. For the summer we close. So he had nothing to do.

A.M.: HOW DID HE EVENTUALLY GET INTO SOUTH BEACH?

F.R.: Because as soon as he no longer take the medicine, he went like, you know, started the same story. He didn't come home. He told us "I sleep with my friend." So we saw as soon as he stopped the medicine he was not himself any more. We try — my husband said, "I take him back to Sicily" because he stayed one year over there from '76 to '78. He stayed one year over there and he was okay because over there the life is different. He was, you know, like you can't control him. So we went back to the hospital. We spoke with the doctor that we knew. We said, "Can you please take him here another couple of weeks" because over there at the hospital they take the medicine. So we said, "Can you keep him here a couple of weeks until he's better?" My husband said, "I'll prepare everything — the passport and everything. And we go back there." But the thing is, when they took him back in the hospital, they sent him to Coney Island Hospital instead. And from Coney Island Hospital, the doctor — my husband spoke with the doctor. He said, "You know, they keep people a little longer in Staten Island." He said, "We'll send him there."

A.M.: SOUTH BEACH?

F.R.: Yeah, because in Coney Island Hospital they keep you only a few days. So he said, "We'll send him there. He'll get better there. They have more facilities."

A.M.: HOW LONG WAS HE THERE BEFORE HE DIED?

F.R.: Only ten days. And the thing is, as soon as they brought him there, they brought him in another building. This was . . . Building E. Before he left there, my husband gave him money — ten dollars. He said, Maybe before we come there if you need something, cigarettes or soda, something. And for the telephone. The first day he went there he called. He gave us the address. He said come and visit. So he gave us the address and everything. And then some social worker — I don't know who it was, somebody that works there — told him, You go back in the room there.

And she told me, Don't come tomorrow. I told my son, Tomorrow we come. So this girl said, Don't come tomorrow because we're going to send him to another building. So she gave me the doctor's name and the telephone, and she said, Tomorrow you call the doctor and he'll give you an appointment.

A.M.: WAS THAT THE LAST TIME YOU SPOKE TO YOUR SON?

F.R.: Yes.

A.M.: YOU NEVER SAW HIM AGAIN?

F.R.: No. He talked nice, you know. Nothing wrong. He talked normal. There was nothing wrong until then. So the next day I called the doctor, and when he asked me the name and everything, I said, Can we come there and visit my son? He said, No, don't do that. He didn't ask me how long he had a problem. He didn't ask me nothing. Nothing.

A.M.: JUST DIDN'T WANT YOU TO SEE HIM.

F.R.: Yeah. He didn't want us to see. Usually, they're supposed to ask you. The other doctors asked us. When his problem started, they wanted to talk with the family, but this time nothing.

A.M.: NOW, YOUR SON WAS HEALTHY — PHYSICALLY HEALTHY. THERE WAS NOTHING WRONG WITH HIM. HE WAS A YOUNG MAN.

F.R.: Sure, he was 175 pounds. Twenty-four years old.

A.M.: AND HOW DID YOU FIND OUT THAT HE DIED?

F.R.: They didn't even call us. They called some friend, his friend. I don't know where they found the telephone number. I don't know if they called the house and we wasn't home that Sunday afternoon.

A.M.: SO YOU FOUND OUT FROM THE FRIEND?

F.R.: Yes.

A.M.: I WAS READING THE QUALITY OF CARE COMMISSION'S REPORT ON YOUR SON'S DEATH, AND IT SOUNDED JUST LIKE HE WAS TORTURED. HE WAS WRAPPED IN A STRAITJACKET FOR HOW MANY HOURS . . . ?

F.R.: Ten days.

A.M.: TEN DAYS, ON AND OFF. AND GIVEN A GREAT AMOUNT OF DRUGS. ALSO I THINK HE HAD A HIGH FEVER — IS THAT TRUE — BECAUSE IT WAS HOT.

F.R.: He perspired. Sure. That month it was so hot and humid.

A.M.: AND THEN AFTER ANTHONY WAS PERSPIRING FROM ALL THIS HEAT AND FROM BEING WRAPPED IN A STRAITJACKET, THEY TOOK THE STRAITJACKET OFF, TIED HIM TO A CHAIR, AND THEN PUT THE CHAIR INTO THE SHOWER, AND TURNED ON THE WATER. HE DIED IN THE SHOWER. IS THAT WHAT HAPPENED?

F.R.: Yes.

A.M.: THAT'S WHAT THEY SAY HAPPENED, AND WHAT DID THE MEDICAL EXAMINER SAY ABOUT THAT? DID THEY LIST A CAUSE OF DEATH?

F.R.: Cardiac arrest.

A.M.: HE, AGAIN, NEVER HAD A HISTORY OF HEART TROUBLE?

F.R.: No! Another thing. I don't know if you read it. He had a problem with the tongue . . . bleeding from the teeth.

A.M.: I DIDN'T READ THE AUTOPSY. I READ THE COMMISSIONER'S REPORT.

F.R.: The Commission covered it up. They put "cardiac arrest."

A.M.: SO HIS TONGUE WAS BLEEDING.

F.R.: Yes, in the autopsy, the tongue, teeth marks, bleeding. It means that he was in convulsions or something.

A.M.: A SEIZURE, A CONVULSION. MRS. RUGGERI IS SAYING THAT HER SON WAS IN A STRAIGHTJACKET

FOR TEN DAYS. IT'S CLEAR THAT THERE'S A BIG COVERUP. WHEN HE WAS PUT IN THE SHOWER WITH THE CHANGE OF TEMPERATURE HIS HEART COULDN'T TAKE IT ANYMORE.

F.R.: Another thing. In the autopsy report, they said he had no food in his stomach, only brown liquid. Where did it come from? Brown liquid, and no food in the stomach? I even forgot about this thing when I talk on TV. How come he didn't have food in the stomach? And how come the tongue was bitten? That means . . . that they torture. What did they do? . . . They didn't tell us nothing because they didn't want us to see him. Once, I implored the doctor. I said, Please, just let me call here in your office just to say hello to him. I said, Maybe he gets mad that we don't come and visit him. In the other hospital we go every night, we bring pizza every night. They have a party. Everybody was so nice. They waited for us. I said, Please let him come here just to say hello. If I had a chance just to say hello. If he told me, Come here — just that little word — then I would understand that there was trouble. You think anybody can keep me from going there?

A.M.: DO YOU THINK THERE'S ANY WAY YOU CAN GET JUSTICE?

F.R.: I'm going to get it. One way or another I'm going to get justice. I know I'm going to get justice.

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GIVING THEM THE BIRD



"If you can keep your head while all around you people are losing theirs — maybe you don't understand the situation."

— Anonymous

There has been a flurry of debate in *The Toronto Star* throughout February over the appointment of Reva Gerstein by Toronto Mayor Art Eggleton to head a voluntary task force on the deplorable conditions of ex-inmates "living" in the Parkdale area. Because of the controversy, the Mayor sent a hurt puppy letter to the editor stating the purpose of Reva's job as "coordination (of) the many good ideas . . . to get the problem resolved."

Reva Gerstein has a string of scholarly accomplishments as a psychologist and sits on the board of four major corporations. And why is this scholar chosen over others? Reva was one of the advocates of deinstitutionalization and claims she wants to find out what went wrong. What makes her appointment seem preposterous and patronizing to concerned ex-inmates (all excluded from the task force: she wants to work on her own) and to the general public is her distance from the problem as an "elegant woman . . . in her posh high-rise condominium . . . trappings of wealth", her total lack of understanding of the real problems ("I don't believe you have to live through everything to understand it," she claims) plus the complete naivete of her statements of how to find out. Said Gerstein: "I've driven around the (Parkdale) area quite a few times."

And how has Reva reacted to previous crisis situations? During the Stratford Shakespearian Festival fiasco several years ago, as Secretary to the Board at the explosive general meeting when the artistic community was about to storm the stage, she remarked, "I just don't understand what all the fuss is about."

So for Reva Gerstein's blatant lack of understanding and for being stupid enough to make public pronouncements that betray her patronizing condescension towards the real problems of ex-inmates, we award her the Phoenix Turkey Tail.

Correction: The quotation (Winter '83, p. 10) "The so-called symptom of schizophrenia . . ." attributed to Judi Chamberlin — although found in Ms. Chamberlin's book, *On Our Own* (p. 113) — is by Dianne Jennings Walker.



THE 11TH ANNUAL INTERNATIONAL CONFERENCE ON HUMAN RIGHTS AND PSYCHIATRIC OPPRESSION MAY 19-24, 1983 AT SYRACUSE, N.Y.

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movement news

MPA - New York Hosts Conference on Human Rights & Psychiatric Oppression

As many of you know, ON OUR OWN hosted the 10th Annual International Conference on Human Rights and Psychiatric Oppression in Toronto last May. It was a great success with over 130 ex-psychiatric inmates and anti-psychiatry activists participating. This year, the Mental Patients Alliance (MPA) in Central New York is hosting the 11th Annual Conference, a key event in the world-wide Psychiatric Inmates Liberation Movement. The Conference will be held over a 5-day period, May 19-24 in Syracuse, New York at Syracuse University.

The Conference is open to people who have been "treated" or incarcerated as "mental patients" and other people who have actively struggled or protested against the psychiatric system. The Conference literature states: "The conference is open to all current and former 'mental patients'. People who may or may not have been 'treated' by psychiatry, are anti-psychiatric system activists, and are endorsed by an ex-patient group are also welcome."

Like all previous conferences, this year's conference will undoubtedly feature a lot of good workshops.

Thursday: registration, dinner, get-acquainted party.

Friday: evening plenary session.

Saturday: general public invited to workshops, arts and crafts displays, evening benefit concert of special entertainment.

Sunday: development, planning.

Monday: tribunals, trials, demonstration of solidarity with inmates of five Syracuse psychiatric facilities.

Tuesday: wrap-up, planning next year.

This is a tentative schedule with the

details to be planned by Conference participants. Should you wish to facilitate a Saturday workshop, contact MPA as soon as possible. Previous workshops included: psychiatric drug withdrawal, shock survivors, advocacy, etc. The committee welcomes comments and suggestions whether or not you attend.

The total cost of this year's 5-day Conference is \$130 (US) or roughly \$156 (Canadian) — the cost includes your food and lodging and a pre-registration fee of \$10. The Conference registration deadline is **April 15**; late registration will cost you an extra \$5.

We hope many people in Canada, especially members of ex-psychiatric groups, will attend this important conference. For more info, people should write to: **Mental Patients Alliance, Conference Committee, Box 158, Syracuse, NY 13201**, or call any of these numbers: Syracuse: (315) 474-8589; Buffalo: (716) 837-5945; Rochester: (716) 342-5707; Ithaca: (607) 539-7772; or Oswego: (315) 947-5822.

For ON OUR OWN members, conference information and the Registration Form are available and can be picked up in the office and drop-in. Let's make this year's conference another **BIG SUCCESS**.

In addition to the Syracuse Conference Committee subsidy fund drive, On Our Own is seeking donations for our members wishing to attend the May 1983 International Conference, but needing a subsidy.

The Conference presents an opportunity for ex-inmates to learn about their rights and how to exercise them, networking, sharing information, mutual support and self-determination.

Donations should be made out to On Our Own and addressed to the International Conference Fund, P.O. Box 7251, Station "A", Toronto, Ontario M5W 1X9. Income tax receipts will be sent on request.

On Our Own International Conference Fund. John Bedford, Connie Neil, Don Weitz. (416) 699-3192.

Berkeley Shock Ban Lifted

Thousands of citizens and hundreds of electroshock victims in Berkeley, California recently suffered a setback and insult in their fight to abolish shock in that city. Although 62% of the voters in the city's last November election supported the shock ban (Measure T), a judge ruled to lift the ban two months ago. On January 13, Alameda County Superior Court Judge Donald P. McCallum issued an injunction which immediately stops Berkeley from enforcing the shock ban. This means that electroshock is continuing at Herrick Hospital, the only hospital in Berkeley which administers shock. (Last year, 40-50 people were electroshocked at Herrick.)

Pro-shock psychiatrists in California, with the financial and legal support of the American Psychiatric Association have been campaigning against the ban for months and in court persuaded Judge McCallum that the ban violates people's "right to privacy" and "choice of treatment". In his decision, Judge McCallum stated, "The right to privacy embraces the right to consult with a doctor and to consent or not to consent to treatment". Further, pro-shock psychiatrist William Schwartzman, a spokesperson for the Northern California Psychiatric Society, had the gall to say the Berkeley ban has "deprived people of the right to a recognized treatment. It would be an infringement on civil liberties in the United States." (*Daily Californian*, Jan. 19, 1983). For people who have endured electroshock and other forms of forced treatment, such "treatment"

Electroshock: a personal account of torture & destruction

BY TED CHABASINSKI

is torture; psychiatrists' concern for our civil rights is hypocritical. Anti-shock psychiatrist Lee Coleman, for example, asserts it's impossible to give informed consent to shock in a psychiatric institution: "People are not freely volunteering their consent because they are not really voluntary patients." That's why lobotomy or psychosurgery was outlawed in prisons in Michigan a few years ago (Kaimowitz case).

Strong and swift reaction to the injunction has come from both city lawyers in Berkeley and the Coalition To Stop Electroshock. (See *Phoenix Rising* winter/83 issue, in which we gave a Phoenix Feather to the Coalition.) City attorney Manuela Scott asserted that the injunction violates voters' rights; she added "It's the consensus of the Berkeley community that every time someone receives shock treatment in the city, he sustains permanent (brain) damage. It's a harm to the public interest that's irrevocable."

Ted Chabasinski and Leonard Frank, shock victims and leaders in the Coalition, have strongly denounced the injunction and vow to continue to fight against the injunction and for the abolition of electroshock in California. Commenting on the injunction, Frank asserts, "It's a great tragedy for those individuals who are going to be subjected to that barbaric treatment. It wouldn't surprise me if the citizens of Berkeley take some type of direct action against the hospital." Chabasinski also asserts that previous Coalition demonstrations against shock will "seem like nothing compared to what's going to come. We will use our constitutional rights of freedom of speech and freedom of assembly to show them how foolish it is to thumb their noses at the will of the people."

The continuing fight against electroshock and the injunction promises to get very hot and stormy this year in California. The American Psychiatric Association is already preparing to sue Berkeley over its shock ban on the grounds that it is "unconstitutional," and the Coalition To Stop Electroshock is getting stronger by gathering more support from shock victims, anti-shock health professionals and the general public who rightly believe that electroshock is a damaging and unethical procedure.

Ed. Note: We urge our readers, ON OUR OWN members and supporters to support the Coalition. Letters of support or requests for information should be mailed to: *Coalition To Stop Electroshock, P.O. Box 3301, S. Berkeley Station, Berkeley, CA. 94703 — (415) 547-4655.* Donations by cheque or money order should be made payable to Coalition To Stop Electroshock.

Electric shock treatment, originally developed to stun hogs so they wouldn't resist being slaughtered, is one of the most destructive ways of treating human beings ever invented. I know, because it happened to me.

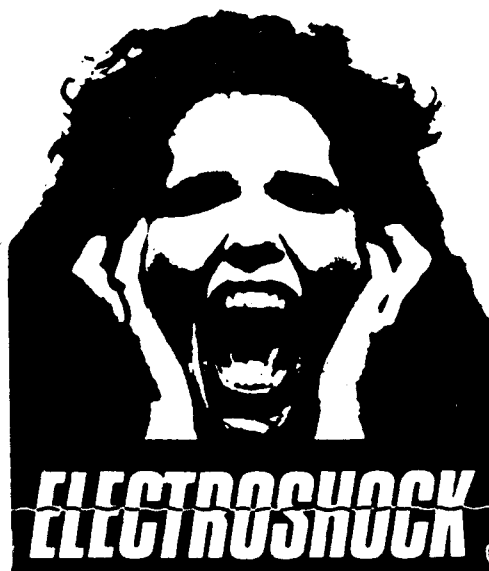
I was six years old. My mother had been locked up in a mental hospital just before I was born, and I was a ward of the state. A psychiatrist at Bellevue Hospital in New York, Dr. Lauretta Bender, had just begun her infamous series of experiments on children, and she needed more subjects. So I was diagnosed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

Of course, my memories of that time are very foggy. Nor do I want to remember what happened to me there. I was beaten and raped (still very common experiences for mental

patients). I was dragged down the hallway crying, a handkerchief stuffed in my mouth so I wouldn't bite off my tongue. And I woke 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 has changed me from a shy little boy who liked to sit in a corner and read to a terrified child who would now only cling to his foster mother and cry. I couldn't remember my teachers, I couldn't remember the little boy I was told was my best friend, I couldn't even find my way around my own neighbourhood. 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



**IS A CRIME
AGAINST HUMANITY**

years of my life.

Was this 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.*

Is this all in the past? A few weeks ago, while debating me on a local radio station, Berkeley's most active shock doctor claimed that what was done to me could never happen today. But this same doctor has in the last few years given shock to at least two teenaged girls that we know of. One of them, Lynette Miller, later died, and Gladman Hospital in Oakland was found liable for up to \$7.8 million in damages. (See *Phoenix Rising*, vol. 3, no. 2). Though this lawsuit has not been concluded, Gladman Hospital has stopped doing shock treatment. But the same psychiatrist who gave those shock treatments to Lynette Miller is still practicing his trade at Herrick Hospital.

Pro-shock psychiatrists are making much of a state law that supposedly makes most shock treatment voluntary. What they don't tell you is that they fought the law tooth and nail, raising several hundred thousand dollars, to try to have it struck down. Now they've learned to live with it, because the state Department of Mental Health, charged with enforcing the law, hasn't the slightest interest in doing so. Six years after the law was passed, there are still no regulations to enforce it and still no standard consent form so that patients would know what they're signing for.

That's why the Citizens Advisory Council, a statewide mental health advisory board appointed by the governor and Legislature, has called for a moratorium on shock in California.

The state law not only isn't being enforced, it never can be enforced, because it's left to the psychiatrists themselves to carry out. And these are the very same people the law was designed to protect patients against! It's as nonsensical as putting a fox in charge of guarding the chicken coop.

Berkeley's psychiatric establishment has just raised a huge sum of money and hired a professional public

relations man to direct their campaign against Measure T. Soon Berkeley voters will find their mailboxes stuffed with slick, expensively prepared literature selling shock treatment like a new brand of toothpaste. The shock doctors' literature will be full of statements from prestigious "experts" touting shock treatment as a new! improved! miracle cure. Don't buy it.

Unlike the shock doctors, shock victims don't profit financially if shock is continued. That's why, when the city of Berkeley called a hearing on shock this April, not one person who had received shock came forward to say it had helped them while dozens of shock victims testified that shock had destroyed their memory, damaged their brains and ruined their lives.

In 1967, just 15 years ago, Herrick Hospital was still performing lobotomies. The same psychiatric "experts" who defended that are defending shock treatment now. It's time for the voters to put a stop to psychiatric abuses.

*Ted Chabasinski is one of the founders of the Coalition to Stop Electroshock.
(reprinted from the Daily Californian)*

Taking Back Power

The Third Annual Conference on Human Rights and Social Responsibility was held at Queen's University in Kingston, Ontario on January 28-30, 1983. Some of the topics covered in the workshops held through the three day convention included: Healing Ourselves, a historical look at women as healers; Beyond Coming Out, an exploration of the social dimensions of gay and lesbian liberation; Building Strength for the Rights of the Disabled; Women in the Third World; Native Rights in Canada; Personal Power; The Charter of Rights and the Prisons; Pornography, Rape and Bill C-127; Grey Power, Nicaragua's Struggle Against Imperialism; The Worker's Struggle in Poland; and Prisons and Community Involvement.

On Our Own was represented as "The Voice of the Psychiatrized" in a workshop held on Sunday by Don Weitz and Robbyn Grant of the Phoenix Rising Editorial Collective. Here are excerpts from the transcript of Don Weitz' portion of the workshop.

ON OUR OWN AND SELF-HELP

I'm here to let you know about what's happening to us, as a group. We don't presume to speak for all the psychiatric inmates or all the so-called psychiatric problems in the world. All we can know about is what we've experienced, or what we've been told, or what we're doing in our lives, and what we're aware of.

We feel very strongly that we must control our own lives, instead of having our lives controlled for us by outside pressures, in this case, from the psychiatric system. The way we feel is that to be genuinely self-help we must provide our own help so that we can retain our independence which is so precious to us. We are providing an alternative, a real alternative to the system. Receiving money from the system has not stopped us from criticizing it.

On Our Own happens to be part of an international psychiatric liberation movement, along with 75 other groups around the world. That's not rhetoric. These groups have just put out a manifesto, a declaration of principles, that was passed at the 11th annual Convention that we hosted in Toronto last year. In that declaration you will find a very strong statement against forced treatment of any kind, including

involuntary civil commitment for whatever reason.

We are not alone, and we are not worried about getting support from other people. We are very concerned about getting public understanding from people like yourselves who may not be part of the movement, but who might walk a tenth of a mile in our shoes before you start criticizing what we're doing. We're not asking for people to automatically agree, but at least to listen for a change. We're asking for the right to develop real alternatives and to get rid of psychiatric institutions which cannot justify themselves morally, financially, or therapeutically.

We are not going to accept the idea that psychiatric inmates are second class or third class citizens. There are constructive ways of saying no. Those of you who have the experience of speaking out and joining with other people in the feminist movement or the civil rights movement or the prison rights movement — we are the same. The force that motivates us is that sense of being put down and saying "We're mad as hell, and we're not going to take it any more." We want to channel that "madness" in a constructive way. We can't do it alone. Of course we need friends and supporters.

We have written 30 points here which could lay a basis for a bill of rights, perhaps the first one in Canada for psy-

chiatric inmates. We happen to feel very strongly about those human and legal rights. All we are saying is that it's about time that people looked at people in psychiatric institutions as PEOPLE. Once you acknowledge that they're people (which may be quite an admission for some) and not "guinea pigs" or "interesting cases," but human beings with the same right to have rights as any other Canadian, the ball game changes. Then you've got to make provisions in the law, and so far this government, any provincial government across Canada, has not taken that point seriously. We are not guinea pigs, we are not here to be given shock treatment or drugs, we are here to be treated humanely. If they don't reflect that in the laws, we will keep speaking out, going to conferences like this one, demonstrating in the street, writing briefs, or taking some kind of action.

ON THE ABUSES OF PATIENTS' RIGHTS

There are physical abuses which are covered up. Let me give you an example of this documented by the government of Alberta. The government of Alberta through the ombudsman, Dr. Randall Ivany, about a year ago published a report. This is the first time to my knowledge that an ombudsman has had the guts to write something about what's happening in the psychiatric wards. What he found was cases of 35 staff committing verbal and very often physical abuse over a six-month period in one particular hospital, the Alberta Hospital in Edmonton. It is public knowledge now. Some of those abuses included pulling inmates by the hair, stomping on them, calling them sexually abusive names, and a host of other abuses. Not one staff member was charged. The only result was that some of these staff were demoted or just sent to another hospital. They still had the power to continue what they were doing, they just weren't on the same ward. To me, it seems like there is one type of justice for some people and another type of justice for people who happen to be labelled psychiatric inmates.

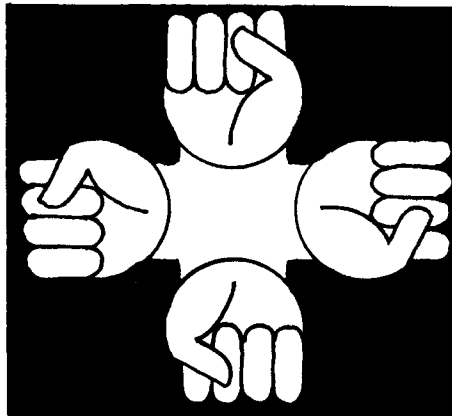
Many people are afraid to complain when they're on psychiatric wards because if they complain or open their mouths against the staff, the staff could either overdose them, or put them in seclusion, or in some way make it hard on them. I have a number of friends, and a number of people I know in our group, that this has happened to. These are not isolated instances.

It isn't "care" when you drug people against their will or shock people

against their will. It isn't care when you treat people like idiots or numbers or guinea pigs to do with them what you wish. There's no way anybody's going to convince me that that's really "care." What I'm saying is that until the public gets aroused and informed enough we're not going to see any concern about the rights of psychiatric inmates.

ON THE PENAL SYSTEM, LAWS, AND THE PSYCHIATRIC SYSTEM

The word "insanity" can't be defined with sufficient precision. That's one of the big scandals of the law. Words such as "insanity" are so vague and so subjectively arrived at (for example, the term "schizophrenia") that you can't really justify using them. Either you are responsible or you're not. What's happening is that many



people, because they act too strange after committing an offence, or during it, are labelled officially crazy. Then what happens, which is a further scandal, is that they're slapped with a warrant of the Lieutenant Governor which means: you're not fit to stand trial or not guilty by reason of insanity. Do you know what that does? That lets the shrinks put you away, indefinitely, in places like Penetang. No fixed sentence, so you don't know when you're going to get out — that's at the pleasure of the Lieutenant-Governor or the Cabinet.

It's supposed to be in the Charter of Rights that we shouldn't lock people up on the suspicion that they might commit crime. That's called "preventative detention" which has been denounced by the United Nations as well as the Canadian Charter of Rights. What's going on now is that some are being locked up in Queen Street or Kingston Psychiatric Hospital because some psychiatrist thinks that he or she

might go out and hurt somebody. It is a fact of law that people have a right to be free and can only be locked up after being convicted of a criminal offense. The burden of proof is on the one who is accusing you of being dangerous. If you have committed a dangerous act, have hurt somebody, have clearly broken any part of the criminal code, then that should be decided in court. It shouldn't be decided in the psychiatric admitting room or in a unit of a psychiatric hospital. People should not be locked up, they should have their freedom until it's been proven legally otherwise.

We should have the right to remain free, in this case, of any psychiatric facility, and alleged dangerous or criminal action should be dealt with through the criminal justice system. That happens to apply to people who have not been labelled "mentally ill," "crazy," "schizophrenic," or "psychotic." The way the mental health act reads right now, in virtually every province, is that on the basis of belief of a physical threat to somebody, often even a verbal threat, people can lose their freedom for 30 days. The point is loss of freedom, the most-precious thing a person can have. It's a very important point, because people are still being locked up unjustly. There was a study done in Ontario three years ago, which shows that the shrinks are not even accurately filling out the form "one's" or committal forms. They put down for "dangerous," "lacks insight, wife doesn't want him home, is paranoid." These are listed as "evidence" of dangerousness to lock people up.

Most inmates are not even told their rights. People don't even know that they have a right to a review board hearing after their 30 days of incarceration. We represent 300 people from On Our Own when we talk about these issues. Many of us have been involuntarily committed. Incidentally, many of the so-called voluntary admissions listed in the statistics of the provincial government of Ontario are actually involuntary, because someone conned or forced them saying, "If you don't come voluntarily, I'm going to make you come involuntarily." So they'd rather go in voluntarily. But that doesn't show up in the statistics.

If there is no "mental illness," then there are no mentally ill. We are questioning the very foundation of psychiatry which uses mental illness, which is often just behavior that is judged strange by some usually conventional, middle-class-standard of morality.

ON THE ROLE OF MENTAL HEALTH CARE PROFESSIONALS

I am not against mental health care professionals being supportive where the relationship is through mutual involvement. I am against mental health ideology, the "mental illness" model. It is a myth and a smokescreen. I am not against individuals who happen to be social workers, psychologists, and perhaps even some psychiatrists — but only if the relationship is truly voluntary. Too often what happens is that the "help" turns into a very coercive, a very oppressive kind of relationship. That's why I'm against mental health professionals in general: because it really doesn't respect a person's right to make their own choices.

ON THE RIGHT TO CHOOSE

I believe that most people are quite capable of making a decision as to whether they want to take something into their body or not, and whether they feel better or not, without having to have a big intellectual justification for it. I've met many people who are "out of it" for any number of reasons — how can they make their own judgements? The point is, if we feel so strongly that people should have a choice over the kind of substances, call it "medicine" in this case, that they take into their bodies, if people in general hospitals have the right to refuse any treatment; if we agree to that, which is the case under common law, then why is it that we don't apply the same principals to institutions labelled psychiatric? There's a double standard here. Do you have a choice or not? Are you controlling your own life or not? Our claim is that in places called psychiatric institutions they take that right, that human right, in fact, that legal right, away from you. But in general hospitals, fine, you still have it. Now why is that?

What we are saying is that people who have been labelled "mentally ill" should equally be given the right to choose. Most of the time such people are not allowed to make basic choices because they have been locked up by a lot of mental health professionals. Under the guise of doing what is for our own benefit, people have been deprived of their rights, very fundamental rights, in the name of therapy, of treatment. We know all the terms that mental health officials have used against us, and that is the point: they've been used against us, not for us, not to support our right to choose, but to stifle it.

ON INFORMED CONSENT

Informed consent implies the right to be told the type of treatment you're going to get, the reason for it, the known safe alternatives to it, the known side effects and adverse reactions, and the right to give your voluntary consent without external threat or coercion. That is common law, in medicine it's practiced, in psychiatry it's violated. Every day in every psychiatry ward people are being given substances because they have been intimidated. They don't even know they have the right to consent.

The way it is now, the psychiatrists will judge you competent or incompetent on the basis of whether or not you agree with their belief that you are mentally ill. If you happen to agree with them, then you're probably going to be called competent. If you protest against it, you are often likely to be labelled incompetent. Incidentally, only the signature of one doctor is sufficient to get you labelled "incompetent", under the Mental Health Act.

ON HELP AND HELPERS

The best help you can give people is to keep them out of institutions and to take them to a 24 hour crisis center staffed by people who really know what it's like, but we don't have enough alternatives. The worst thing to do when you use the word "help" is to take somebody to a psychiatric institution. You have to experience what it's like to be invalidated, to be drugged against your will, to be not listened to. You can't still call that "help," if your ideas are ignored and your needs are not taken seriously and you've been drugged against your will. There's not one good thing about psychiatric institutions that is humane or respects the human rights of the patients.

ON ALTERNATIVES

If we had a range of alternatives, there's not one person who couldn't get the help they need when they needed it. Suppose you had a 24 hour crisis center here in Kingston, where someone could come in and talk just because they're feeling uptight for whatever reason, and that it was staffed by people who had themselves gone through heavy crises and had credibility because of their experience: you could save not only lives but a lot of money and be more helpful to people than taking them to Kingston Psychiatric Hospital. I'm not being over-dramatic — I'm serious. This has never been seriously

tried yet, a 24 hour crisis center, independent of the hospital emergency room. You could have different kinds of group homes, for people that need more support, graduating to those needing lesser support. Not only housing, but you could also have some kind of telephone answering service which is not staffed by straight mental health professionals but by people who have been there — a hot line. But this government is not committed to humane alternatives, they're committed to safe, hyper-controlled, medically controlled treatment, which very often is cruel and unusual treatment. In our group, we see the recipients of these "treatments" — the "walking wounded," as the press talks about them. In our group they are *not* a minority.





Rights and Wrongs

A 50-year-old woman in Michigan recently was awarded \$1,350,000 in damages she suffered as a result of psychiatric treatment. As a result of being drugged with many powerful "anti-psychotic" drugs, she developed tardive dyskinesia. The doctors further misdiagnosed her condition as Huntington's chorea, a genetic disease. The case is known as *Faigenbaum v. Oakland Medical Center* and was reported in the *Atlanta Law Reports* in December 1982. The report reads:

"\$1,350,000 jury verdict, including interest, for a 50-year-old woman who suffers tardive dyskinesia and psychosis as a result of prolonged drug therapy.

Plaintiff underwent extended psychiatric treatment during which she was prescribed the antipsychotics Thorazine, Mellaril, Stelazine, Haldol and Triavil. When plaintiff exhibited loss of control of her limbs and facial muscles, she voluntarily admitted herself to defendant Clinton Valley Center, a state psychiatric hospital, on the advice of her physician, who attributed her symptoms to a hysterical conversion neurosis. When plaintiff's condition did not improve she was referred to defendant Oakland Medical Center, a state medical-surgical facility, where a neurologist diagnosed genetic Huntington's chorea although plaintiff's family history was negative for the disease. The neurologist recommended continuation of anti-psychotic medication. Plaintiff ultimately was diagnosed as suffering permanent tardive dyskinesia and associated tardive psychosis.

Plaintiff settled with the physicians and hospitals which had treated her before her institutionalization for \$378,000 and proceeded to trial against the staff members of the state hospitals, alleging negligent failure to diagnose tardive dyskinesia due to prolonged administration of psychotropics, failure to discontinue the drugs in the face of plaintiff's symptoms, and improper diagnosis of a genetic disease notwithstanding a negative family history. The trial court ruled that the psychiatrists who treated plaintiff at

Clinch Valley were immune from suit, although plaintiff was treated primarily for physical disorders. The jury found for plaintiff against Oakland Medical Center and its staff, awarding \$1 million."

In another case, a 31-year-old Florida woman sued a psychologist and was awarded \$135,000 in damages. She charged the psychologist with sexual battery. The case of *Lopez v. Avent* was settled in February 1982; the account in *Atlanta Law Reports* is from December 1982:

"\$135,000 settlement for the psychotic neurosis of a 31-year-old housewife who suffered sexual battery by her psychologist. Plaintiff consulted defendant for treatment of her depression and was involved in a sexual relationship with him, under the guise of treatment, for approximately a year. She became suicidal and alienated from her family and ultimately was committed to a psychiatric hospital."

Finally in Oklahoma a landmark decision against the drug company Hoffman-LaRoche — manufacturers of Valium — awarded a structured settlement of \$700,000 to a 6-year-old born with brain damage caused by his mother's ingestion of Valium during pregnancy. According to the February, 1983 *ALR*:

"In 1976, during her last two months of pregnancy, plaintiff's mother was prescribed Valium, manufactured by defendant. Plaintiff was born with permanent brain damage. Plaintiff brought suit against Hoffman-LaRoche claiming that his brain damage was caused by his mother's ingestion of Valium and that Valium was defective

in that it was marketed without a warning to prescribing physicians concerning the possible dangers to a fetus if taken during pregnancy. Defendant contended that since plaintiff was also born with various birth defects not attributable to Valium, and since no case of permanent brain damage caused by Valium was reported in the medical literature. Valium was not the cause of plaintiff's brain damage. Plaintiff argued that studies both before and after 1976 revealed short-term nervous system depression and withdrawal symptoms in fetuses whose mothers had taken Valium late in pregnancy and that plaintiff exhibited these symptoms. Plaintiff will require 24-hour custodial care for the remainder of his life."





personal stories

On Their Behalf

BY KATHLEEN A. PICARD

I see Susan Rosenthal. Olivia might be in for a long time and in the back of my mind lingers the fact: maybe for life.

The two closest friends in my life are both women. My mother, and my little dove Olivia taken from me "on their behalf," they say.

Strange, if you were a true scientist you could see that neither of these women or myself are crazy. I would not join her there; it would be better to be here and support her and hope she works to come again into the world that is her world as it is his.

I feel numb that those dreams hold hideous facts. Numbed that my little friend could end her days in an institution for crazy people knowing that she is not crazy.

"Seeing herself crazy, she acts crazy. They say she is crazy."

I would say if it was in my power, "You're not crazy, but you think you are."

And Olivia would reply, "but so do others."

"As long as you know you are not."

And my little friend has not learned that her family will always have her in. They have low opinions of us both. They are not a good family, Olivia. They're not thinking of you, getting you out, and demanding the doctors have you out quickly.

So, she says she is crazy and they say "yes." How unscientific. How low. These people, Olivia, as you know are not helping. They are the ones who should be in the institution. Do not let your work, your poetry, your film-scripting go to waste.

Honey, come out where your good friend can help you and be with you.

"If it wasn't for you, Kathy, Olivia would be even worse off." It seems incomprehensible considering I was always considered to be a racist and without feeling.

I can now comprehend my warmth and the loving and affectionate generosity Olivia always told me I had. I cannot comprehend how her feeling is low just like mine.

I see and know and in telling Nancy I have a friend for her there for she knows the craziness directed at her.

The sinking into hospital space can be so easy. The detaining can be so hard. It is easier to fall back and not fight all that shit outside. Some ill safety comes.

And she sees me getting stronger, her heart knows I care for her and there is always tomorrow and, sometimes, hope.

In the dream it is Christmas, and I see Olivia being taken, and I say in my dream, "There goes Olivia again."

"That must be hard on you," replies Susan. "Your friendship cannot go anywhere with her in."

And I tell her my mother was put in when I was four for

life. Olivia is only twenty-seven.

"She must remind you of your mother."

"My two best friends, my mother and Olivia, taken from me on "their behalf."

I suppose, Susan, it can't go anywhere, but the memories and the hanging on to the hope that tomorrow is the end of the nightmare.

Cora

BY LORRAINE THOMPSON

Christmas is a time of celebration and merriment, of remembering old friends and making new ones, but this Christmas Day I found out that a friend of mine was dead. I had met Cora a few years ago through the wrong kind of crowd which I happened to be hanging around with as well. She had inherited her petite dark looks as well as a fondness for alcohol from her French-Canadian background. Her liking for Mandrex was perhaps a result of the bad company she was keeping and the fact that her husband had been killed in an industrial accident. She had a little boy that she was devoted to, but she had lost the only man she had truly loved and that was the first thing that broke her heart and spirit. Life to her was a series of late-night parties, too many beers and pills, and too many affairs with the wrong kind of men, never finding the love and affection she craved.

This was about the only thing we had in common, aside from our love of cats and coffee, gossiping in the sunshine, laughing and crying. Whereas I tended towards art and the intellect, Cora watched the soaps on her colour TV and read the *National Enquirer* religiously. She wasn't as intelligent or cultured as some of my friends, but I trusted her for some reason and told her all my secrets, and she told me hers, chain-smoking, drinking endless coffees, playing cribbage. She was not a wise woman; she smoked far too much, did too many drugs, abused herself in general, but she had a warm heart and listened to me when no one else had the time.

The things that drove Cora to pills and booze could also have easily led to madness. Many times we spoke of the insanity that is implicit in living these days. She had been used and abused so many times that she had given up on ever finding happiness, seeking fulfillment in oblivion and her little boy and the songs on the radio. I often wondered why I took an interest in such a person, because I really didn't like her much as a person, but I loved her as a human being.

Cora once adopted a scrawny orphan kitten. It was such a mess! But Cora forked over \$200 from her monthly compensation cheque and fixed up this half-dead kitten, fed it until it was plump and healthy, and then was rewarded for her effort when the little bugger ran away from home. She cursed it up and down, but we had to laugh about it because life was just like that!

I eventually stopped seeing Cora when she became drunker and more confused every time I saw her. I moved to an area

of town just up the street from the bar she often went to and didn't give her my address, afraid she would bring her drunk friends over and embarrass me. Besides, I was trying to put my own shattered life together. I moved again, to another city, found a job.

I hadn't seen her for almost a year, can't even recall the last time I had spoken to her, and had felt no guilt until now. What was it that killed you, Cora darlin' darlin'? Was it the pills and booze? Was it a broken heart? Perhaps it was the breakdown her mother had a while ago that broke Cora's sense of reality down and destroyed her will to live. All she wanted was a good home for her kid and a man to love her, the things that everyone has a right to.

I never did find the time to get around to seeing her one last time to tell her about the happiness I had found in a new life in a different city. It was a small selfishness on my part not to have shared my time and good news, but I had so much to do and so little time in which to do it. I feel ashamed that I abandoned someone who was in need, even if it was to attend to my own needs.

Forgive me, my friend, for not sharing one last cup of coffee with you because I was too busy with a new man and a shiny new life. It makes me want to live my life to the utmost, to laugh and cry twice as hard, in order to make up for the life she missed. Cora was a casualty in the day-to-day war we call living.

Sometimes These Things Happen

BY SUZANNE A. CHRISTOU

I was hired by Gladman Hospital in 1970 as a night nurse in spite of my open objection to electroshock. My tenure was for 2-1/2 years.

Two doctors, who used electroshock to the exclusion of any other treatment, told me during my orientation not to pay attention to the horror stories that I had heard about it. They could, or would not, however, explain how electroshock worked or what the long term effects were of the treatment, but they believed in it and said, "It just works, that's all."

Electroshock treatments, or E.S.T., were given in a series, 3 times a week. A patient would receive 9 to 18 treatments in a 3 to 6 week period. At about 7:00 A.M. I would prepare the E.S.T. patients on my unit by checking and recording their vital signs, briefly explaining the procedure and warning them of the danger of ingesting food or liquid. They were then to sit in the hallway and wait to be brought to the electroshock room. My shift ended at 8:00 A.M. — Treatments began at 9:00 to 10:00 A.M.

Among those that I prepared for E.S.T. were: patients labelled "schizophrenic" and "manic depressive," a hypoglycemic, a battered woman, a Portuguese-speaking woman who knew not a word of English and could communicate with no one in the hospital, a woman in depression because of the murder of her son, an 86 yr. old terminal cancer patient, many maladjusted adolescents and many senile geriatrics. When it became hospital policy not to give E.S.T. to "schizophrenics," they merely changed the patients' diagnosis — so anyone could really qualify.

Oddly enough, when the house count was low the number of E.S.T. patients always seemed to increase.

I observed a great many examples of negative effects from electroshock, although the usual docile, compliant, zombie-

like state observed in patients immediately following the treatment might have been deemed "desirable" by certain doctors. Patients regressed and babbled childishly; one person forgot how to speak English; one woman couldn't stand up straight after her first treatment, but they continued her treatments until she couldn't stand at all and had to be spoon fed; an attractive young film actor was given E.S.T. punitively for making suggestive comments to the staff. He was "treated" with shock until he walked around slack-jawed and drooling, and there were many others.

There were the jokes about patients being "zapped," "buzzed" or having their brains "fried," "burned" or "scrambled." There were the stories of the older doctors that enjoyed watching young girls' bodies jump and convulse while their mouths were gagged with large rubber mouth-pieces.

Some people did respond "favourably" to E.S.T. They forgot their problems as their minds became duller from the treatment. But when their brains began to heal from the trauma their problems returned, and they were given more E.S.T.

Several days before Christmas in 1972 I was transferred to another unit of the hospital, Station I. I was not familiar with any of the patients on this unit or their histories. There were a half dozen patients on this unit scheduled for E.S.T.

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. This patient of Doctor Sadler would be receiving his 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 will 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 E.S.T. nurse came to pick up the charts of those that would receive E.S.T. 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 being on duty I learned from a nurse on Station I that patient Zappane had died. I went to station I 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 E.E.G. work-up.

That morning I questioned several members of the day staff. Yes, they told me, he screamed. Yes, he had to be carried to the E.S.T. 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 E.S.T. 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 E.S.T., 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.

PHOENIX RISING



An Annotated Index of Back Issues

FIRST ISSUE (Vol. 1, no. 2) (out of print).

Boarding Homes in Toronto; Valium; gays & psychiatry; **Book Review:** I'm Dancing as Fast as I can, by Barbara Gordon.

PRISON PSYCHIATRY (Vol. 1, no. 2)

Editorial: What it means to be an inmate, psychiatric compared to correctional, and why we use the term rather than "patient". **Minds Behind Bars:** Bizarre dehumanizing U.S. and Cdn. "criminally insane" treatment practices called "therapy". Lieutenant-governor's warrant means indefinite term (decades sometimes) without due process of law. **Thorazine:** and the Smith/Kline boycott. **8th Annual International Conference:** San Francisco report. **Profile:** House Link Co-op Homes. **Blindness:** How the system handicaps blind people through segregation; problems of information access, self-esteem, alcoholism and drugs. **Involuntary Detention in Hospitals:** legal process in Ontario. **Book Reviews:** Go-Boy!, Memoirs of a Life Behind Bars, by Roger Caron; Kind and Usual Punishment, by Jessica Mitford — USA prison system criticism; Cruel and Unusual, by Gerard McNeil and Sharon Vance — Cdn. prison system criticism. **Annotated Antipsychiatry Bibliography.**

SHOCK (Vol. 1, no. 3)

Death of Aldo Alviani: drug overdose and attempted cover-up. **Shock of Your Life:** Canadian Weekend magazine article reprinted with Dr. David D. Heath's complaint of irresponsibility to Ontario Press Council, their decision and reactions pro and con. **Haldol. Consent to Treatment in Psychiatric Settings:** competence, subsequent blurring of the law and tactics to explore to keep your rights. **Profiles:** Friends & Advocates, Toronto; Mental Patients Liberation Front, Boston. **Book Reviews:** Shock Treatment is Not Good for Your Brain, by John Friedberg; The History of Shock Treatment, by Leonard Roy Frank; Electroshock: Its Brain Disabling Effects, by Dr. Peter Breggin. **Annotated Antipsychiatry Bibliography.**

WOMEN AND PSYCHIATRY (Vol. 1, no. 4)

Editorial: Institutional treatment of women remains stereotyped. **Aldo Alviani Death:** Inquest finds therapeutic misadventure, reaction. **Since Women and Madness:** an interview with author Dr. Phyllis Chesler, her views on therapy, feminism, and groups. **Do "Crazy Ladies" Get Raped?** Rape Crisis Centre reports on attacks by staff, other inmates and landlords not believed. **Women's Bodies — Men's Decisions:** Forced sterilization, a socio-economic decision with male bias. **Lithium. Wrongful Sterilization:** Is it a medical or legal decision? Law reforms needed. **They've Got Us Covered — Maybe:** insurance coverage spotty for psychiatrized; results in some employers not hiring, difficult to legally fight, discriminatory information access by companies. **Profiles:** Women's Counselling, Referral and Education Centre, Toronto (WREC); Women Against Psychiatric Assault, San Francisco (WAPA). **Book Reviews:** Women and Madness, by Dr. Phyllis Chesler; Women Look at Psychiatry, by Dorothy E. Smith and Sara J. David; Shadowland, by William Arnold, the story of Frances Farmer; Will There Really Be a Morning? by Frances Farmer; About Men, by Dr. Phyllis Chesler. **Annotated Antipsychiatry Bibliography.**

FROM KINGSTON PSYCHIATRIC TO CITY HALL (Vol. 2, no. 1)

Editorial: Overcoming the fear of going public on system abuses. **Access to Medical Records:** linked to informed consent; in legal actions. **The Tricyclics. Don't Spyhole Me:** Toronto Alderman David Reville's excerpted journal kept during his 18 months at Kingston Psychiatric Hospital where psychiatrists saw him no more than eleven times. **Kingston Revisited:** Update on how the facility has changed since the late sixties and David Reville's stay there. **Krever Commission:** recommends qualified record access to stop information abuses; professionals opposed to access by "patient"; Health Commissioner can refuse access. **Profiles:** People First, international mentally retarded group; Jay MacGillivray of Nellie's Hostel. **Book Reviews:** Getting Doctored, by Martin Shapiro; Blue Jolts — True Stories of the Cuckoo's Nest, by Charles Steir. **Annotated Antipsychiatry Bibliography.**

KIDS AND PSYCHIATRY (Vol. 2, no. 2)

Kids and Psychiatry: Suicides and emotional problems grow but care inadequate because of varied jurisdictions. Abuse registry. How to identify problems. Overdrugging by GP's. Training schools as jails, some children in adult psych wards. Thistletown Regional Centre — then and now. Browndale. Ted Chabasinski story — electroshocked at age six. Laws — committal appears more often than for any other age group, "in their best interest." Incest — attempts to change the law. **Special Education:** Bill 82 funding and parental input for troubled children decisions. **Ritalin. Lectopam. Profiles:** Parents Anonymous, international crisis group; The Society for the Protection of the Rights of the Emotionally Distraught, Niagara/Hamilton (SPRED); David Petterson, Toronto. **Book Reviews:** The Powers of Psychiatry, by Jonas Robitscher; The Myth of the Hyperactive Child and Other Means of Mind Control, by Peter Schrag and Diane Divoky. **Annotated Antipsychiatry Bibliography. Psychiatric Inmates Liberation Directory.**

THE MOVEMENT (Vol. 2, no. 3)

Editorial: Empowerment through self-help groups as an alternative to psychiatry. **Psychiatric Inmates Unite:** Toronto conference report. **Creative Contest Winners:** Poetry "Electric Holocaust" by June Bassett; "Suicidal See-Saw" by Sharon Crawford; Fiction — The Thirteenth State by Batya Weinbaum. **The Movement:** Its origin and history in Europe and North America. Mutual support with loose links to similar disabled groups. **Canadian Groups:** in detail. **Ninth International Conference:** Cleveland Report. **Cuernavaca Conference:** report. **International Year of Disabled Persons:** What has it accomplished? Rights, exclusion of mental handicaps in legislature. **Injectables:** the fluphenazines. **Profiles:** CMHA Social Centre, Newfoundland; Kendra Russell of Last Boost, Winnipeg.

PSYCHIATRY AND THE AGED (Vol. 2, no. 4)

Editorial: Institutions and overdrugging; lack of community support systems. **Ellerton Inquest:** Third drug death at Queen St. in 18 months; recommendations concentrate on security; COPS review findings. **Dumped and Drugged:** a special report on aged; life on a psych-geriatric ward; Cdn. unions report deplorable conditions; private facilities; overdrugging for control produces serious health risks and senility symptoms; depression and ECT; positive alternatives, older residents' rights, things to watch for. **Phenothiazine:** related deaths. **Are Doctors Responsible?:** Standards based on common practice, not on ideals, hearings private, court cases impractical, no hospital complaint system; possible solutions re: accountability. **Legal Chart:** insert, how you get in or out of institutions across Canada. **Profiles:** Coast Foundation Society, Vancouver; Donna Lovell, Whitby. **Book Reviews:** Clifford W. Beers, Advocate for the Insane, by Norman Dain; Asylums — Essays on the Social Situation of Mental Patients and other Inmates, by E. Goffman. **Annotated Bibliography.**

THE 10TH INTERNATIONAL CONFERENCE (Vol. 3, no. 1)

Norman Davis Inquest: another unnecessary drug death at Queen St.; recommendations largely ignored, COPS reaction. **10th International Conference:** Toronto, two personal reports, selected testimonies, Leonard Roy Frank interview, Sheraton sit-in and reaction. **Paraldehyde:** a killer drug still in use. **Canada's New Constitution:** and the right to treatment. **Psychiatry's Assumptions Biased:** a study in social status and treatment according to biased class distinctions. **Profiles:** Auto-Psy, Montreal; Freedom From Fear Foundation, Toronto; Steve Stapleton of By Ourselves, Regina. **Book Reviews:** The Therapy Kit, by Norman Forman; Madness — An Indictment of the Mental Health Care System in Ontario, by John Marshall. **Shock Docs List.**

HOUSING (Vol. 3, no. 2)

Editorial: The psychiatrized in the community not accepted. **Housing — Not Warehousing:** Licensing and inspections of boarding homes inadequate, lack of government concern, recommendations in studies ignored. **Boarding Homes Not the Answer:** hazardous conditions mean psychiatrized welcome return to institution. Summaries of three briefs on housing. Personal accounts by those living in "homes". **A Patient-Run Residence:** alternative Florida resident-controlled home. **Some Facts:** Toronto information prepared by Supportive Housing Coalition. Housing alternatives and emergency accommodations in Toronto lists. **B.C. Law:** incompetence. 10th International Conference press panel presentation and Declaration of Principles. **Lynette Miller Death:** Mistrial declared in California ECT and drug death, family will proceed. **Tardive Dyskinesia:** epidemic. **Profiles:** Margaret Gibson, Toronto writer; Bytown Association for Self-Help, Ottawa (BASH). **Film Review:** "Titicut Follies." **Book Reviews:** Decarceration, by Andrew Scull; The Effects of Tranquillizers — Benzodiazepine Use in Canada, by R. Cooperstock and J. Hill; Holiday of Darkness — A Psychologist's Personal Journey Out of His Depression, by Norman Endler.

SCHIZOPHRENIA (Vol. 3, no. 3)

Schizophrenia: Exploding the myth, a challenge to the medical model that labels different behaviour as disease; vague symptoms, theories of cause; unsuccessful "treatments"; pseudopatient study. **Personal Stories:** two "schizophrenics" talk of their history and feelings. **Don Weitz's Discharge Summary:** and his reaction to it. **CIA and Mind Control:** Reprinted from The Search for the Manchurian Candidate, by John Marks; psychological torture of psychiatric inmates in a Canadian hospital funded by CIA in an attempt to depattern people by ECT, LSD, sensory deprivation and over-drugging. **Moditen (Prolixin):** the fluphenazines. **Psychiatric Treatment — Your Right to Decide:** consent in common and written law. **Feminist Ex-inmate Analysis:** Mental Health and Violence Against Women; statement developed at 10th International Conference, Toronto; how the system beats women, why feminist therapy failed them, the place for anger as power. **Profiles:** ?Friends of Schizophrenics?, Ontario; David Oaks, Chicago. **Book Reviews:** Is There No Place on Earth for Me?, by Susan Sheehan; A Mad People's History of Madness, by Dale Peterson; Living and Working with Schizophrenia, by M.V. Seeman et al. **Shock Docs List. Annotated Antipsychiatry Bibliography.**



profiles

Common Sense and Friendship

HOPE SCOVILLE

INTERVIEWED BY CONNIE NEIL

Hope Scoville, manager for the past year-and-a-half of On Our Own's Mad Market, had mixed feelings about taking it on: "I've always believed in recycling and have to have challenges in my work. Anything that can relieve the plight of so-called mental patients is meaningful work for me. But, could I do it?"

There have been many changes since Hope took over the store. Sales and donations have more than doubled, as have the paid staff. The program is more rigorous and demanding, and the new location at 1860 Queen Street East proved to be a happy challenge.

"I felt the volunteers weren't benefiting the store or themselves. That had to change if they were to find jobs. I actively sought volunteer members to get their support both in the store and picking up donations and started a more demanding program. I looked for things people liked doing, had knowledge about, or talent for, and gave them responsibility for that area. Originally they were resentful, but in the long run it's better for them so that when they go to other jobs, demanding work won't be such a big change or shock to them. But it was hard for me to do that."

Ron Shannessy worked as a volunteer for a year. "Some days Hope is bright and happy and might ask you to go for a beer after work, and you think 'I've found a friend'. And then sometimes she's critical and might say I haven't learned enough. You just never know. But she's a good boss. She gave

me a lot of responsibility, and I'd like to take a job in a store."

Although never institutionalized, Hope's family was full of mental problems. "It isn't a new thing for me. I grew up with it." Her father, who died in 1972, was diagnosed as paranoid schizophrenic, and her mother was hospitalized involuntarily for three months when Hope was eleven. The ten brothers and sisters, now scattered across Canada, "have forms of madness that are acceptable to this

society — are workaholics, materialistic, driven. Some were hospitalized for suicide attempts or depression, but mostly they're doing okay."

From age three to nine Hope was shifted through the foster home circuit. "I suffered abuse — mostly verbal from my mother and sisters — and some sexual and physical abuse in foster homes, one in particular. They didn't give me enough to eat, kept me in the basement in cold weather and in



the yard in good weather. They just wanted the money to pay their mortgage. But the worst was the confusion of not knowing where you belong, different religions and expectations of how they want you to be. I had a constant turmoil in my mind

“Try a little harder to find common sense solutions, or talk with friends, not professionals. There’s no magic there. That’s where the problems start.”

and felt there was no focus. Today these conflicts still mean it’s difficult to make decisions.”

“At 22, my doctor suggested I see a psychiatrist for depression, which was a disaster. I was naive enough to think I could take him to court and win for his mental abuse and subtle attempt at seduction. He sent me to his ex-lover, a left-over hippie psychologist, who socialized with her patients and told things revealed in confidence. Then there were three other psychiatrists and a G.P. which was one of my better therapy experiences.”

For Hope the solution lay in self-help groups. She replied to an ad and came to the drop-in. “I had found my home, my family and felt comfortable. When I was alone, I thought I must be really crazy if I can’t get along with my psychiatrist, thought that I was the only exception. But here were many who felt the same way, and it made me feel better about myself, less alone. I could hear others’ problems, get support and sometimes provide it for others. We talk about how we feel in the present. At the general meetings I was very impressed and realized many intelligent, articulate people suffered problems and not me alone. Through the *Mad Market*, I find acceptance and satisfaction that I am doing useful work to bring money and skills to the members.”

Before coming to manage the store Hope worked long hours in a dress-making house and felt the work to be exploitative: “I really couldn’t live or die so some rich old bag could have a \$400 dress while others were starving in Toronto. Life had to mean more than that. I promised myself to get into meaningful work and, it turned out to be the *Mad Market*.”

Russell Guspie, her husband since a December 28, 1982 ceremony in the drop-in, says: “I was immediately

attracted to Hope, but it was several weeks before we had our first date. Before that evening was out, it was as if we had known each other all our lives. Without a doubt, some of the best times that Hope and I have shared have been at the drop-in, with other members of On Our Own. And I know that when the day comes that we are leaving Toronto, we will have only one regret — that we can’t take you all with us.”

They talked of marriage from the beginning, but Hope felt with her mood swings it wasn’t for her. Four months ago she changed her mind: “My expectations are more reasonable now. I’ll always keep part of my life separate, not build everything around the relationship. It’s more healthy that way. I expect less and he is less selfish. We both compromised. It’s a first marriage for us both. I guess we’re both cautious. I want to have children, but have some misgivings about both hereditary and learned consequences. If I’d married ten years ago, I might have been the same pattern as my mother,

“I really couldn’t live or die so some rich old bag could have a \$400 dress while others were starving in Toronto.”

but now I don’t think I would be abusive. With my concerns about overpopulation, I’d prefer to be a foster parent to an older child or to adopt unless the agency would rule me out because of my psychiatric treatment. I think it’s good they investigate, unless they have a fixed idea that psychiatric treated people are totally unfit to be parents.”

Before Hope joined the group, she had a phobia about groups of people, probably a result of her childhood experiences. But recently she has overcome it to a point where she accepts speaking engagements at universities, and on radio and television. “At first, at the general meetings, when they go around the circle to give your name and a bit about yourself, I thought I’d die. Later, when I had to give the store report, I almost did die. The job helped overcome that. I had to force myself to get over it and persevere. Now I’m more comfortable generally in groups. It was much later that I could go to be a speaker. This has probably been the most help that

the group has been to me. You have to just push out of these things yourself.”

For Hope, nightly medication of amitriptyline and etrafon has levelled out the mood swings. “I think the medication will always be necessary. It was like being in a long dark tunnel and unable to see the light at the end. Sometimes I’d have a clear thought in my mind, but the sentence would come out all scrambled. Now, although there’s a feeling of deadness, I’d rather have that than the mood swings. Therapy, which my doctor insists on as a condition of giving me the medication, makes me feel guilty about things that never bothered me before. The constant living in the past is not helpful. It’s not a pure science: people can’t know enough to delve into other minds and their problems.

“I put the past behind me and the *Mad Market* work became the involving focus for me. Don’t go for therapy thinking it will be an exciting experience to have an intelligent person listen to your problems. No one can solve your problems. It isn’t all them trying to make psychiatric patients of us, but some of us who make careers out of what looks like a comfortable dependent life. Try a little harder to find common sense solutions, or talk with friends, not professionals. There’s no magic there. That’s where the problems start.”

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SHIATSU

THE TORONTO SHIATSU CENTRE

"Hey, it's OK!"

PHYLLIS MOSS

INTERVIEWED BY ROBBYN GRANT

In September of 1979 I was first confined in hospital. I stayed until December of '80 and had six shock treatments. I went back in January of 1981 and was in there for 3 weeks. At that time I only needed daycare. I went home and had day treatment for 4 months, and then was put back into the hospital for 3 weeks and at that time had two more shock treatments.

I was in the process of separating from my husband. It was a matter of finding out what I wanted to do with my life, making sure I could manage, adjusting to life alone with my kids.

I had been told about On Our Own by the public health nurse. At that time they had the old store on Queen St. West. I had an interview with Hope and did volunteer work for the store for 3 months, working 2 and 3 days a week. During this time I began coming around a lot more. By going and doing volunteer work in the store I had to make myself come out, meet people again, and be able to talk with them.

When I went into the hospital I had withdrawn completely from all life. I couldn't answer the door. The kids had special phone signals; I wouldn't answer it unless it was that signal. I wouldn't answer mail, I'd send my kids to pay the rent. I wouldn't have anything to do with anything outside the family. I was losing weight. I was on heavy medication, and I couldn't do anything but just cry all the time.

My family doctor suggested going to a psychiatrist. I went up on a Friday for my first meeting with him, and I was so uncontrollable that I couldn't do anything. I couldn't think, I couldn't even talk to him. By 7:00 that evening I was in hospital.

I had had thoughts of suicide and my doctor was afraid for me to go home. I don't know whether or not I would have gone through with it, but the thoughts were there. I was at the breaking point. One more thing would have just completely done me in.

After three weeks in hospital under drug treatment I was no better, no worse. I couldn't communicate with anybody. I had six shock treatments. Finally I came full circle. I could plan my life. I knew exactly where I was heading. During the time I was in the hospital for the first six months I was

still with my husband, and he refused to acknowledge where I was or why I was there. He kept saying that he would change, but he never did. Finally I realized that he never would. He'd been that way for too long, and if anyone was going to change it had to be me. So that's what I did.

By getting in touch with On Our Own I learned to go out, meet people, and find out that I wasn't as useless as I thought I was. That I could put something into On Our Own and life in general. It wasn't as bad as I thought. So when we moved here from the old store I worked practically every day for about four months.

Finally, I got on the work adjustment program from Manpower, and from June until October I also worked half of the time in the office and learned a lot about office work. So I got double training actually. This all made me feel really good because I realized that *if* I wanted to do something for myself I could.

When it was suggested to me that I take the Manpower retraining course at George Brown College I went down, and for 12 weeks was in an orientation

program which gives you an idea of the different jobs which they will train you for. While I was there I realized that I needed an upgrading in math to get a grade 10 education, and that's what I am now in. In May I go into a 10 month training course for either offset printing or to become a sewing machine mechanic. I found that I am mechanically inclined, and I really enjoy that kind of work. From this training I will get a job.

I feel that I am able to be self-sufficient now. Since coming into the group I've been on the Board of Directors as Recording Secretary and am on the Speaker's Committee. It's all through On Our Own that I've learned I can do things. Even 6 or 7 months ago I wouldn't have wanted to take the risk. But working with this group has given me confidence.

When I was on the Manpower program at On Our Own I had evaluation about every 4 weeks, and I really learned something about myself. Getting the opinion of the people you are working with allows you to find out your shortcomings. That, for me, was a big breakthrough, because I



thought I was coming across in a certain way. To have somebody sit there and say they saw it completely differently really makes you have to look at yourself. Earlier I would not have been able to take this criticism at

"You get strength from a shared experience, and you know that if there is a problem that comes up someone is there who's been through it before."

all. In fact, when this did happen, I was broken up for a week, but I learned something about myself. The feedback was a very important part for me.

Being in the group has helped me to learn to ask for help from others more when I need it. You find that when you talk to people in the group who have been through what you're going through now and they say, "Hey, it's OK." There is going to be a change: You're not so frightened — you can see somebody else that's gone through it and survived. You find that you are able to say to yourself, "Hey, it's OK to be frightened. There's nothing wrong with being frightened. You are just an ordinary human being." You get strength from a shared experience, and you know that if there is a problem that comes up someone is there who's been through it before.

Self-help is great because you know it actually depends on you and what you want to do. Nobody is pushing you. You can go as far as you want as fast as you want with support. What you get out of life depends on you.

The one problem that I have right now is that my kids will be leaving me in the next 3-4 months, and all of a sudden I'm going to be by myself, supporting myself, and because of school, living on much less money. All this means that I'm going to have to change my whole life style. It's going to be a heck of a change. I've been a mother for 21 years. But I also know that there are people willing to help, and that I'm not alone. And through On Our Own I've learned of different groups to get in touch with so that if I need help with something all I have to do is say, "Hey, how do I go about it?"

"A year ago there was no way I would have said that I would be going back to school and doing the things that I am doing."

For instance, I am now going through drug withdrawal and am in a women's self-help group for that, I was put in touch with the group through On Our Own. We're all doing the same thing and we're all just as

frightened, but together we can face the reality of life and what it holds.

A year ago there was no way I would have said that I would be going back to school and doing the things that I am doing. I'm scared, but I'm not terrified, and I'm not withdrawing. I can feel good about myself because I can say in this length of time I've gone full circle: I'm looking after me and what I want. This was the big thing in my life when I finally realized, "Hey, you are a person, you're worth something, and what you feel about yourself is the whole key to the thing."

"Being in the group has helped me to learn to ask for help from others more when I need it."

If you really believe in yourself, and work for yourself, then you feel twice as happy."

There are so many people in hospitals that don't know about groups like On Our Own or self-help. I'd like to see the word get out. There are so many who feel that people just don't care, and that they're alone, and they've got no place to go. A lot of people go back into hospital because there is nothing for them. A lot of getting better is being able to communicate and to see that other people have done it, and you can do it, too.

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ON OUR OWN: SELF-HELP MODEL

From COMMUNITY HEALTH ACTION: Primary Prevention Programming in Canada, ed., D. Paul Lumsden. Available from Canadian Public Health Association.

BY DON WEITZ¹

"I would rather be mad with the truth than sane with lies."
— an unknown "mental patient"

Self-help is the oldest and soundest strategy for helping us confront and overcome a personal problem or crisis. While we must do most of the psychological work ourselves, we also need the support, acceptance and understanding of other people, particularly people who share and identify with some of our problems. People who have experienced a particular problem, illness, institutionalization or invalidating label such as "mental patient" or "schizophrenic" know what it's like, they've "been there" too. Such people have an almost instinctive grasp of each other's problem(s). It is this intuitive understanding and acceptance together with mutual caring, sharing personal experiences, and giving each other support which are the real sources of strength and solidarity.

In a genuine self-help group, members usually treat each other as equals: everyone has the same rights, the social structure is more horizontal than vertical. Also, there are few or no formalities, no rigidly defined roles, rules or procedures. The group atmosphere is conspicuously relaxed and friendly; members typically call themselves and others by their first names and treat each other like friends, brothers or sisters — not "clients" or "patients."

Self-Help in The Movement

What is new and challenging about self-help is its relatively recent emergence as a legitimate therapeutic force in and alternative to the "mental health system." During the past ten to fifteen years, there has been a pheno-

menal growth of ex-psychiatric inmate-controlled self-help groups in North America and Europe. Currently, there are roughly one hundred such groups around the world, including twelve in Canada. (See list of Canadian self-help groups at end of chapter.) Eight of these Canadian groups were established only within the last three years. Together, all these groups form a loose and informal but vocal network called the Psychiatric Inmates Liberation Movement. The growth of this international Movement over the past eleven years must be viewed as both a protest against and an alternative to the "mental health system," particularly institutional psychiatry.

Two key consciousness-raising terms in the Movement are *psychiatric inmate* or *ex-psychiatric inmate* and *anti-psychiatry*. Many people who have been involuntarily committed, or even voluntarily admitted, and "treated" in psychiatric institutions frequently feel like prisoners or inmates, because they're forcibly treated and lose many human or civil rights.

Psychiatric inmates, like prisoners, are the most powerless people in society. Locked up and treated against their will, people are denied control over their own bodies, minds and lives and usually not informed as to when they will be released. Psychiatric inmates have no say in decisions which directly affect their daily institutional existence; they have no civil or legal rights such as the right to communicate openly, the right to refuse treatment, the right to vote, the right to manage their own money or property, the right to make contracts or the right to wear their own clothes.

Widespread resentment of and resistance to institutional psychiatry among thousands of psychiatric inmates and ex-inmates have surfaced because of the unjust denial of many fundamental human and civil rights. Psychiatry's illegitimate use of the medical model, which has resulted in incarceration and forced treatment of people for non-criminal conduct, is another reason for protest. Other

reasons for this anti-psychiatry position include the severe and frequently permanently damaging effects of forced psychiatric treatments (e.g., drugging, electroshock, psychosurgery and behavior modification), as well as the paternalistic and mentalistic attitudes of many psychiatric staff, and the severe, inexcusable shortage of community alternatives.

People join and become active in the Movement or self-help groups of ex-psychiatric inmates for one or more of these reasons: support; information-sharing; power; developing alternatives to psychiatry; changing unjust "mental health" laws.

When people are lonely or isolated, they need a lot of support. This is most essential for people recently released from psychiatric institutions where they feel abandoned or rejected by their family, friends or community, and infantilized, humiliated or abused by ward staff. To help combat this isolation and oppression, many self-help/support groups of ex-inmates provide a real sense of belonging, acceptance and understanding. The Movement is actually one big support or self-help group. People who have experienced similar crises or abuses can easily identify with and share some of their own experiences and feelings. Support groups are essential — they are the backbone of the Movement.

Through the Movement, psychiatric inmates and ex-inmates are *kept informed* about what many groups are doing, where they are, what they plan to do, how they got started, and how groups can struggle together and forge links in their fight for humane alternatives and civil and legal rights. As psychiatric inmates, we were kept ignorant; the institutional staff and administration denied us a lot of critical information about our legal rights — not to mention the many risks and dangers ("side effects") of drugs and electroshock. Regional and national newsletters and magazines such as *Madness Network News*, *Off the Shelf*, *ACT/ACTION*, *In A Nutshell*, and

Phoenix Rising help the Movement people and groups keep in touch with what's happening elsewhere. In addition, the Movement's annual (since 1973) International Conference on Human Rights and Psychiatric Oppression plays a key role in building national and international solidarity and fostering grass-roots alliances, coalitions or networks with other oppressed people. In May 1982, ON OUR OWN hosted the very successful Tenth Annual International Conference; the eleventh annual Conference will be held this May in Syracuse, New York.

By participating in the Movement and small self-help groups, people experience a real sense of *power*. They express their own feelings and opinions on almost any issue, they are listened to and taken seriously for a change; they can vote on issues affecting the group or the Movement, and they help make significant changes in their own and the group's or Movement's life. It is this empowerment process which is supported by and sustains the Movement.

Power also provides people with the self-confidence and strength to start and maintain *alternatives to psychiatry*. An ex-inmate-controlled group is itself an alternative; it allows people real choices, alternate life styles and hope. Inmate/ex-inmate-controlled alternatives such as drop-ins, co-op houses, crisis centres, support groups, advocacy/political action groups, and the annual conferences help bring and keep us together. The Movement continues to inspire and support such alternatives, provided they are chiefly or exclusively controlled by inmates and ex-inmates.

Some people join the Movement for the specific purpose of changing "mental health" legislation, which is notoriously unjust and discriminating. NAPA (Network Against Psychiatric Assault in California), MPLF (Mental Patients Liberation Movement in Boston), and ALMP (Alliance for the Liberation of Mental Patients in Philadelphia) are some of the politically active groups in the Movement. They have successfully organized and supported many groups in their struggles to change laws relating to involuntary commitment, electroshock, lobotomy or psychosurgery, lack of informed consent and the right to refuse treatment. By organizing protest demonstrations, marches, public tribunals, press conferences and

political lobbying, the Movement exposes many psychiatric myths and abuses, helps to change public opinion about "mental illness" and "mental patients" and pressures governments to enact humane and just laws. The recently adopted DECLARATION OF PRINCIPLES of the Movement (May 1982) and A Draft Bill of Rights For Psychiatric Inmates in Canada (adopted by ON OUR OWN in October 1982) can serve as educational and political tools in our continuing fight for more rights and respect.



ON OUR OWN: Self-Help in Action

Two ex-psychiatric inmates (Harvey Jackson and myself) co-founded the group in the summer of 1977 in Toronto. Our immediate objectives were: to provide support and friendship for many lonely and isolated people recently released from psychiatric institutions (the "target group"); to do whatever we could to help people stay out of psychiatric institutions; to establish a meeting place, and ensure that the group was totally controlled by former inmates. Another — perhaps less explicit — reason for starting ON OUR OWN was to prove to ourselves and the general public that present and former psychiatric inmates can be as independent, competent and responsible as non-inmates.

From our own personal experiences and knowledge and those shared with

other inmates and ex-inmates, we knew there was (and still is) a pressing need for many such self-help groups. We also knew that none existed at the time in Toronto. ON OUR OWN is still the only self-help group in Toronto completely controlled by former psychiatric inmates.

The founding meeting was held on August 9, 1977 in a large room in All Saints Church in Toronto's "Cabbagetown." A supportive article which appeared in *The Toronto Star* one or two days previously helped to bring approximately one hundred and fifty people to this meeting. The three-hour meeting was sometimes chaotic but mostly charged with energy and excitement and hope. At the meeting, we decided to start the group which we called the Ontario Mental Patients Association, a name which was partly inspired by the group in Vancouver — Mental Patients Association. We also agreed to one membership rule: any person who was or is a psychiatric inmate could join us. And membership was free — we still don't charge any membership fee or dues. We also decided to hold weekly meetings in a room generously donated to us by All Saints. At the time, we could not afford to pay the rent. The room in the church was our meeting place or drop-in for the first year.

Our first two years of existence were marked by an intense struggle to survive. We had no funding or prospect of funding. Virtually all of our fifteen or twenty members had little or no money to contribute; most were unemployed and forced to survive on welfare cheques or disability pensions (70% or 75% still are). Nevertheless, people started dropping in regularly to have coffee, "rap", share some of their psychiatric and other personal experiences or just relax. Mutual support, sharing and caring were starting to happen.

Within two months, some of us started talking about the need to earn some money for the group. Harvey "Alf" Jackson was the prime mover or organizer; he helped us open and operate a small booth in a flea market where some of us sold used goods. The flea market operation was our first business venture, a first step toward financial security and independence for the group. Except for "Alf", none of us had any business or selling skills; "Alf" trained and encouraged many interested members including myself. One member volunteered the use of his pick-up truck to collect goods donated by supportive neighbours and friends.

At the end of two years and by working only on weekends, we had earned approximately \$15,000 in flea market sales. During this time, nobody was paid a wage or salary; members generously volunteered whatever time, energy and skills they had. Some people who had no selling experience and were not used to dealing with the public learned many practical business and social skills and grew in self-confidence.

John, one of our first members, would not talk with anyone for the two or three months after he joined the group. (In a psychiatric institution, he would have been labeled "catatonic" or "schizophrenic".) Within a few weeks after working in the flea market with "Alf", John was not only talking with customers and selling but had started socializing with other members. John was elected as our first chairperson. He was unemployed at the time. During the last four years, he has held a full time and responsible job with a major electronics company and has been promoted. He's also managed to stay out of psychiatric institutions: John's one of our many success stories.

In 1978, the group moved out of the church and into a house in a residential area in Toronto's East End where we tried to set up a drop-in and crisis centre. We didn't bother asking permission from anyone or the community to move into the house; our neighbours and landlord accepted us just as people — not "dangerous mental patients." A small grant of \$1200 from the City of Toronto helped us pay the rent for about four months; however, we had to move out five months later because we no longer could afford the

rent. As a result of this financial crisis and bitter conflicts among a few members, the group almost fell apart. A few of the stronger and committed members such as "Alf", John and Carla helped keep us together.

Carla joined the group in the spring of 1978 while she was in her first year of law school and working in the legal aid clinic at Queen Street Mental Health Centre. About ten years before joining us, she had fifteen shock treatments in Hamilton Psychiatric Hospital; her marriage was falling apart and she was about to get a divorce — she was very down. Nevertheless, she somehow found the strength to help an elderly woman inmate in a psycho-geriatric ward of 'Queen Street.' At this woman's review board hearing, Carla acted as her advocate and succeeded in forcing the hospital to remove the stigmatizing label of "incompetent" from her record; Carla also helped her to gain her freedom and self-respect. As she became increasingly involved in the group, Carla received and gave a great deal of support. Within two years, she was elected a member of our board of directors, served as our first treasurer for over a year, largely drafted our Constitution and by-laws, researched and wrote many funding briefs and became an outstanding spokesperson for the group and a patients' rights advocate. Carla is now a practicing lawyer; she plans to specialize in medical malpractice.

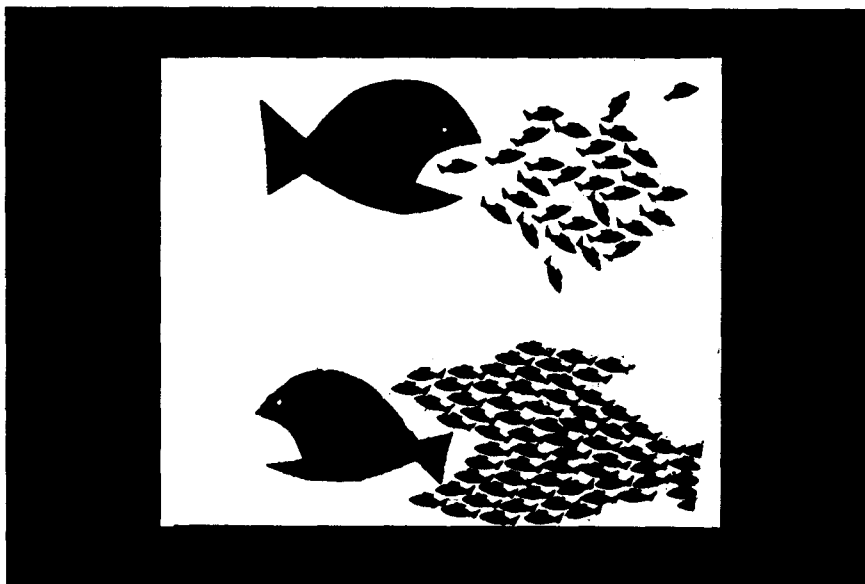
By 1979, the group had fifteen to seventy-five members and was meeting twice a week in a single room (rent-free) in Woodgreen Community Centre. We still had no funding. However, we were becoming more organized. We

had an elected board of directors, had drafted our first Constitution and by-laws and become incorporated as a non-profit, charitable organization. About that time, we also changed our name to our present name — ON OUR OWN: Ontario Patients' Self-Help Association — in order to reflect our growing independence and commitment to self-help. Many of us had read and were inspired by Judi Chamberlin's book, *On Our Own: Patient-controlled Alternatives to the Mental Health System* (McGraw-Hill, 1979).

Our major objectives were also becoming clearer — we articulated them in our by-laws. We committed ourselves to provide emotional and social support to members; social and recreational activities; job-training opportunities and financial assistance (whenever possible) for members; to educate members and the public about the special needs and problems of present and former psychiatric inmates; to work for changes in the "mental health system"; to network with other self-help groups with similar objectives. We also changed our criterion for membership. At first, we limited membership to people who had been or were still being treated in psychiatric institutions or psychiatric wards of general hospitals. We now broadened membership to include outpatients or people who had received psychiatric treatment in the community.

Since 1980, ON OUR OWN has grown rapidly. The group's current membership is over 300; at least fifty members have become actively involved in various activities and programs. Many have also become leaders in the group. We now have a paid staff of eight members and many volunteers (all members) and manage a yearly budget of approximately \$200,000. Much of this growth is due to our recent successes in securing federal, provincial and municipal funding. Our two largest grants are from the Ministry of Health and Health and Welfare Canada. However, applying for grants and reporting to funding bodies have consumed a lot of staff time and energy — the risk of "burnout" is a very real risk.

The grants have allowed us to develop more activities and hire more members as staff. For example, since 1980 we have managed our own non-profit, used goods store, The Mad Market. The Store Committee runs the store. The store manager and assistant manager, van driver, sales clerks and

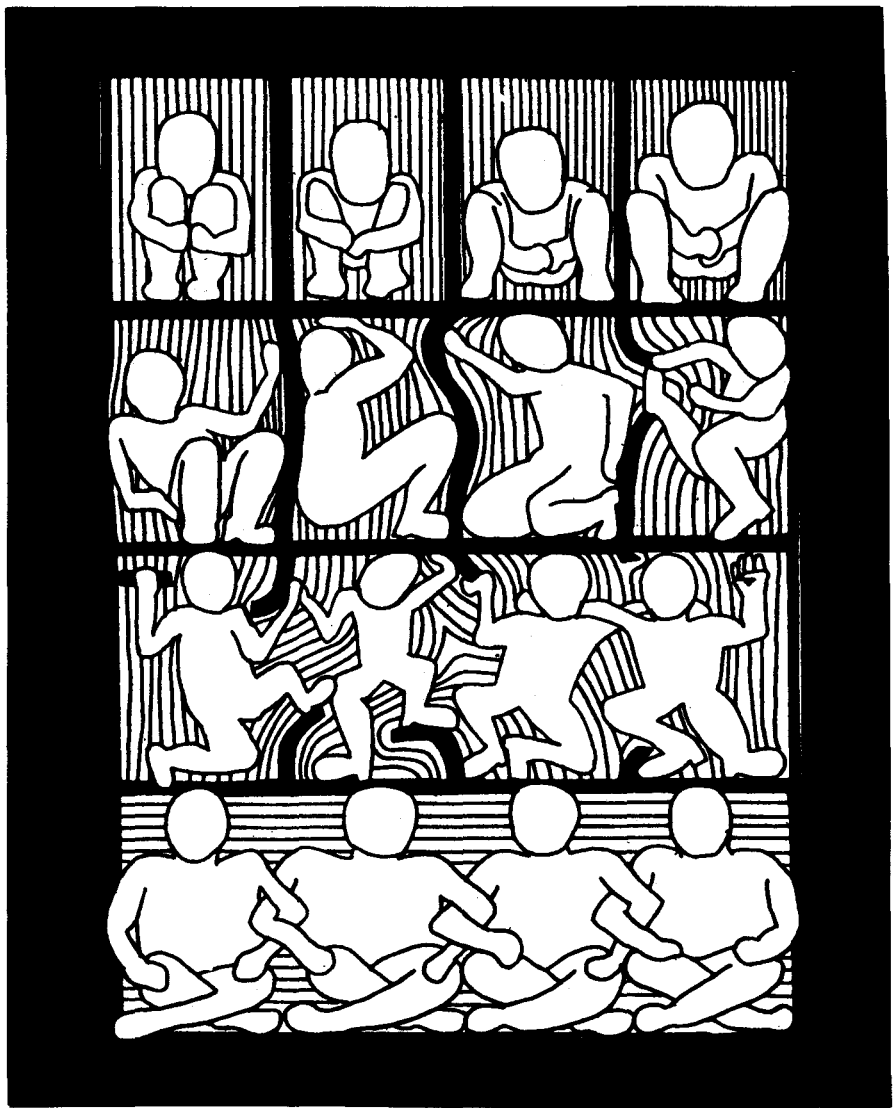


volunteers are all members. Partly funded by a city grant, the store manager and assistant manager and van driver are paid a salary; volunteers receive money to cover basic expenses such as meals and travel. The Mad Market has served as a valuable training ground for many unemployed members who lack various skills, self-confidence or both. At least twelve members have found permanent or temporary jobs largely as a result of their store experiences. Their growth in self-confidence, self-respect and competence has been priceless. The Mad Market has proved to be more helpful and humane than any "industrial therapy" program or "sheltered workshop". We are proud of The Mad Market and its successes.

Susan joined the group about four years ago. She had been very depressed, talked little and was in and out of psychiatric institutions for many years. She rarely worked longer than six months at a time. Encouraged by "Alf" and her brother John, Susan occasionally volunteered to work in our flea market booth. When the store opened in 1980, she began working as a volunteer and shortly thereafter as a sales clerk trainee under Canada Manpower's "Work Adjustment Program." Four or five months later, Susan found herself a full time and permanent job as a tourist guide for the Ontario Government. She's currently ON OUR OWN's full-time secretary.

ON OUR OWN also publishes a bi-monthly newsletter, The Mad Grapevine, which is distributed free to all members, and a quarterly magazine, *Phoenix Rising*. We're very proud of our publishing efforts. *Phoenix Rising* is currently distributed nationally and has over six hundred paid subscribers and a circulation of roughly three thousand. An elected editorial collective produces the magazine. A seed grant from Ontario PLURA² helped us start the magazine in 1980; *Phoenix Rising* currently receives most of its funding from Health and Welfare Canada while it strives to be financially self-sufficient. As the educational arm of the group, *Phoenix Rising* features articles on alternatives, regular columns on legal and drug issues, exposés of psychiatric treatment abuses, as well as regional, national and international news concerning ON OUR OWN, other self-help groups and the Movement. Within the past two years, the magazine has helped to stimulate the growth of three other groups of former psychiatric inmates in Ontario.

Although the day-to-day work of the group is largely performed by staff



members, the membership runs ON OUR OWN through a committee structure consisting of an elected board of directors and four standing committees which deal with: The Mad Market, the drop-in, social/recreational activities, finances and public speaking engagements. Our seven member board includes a chairperson, treasurer, recording secretary and membership secretary and meets twice a month. Its chief responsibilities are to make administrative decisions, recommend changes in program or policy and carry out all policy decisions of the membership. It does *not* make policy — only the members have this power which they exercise at the monthly General Meeting.

The democratic and open nature of ON OUR OWN is probably most evident at the monthly General Meeting. Anybody may attend the meeting, but only members can vote. Each member has one vote on any issue being discussed; all members are equally eligible to be elected to the

board or any committee. All decisions are made by open and majority vote. Reports from the various committees and the editorial collective are also discussed. The meeting is typically long and serves as both a business meeting and open forum for specific complaints or problems.

Most of the group's public relations work is carried out by our elected Speakers Committee. Group policy requires that committee members speak in pairs; an experienced speaker usually accompanies a less experienced one for mutual support. During the last two or three years, ON OUR OWN has received and accepted numerous invitations to speak about the group or selected issues such as inmates' rights, the *Mental Health Act*, psychiatric drugs and their risks, and strategies for starting a self-help group. We have spoken to various professional and community organizations, branches and divisions of the Canadian Mental Health Association, classes of high school and university students and other self-help

groups of ex-psychiatric inmates in Ontario, Manitoba, Quebec and Saskatchewan. In addition, some of our members have been interviewed on radio and TV. One member is featured in a film recently produced by TV Ontario³ The film is titled "Liz"; it's about ON OUR OWN and deals with some of the many problems and challenges facing ex-psychiatric inmates.

Do self-help groups work? Yes, for many people, particularly ex-psychiatric inmates who have been powerless and want to start running their own lives instead of allowing mental health professionals to run their lives for them. Self-help groups of ex-inmates can survive and retain their independence and integrity if they are predominantly or totally controlled by the ex-inmates themselves, and they will grow if adequately funded. ON OUR OWN has been very fortunate; many other groups have died because of lack of funding and/or community support.

Self-Help: A Brief Assessment and Conclusion

ON OUR OWN is only one model of a self-help group. It isn't perfect, it's not for everyone. However, it has earned credibility by helping many people survive heavy emotional crises, helping others stay out of psychiatric institutions and saving hundreds of thousands of tax dollars in health care each year. In a more fundamental sense, ON OUR OWN has helped many people by allowing them to feel accepted and respected again or for the first time in their lives, and by supporting their basic human right to control their own lives and to be themselves.

¹My sincere thanks to Connie Neil, Mel Starkman, Coreen Gilligan and Robbyn Grant for their helpful suggestions and constructive criticisms.

²A multid denominational, Canadian church organization which frequently provides start-up funding for minority or oppressed groups. The initials stand for: Protestant, Lutheran, United, Roman Catholic and Anglican.

³This film was produced and aired by TV Ontario in 1981 as part of a series on "handicapped" people. The videotape or film is available from: Central Order Desk, TV Ontario, 2180 Yonge St., Toronto, Ont. M4T 2T1. (416) 484-2610.

Shock doctors up to date

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

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

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| Allodi, Federico. Toronto Western Hospital, Toronto, Ont. | Kolivakis, Thomas. McGill University School of Medicine, Montreal, P.Q. |
| Ananth, Jambur. McGill University School of Medicine, Montreal, P.Q. | Littman, S.K. Foothills Hospital, Calgary, Alta. |
| Arndt, Hans. Northwestern Hospital, Toronto, Ont. | Martin, B.A. Clarke Institute of Psychiatry, Toronto, Ont. |
| Boyd, Barry. Penetanguishene Mental Health Centre, Penetanguishene, Ont. | McFarlane, W.J.G. Riverview Hospital, Port Coquitlam, B.C. |
| Conn, Bert. Belleville General Hospital. Belleville, Ont. | Mitchell, Wallace. Greater Niagara General Hospital, Niagara Falls, Ont. |
| Cornish, David. Alberta Hospital, Edmonton, Alta. | Pankratz, Werner John. Lions Gate Hospital, North Vancouver, B.C. |
| Denew, Paul. Hamilton Psychiatric Hospital, Hamilton, Ont. | Peacocke, J.E. Clarke Institute of Psychiatry, Toronto, Ont. |
| Eades, B. Riverview Hospital, Port Coquitlam, B.C. | Plumb, Lois. Women's College Hospital, Toronto, Ont. |
| Eastwood, M.R. Clarke Institute of Psychiatry, Toronto, Ont. | Rapp, Morton S. Sunnybrook Medical Centre, Toronto, Ont. |
| Giles, Charles. Alberta College of Physicians & Surgeons, Edmonton, Alta. | Rodenberg, Martin. Kingston Psychiatric Hospital, Kingston, Ont. |
| Gulens, Vlademars, Jr. Chodoke-McMaster Hospital and St. Joseph's Hospital, Hamilton, Ont. | Roper, Peter. Douglas Hospital, Montreal, P.Q. |
| Harvey, Michael. Misericordia Hospital, Winnipeg, Manitoba. | Shoichet, Roy P. Toronto Western Hospital, Toronto, Ont. |
| Heath, David S. Kitchener-Waterloo Hospital, Kitchener, Ont. | Shugar, Gerald. Clarke Institute of Psychiatry, Toronto, Ont. |
| Hoffman, Brian. Clarke Institute of Psychiatry, Toronto, Ont. | Sim, David G. Hamilton General Hospital, Hamilton, Ont. |
| Jeffries, Joel. Clarke Institute of Psychiatry, Toronto, Ont. | Solursh, Lionel. Toronto East General Hospital, Toronto, Ont. |
| Jeny, Leslie. St. Joseph's Health Centre, Toronto, Ont. | Stevenson, Cameron M. Kingston Psychiatric Hospital, Kingston, Ont. |
| Kedward, H.B. Clarke Institute of Psychiatry, Toronto, Ont. | Zamora, Emil. St. Joseph's Hospital, Hamilton, Ont. |
| | Zielonko, Walter. Guelph General & St. Joseph's Hospital, Guelph, Ont. |



phoenix pharmacy

Thorazine, Mellaril, Haldol, Prolixin:

BY DAVID OAKS

Reprinted with permission from *Madness Network News* (Vol. 6, No. 6)

Psychiatry and its "scientific" drugs have quite a history. Consider this true story: On November 23, 1667, a Dr. King injected *sheep's blood* into psychiatric inmate Arthur Coga, to try to make a "mad" human sheep-like. "The Experiment of Transfusion" was witnessed by top British physicians, all aware no doubt that someone had already died in Paris from similar "treatments." Dr. King said his experimental subject "consulted his instinct rather than the interests of his health," and escaped a second round of sheep's blood injections.¹

Today, the medical foundations of the neuroleptic drugs are about on the level with the sheep's blood theory. You've probably heard of these drugs — maybe like me you've been forced to take some: Thorazine, Stelazine, Mellaril, Prolixin, Trilafon, Haldol, Navane, Loxitane, and dozens of other brand names.

Though drug companies produce many different neuroleptics, they are all similar. In their own words they are "equieffective for treatment of psychosis." That is, their major effects — such as the possibility of brain damage (tardive dyskinesia) — can occur with *any* of the neuroleptics. To attempt to mystify us even more, the medical profession also calls the neuroleptics "major tranquilizers" and "anti-psychotics."

Obviously, psychiatry is very fond of these drugs, but general practitioners give out a lot of the stuff too. Any institutionalized person is a possible user: a nursing home resident, prisoner, someone labelled retarded, or even a locked-up kid. There's a surprising number of users among the non-institutionalized, too. A 1979 survey found that at least 1 percent of men and 1.5 percent of women had taken a neuroleptic drug in the previous year.²

A Strange and Ugly Birth

Little medical mysticism was involved in selecting the first neuroleptic. It was a case of "choose the side effect" for the researchers.

In the mid-1940s researchers were screening similar drugs, the anti-histamines, for unwanted side effects such as drowsiness. They used a simple test: rats were trained to climb a rope to reach food. The researchers found that when they gave the rats a certain kind of anti-histamine, the rats would become "confused and unable to decide whether or not to climb."

At about the same time, surgeons were beginning to use antihistamines to lower their patients' metabolism during operations, and it turned out the most effective antihistamines for this were the very same chemicals which were bewildering the rats. Suddenly, the French company Rhone Poulenc — which had been screening OUT antihistamines because of their sedative side effects — reversed its search, this time looking for any drugs with "maximum behavioral disruption."³

On Monday, December 11, 1950, Paul Charpentier sent a sample of chlorpromazine to Simone Courvoisier for testing. It took the maximum-behavioral-disruption prize. It would one day be called "Largactil" for the *large activity* it had on the body. Later it would be distributed in the United States by Smith Kline and French as Thorazine — named after Thor, the mythical god of thunder and war.

At first, several medical specialties used this drug but psychiatry was hesitant. In France, Dr. Henri Laborit — a former military surgeon during World War II — tried for months informally over lunches to convince his psychiatrist friends to investigate the drug.

Finally, a shrink agreed to try it. Dr. C. Quarti, with several assistants present, gave the drug to herself on November 9, 1951, at 11:00 A.M. Later she wrote up her experience:

"No subjective change was felt until 12:00, when I began to have the impression that I was becoming weaker, that I was dying. It was very painful and agonizing.

"At 12:10, one of the assistants tried to take advantage of this state to hypnotize me; I gathered all my strength to cry out to him (it seemed to me): 'No, you annoy me.' In fact, however, the tape recording of the experience transmitted a faint and flat voice."

Bizarre Facts About Neuroleptics

At 1:00 she reported, "I felt incapable of being angry about anything..."⁴

The test was pronounced a success, and within ten weeks doctors tried the drug on a French psychiatric inmate, 24-year-old Jacques L. The inmate at first winked his eye, and stuck out his tongue at the doctors, but then he rested. In 20 days he was judged "adaptable a une view normale" (fit for normal life). Finally the drug caught on among psychiatrists. In 1955, an early proponent, Heinz Lehmann, called it "a pharmacological substitute for lobotomy."

As you can see, the birth of this drug involved very little medical mumbo-jumbo. It was just a powerful drug that could stun people without just putting them to sleep. And that is the way it was sold, too.

Smith Kline and French (SKF) started selling Thorazine in the United States in the mid-fifties, but they encountered resistance to the drug from psychiatrists and institutions. In 1954 they set up a Task Force of 50 men who "worked intensively with state legislatures and with mental hospitals and their staff." When drugged-up inmates were released, SKF found "the family physician tended to worry about side effects with high doses," so the company became involved with a new concept — so-called "aftercare."

It was a travelling medical side-show that really took off. Many drug companies — one of the most profitable industries in the United States — made enormous profits by selling varieties of neuroleptics.

The Experience of Mind Control

Now, there are a number of people who take the neuroleptics voluntarily, even though they know there are dangerous effects. Often, these people feel they have no alternative available to get them through a rough time. Some even say they experience little discomfort from the drugs. But the fact is, many people have experienced horrible effects from these drugs, and many have been forced to take them.

Two psychiatrists once injected themselves with 5 mg. of Haldol and wrote up their experiences for the British Journal of Psychiatry⁵:

During 1956 and 1957, Smith Kline tested Thalidomide on 875 human beings. Although SKF found "no measurable acute toxicity," they abandoned the drug because as they put it, it was "without interesting pharmacological activity."

"... a marked slowing of thinking and movement developed, along with profound inner restlessness. Neither subject could continue work, and each left work for over 36 hours. Each subject complained of paralysis of volition, a lack of physical and psychic energy. The subjects felt unable to read, telephone or perform household tasks of their own will, but could perform these tasks if demanded to do so. There was no sleepiness or sedation; on the contrary, both subjects complained of severe anxiety."

They added that such results might be "desirable" and "therapeutic" for psychiatric inmates!

Madness Network News, in its Winter 1981-1982 issue (Vol. 6, No. 4), gave a good summary of the harmful effects which can occur from neuroleptics. These drugs are not aspirin or Valium. Even some of neuroleptics' supporters call them some of the most powerful drugs used anywhere in medicine, with effects on every organ system in the body.

Many of us who have taken a neuroleptic are familiar with effects, such as dry mouth, muscle tension, anxiety, blurred vision, dizziness, twitching. But there can be other effects, too, which are even more bizarre and frightening: for example, skin colour changes, liver damage, and 'oculogyric crisis,' where the eyeballs temporarily roll up into the head. In addition, one study found that 60% of 57 patients on Mellaril experienced sexual dysfunctions, such as being

Neuroleptics are one of the few psychiatric drugs not sold on the street. People usually don't enjoy taking Thorazine.

unable to ejaculate.⁶

Of course, two of the worst possible effects of the neuroleptics are permanent brain damage and death. One variety of brain damage — tardive dyskinesia — often begins with fine tongue movements. In the most severe cases the tongue, face, mouth, and at times the limbs move involuntarily and rhythmically, even after the drug is stopped. Sometimes it goes away. Sometimes it doesn't. No effective cure has been found.

The ultimate "side effect" is sudden death. Drug companies list it in their ads and promotional material as a possible side effect, though they usually deny a cause-and-effect relationship. These deaths have been regularly reported since 1956. The profession calls them rare, but no rate has been established. Over the past few years public officials in Massachusetts, California, Illinois, New York, and Texas have held widely publicized investigations of some of these deaths.⁷

One official, Dr. Frederick Zugibe, Chief Medical Examiner of Rockland County in New York, conducted autopsies on a large number of drug victims and made headlines with his findings.⁸ He told me in a recent phone interview that death can occur even at the neuroleptic's so-called "therapeutic" level. He said some victims aspirate on food or vomit; others suffer heart problems. Sometimes, the temperature regulator in the brain goes haywire and too much hot or cold weather can kill.

The Forcible Injection

Neuroleptics are one of the few psychiatric drugs not sold on the street. People usually don't enjoy taking Thorazine. Thus, psychiatry has often resorted to deception, pressure, and outright violence to make people take their drugs. An ad for liquid Haldol, for instance, bragged that the drug is tasteless, colorless, and odorless: "It can therefore be added without patient detection to any routine vehicle pleasing to the patient's taste, including fruit juice and even water."

There are cases today where courts have ordered individuals living in the community to report regularly to their community mental health centers for special injections of Prolixin, the effects of which can last more than a month.

In institutions the last word in forced drugging might well be called hold-em-down-and-inject-em-in-the-ass—"therapy." On June 18, 1982, the U.S. Supreme Court, dealing with a class-action suit challenging the constitutionality of such injections, avoided a ruling on the case (*Mills vs Rogers*) by remanding it back to the First Circuit Court of Appeals. The Supreme Court said that the lower court should consider the legality of forcible drugging in light of a recent decision by the Massachusetts Supreme Court on the right of a "mentally incompetent" outpatient to refuse drug treatment imposed by his guardian (*In re Roe*).

Attorney Richard Cole, who has argued the case for the

Boston State Hospital psychiatric inmates since it was introduced in a federal district court on April 27, 1975, said "A lot of people are happy (about this action)." He feels some kind of victory will occur however the lower court rules, but it may apply to Massachusetts only.

And another twist: *The New York Times Magazine* (March 21, 1982) did a piece supporting forcible drugging. I called up the author, psychiatrist Paul Applebaum, and happened to find out he wears a beard and is a vegetarian. I told him that an ex-psychiatric patient, Leonard Frank, had been given forcible electroshock for just such personality traits. The doctor exhibited confusion.

Imaginary Medicine

It seems many psychiatrists, when handing out neuroleptics like aspirin, want their patients to believe that the drugs work like the medicine in a television commercial: Thorazine courses through the brain, finds the awful chemical imbalance, and clears up the problem. This imagery — the medical model — is one of the main props in the medical side show. These are, after all, physicians prescribing medication for patients diagnosed as having a "mental illness" — a real disease, they would have us believe.

The problem is that none of this has been proven. I asked Dan Fisher, M.D., a Cambridge psychiatrist with a Ph.D. in biochemistry, what he thought of the medical model for the neuroleptics. He said, "It's like a religion. Doctors take it on faith. Nine out of ten doctors have no idea about the chemical action of these drugs. They're not 'specific' at all. That theory is garbage."

This medical-model nonsense can get out of hand. For instance, over at the New York University Medical School, there is a true believer in the medical model, Dr. Arnold J. Friedhoff. He's testing his hypothesis that perhaps — he's not sure yet, you understand — giving neuroleptics to pregnant "schizophrenic" women will alter the chemistry of their fetuses' brains in such a way that the children will grow up to be "schizophrenia"-resistant!

Baby rats born of drugged-up mothers had a pattern of brain damage which pleased Dr. Friedhoff. He figures that so-called schizophrenia exists, that it is biochemically based, that it is transmitted genetically from generation to generation, and that neuroleptics act specifically to treat this problem.

I called him up and found that he is now reviewing a study of 50,000 women labelled "schizophrenic", many of whom had taken a neuroleptic while pregnant, to see if his theory — that their children would tend to be less schizophrenic than might be expected — is correct.

I asked him why he wasn't *warning* people not to take the drug while pregnant, instead of searching for a benefit. Remarkably, he claimed, "These drugs are among the least toxic known." Actually, while an overdose doesn't necessarily kill, a "therapeutic" dose can. Moreover, the Physicians Desk Reference (PDR) says safety has not been established for use by pregnant women.

I asked him why a pregnant woman should risk taking the drug, and he replied that otherwise the woman might "die of exhaustion" from her so-called mental illness. (Quite an imagination!)

This is, after all, a case where one of the richest, most privileged groups of white men have unchecked power over one of the poorest, most oppressed, isolated, stigmatized, and silent groups of people — often women, young or old, Third World, unemployed people. Behind closed doors, where current laws don't apply. It doesn't take an expert in human behavior to know that absolute power corrupts absolutely, whatever the intentions.

One comforting thought is that we are a huge minority.

For example 11.8% of the population in the U.S. (more than 25 million people), according to a 1978 study, was diagnosed as having a "mental disorder" in the past year.⁹ Often, these are the people who have rebelled, been oppressed, and continued to rebel!

A Word from the Drug Companies

But let's get the story from the drug industry itself. I called up Smith Kline and French (now called SmithKline Beckman, by the way), and reached Alan Wachter, Medical Writer, and Manager of Media Communications.

He said that Smith Kline has "redirected its focus from Thorazine and Stelazine." Today, Tagamet, its new ulcer drug, has become one of the best selling drugs in history. He also added that they no longer concentrate on institutions, and that only 10% of Thorazine is sold for use on wards.

It would be interesting if these decisions were caused by the psychiatric inmates liberation movement's boycott of Smith Kline, and its publicity of Thorazine's problems! After all, Smith Kline sold off all of the consumer products — Contac, Sea & Ski, and Love Cosmetics, etc. — which were being boycotted, to other corporations. Perhaps the boycott was a success?

Mr. Wachter did not seem informed about how Thorazine was being used. He claimed that forcible injections without a court order could not occur. And then he said, "We never advocate the forcible drugging of people. It isn't moral, it isn't the right thing to do. We would never do that. We do not advocate forcible drugging." What?

This is a case where one of the richest, most privileged groups of white men have unchecked power over one of the poorest, most oppressed, isolated stigmatized, and silent groups of people.

Smith Kline *introduced* the injectable form of Thorazine into the United States in the 1950s. I myself have experienced forced drugging in the 1970s. I read him one of their ads for liquid Thorazine which advised that, "Warning! Mental Patients are Notorious Drug Evaders." He said he didn't see what this had to do with forcible drugging. I said it didn't sound like "drug evaders" wanted to take the drug. He had no response. Though he denied the reality of forcible drugging, Mr. Wachter did admit the company had tested Thalidomide on people (but Kline Smith liked the way another drug worked, and abandoned Thalidomide). And he said, "Yes, money is the corporation's motivation. It's not our only motivation. There's nothing wrong with it. Profit is what funds our research" — which in turn creates the profits.

He said Thorazine had revolutionized psychiatry. "You have to remember that back then, to control psychotic behavior, there was no other way than to strap them down . . . They were in their own feces. Later with Thorazine, wards had pianos and flowers."

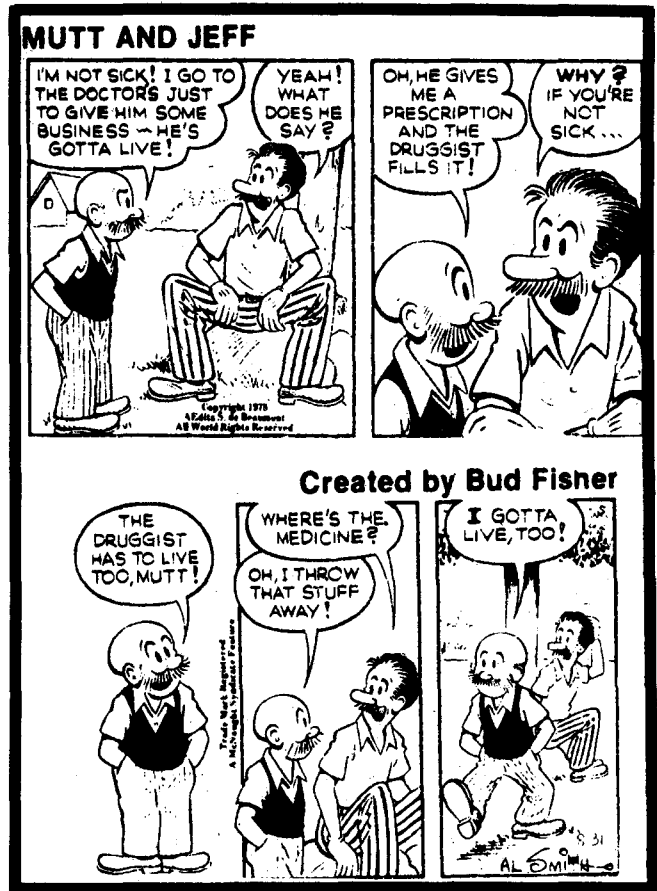
"Thorazine causes pianos to appear?" I asked, not aware of this new therapeutic claim.

"No, it causes the atmosphere that allows the pianos," he explained.

Finally, I asked him about the medical model: was Thorazine a form of control, or a specific medicine? They don't know, he said. "Enormous work has been done over the past 25 years to try to identify the mechanism of action, and to determine if they substitute for an imbalance, or control certain functions. That hasn't been determined."

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La Psychiatrie vā mourir

(Psychiatry is gonna die)

video couleur, 30 minutes, réalisations, groupe Auto-Psy

Groupe Auto-Psy has produced a 30-minute, 3/4 inch videotape of the Tenth International Conference on Human Rights and Psychiatric Oppression (Toronto, May, 1982). Titled "Psychiatry is gonna die," the tape may be purchased for \$80.00 (U.S.) Contact: Paul Morin, Groupe Auto-Psy, 332 St. Luc (#3), Quebec, Canada.



the Book worm turns

Let's Talk About Me

by Anthony W. Clare with
Sally Thompson

British Broadcasting Corporation, 1981

REVIEWED BY PATRICIA URQUHART

The product of a collaboration between a prominent British psychiatrist and a producer for the BBC, this new book offers both an introduction and excellent criticism of the entire range of new psychotherapies as well as of the older orthodox therapies from which they stem. The authors not only have done a vast amount of research—traveling to interview the major figures in any area as well as, whenever possible, attending sessions of the particular therapy. They also have at their disposal a wealth of information, both professional and general, both personal and theoretical, as well as a breadth of perspective that is, to my knowledge, sound and unique. The result is a book that is, on the surface, wonderfully well-written and entertaining (the gamut of wit varies from the brilliantly precise to the snide), and, below the surface, an exposition and criticism that are accurate and illuminating. As a good read, as a reference book and as a source of insight on basic issues and values—it is highly recommended.

Incidental evidence—first-person lapses as well as several interviews reported with but one author—as well as the underlying tone of well-assimilated professionalism, all indicate that the author most responsible for the text is Anthony Clare. To simplify, I'll assume so here.

After an introductory chapter focusing on the exclusiveness, expense and theoretical complexity of Freudian analysis and the other kindred orthodox therapies, the account turns (chapters two through seven) to major representatives of the new "fringe" therapies. Each of these basic therapies is examined in far too much detail—and with corresponding insight—to be fairly summarized here. But an overview of

each, while unjust, may still give some indication of the account and conclusions offered in the book:

Rogsonian client-centered therapy is perceived as well-meaning, honest and humane, but also simpleminded, lacking in critical judgement and naively optimistic.

Gestalt therapy and the holistic movement—further aspects of the "growth" or "human potential" movement—are also found to be salutary responses to the narrowness of modern reductionist technology as well as, at the same time, anti-intellectual and unscientific.

The *body therapies* get less sympathy: Reichian orgone therapy, founded on the importance of libidinal energy, is just unbowdlerized Freud, and Rolfing is just energetic physiotherapy with a bit of talking therapy thrown in.

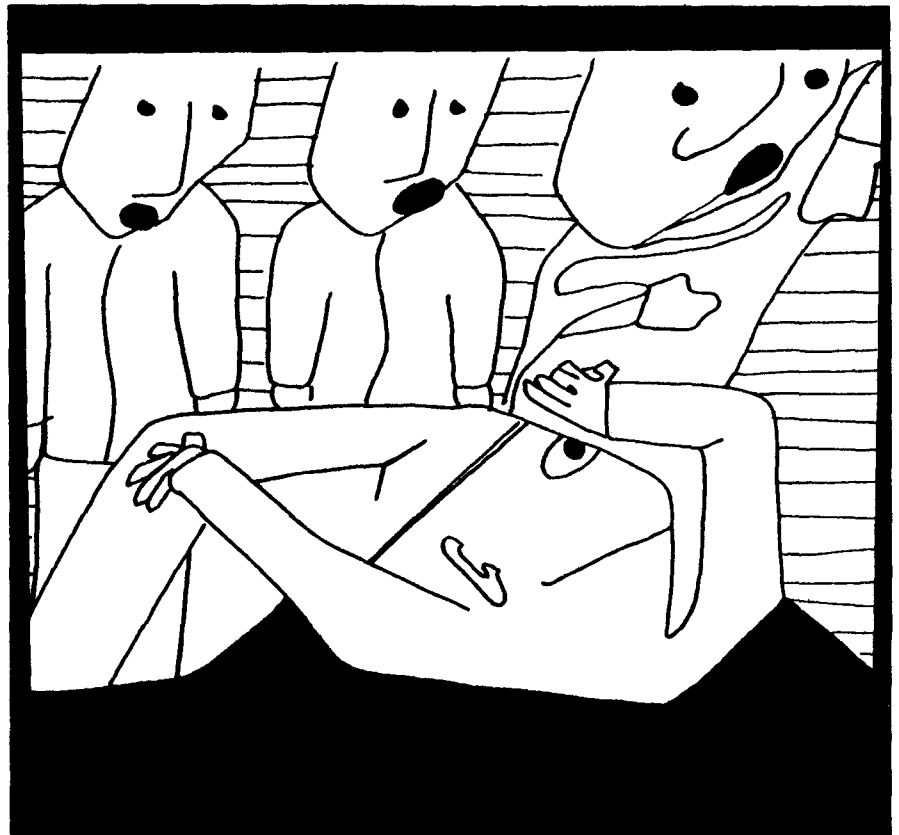
Psychodrama, although sometimes beneficial, comes off as more depend-

ent on the charisma of the director than theoretically sound, and *primal therapy* rests its blinkered child-centeredness on pseudoscience alone.

Transactional analysis is basically a descriptive admixture of psychoanalytical theory and sociological thought intent on placing responsibility on the player-of-games: the individual.

EST: in the moral relativism—and social irresponsibility—of its core mystical experience is viewed as the logical conclusion of the direction perceived in all the therapies, old and new—the progression from an idea to a therapy, from a therapy to a cult, and from a cult to a religion.

From a thorough and sound examination of the new therapies the book turns, in chapters eight through ten, to evaluate the values that are inherent in all the psychotherapies. If the specific discussions are the material, this overview and appraisal is the heart of the



book:

Publicly, psychoanalysis to this day maintains a Freudian stance. It distances itself from religious notions and emphasizes its medical, nay, its scientific roots. But its basic model owes more to religion than to medicine, more to Jung than Freud. In medicine, there is presumed a *health* from which the diseased organ, system or individual deviates. Cure is the return of the diseased object to the presumed state of health. It is a discontinuous model securely founded on a notion of health which, while never explicitly defined, is always assumed to exist in the absence of clear-cut disease. Psychoanalysis, in contrast, uses a model of disease from the outset. Man is flawed, imperfect, incomplete. From the moment of birth, indeed from conception, he is engaged in a constant struggle for perfection, for completeness. No man is free from the contamination of 'sickness.'

For Freud, then, the analyst was a "secular pastoral worker" intent on enriching each client from "his own internal resources." And psychotherapists since have relied ever more closely on ideas of "experience" and "self-knowledge" which involve much more than acquiring psychological strength, personal independence and "meaningful relationships": which are fundamentally religious ideas aimed at restoring the individual—momentarily or permanently—to a life that is whole. That is, one which is "authentic," significant, fulfilled. Or, as one report put it: "patients don't just want to *feel* better, they want to *be* different." Given such larger objectives, it is hardly surprising to find that in neither theory nor practice do the therapies ever achieve anything approaching scientific validation.

Furthermore, there is no evidence that, with these values and objectives, the long and expensive experience of orthodox psycho-analysis is any more effective than any of the far briefer and less expensive—though seldom inexpensive—varieties of the new therapies. The weaknesses show up from one study to the next. One recent study, for example, shows that psychoanalysis is primarily beneficial for "reasonably healthy, well-motivated, socially functioning and reasonably personable individuals. Plainly it is not for the sick." Another study indicates that a sample of depressed/anxious/etc. men showed as much improvement when treated by a group of professors as a comparable sample treated by "highly reputed psychotherapists" averaging 23 years of clinical experience. And a mas-

ter study of 33 such studies was "forced to conclude" that one of the most significant therapeutic elements was the personality of the therapist!

Examination of the newer therapies yields much the same results. One study of group therapy, for example, finds: "What actually happened in each particular case appeared to be more a function of the kind of person the leader was, the sort of leadership actually practised, the persons convened and the atmosphere they created than of the theories that the leaders actually professed and implemented." Overall, transactional analysis and Rogerian client-centered therapy seem to be roughly equivalent in benefit to one another and to orthodox psychodynamic (i.e. non-behavioristic) therapies; Gestalt—much less so. There have been, the book claims, no worthwhile systematic evaluations of primal therapy, psychodrama or Rolfing. Of those newest-of-all therapies devoted to marriage, sex, and the family, those that are directive in approach (Masters and Johnston style) fare somewhat better than those relying chiefly on interpretation. With one final study which supports "the claim that patients' religiosity is significantly correlated with success in psychotherapy" the author's argument is brought full circle, again.

If those most likely to benefit from the psychotherapies are those already "reasonably well-adjusted," on the contrary those most likely to seek them out are found to be those most easily exploited—"the weak, the insecure, the nervous, the lonely, the inadequate, and the depressed." The author's general conclusion is, then, that the very real threats of commercial exploitation and personal abuse are only on occasion and modestly offset, in the whole therapy business, by any gains:

This book opened with a quotation from an article in *Time* magazine concerning the state and the future of contemporary psychiatry. The article ended prophesying that psychiatry would split into so-called 'biological' psychiatry, with its emphasis on the physical organism, the central nervous system, drugs and other physical treatments, and the human potential movement with its emphasis on meaning, growth, earthly salvation and earthly perfection. Allowing for its characteristic exaggeration, *Time* may be close to the truth. In the fifty years since his creation by Freud, the 'secular pastoral worker' has worn the clothes of the man of medicine while actually engaged in the work of a man of God in a godless society. As the century moves to its close, it is becoming harder to

conceal the true nature of the psychotherapies. We cannot believe it is in the interests of anyone to continue to try.

This final paragraph brings to light the author's own attitude, which otherwise is very much in the background of the book and which does not interfere with either the book's pointed and just criticism or with the reliable perspectives on which they are based. But Dr. Clare himself is a psychiatrist practicing in and clearly very sympathetic towards Britain's National Health Service: and the medical model finally makes a full-fledged appearance here.

However, because the author was thoroughly critical not only of all pseudoscience but of scientific reductionism as well, it seemed hasty to assume that Dr. Clare's model was the usual simplistic biological reductionism. It isn't. In his own account of his background and present position that appears in an even more recent book, *Psychiatrists on Psychiatry* (Cambridge University Press, 1982), Dr. Clare indicates the direction he believes psychiatry will have to take, if it is to be useful at all. He advocates there the "reintegration of psychiatry into the mainstream of medicine," a process by which the *specialty* of psychiatry will become "virtually redundant" whereas such knowledge (?), techniques (?), and breadth of cultural involvement (?), as it has evolved will simply become accessible—if I understand this rightly—to all health practitioners. For example, will become a resource expected of every general practitioner. But Dr. Clare admits, "It may well be that psychiatry will not survive at all and that any attempt to widen the perspective and the horizons of medicine to take into account not merely the psychological aspects of illness but also its behavioural manifestation, social epidemiology and cultural significance will falter in the face of an insistent and confident biological and technological reductionism."

There is a real seriousness of concern underlying this view, the same concern that turns up in *Let's Talk About Me* in the frequent distinction made between "serious disorders" which benefit little if at all from the new therapies and those—more "moderate," less "serious"—that, sometimes, do. This concern merits respect. Nor is the thought behind this re-integration attitude intellectually cheap. On the contrary, it is as well-considered and honest a position as can be found from within the psychiatric camp: for essentially it seems no more than an attempt to rehumanize the medical profession (assuming such a moderately socially-responsive one as

Britain's, in the first place).

Whether such a direction is fruitful—or even possible—or whether it is misguided is another matter. Misguided, I suspect. Rehumanizing an institution and technology long grown barren and inhumane seems oddly like the wonder cures (drugging, etc.) that the medical establishment is itself so fond of. At any rate if it is a bit late to expect a fruitful new injection of responsibility and responsiveness, it is even later—*too late* to expect any such professional renewal to extend as far as the “*patient's*” right to information and control over all the areas of his or her life. So it seems more prudent as well as more just to pursue new alternatives across the board—for those generally labelled “seriously disturbed” and those more moderately “troubled” as well as for the hordes of “self-fulfillment seekers.” And for alternatives, the sympathetic account of the self-help movement in *Let's Talk About Me* presents not only a fair description of the movement to date but indicates further its potential to aid even the “seriously mentally ill:”

... the self-help movement may represent a significant alternative response to what hitherto has been an assumption at the heart of the psychotherapies, both old and new, that life's problems require a system, a technique, a body of skill, be it Freudian, Rogerian, transactional, primal or psychodrama theory. ... The characteristics of self-help groups include the mutual help and support members provide, the notion that it may be the helper who benefits most from the therapeutic exchange, the valuable notion of normality which groups foster, the promotion of greater factual understanding, the action-oriented philosophy (the notion that members learn by doing and are changed by doing—rather than by developing intrapsychic understanding) and the collective will-power and belief which enables each person to look to others in the group for validation of his feelings and attitudes.

What Are Your Rights? if you are a person with a Psychiatric Disorder?

A Project of:
Aid to Local Groups
Funded by:
The Ontario Ministry of Tourism and
Recreation, Wintario.

REVIEWED BY DAVID DRAPER

This booklet was written for persons in Ontario who have, or purportedly have, a psychiatric disorder. It is a self-help guide to existing services, benefits and generally recognized civil rights. As such, it is a useful educational tool provided that the reader is aware of its limitations.

The Citizen's Guide Series was prepared as part of an International Year of Disabled Persons project funded by the Ontario Government. The series consists of five booklets dealing separately with the rights of persons having a hearing impairment, developmental handicap, psychiatric disorder, visual impairment and physical disability. There is considerable overlap among the booklets, but each has information specific to the target group. All are written in a community legal education style with clearly presented topics and understandable explanations.

Following a very brief discussion of the label “mentally ill”, the first half of the booklet deals with rights in psychiatric facilities. The realities of institutionalization are presented in a practical, helpful manner, not by describing the day to day experience of being a psychiatric patient, but rather by explaining the law as it relates to various aspects of institutionalization. Assessment, admission

(voluntary and involuntary), treatment, medical records, finances, and the effect of institutionalization on other civil rights are all considered.

One of the strengths of the booklet is that it provides helpful hints and words of encouragement throughout. In discussing the difficulty of complaining to the authorities, the reader is reminded that “if you do not speak out when injustice occurs, you will never change a situation that might be improved.”

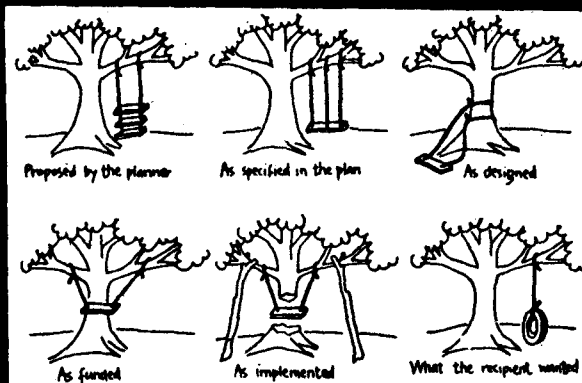
Too often professionals, particularly lawyers, concentrate on the issues of commitment and release and forget that people do not stop having many of the needs and problems faced by other people simply because they have been institutionalized. Fortunately, this booklet avoids that shortcoming. The second half of the booklet deals with community services. The subjects discussed are employment, money matters, housing, counselling, recreation, self-help/personal advocacy and legal advice. This part provides information which will be helpful to persons who have a psychiatric disorder, whether or not they are at a psychiatric facility.

Preparing this type of self-help guide is a difficult task. As noted above, the booklet is limited. This is inherent in this type of document and not due to any shortcoming of the writer. The goal appears to have been to produce something which would be useful for as many people as possible. To do so, certain sacrifices must be made: Some information must be omitted or the document would become too lengthy; subtle points may have to be ignored to avoid complexity; and controversies cannot be explored because to do so would add both length and complexity. The result tends to be a conservative description of the status quo.

Rights are not static, but rather continually evolve. Most developments in the rights of psychiatric patients in Ontario have come through changes in legislation. Advocacy groups of and for psychiatric patients have been actively involved in lobbying for changes.

In the United States, judicial interpretation of the Constitution has played a crucial role in the development of the rights of psychiatric patients. Rights such as the right to treatment, the right to refuse treatment, the right to treatment in the least restrictive setting and procedural requirements for institutionalization have been established by the courts.

With the repatriation of the Canadian Constitution, including the Charter of Rights, in April of 1982, the situation in Canada has changed. However, “What Are Your Rights?” does not incorporate the Charter of



Rights. The Charter is a positive statement of rights which undoubtedly will have an important impact on the rights of psychiatric patients. It creates the possibility of judicial decisions similar to those which we have seen in the United States. This is an exciting prospect for advocates.

The booklet demonstrates a sensitivity to the experience of the psychiatric patient in Ontario by addressing many commonly held misconceptions. For example, the point is made early in the book that there are different types of psychiatric facilities in Ontario which operate under the provisions of the Mental Health Act and that by far the greatest number of facilities are psychiatric wards at general hospitals. This is a simple point, but an important one. Although the psychiatric wards of some general hospitals may offer a more pleasant environment, many people seem to forget or not realize that these wards have the same intrusive powers, and responsibilities, as the large psychiatric institutions.

Many patients are not aware of their right to refuse treatment and the limitations placed upon that right. This is not surprising in that the rules are somewhat complex and doctors are often loathe to advertise this right because it interferes with their concepts of treatment. The booklet properly states that a competent patient has the right to refuse treatment, unless the patient has been involuntarily committed *and* the doctor had obtained an order of the Regional Review Board that treatment may be imposed, notwithstanding that patient's objection. Possible legal actions are suggested if treatment has been imposed illegally. Another limitation on the right to refuse treatment which is not raised in the booklet must be considered before a legal action is contemplated. Disputes often arise because medication may be imposed to "restrain" rather than treat the patient. Under the Mental Health Act, the facility has the authority to restrain patients who are being involuntarily detained. "Restrain" is defined in the Act to include the reasonable use of chemicals. This is problematic because the dividing line between using medication for restraint and treatment is extremely fuzzy.

The booklet takes a conservative view of rights which may be inappropriate, particularly in light of the Charter. It states that "Both the provincial (Ontario) and the federal government make laws which give you rights, or take away your rights while you are in a psychiatric facility." Many



would argue that rights are not given by the government. Rather, there are inherent human rights which merely are recognized in legislation by the government. Patient's groups such as On Our Own have taken the position that psychiatric patients have basic rights which have yet to be recognized in law.

A self-help guide is useful only as long as its information is up-to-date. In fact, it could become harmful if the information is no longer correct and people act on it. This is not merely an academic concern. Things change quickly. On a trivial level, the Lawyer Referral Service fee for a half hour interview had been increased from \$10.00 to \$20.00. More importantly, the effect of the Charter will have to be incorporated. The Ontario Government has announced that it will be implementing a "patients' advocate system", at least in the large psychiatric facilities. We will have to wait to see exactly what this will entail, but the Advocacy section of the booklet will have to be amended to incorporate these changes.

"What Are Your Rights?" provides a great deal of information useful to persons in Ontario who are involved in the psychiatric system. Although it is important that it not be regarded as a final statement of the rights of psychiatric patients, this booklet should help many people understand what is available to them. It must be periodically updated to ensure its currency. One concern is that because this was a project funded by the Ontario Government during the International Year of Disabled Persons, it may be a one-shot deal. It is hoped that some way will be found to ensure that a current self-help guide will remain available.

Copies of this booklet are available free of charge from:

The Canadian Mental Health
Association
Ontario Division
8 Pailton Crescent, 2nd Floor
Toronto, Ontario
M4S 2H8
Phone: (416) 487-5361



what's happening

“PATIENT ADVOCATES” — IN NAME ONLY

Advocacy for the rights of psychiatric inmates in Ontario and everywhere else in Canada has been virtually nonexistent and long overdue. So it was good news when Health Minister Larry Grossman announced his “Patient Advocates” program last May. Basically, Grossman’s plan is to appoint ten advocates for all inmates in the province’s ten public psychiatric institutions, one per institution. As Grossman sees them, the advocates will investigate and act on inmates’ complaints, “mediate” inmate/staff problems, inform inmates of their legal rights, and (this is priceless) “reinforce the image of the hospital as a fair and humane institution.” (For more details, see *Phoenix Rising*, Aug.-Sept. 1982, vol. 3, no. 1)

The *independence and accountability* of the advocates are the two most controversial and crucial issues. In its brief titled “Advocacy for the Institutionalized”, C.O.P.S. (Coalition On Psychiatric Services) argues that the advocates should report directly to a body outside the Ministry such as community legal clinics. Funded by the Ontario Legal Aid Plan, the community legal clinics would be ideal for the advocates, since they could provide the necessary legal backup and community support. (There are roughly 40 CLCs in Ontario). In their briefs on the advocates program to the Ministry, both ARCH (Advocacy Resource Centre for the Handicapped) and the Association of Community Legal Clinics strongly support the C.O.P.S. position on independence and accountability to the legal clinics. Even psychiatrist Gilbert Heseltine, appointed last year by the Ministry to conduct an “in-house” study of Ontario’s “mental health system,” recommended in his recent “Blueprint/Interim Report” that a “Patient Care Representative” in each psychiatric institution be independent — “not be a member of its staff . . . be appointed by Legal Aid.”

The Ministry disagrees. Health bureaucrats such as psychiatrist Boyd Suttie (Assistant Deputy Minister in charge of public and mental health), Ted Ball (his assistant) and Dr. Ty Turner (Co-ordinator of the advocates program) minimize the importance of civil or legal rights issues and violations arising from inmates’ complaints. In a meeting with C.O.P.S. members last January, Ball claimed that inmates’ complaints of legal rights violations constitute “no more than 15%” — he cited no research evidence for this statement. If inmates were fully informed of their legal rights (few as they are), the figure would probably be closer to 50% or higher.

The Ministry obviously wants to control the advocates by making them report directly to Dr. Turner as well as Ministry-controlled Community Advisory Boards, which are still being set up and have no credibility or track record on inmates’ rights issues. All this has been done without prior consultation with C.O.P.S. Dr. Suttie violated his agreement with C.O.P.S. In his letter to C.O.P.S. dated October 5, 1982, Suttie writes: “Plans concerning the establishment and further role of Patient Advocates have by no means been finalized. Before this can occur, consultation with interested groups such as yours, along with District Health Councils, must occur.” A month and a half later in November, the Ministry hired family doctor Ty Turner as Co-ordinator of the advocates program; in early December they hired researcher Joan Best as his assistant. No consultation with C.O.P.S. about the need for a co-ordinator, no consultation with C.O.P.S. concerning the basic issues of the advocate’s independence, accountability and responsibilities — until last January. By then, it was a fait accompli. Since Turner had already been hired, it was clear the Ministry was committed to controlling the advo-

cates through Turner and the advisory boards — *not* the legal clinics or any other body outside the Ministry. The two Ministry C.O.P.S. meetings in January and February served as only token gestures of consultation.

The Ministry killed any hope of independence for the advocates. By reporting to the Ministry through Turner, they will be put in frustrating conflict-of-interest situations. How can the advocates fully and independently work for inmates when they’re paid by and accountable to the Ministry which runs the psychiatric institutions in which they work? You can be sure the institutional staff, administration and/or the Ministry will block any advocate who starts exposing or acting on staff abuses or violations of inmates’ rights. If the Grossman-Suttie-Ball-Turner gang have their way, the advocates will actually be ensuring the “patient’s right to treatment” — like the right to be drugged, electroshocked, locked up or denied legal rights. In fact, these bureaucrats have started calling the advocates “therapeutic advocates.”

It’s also interesting to compare some of the Ministry’s qualifications for the advocates with those proposed by C.O.P.S.; they highlight the Ministry’s commitment to the medical model and C.O.P.S.’s commitment to inmates’ rights.

MOH QUALIFICATIONS

- “experience in psychiatric nursing, social work and volunteer agencies.”
- “knowledge of mental illness and familiarity with the problems of the mentally ill.”
- “familiarity with legal preparations and procedures re conflict mediation.”

C.O.P.S. QUALIFICATIONS

- “community legal worker with specialized training . . . experience as a former psychiatric patient in an institution . . . a definite asset.”
- “familiarity with mental health law, the *Mental Health Act* . . . civil rights and human rights legislation.”
- “special training . . . professional development (provided by) ARCH . . . minimum of one year’s experience as a human or civil rights advocate.”

The Ministry will undoubtedly hire a

lot of mental health professionals — not ex-psychiatric patients. They'll start working this April and be paid a salary of \$25,300-\$29,700.

Since the Ministry has rejected independence for the advocates and their accountability to community legal clinics, we are convinced that numerous violations of psychiatric inmates' rights in Ontario will continue to be ignored. The Ministry's "Patient Advocates" program is an insult and injustice to thousands of our brother and sister inmates in immediate need of legal support and justice — *not* "treatment."

Ed. Note: We urge our readers to write letters to the Ministry of Health to protest lack of independence for the advocates and recommend they be accountable to community legal clinics. Letters should be sent to: The Honourable Larry Grossman, Ministry of Health, 10th Flo., Hepburn Block, 80 Grosvenor Street, Toronto, Ont. M7A 2C4, Dr. T. Turner, Co-ordinator of Patient Advocates Program, 880 Bay Street, 5th Floor, Toronto, Ont., M5S 1Z8, (416) 927-1575, and your local Member of Provincial Parliament.

ECT and Memory Loss

Marilyn Rice, featured in the January/February '83 *Saturday Evening Post* stories against electroshock therapy (ECT or electroconvulsive treatment), tells a chillingly convincing tale of the disastrous memory impairment that resulted from her ECT experience ten years ago. Because of the specific and specialized nature of her job (20 years an economist and analyst for the U.S. Department of Commerce), and despite her earnest effort to relearn her job, Marilyn found her ability to retain the relearned knowledge was gone forever, and took a disability retirement.

Since then, Marilyn has fought to have psychiatry admit the previously denied fact that ECT produces brain damage. She discovered there were no studies on memory loss from ECT, and maintains that a CAT brain scan should be done on each person undergoing ECT and at yearly intervals thereafter to check for brain shrinkage. Marilyn, at 53, had shrinkage three times greater than normal, equivalent to a 90-year-old brain.

Included in *The Saturday Evening Post* feature is an Electroshock Therapy Questionnaire concerning memory loss, the ability to learn or understand, effectiveness in alleviating depression, and informed consent. We

recommend you take the time to fill out and return it to supply much-needed statistics on a result of ECT that psychiatrists still deny. This is particularly pertinent as the Food and

Drug Administration has upgraded ECT's classification in November '82 despite the clear testimony of Marilyn Rice and other well-documented cases of impairment.

A public forum on **"ADVOCACY FOR PSYCHIATRIC PATIENTS"**

Date: Wednesday, April 27, 1983

Time: 8:00 p.m. - 10:00 p.m.

**Place: St. Lawrence Centre Town
Hall, 27 Front St. E., Toronto
(next to O'Keefe Centre)**

FREE admission and coffee

This forum is being organized by C.O.P.S. (Coalition On Psychiatric Services) with the assistance of Theatre Arts Productions. The shocking lack of rights and advocacy programs for psychiatric inmates in Canada, including the Health Ministry's new "Patient Advocates" program, will be discussed by panelists and the audience. Panelists include: **David Baker**, lawyer and Executive Director of ARCH; **an official from Ontario's Ministry of Health**; **Winnie Norton**, hospital ombudsman in Windsor; **Dr. Morton Rapp**, psychiatrist at Sunnybrook Hospital and **Don Weitz**, ex-psychiatric inmate and co-founder of ON OUR OWN. **Alderman David Reville** will be the moderator.

Please make a special effort to attend and participate in this important event. For more info, call: Pat Higgins at **362-7041** or Pat Black at **745-2684**.

Psychiatric Inmates' Liberation Anti- Psychiatry Groups



Note: Listed by country in alphabetical order. Many of these groups were listed in *Madness Network News* (vol. 6, no. 6, fall/winter 1982-83). Many others were not. We would appreciate knowing whether any of these groups no longer exist or are listed incorrectly. We will make all necessary corrections to the list in a later issue. Our sincere thanks to *Madness Network News* for making this task easier.



AUSTRALIA

Campaign Against Psychiatric Injustice
90 Elgin St. and Coercion
Carlton 3053
Victoria, Australia
Ph: 348-15

Elemental-Union For Psychiatric
Change
Elemental (journal)
P.O. Box 153, Waverly,
N.S.W., Australia 2024

Pala Society/Louise Lawson Women's
Collective
P.O. Box 153, Waverly,
N.S.W., Australia 2024
Ph: (02) 349-5806 or 389-2521

BELGIUM

Coordination International Reseau
Alternative A La Psychiatrie
ave. Louis Bertrand 39,
Bruxelles, Belgium

Groupe Information Asile,
c/o Yves-Luc Conreur
rue Langeveld 146,
Bruxelles, Belgium 1180

SPUIT,
c/o Theo Peeters
Cogels-Osylei 67,
2600 Antwerpen-Belchem Station,
Belgium

CANADA

Alberta

Calgary Association of Self Help
1117 Macleod Trail S.E.
Calgary, Alta. T2G 2M8
Ph: (403) 266-8711

British Columbia

Mental Patients Association
2146 Yew Street
Vancouver, B.C. V6K 3G7
Ph: (604) 738-5177

Manitoba

Last Boost Club
330 Edmonton St., 2nd Fl.
Winnipeg, Man.
Ph: (204) 924-1027

Newfoundland

Newfoundland Association of
Psychiatric Patients
11 Church Hill St.
St. John's, Nfld. A1C 3Z7
Ph: (709) 753-2143

Ontario

ON OUR OWN/Phoenix Rising
(journal)
P.O. Box 7251, Station A,
Toronto, Ont. M5W 1X9
Ph: (416) 699-3192/3194

Psychiatric Association of Timmins
(PAT),
c/o Florence Henderson
168 William Ave., Box 953,
S. Porcupine, Ont. P0N 1H0
Ph: (705) 233-3814

Self-Esteem Through Independence (SETI)

c/o Brenda Ruddock
No. 2, 565 Adelaide St. N.,
London, Ont. N6B 3J7
Ph: (519) 434-9178

Society for the Preservation of the
Rights of the Emotionally
Distraught (SPRED)
4927 Morrison,
Niagara Falls, Ont. L2E 2C4
Ph: (416) 358-7659

Quebec

Association Quebecoise Pour
La Promotion De La Sante,
c/o Claude Labrie
5285 rue Aurele,
St. Hubert, Que. J3Y 2E8

Auto-Psy,
45 St. Francois Est.,
Quebec City, Que. J1K 1Y4
Ph: (418) 529-1978

Program for Alternative Lodging
(PAL)
3694 Wellington, Verdun,
Montreal, Que. H4G 1V2
Ph: (514) 767-4701

Solidarité-Psychiatrie Inc.,
7401 rue St. Hubert,
Montreal, Que. H2R 2N4
Ph: (514) 271-1653

Saskatchewan

By Ourselves,
1821 Scarth Street,
Regina, Sask.
Ph: (306) 525-1093

DENMARK

Amalie (journal),
Linnesgade 26, kld, tv.,
1361 Copenhagen, K.

ENGLAND

Camden Mental Patients Union,
c/o Mike Cardew,
20a Camden Road,
London, NW1, Eng.,
Ph: (01) 485-3261

Depressives Associated,
c/o Mrs. Janet Stevenson,
19 Merley Mays,
Wimborne Minister,
Dorset, BH21-1QN, Eng.

Friends and Family of Richard
Campbell Committee,
c/o 135a Lavender Hill,
London, SW 11, Eng.

Hackney Mental Patients Assoc.,
c/o The Secretary,
101 Median Road,
London, E5, Eng.

"Inquest": United Campaigns for
Justice,
Box 37, 136 Kingsland High Street,
London, E8 2N3, Eng.

Matthew O'Hara Committee,
c/o 177 Glenarm Road,
London, E5-0NB, Eng.

Mental Patients Action Group,
c/o Joe Griffy,
Second Chance,
56 Dames Road, Forrest Gate,
London, E7-0DR, Eng.
Ph: (01) 555-0298

People Not Psychiatry,
c/o Lawletter,
90 Fawcett Estate,
Clapton Common,
London, ES-9HX, Eng.

PROMPT/PROMPT Newsletter,
c/o 11 Ottershaw House,
Horsell Road, St. Paul's Cray,
Kent, Eng.
Ph: (01) 693-0011

Protection for the Rights of
Patients at Rampton,
University of Nottingham, Nottingham,
Nottinghamshire, Eng.

Winston Rose Action Campaign,
c/o 25 Church Hill,
London, E17-3AB, Eng.

FRANCE

C.R.A.A.P.,
c/o G.E.R.P.,
9 rue St. Vivien,
7600 Rouen, Fr.

G.I.A., Lyon,
c/o Maurice Dumoulin,
BP 8461,
Lyon Cadex 2, Fr. 69359

G.I.A. Paris,
158 rue Legendre,
Paris, Fr. 75017

Mise A Pied (periodical)
BP 2038, 31018 Toulouse Cedex, Fr.

ICELAND

Gedhjalp
Baragotu 11
101 Geykjavik
Ph: 25990

MEXICO

Procesos de Action Communtaria,
ADPO 698,
Cuernavaca, Morelos, Mexico

NETHERLANDS

Clientenbond in de Welzijnszorg,
Postbus 13541,
2501 EM den Haag,
The Netherlands
Ph: 070-458695

Geh-ooit
Postbus 43097
Amsterdam
The Netherlands

Wegloophuis Haarlem,
Herensingel 7,
Haarlem, The Netherlands
Ph: (023) 335-103

Wegloophuis Amsterdam
Heizergracht 252,
Amsterdam, The Netherlands
Ph: (020) 223-755

Stichting "Pandora"
2e Constantijn Huijgensstraat
1054 Amsterdam, The Netherlands
Ph: (020) 127552

Werkgroep Krankzinnigenwet,
c/o Stichting "Pandora",
2e Constantijn Huijgensstraat 1054,
Amsterdam, The Netherlands
Ph: 12-75-52

NEW ZEALAND

Campaign Against Psychiatric
Atrocities,
Box 6899,
Auckland, N.Z.

Mental Patients Resistance,
1/38 Cumberland Street,
The Rocks, N.S.W., N.Z. 2000

SWITZERLAND

Association des Usagers
de la Psychiatrie (ADUPSY),
22 rue Neuve du Molard,
Geneva, Switzerland
Ph: 21-95-75 (Tues. 6-9 p.m.)

Interessen Gemeinschaft
Psychiatrie
Sektion Zurich
Postfach 104
8402 Winterthur, Switzerland

WEST GERMANY

Beschwerdezentrum Psychiatrie Bonn,
Bornheimerstrasse 92,
Bonn 53, West Germany
Ph: 0228/655409

Dr. Mabuse (journal)
PF 70 07 47
6000 Frankfurt 70
West Germany

Winterreldstr. 38
100 Berlin 30
West Germany

Sozialistische Selbsthilfe
Cologne (SSK),
Liebigstrasse 25,
5 Cologne 30,
West Germany
Ph: 0221/556189

Sozialtherape Frankfurt,
e.v. Egenolfstr. 28,
6000 Frankfurt/Main,
West Germany

<p style="text-align: center;">UNITED STATES</p> <p>Arizona Advocates Coming Together (ACT), c/o Arizona Dept. of Health Services, 2500 E. Van Buren, R-30, Phoenix, AZ. 85008</p> <p>OR— 117 W. Merrell Street, No. 6, Phoenix, AZ. 85013 Ph: (602) 277-8607 or 241-0040</p>	<p>Illinois Fire and Rain, c/o Dan and Genie Burns, 1157 W. Grace, Apt. 1 South, Chicago, IL. 60613</p>	<p>New York Albany Mental Health Advocates, c/o Marin Lee Erwin, 66 Judson Street, Albany, NY 12206</p>
<p>California Center for Independent Living, 2439 Telegraph Avenue, Berkeley, CA. 94704 Ph: (415) 841-4776</p> <p>Coalition to Stop Electroshock, P.O. Box 3301, S. Berkeley Station, Berkeley, CA. 94703 Ph: (415) 644-1899</p> <p>Madness Network News, P.O. Box 684, San Francisco, CA. 94101 Ph: (415) 548-2980</p> <p>Mental Health Consumer Concerns (MHCC), 2727 Alhambra Ave. #2B Martizez, CA 94553</p> <p>Newtork Against Psychiatric Assault (NAPA) - Los Angeles, P.O. Box 5728, Santa Monica, CA. 90405</p> <p>Network Against Psychiatric Assault and Women Against Psychiatric Assault, 2054 University Avenue, Room 406, Berkeley, CA. 94703 Ph: (415) 548-2980</p> <p>Psychiatric Inmates Rights Collective, P.O. Box 299, Santa Cruz, CA. 95061 Ph: (408) 475-7904</p> <p>REAL Inc., c/o Lynn Stewart, P.O. Box 38302, Hollywood, CA. 90038</p>	<p>Kansas Advocates for Freedom in Mental Health, c/s S. Jacobs, 4448 Francis, Kansas City, KA. 66103 Ph: (913) 236-9312 (Kansas City) (913) 842-4088 (Lawrence)</p> <p>Project Acceptance, P.O. Box 187, Lawrence, KA. 66044</p>	<p>Mental Patients Alliance of Central New York — Ithaca, P.O. Box 22, Brooktondale, NY 14117 Ph: (607) 539-7772</p> <p>Mental Patients Alliance of Central New York — Oswego, P.O. Box 1012, Oswego, NY 13126 Ph: (315) 947-5822</p>
<p>Colorado Big Mama Rag (feminist journal), 1724 Gaylord Street, Denver, Colo. 80206</p>	<p>Massachusetts Mental Patients Liberation Front, P.O. Box 514, Cambridge, MA. 02238</p> <p>Project Liberation from Psychiatric Oppression, c/o Charles Hobbs, Indian Hill Road, Goroton, MA. 01450 Ph: (617) 448-5336</p>	<p>Mental Patients Alliance of Central New York — Syracuse, P.O. Box 158, Syracuse, NY 13201 Ph: (315) 474-8569</p> <p>No More Cages, (Women's Prison Newsletter), P.O. Box 90, Brooklyn, NY 11215 Ph: (212) 499-8177</p>
<p>Florida Alternatives to Psychiatry Assoc. (formerly Mental Patients Rights Assoc.) 410 Dixie Hwy/Unit 10, Lake Worth, FL. 33460 Ph: (305) 582-9750</p>	<p>Maryland On Our Own, c/o P. McCusker, 3142A E. Joppa Road, Baltimore, MD. 21234</p>	<p>Project Release, P.O. Box 396, FDR Station, New York, NY 10022 Ph: (212) 595-8585</p>
<p>Michigan Oakland Patient Environmental Nexus/ <i>OPEN Newsletter</i>, 35 W. Huron Suite 226 Pontiac, MI. 48058 Ph: (313) 335-3377</p> <p>F.O.C.U.S./Voices Heard 600 Cass S.E. Grand Rapids, MI 49503</p> <p>Psychiatric Alternatives Alliance, 32658 Menominee Ct., Westland, MI. 48185</p>	<p>Minnesota Mental Health Advocates Coalition, 265 Fort Road, St. Paul, MN. 55102</p> <p>Minnesota Association to Stop Psychiatry and Psychology (MASPP), P.O. Box 13027, Dinkytown Station, Minneapolis, MN. 55414 Ph: (612) 874-0228</p> <p>Project Overcome, 1900 Hennepin Avenue Mpls, MN 55403</p>	<p>Community Health Consumers' Group c/o Peter Anderson P.O. Box 372, University Station Syracuse, NY 13210</p> <p>Pennsylvania Alliance for the Liberation of Mental Patients/Inmates Voice P.O. Box 30228 Philadelphia, PA 19102</p>
<p>South Dakota South Dakota Mental Health Advocacy Project, Box 618, 904S Phillips Avenue, Sioux Falls, SD 47104</p>	<p>Vermont Vermont Liberation Organization, RD No. 1, Johnson, VT 05656 Ph: (802) 635-7547</p>	<p>Virginia Mental Patients Liberation Project, c/o George Brewster, 3407 Wessynton Way, Alexandria, VA 22309</p>

**PSYCHIATRIST'S ABUSE NO
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Six women out of many who have been sexually abused by a Toronto psychiatrist (male) for over 20 years have become aware of their common experience and banded together to call his misconduct to the attention of The College of Physicians and Surgeons and to demand the revocation of his licence. They have been advised that legal counsel together with their similar evidence would offer a good chance of their winning; and, by winning, setting the example that such behaviour need not be

tolerated by women patients.

The group is seeking, then, a maximum of \$1000 to cover all foreseeable legal costs; in case there are any funds left after costs, the balance will be used to set up a fund for other women who have been similarly abused. Anyone who wishes to contribute is asked to make their donation payable to the Sexually Abused Patients' Defense Fund, c/o Toronto Rape Crisis Centre, P.O. Box 6597, Station "A", Toronto.

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ON OUR OWN

Friday, April 22 is the date of On Our Own's annual Open House this year. Any interested person or group is invited, as well as all our own members. Staff and volunteers of On Our Own, The Mad Market and Phoenix Rising will be on hand from 3-8 pm with information about the group and all its activities, and refreshments will be served. There will be a dance in the evening for everyone.

On Our Own wishes to express its gratitude to Sam Mortony who has re-

peatedly offered funds for the direct use of members. Mr. Mortony's most recent gift was for \$400.

The Mad Market, On Our Own's ex-inmate run used goods store, is sponsoring a raffle: tickets may be purchased for \$1.00 each at the store. The draw will be held May 2 with the first prize winner receiving a dinner for two at the Beech Tree Cafe as well as two theatre tickets.

The Mad Market also plans a fashion show on Saturday, April 9, with new

wave and punk customers modelling store clothing. Anyone interested in participating is encouraged to contact the store.

On Our Own has received \$1800 from The Laidlaw Foundation to cover six month's printing costs and postage for the group's newsletter — The Mad Grapevine. The \$300/month grant may be renewed for the remainder of the year when the six-month commitment is satisfactorily met.

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We Need Your

Help

Even the finest birds cannot soar without sustenance and *this* Phoenix is low on funds for 1983: reduced funding, larger issues and higher costs for everything have all taken their toll till we are beginning a year's publishing with far lower financing than we got by with in 1982.

So skimp as we will, we need your help if Phoenix Rising is to continue — same format, same size — through 1983. Any contribution by an individual or group will go directly into the publication of the magazine. All contributions will be acknowledged in a future issue, and a receipt for income tax purposes will be sent, whenever requested.



PUBLICATIONS AVAILABLE

- **Phoenix Rising*, vol. 1, no. 1. Boarding homes in Toronto; Valium; gays and psychiatry; and more — not available at present.
- **Phoenix Rising*, vol. 1, no. 2. Prison psychiatry; Thorazine; blindness and emotional problems; commitment; and more. \$2.50
- **Phoenix Rising*, vol. 1, no. 3. Electroshock; Haidol; how to say no to treatment; a Toronto drug death; and more. \$2.50
- **Phoenix Rising*, vol. 1, no. 4. Women and psychiatry; lithium; involuntary sterilization; battling the insurance companies; and more. \$2.50
- **Phoenix Rising*, vol. 2, no. 1. From Kingston Psychiatric to City Hall — an alderman's story; tricyclic antidepressants; access to psychiatric records; and more. \$2.50
- **Phoenix Rising*, vol. 2, no. 2. Kids and psychiatry; Ritalin; informed consent; special education; and more. \$2.50
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- **Phoenix Rising*, vol. 3, no. 1. Tenth International Conference; class bias in psychiatry; paraldehyde; and more. \$2.50
- **Phoenix Rising*, vol. 3, no. 2. The Housing Crisis; Tardive Dyskinesia; Titicut Follies; and more. \$2.50
- **Phoenix Rising*, vol. 3, no. 3. Schizophrenia, CIA and Mind Control; Modicate; and more. \$2.50

Phoenix Publications:

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

Distributed by ON OUR OWN:

- On Our Own: Patient-Controlled Alternatives to the mental Health System**, by Judi Chamberlin (McGraw-Hill Ryerson). "Required reading for 'mental health' professionals . . . who still believe that 'mental patients' are too 'sick', helpless and incompetent to run their own lives." \$7.00
- The History of Shock Treatment**, edited by Leonard Roy Frank. A compelling and frightening collection of studies, first person accounts, graphics and other material covering 40 years of shock treatment. \$8.00

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

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- On Our Own* - \$1.00 per copy
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Make cheque or money order payable to *Phoenix Rising*, and mail to: Publications, Box 7251, Station A, Toronto, Ontario, Canada M5W 1X9.

“Of all the tyrannies a tyranny sincerely exercised for the good of its victims may be the most oppressive. It may be better to live under robber barons than under omnipotent moral busybodies. The robber baron’s cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their conscience. They may be more likely to go to Heaven, yet at the same time likelier to make Hell of earth. Their very kindness stings with intolerable insult. To be ‘cured’ against one’s will and cured of states which we may not regard as disease is to be put on a level with those who have not yet reached the age of reason or those who never will . . . ”

C.S. Lewis, “The humanitarian theory of punishment” (1949).
In *God in the Dock*.