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ELECTROSHOCK: A CRIME AGAINST THE SPIRIT

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Note: This article is based on my testimony at a public hearing on electroconvulsive "treatment" conducted by the Mental Health Committee of the New York State Assembly in Manhattan on May 18, 2001. I was representing Support Coalition International, a human rights group headquartered in Eugene, Oregon. SCI unites 100 sponsoring organizations that oppose all forms of psychiatric oppression and support a broad variety of approaches for assisting people said to be "mentally ill." In 2001, the United Nations recognized Support Coalition International as "a Non-Governmental Organization with Consultative Roster Status." For more information about Support Coalition International and electroshock, see http://www.MindFreedom.org (phone 541-345-9106) and http://www.ect.org.

In remembrance lies the secret of redemption.
Bal Shem Tov (1690-1760), founder of Hasidism (cited in Lieberman, 2001)

INTRODUCTION

Some personal background will be helpful in understanding my perspective on electroshock. I was born in 1932 in Brooklyn and was raised there. After graduating from the Wharton School at the University of Pennsylvania, I served in the U.S. Army and then worked as a real estate salesman for several years. In 1962, three years after moving to San Francisco, I was diagnosed as a "paranoid schizophrenic," involuntarily institutionalized, and eventually subjected by force to 50 insulin coma and 35 electroconvulsive procedures (Frank, 1976, 1978, 1990, 1993).

"Combined insulin coma-convulsive treatment" was routinely administered to "schizophrenics" in the U.S. from the late 1930s

through the mid-1960s. (The electroconvulsive "treatments" are given while the subject is in the coma phase of the insulin coma "treatments"; sometimes the two procedures are given separately on alternating days.) Individual sessions last from four to five hours. Large doses of injected insulin reduce the blood's sugar content triggering a physiological crisis manifested in the subject by blood pressure, breathing, heart, pulse, and temperature irregularities; flushing and pallor; "hunger excitement"; incontinence and vomiting; moans and screams (referred to in the professional literature as "noisy excitement"); sobbing, salivation, and sweating; severe restlessness; shaking and spasms, and sometimes convulsions.

The crisis intensifies as the subject, after three or four hours, goes into a coma. Brain-cell destruction occurs when the blood can no longer provide the sugar essential to the brain's survival; the sugar-starved brain begins feeding on itself for nourishment. The hour-long coma phase of the procedure ends with the administration of carbohydrates (glucose and sugar) by mouth, injection or stomach tube. If the subjects cannot be restored to consciousness by this method, they go into what are called "prolonged comas," which result in even more severe brain damage and sometimes death. According to the United States Public Health Service Shock Therapy Survey (October 1941), 122 state hospitals reported 121 deaths among 2,457 insulin coma treatment cases, or 4.9% (Ebaugh, 1943, pp. 294-295).

After gaining my freedom, I made a determined effort to find out how psychiatrists justified their use of this procedure. One of the clearest statements I uncovered came from Manfred Sakel, the Austrian psychiatrist who introduced the insulin method in 1933 and, after arriving in the United States a few years later, became its most active promoter. In a popular book on the state of psychiatry published in 1942, Dr. Sakel was quoted as follows: "With chronic schizophrenics, as with confirmed criminals, we can't hope for reform. Here the faulty pattern of functioning is irrevocably entrenched. Hence we must use more drastic measures to silence the dysfunctioning [brain] cells and so liberate the activity of the normal cells. This time we must <u>kill</u> the too vocal dysfunctioning cells. But can we do this without killing normal cells also? Can we <u>select</u> the cells we wish to destroy? I think we can" (cited in Ray, 1942, p. 250, italics in the original).

Of course, I did not see it that way. For me, combined insulin coma-convulsive treatment was an attempt to break my spirit, to force on me a belief system and lifestyle which I, of my own free will, had rejected. It was also the most devastating, painful and humiliating experience of my life. My memory for the three preceding years was gone. The wipe-out in

my mind was like a path cut across a heavily chalked blackboard with a wet eraser. Afterwards I did not know that John F. Kennedy was president although he had been elected three years earlier. There were also big chunks of memory loss for events and periods spanning my entire life; my high school and college education was effectively destroyed. I felt that every part of me was less than what it had been.

Following years of study reeducating myself, I became active in the psychiatric survivors movement, becoming a staff member of Madness Network News (1972) and co-founding the Network Against Psychiatric Assault (1974)—both based in San Francisco and dedicated to ending abuses in the psychiatric system. In 1978 I edited and published The History of Shock Treatment. Since 1995, three books of quotations I edited have been published: Influencing Minds, Random House Webster's Quotationary, and Random House Webster's Wit & Humor Quotationary.

Over the last thirty-five years I have researched the various shock procedures, particularly electroshock or ECT (the focus of the remaining part of this paper), have spoken with hundreds of ECT survivors, and have corresponded with many others. From all these sources and my own experience, I have concluded that ECT—which "between 1 and 2 million patients per year receive... worldwide" (Abrams, 1997, p. 9)—is a brutal, dehumanizing, memory-destroying, intelligence-lowering, brain-damaging, brainwashing, life-threatening technique. ECT robs people of their memories, their personality and their humanity. It reduces their capacity to lead full, meaningful lives; it crushes their spirits. Put simply, electroshock is a method for gutting the brain in order to control and punish people who fall or step out of line, and intimidate others who are on the verge of doing so (See Frank 1978, 1990, 1993; Morgan, 1999).

BRAIN DAMAGE

Brain damage is the most important effect of ECT. It is also the 800-pound gorilla in the living room whose existence psychiatrists refuse to acknowledge, at least publicly. Nowhere is this more clearly illustrated than in the American Psychiatric Association's recent Task Force Report on ECT (APA, 2001) which states that "in light of the accumulated body of data dealing with structural effects of ECT, 'brain damage' should not be included [in the ECT consent form] as a potential risk of treatment" (p. 102).

Excluded from the Task Force's "accumulated body of data" were the following facts:

During the 1940s, when some proponents were a bit careless with the truth about ECT, Paul H. Hoch, co-author of a major psychiatric textbook and New York State's Commissioner of Mental Hygiene, commented, "This brings us for a moment to a discussion of the brain damage produced by electroshock.... Is a certain amount of brain damage not necessary in this type of treatment? Frontal lobotomy indicates that improvement takes place by a definite damage of certain parts of the brain" (Hoch, 1948, p. 49).

More recently, neurologist Sidney Sament (1983) backed the brain-damage charge in a letter to a professional journal:

> After a few sessions of ECT the symptoms are those of moderate cerebral contusion, and further enthusiastic use of ECT may result in the patient functioning at a subhuman level.
> Electroconvulsive therapy in effect may be defined as a controlled type of brain damage produced by electrical means....
> In all cases the ECT "response" is due to the concussion-type, or more serious, effect of ECT. The patient "forgets" his symptoms because the brain damage destroys memory traces in the brain, and the patient has to pay for this by a reduction in mental capacity of varying degree (p. 11).

Psychiatrist Peter R. Breggin (1998), ECT's foremost critic, summarized his findings on electroshock's brain-damaging effects after having studied the scientific evidence for more than 30 years (see Breggin, 1979, 1981, 1991, 1992, 1997, 2001):

> [Brain] damage is demonstrated in many large animal studies, human autopsy studies, brain wave studies, and an occasional CT scan study. Animal and human autopsy studies show that ECT routinely causes widespread pinpoint hemorrhages and scattered cell death. While the damage can be found throughout the brain it is often worst in the region beneath the electrodes. Since at least one electrode always lies over the frontal lobe, it is no exaggeration to call ECT an electrical lobotomy (p. 15).

Additional evidence of ECT-caused brain damage was published in an 1978 APA Task Force Report on ECT. Forty-one percent of a large group of psychiatrists responding to a questionnaire agreed with the statement that ECT produces "slight or subtle brain damage." Only 28% disagreed (p. 4).

And finally there is the evidence from the largest published survey of ECT-related deaths (Impastato, 1957). Psychiatrist David J. Impastato was a leading ECT proponent who, interestingly enough, was the first to use the procedure in the United States, in January 1940. He reported 66 "cerebral" deaths among the 235 cases in which he was able to determine the likely cause of death following ECT (p. 34).

MEMORY LOSS

If brain damage is electroshock's most important effect, memory loss is its most obvious one. Such loss can be, and often is, disastrous as these statements from electroshock survivors indicate:

> My memory is terrible, absolutely terrible. I can't even remember Sarah's first steps, and that's really hurtful... losing the memory of the kids growing up was awful. I can be reading a magazine and I get halfway through or nearly to the end and I can't remember what it's about, so I've got to read it all over again. People would come up to me in the street that knew me and would tell me how they knew me and I had no recollection of them at all... very frightening (cited in Johnstone, 1999, p. 78).

Electroshock proponents are dismissive of the memory problems associated with their procedure. The following is from the sample ECT consent form in the APA's 2001 Task Force Report: "The majority of patients state that the benefits of ECT outweigh the problems with memory. Furthermore, most patients report that their memory is actually improved after ECT. Nonetheless, a minority of patients report problems in memory that remain for months or even years" (pp. 321-322). Nowhere in the text of the report is the claim made in the first sentence directly addressed, while the assertion in the second sentence is patently absurd. The claim made in the third sentence, at least, is closer to the truth than coverage of the same point in the sample consent form of the first edition of the APA's 1990

Task Force Report, which reads: "A small minority of patients, perhaps 1 in 200, report severe problems in memory that remain for months or even years" (p. 158). And even the more recent Report underestimates the prevalence of memory loss among ECT survivors.

Accounts from the hundreds of survivors I have communicated with over the last three decades suggest that the majority experienced memory loss from electroshock that was permanent in nature and moderate to severe in degree; not just for the time surrounding the "treatment" period but covering years of their lives. That findings such as these do not appear in published ECT studies may be explained by the bias of electroshock investigators, virtually all of whom are ECT proponents, by denial (from ECT-induced brain damage) on the part of survivors and their fear of punitive sanctions if they were to report the extent and persistence of their memory loss, and finally by the difficulty in having anything published in a mainstream professional journal that seriously threatens the vested interests of an important segment of the psychiatric community (the 1978 APA Task Force Report on ECT suggested that 22% of all psychiatrists were electroshock "users." p. 5).

DEATH

The APA's 2001 Task Force Report on ECT states, "a reasonable current estimate is that the rate of ECT-related mortality is 1 per 10,000 patients" (p. 59). However, other accounts suggest that the ECT death rate may be 1 per 100—100 times greater than the Task Force estimate. For example, in Texas, where psychiatrists are required to report all deaths that occur within 14 days of ECT, officials at the Texas Department of Mental Health and Mental Retardation said that between 1993 and 1996 they had received reports of 21 deaths among an estimated 2,000 patients (Boodman, 1996, p. 20).

Even the 1% estimate, however, may understate the true risk of death from ECT because elderly persons are now being electroshocked in growing numbers: statistics based on California's mandated ECT reporting system indicate that upwards of 50% of all ECT patients are 60 years of age and older. Because of infirmity and disease, the elderly are more vulnerable to ECT's life-threatening dangers than younger people. One study involving 65 patients aged 80 and older who were hospitalized for major depression, showed a much higher risk of death from ECT. The patients were divided into two groups. One group of 37 patients was treated with ECT; the other group of 28 patients was treated with antidepressants. After one year, one patient (4%) in the antidepressant group was dead,

while in the ECT group, 10 patients (27%) were dead (Kroessler & Fogel, 1993, p. 30).

BRAINWASHING

The term "brainwashing" came into use during the early 1950s. It identified the technique of intensive indoctrination, combining psychological and physical pressure, developed by the Chinese for use on political dissidents following the Communist takeover on the mainland and on American prisoners of war during the Korean War. While electroshock is not used overtly against political dissidents, it is used throughout most of the world against cultural dissidents, nonconformists, social misfits and the unhappy (the troubling and the troubled), whom psychiatrists diagnose as "mentally ill" in order to justify ECT as a medical intervention.

Indeed, electroshock is a classic example of brainwashing in the most meaningful sense of the term. Brainwashing means washing the brain of its contents. Electroshock destroys memories and ideas by destroying the brain cells which store them. As psychiatrists J. C. Kennedy and David Anchel, both ECT proponents, described the effects of this tabula rasa "treatment" in 1948: "Their minds seem like clean slates upon which we can write" (p. 318). Soon after published accounts of the erasure of 18 minutes from secret White House audiotapes during the Watergate investigation, another electroshock psychiatrist reported, "Recent memory loss [from ECT] could be compared to erasing a tape recording" (Arnot, 1975, p. 500).

For these reasons, I propose that the procedure now called electroconvulsive treatment (ECT) be renamed electroconvulsive brainwashing (ECB). And ECB may be putting it too mildly. We might ask ourselves, Why is it that 10 volts of electricity applied to a political prisoner's private parts is seen as torture while 10 or 15 times that amount applied to the brain is called "treatment"? Perhaps the acronym "ECT" should be retained with the "T" standing for torture—electroconvulsive torture.

SEVEN REASONS FOR THE PERSISTENCE OF ECT IN PSYCHIATRY

If electroshock is an atrocity, as I and other critics maintain, how can its use on more than 6 million Americans since being introduced more than 60 years ago be explained? Here are seven reasons:

1. ECT is a money-maker. Psychiatrists specializing in ECT earn $300,000-500,000 a year compared with other psychiatrists whose mean annual income is $150,000. An in-hospital ECT series

costs anywhere from $50,000–$75,000. A 1988–89 APA survey estimated that 100,000 Americans undergo ECT annually. Based on this figure, I estimate that electroshock in this country alone is a $5 billion-a-year industry.

2. ECT supports the biological model. ECT reinforces the psychiatric belief system, the linchpin of which is the biological model of mental illness. This model centers on the brain and reduces most serious personal problems down to genetic, physical, hormonal, and/or biochemical defects which call for biological treatment of one kind or another. The biological approach covers a spectrum of physical treatments, at one end of which are psychiatric drugs, at the other end is psychosurgery (which is still being used, although infrequently), with electroshock falling somewhere between the two. The brain as psychiatry's focus of attention and treatment is not a new idea. What Swiss psychiatrist Carl G. Jung wrote in 1916 applies today: "The dogma that 'mental diseases are diseases of the brain' is a hangover from the materialism of the 1870s. It has become a prejudice which hinders all progress, with nothing to justify it"(Jung, 1969). Eighty-five years later, there is still nothing in the way of scientific evidence to support the brain-disease notion. The tragic irony is that the psychiatric profession makes unsubstantiated claims that mental illness is caused by a brain disease (or is, in fact, a brain disease) while hotly denying that electroshock causes brain damage, the evidence for which is overwhelming.

3. Informed consent about ECT does not exist. While outright force is no longer commonly used in the administration of ECT, genuine informed consent today is never obtained because ECT candidates can be coerced into "accepting" the procedure (in a locked psychiatric facility, it is often "an offer that can't be refused") and because electroshock specialists refuse to accurately inform ECT candidates and their families of the procedure's nature and effects. ECT specialists lie not only to the parties vitally concerned, they lie to themselves and to each other. Eventually they come to believe their own lies, and when they do, they become even more persuasive to the naïve and uninformed. As Ralph Waldo Emerson wrote in 1852, "A man cannot dupe others long who has not duped himself first." Here is an instance of evil so deeply ingrained that it is no longer recognized as such by the perpetrators themselves. Instead we see such outrages as ECT specialist Robert E. Peck titling his 1974 book, The Miracle of Shock Treatment and Max Fink, a leading ECT proponent who for many years edited Convulsive Therapy (now called The Journal of ECT), the most influential

journal in the field, telling a Washington Post reporter that "ECT is one of God's gifts to mankind" (cited in Boodman, 1996, p. 16).

4. ECT serves as backup for "treatment-resistant" psychiatric drug users. Many, if not most, of those being electroshocked today are suffering from the ill effects of a trial run or long-term use of antidepressant, anti-anxiety, neuroleptic, and/or stimulant drugs. When such effects become obvious, the patient, the patient's family, or the treating psychiatrist may refuse to continue the drug-treatment program. This helps explain why ECT is so necessary in modern psychiatric practice: it is the treatment of next resort. It is psychiatry's way of burying mistakes without killing the patients—at least not too often. Growing use and failure of psychiatric-drug treatment has forced psychiatry to rely more and more on ECT as a way of dealing with difficult, complaining patients, who are usually hurting more from the drugs than from their original problems. And when the ECT fails to "work," there's always—following an initial series—more ECT (prophylactic ECT administered periodically to outpatients), or more drug treatment, or a combination of the two. That drugs and ECT are for practical purposes the only methods psychiatry offers to, or imposes on, those who seek "treatment" or for whom treatment is sought is further evidence of the profession's clinical and moral bankruptcy.

5. Psychiatrists account to no one. Psychiatry has become a "Teflon profession": what little criticism there is of it does not stick. Psychiatrists routinely carry out brutal acts of inhumanity and no one calls them on it—not the courts, not the government, not the people. Psychiatry has become an out-of-control profession, a rogue profession, a paradigm of authority without responsibility, which is a good working definition of tyranny.

6. The government supports the use of ECT. The federal government stand by passively as psychiatrists continue to electroshock American citizens in direct violation of some of their most fundamental freedoms, including freedom of conscience, freedom of thought, freedom of religion, freedom of speech, freedom from assault, and freedom from cruel and unusual punishment. The government also actively supports ECT through the licensing and funding of hospitals where the procedure is used, by covering ECT costs in its insurance programs (including Medicare), and by financing ECT research (including some of the most damaging ECT techniques ever devised). One recent study

provides an example of such research. This ECT experiment was conducted at Wake Forest University School of Medicine/North Carolina Baptist Hospital, Winston-Salem, between 1995 and 1998 (McCall, Reboussin, Weiner, & Sackeim, 2000). It involved the use of electric current at up to 12 times the individual's convulsive threshold on 36 depressed patients. The destructive element in ECT is the current that causes the convulsion: the more electrical energy, the greater the brain damage. This reckless disregard for the safety of ECT subjects was supported by grants from the National Institute of Mental Health (p. 43).

7. Professionals and the media actively and passively support the use of ECT. Electroshock could never have become a major psychiatric procedure without the active collusion and silent acquiescence of tens of thousands of psychiatrists and other allied health professionals. Many of them know better; all of them should know better. The active and passive cooperation of the media has also played an essential role in expanding the use of electroshock. Amidst a barrage of propaganda from the psychiatric profession, the media passes on the claims of ECT proponents almost without challenge. The occasional critical articles are one-shot affairs, with no follow-up, which the public quickly forgets. With so much controversy surrounding this procedure, one would think that some investigative reporters would key on to the story, but until now this has been a rare occurrence. And the silence continues to drown out the voices of those who need to be heard. I am reminded of Martin Luther King's 1963 "Letter from Birmingham City Jail," in which he wrote, "We shall have to repent in this generation not merely for the vitriolic words and actions of the bad people, but for the appalling silence of the good people" (cited in Washington, 1986, p. 296).

CONCLUSION

Especially in these perilous times, Dr. King's words need to be taken seriously. While electroshock is being used anywhere on anyone and I am free to express my views, I will continue to write and speak the truth about electroshock. I will do so not only on behalf of those of us who have survived electroshock more or less intact, but on behalf of those who are right now undergoing ECT or who will be faced with the prospect of undergoing ECT at some time in the future. I will also do so on behalf of the silenced ones, the ones whose lives have been ruined, and the ones who died—the true victims of electroshock, all of whom bear witness through my words.

By way of summary, I will close with a short paragraph and with a poem I wrote in 1989.

If the body is the temple of the spirit, the brain may be seen as the inner sanctum of the body, the holiest of holy places. To invade, violate, and injure the brain, as electroshock unfailingly does, is a crime against the spirit and a desecration of the soul.

Aftermath

With "therapeutic" fury
search-and-destroy doctors
using instruments of infamy
conduct electrical lobotomies
in little Auschwitzes called mental hospitals.

Electroshock specialists brainwash
their apologists whitewash
as silenced screams echo
from pain-treatment rooms
down corridors of shame.

Selves diminished
we return
to a world of narrowed dreams
piecing together memory fragments
for the long journey ahead.

From the roadside
dead-faced onlookers
awash in deliberate ignorance
sanction the unspeakable—
Silence is complicity is betrayal.

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