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## Electroshock: The Gentleman's Way to Batter Women

by Bonnie Burstow, Ph.D.

Daily, in institutions in almost every part of the world, people—mainly women—are wheeled into special rooms and administered ECT (electroshock or electroconvulsive therapy). In the United States alone, six million human beings have undergone this treatment (see Frank, 2006), and ECT is on the horizons of many more. This is so because there is a profitable industry built on it (see *MindFreedom*, 2002–2003). This happens because psychiatry is what sociologist Dorothy Smith (1987) calls “a regime of ruling”, that is, a regime with the power to dictate reality; and in psychiatric discourse, ECT is a benign, safe, and effective solution to a troubled mind—one which has received bad press to be sure, but which is new, modified, and to be trusted (see, for example, the discourse of Fink, 1999). This happens for other reasons also which will become clearer as this article unfolds.

Now, for a safe and effective treatment, ECT has been marked by a strange history of the people presumably benefiting from it curiously rallying to have it discontinued. There have long been protests and, indeed, formidable campaigns waged against ECT by survivors and their allies—books written, demonstrations staged, city councils appealed to (see Burstow, 2006a and 2006b)—but they have not succeeded in curtailing the treatment. Indeed, as shown in *MindFreedom* (2002–2003), it is on the rise.

As suggested by Breeding (2007), while the average person is unaware that ECT is still used—never mind on the rise—where people become aware, initially, they may be concerned, for something about ECT sits wrong, but they generally back off, announcing that they are not medical experts and suggesting that perhaps the treatment is necessary. Such is the power of a regime of ruling. The fact is, despite decades of protest and despite a degree of public discomfort with ECT, it is protected by medical hegemony which frames how we are to think. That being the case, what I am doing here—addressing electroshock as violence and situating an article to that effect in a publication on violence—necessarily flies in the face of common sense. The point is, psychiatry is a prestigious helping profession, and electroshock is a standard psychiatric treatment intended to help, and as such, common sense dictates, it must be of some use, and whatever its shortcomings, minimally, it could not qualify as violence. As feminists have long understood, however, deconstruct what is purportedly done for one's own good, and violence will often be found.

Professional misrepresentations of electroshock are the backdrop against which this article is written. What this

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article will demonstrate is that contrary to hegemonic medical discourse, electroshock harms—indeed violates. Moreover, despite the gender-neutral terms in which it is couched, it is only too gendered and is properly understood as a form of violence against women. Most of this article explores the violent nature of ECT, particularly focusing in on the gendered nature of that violence. The article ends with a reflection on the implications for those concerned with violence against women. While the article in no way limits the understanding of that violence to comparisons to domestic abuse, at various points throughout, additionally, the resemblance to domestic abuse and what this resemblance reveals is highlighted.

### Technically Speaking, What Is ECT?

ECT is a psychiatric procedure which consists of passing sufficient electricity through the head (100–190 volts) to produce a grand mal seizure or convulsion—hence the term “electroconvulsive therapy”. In unilateral shock, both electrodes are placed on one side of the head, while in bilateral shock, one electrode is placed on each side. While the term “new improved shock” or “modified shock” creates the impression that something substantial changed

recently, modified shock was introduced in the 1940s and was standard practice by the mid-fifties. The major modifications are use of a muscle relaxant and application of oxygen during the procedure—the purpose being to prevent bone fractures and joint dislocations. Typically, a single ECT series consists of at least six to ten treatments (see Frank 1978 and 2006; the Electro-convulsive Therapy Review Committee, 1985; Breggin, 1979; Breggin, 1991; Breggin, 1997; Breggin, 1998).

### How Did ECT Begin?

While no treatment could be adequately assessed on the basis of its origins, beginnings can be instructive. Invented in fascist Italy, ECT was inspired by the sight of animals en route to the slaughter being rendered docile by an electrical cattle prod. The first human recipient was a homeless man who was dragged off the street and administered it against his will. As documented in Frank (1978, pp. 8–11), no sooner did the first jolt of electricity surge through the head of the first electroshock recipient than he bolted upright, screaming in horror, “Non una seconda! Mortificare!” (Not again, it will kill me.) Later, the inventor, Cerletti, acknowledged, “When I saw the patient’s reaction, I thought to myself: This ought to be abolished” (see Frank, 1978, p. 11).

### The Scientific Findings: ECT as Damage

As early as the 1950s, animal experiments established that ECT causes brain damage. For example, in a definitive double blind study, Hartelius (1952) examined the slides of the brains of cats—half of which had received electroshock. On the basis of observable brain damage (cell death and hemorrhages), with almost complete accuracy, he was able to identify which animals had been administered shock.

To cite relevant research on human beings with respect to both unilateral and bilateral shock, Weinberger (1979) found more cerebral atrophy in the brains of “schizophrenics” who have had ECT than those that have not. And in an ECT study, Calloway (1981) found a correlation between frontal lobe atrophy and ECT.

Memory loss, intellectual impairment, and the creation of neuropathology are standard and well documented. An experimental study (Templer, Ruff, and Armstrong (1973)) establishes that ECT causes permanent memory loss and general intellectual impairment. On the basis of a critical review of the literature—including animal and human autopsy, epilepsy and seizure studies, and studies of memory loss and intellectual impairment—Templer and Veleber (1982) concluded that ECT causes permanent brain pathology. Breggin’s

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extensive literature review (1998, p. 27) culminated in the following conclusion: "ECT causes severe and irreversible brain neuropathology including cell death. It can wipe out vast amounts of retrograde memory while producing permanent cognitive dysfunction."

Especially significant and equally harrowing are the conclusions of neurologists. While few neurologists have conducted research into ECT or indeed, even commented on it, they have special credibility here for they are uniquely qualified to speak of brain damage and they have no vested interests, that is, no personal or professional reason to either approve or disapprove of ECT. Those neurologists who have researched it have been unequivocal, declaring it a brain-damaging procedure, one neurologist (Friedberg, 1977) actually naming one of his articles "Shock Treatment Is Not Good for Your Brain," and another, Sidney Samant, redefining electroshock as "brain damage produced by electrical means" (quoted from Breggin, 1991, p. 184).

While minimizing or totally denying the damage done, ECT promoters defend the use of shock on the basis of its alleged effectiveness in alleviating depression and preventing suicide. However, research shows that the efficacy claims are false. In a rigorously controlled double blind study, Lambourne and Gill (1978) found that a month after shock and simulated shock, there was no discernable difference in improvement between the shock and control groups. They concluded that shock's alleged effectiveness is probably due to placebo. Research by Johnstone (1980) and Crow and Johnstone (1986) produced similar results. In 1991, Breggin (p. 207) concluded, "after more than fifty years there is no meaningful evi-

dence that this dangerous treatment has any beneficial effect." As late as 2006, Colin Ross (2006) did an extensive review of the literature on sham ECT. No indication was found that this brain-damaging treatment outperforms placebo.

### **The Latest Significant Piece of Research**

Shortly after the Ross (2006) finding, the largest and most ambitious study in ECT history was concluded. It involved 346 shock recipients, used a barrage of different measures, and involved six month follow-up. Headed by a long time and staunch shock advocate, the study (Sackeim et al., 2007) established cognitive impairment, brain damage, and memory impairment to the level of statistical significance—moreover, a high level of significance—with respect to both unilateral and bilateral electroshock, and indeed, for every method of delivering electroshock, including the newest.

### **Effective in Doing What?**

Profits and career motivations aside, the longstanding discrepancy between the doctors' claims of effectiveness and what research actually establishes raises the question of whether or not psychiatrists' impression of effectiveness is based on something other than lowering depression and preventing suicide. Psychiatrist Peter Breggin (1991, p. 212) attributes it to ECT's ability to control behaviour via fear and punishment, and by way of illustration, he calls attention to telling statements made by his colleagues. For instance, he cites one colleague who used the expression, "let's throw the book at him" to denote "let's give him ECT" and another as telling a man that the treatment would help his wife "by virtue of a mental spanking." Indeed, such statements are suggestive. What is

also significant, psychiatry's long and documented use of terror and torture, lends support to Breggin's position. Note, in this regard, such torture apparatus as the ovary compressor and such torturous procedures as repetitively dunking a patient in ice water (see Szasz, 1977 and Frank, 1979).

Breggin (1979) and (1991) advances a further explanation. A good part of what is impressing his colleagues, he suggests, is precisely the controlled behaviour, memory loss, and intellectual impairment arising from brain damage. He also maintains that his colleagues are aware that brain damage is operant.

There is merit to these claims. Without question, brain damage frequently renders people easier to control and in a profession with the job of controlling behaviour, "more controlled" easily translates into "improved." There is no question, additionally, but what inspired the inventor of ECT was precisely the docility of the animals who had been stunned by the electrical cattle prods. And minimally, psychiatrists who administer shock would have to be aware of memory loss, for there is a huge literature on it and patients routinely complain about it (see, in this regard, Burstow, 2006 and Frank, 2006). Correspondingly, psychiatrists who administer shock have been known to make statements which show that they are not only aware of but are counting on that memory loss. By way of example, at a review board hearing at which I testified as an expert witness, the psychiatrist who was seeking permission to force electroshock on a woman who was not eating took the patient's lawyer aside and told the lawyer that electroshock would solve the problem, for after shock, the woman would not remember why she was not

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eating and so would likely resume eating. Additionally, there is reason to believe that electroshock promoters throughout the years have been aware of profound damage beyond memory loss and, to varying degrees, have counted on that additional damage. Take Abraham Myerson—a

the prospect of brain damage evokes terror and keeps patients in line.

### Statistics: What Do They Tell Us?

The quotation from Myerson suggests that *some people's* brains are expendable. A look at electroshock statistics quickly reveals *which people's* brains. Throughout the history of ECT, one statistic remains constant: Women

study proves conclusively that women incur more damage from electroshock than men. To be clear, this finding comes as no surprise to those of us who have been listening carefully to shock survivors over the decades. We were well aware that we were hearing more horrendous stories from the women than from the men—stories of 20 years of memory wiped out, stories of not being able to navigate their lives any more (see Ontario Coalition to Stop Electroshock, 1984). However, it does bring home a frightening truth about electroshock. Strip away the medical verbiage and the simple fact is that the people most damaged by electroshock (women) are administered electroshock two to three times as often as the people less damaged by it (men), with the damage coming overwhelmingly at the hands of men.

Now as lawyer and shock survivor Carla McKague points out (Burstow, 1994), psychiatrists who promote shock typically defend the ratio by pointing out that shock is most commonly given for depression and that women are simply depressed approximately two to three times more often than men. However, besides that damaging women's brains is hardly a satisfactory solution to the societal ills that depress women, as has already been shown, electroshock has no special efficacy in relieving depression. Moreover, as the Electro-convulsive Therapy Review Committee (1985) found, women are electroshocked two to three times as often as men *irrespective* of diagnosis.

In other words, the justifications do not add up. Indeed, it is difficult to make sense of what is happening unless we shift the lens and dispense with notions like "treatment". The point is, despite the medical arena in which it is played out, what we appear to be witnessing is intentional injury—not legitimate treatment. And while injury is horrific regardless of who is being injured, we are particularly seeing women targeted. To put the statistics and the findings into the larger context of gender violence, we are seeing the gender most commonly hurt by the other gender targeted by that gender. And we are seeing the gender most likely to be horrendously hurt by the treatment targeted by the other

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## *Women are subjected to electroshock two to three times as often as men. Approximately 95% of all shock doctors are male.*

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prominent psychiatrist who was absolutely pivotal in popularizing electroshock. Significantly, Myerson explicitly lists the brain-damaging capacities of ECT as a virtue, explaining:

I believe there have to be organic changes or organic disturbances in the physiology of the brain for the cure to take place. These people have for the time being at any rate more intelligence than they can handle . . . and the reduction of intelligence is an important factor in the curative process (quoted from Breggin, 1979, pp. 142–143).

By the same token, in the days before acknowledging brain damage became verboten, current electroshock guru Max Fink (1973) expressly and repeatedly linked ECT effectiveness with brain dysfunction.

The point is clear. At very best, damage to the integral person is being accepted as necessary even if unfortunate. And at worst, it is damage *per se* which is being seen as the *source* of the improvement; and it is damage *per se* that is being actively sought. In both cases, but most dramatically with the latter, what is happening constitutes violence.

Doctors, of course, can deliberately damage the brain without intending the damage as punishment or control. However, as Breggin (1991) documents, routinely, shock doctors identify the patients' greater compliance as *evidence* of shock's effectiveness. Moreover, irrespective of conscious intent, brain damage renders patients more compliant, and, as will be demonstrated in later sections of this paper,

are subjected to electroshock two to three times as often as men. To cite as examples statistics from different eras and locations, a 1974 study of electroshock in Massachusetts reported in Grosser (1975) revealed that 69% of those shocked were women. By the same token, in Ontario in 1999–2000, 75% of the shock administered was administered to women. And in 2007, British Columbia psychiatrists billed for 558 ECT treatments for women as contrasted to 275 for men (see Health Planning Division, British Columbia Ministry of Health, 2008). Another statistic that seems relevant is that approximately 95% of all shock doctors are male (see Grobe, 1995).

Factor in these statistics, and a frightening and indeed anti-woman picture of ECT emerges: Overwhelmingly, it is women's brains and lives that are being violated by shock. Overwhelmingly, it is women's brains, memory, and intellectual functioning that are seen as expendable. Insofar as people are being terrorized, punished, and controlled, overwhelmingly, those people are women. And what is likely not coincidental, almost all the people making the determinations and wreaking the damage are men.

These statistics and their implications are alarming in themselves. A finding in 2007 makes the statistics all the more alarming. In the 2007 study referred to earlier—the largest study in electroshock history—Sackeim et al. (2007) broke down the findings by gender. Using a battery of scientific tests, with all measures established to the level of statistical significance, the

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gender. What we are seeing, in other words, is violence against women.

Something of the purpose of this violence is suggested in Breggin's reference to a colleague who urged a husband to agree to the shocking of his wife because it would help, functioning as a "mental spanking" (Breggin 1991, p. 212). "Spanking" bespeaks the infantilization of women at the hands of men. Moreover, the entire incident bespeaks men's use of violence to keep women in line.

As feminists, it is critical that we understand this violence better. And it is critical to approach the issue from the standpoint of those most affected. I proceed, accordingly, to what women who have been electroshocked say about their experiences.

### Women Electroshock Survivors Speak Out

**Damage, Impairment, Diminished Lives.** Damage to the brain, impairment of memory and other cognitive functions, and the dismal effects on the women's lives are recurring themes in women survivors' testimony. Significantly, solely on the basis of what they were experiencing, all ten women shock recipients discussed in an article on women electroshocked in the Bay area (Warren, 1988) thought that the purpose of electroshock was to erase memory. Correspondingly, all women shock survivors interviewed for my video (Burstow, 1994), all women shock survivors who testified in front of the Toronto Board of Health (Phoenix Rising Collective, 1984), all but one woman survivor who testified at the first ECT hearing in Toronto (Ontario Coalition to Stop Electroshock 1984), and all but one who testified at the second (Electroshock Panel 2005) spoke at length about their difficulty navigating the world because of electroshock-induced damage. Examples of problems listed by women include: not being able to recall current conversations and ongoing events; inability to remember events that happened or people they knew prior to shock; loss of skills; being able to manage mundane repetitive jobs only; the sense of being diminished. To quote one survivor to give you an extent of the injury:

I'm missing between eight and fifteen years of memory and skills . . . I was a trained classical pianist . . . Well, the piano's in my house, but . . . it just sits there. I don't have that kind of ability any longer . . . People come up to me . . . and they tell me about things we've done. I don't know who they are. I don't know what they're talking about . . . Mostly what I had was . . . modified shock, and it was seen as effective. By "effective", I know that it is meant that they diminish the person. They certainly diminished me . . . I work as a payroll clerk for the Public Works Department. I write little figures, and that's about all . . . And it's the direct result of the treatment (Phoenix Rising Collective, 1984, 20A–21A).

Damage to memory and other cognitive functions and profound interference in family and other social life, correspondingly, are highlighted in Shirley Johnston's testimony (Phoenix Rising Collective, Ed., 1984, 21A–22A):

The damage done to my brain . . . is still evident . . . The memory loss is especially painful, since I could not remember a lot of times while the children were growing up . . . The two older children—I do not remember their graduations. Many times, my family and friends would bring up happenings that I had to question them about, to test whether my memory would return. Usually not. I feel so alien because of this damage . . . One of my children's school interviews was terrifying, because I didn't want to reveal . . . the gaps in my memory—I was still in the closet. Finally when the anxiety got so bad, I would completely avoid people.

Typically, other women's stories likewise reveal profound disruption in their being-in-the-world. Wendy Funk (1998) writes about being cared for by strangers whom she never came to remember (husband and children). Linda Macdonald writes about never retrieving any of her pre-shock memory (see Burstow and Weitz, 1989). Sue Clark-Wittenburg (see Clark-Wittenburg, 2008), who received five shocks only—an unusually small number—reports that 35 years later, she still has

difficulty keeping track of what she is about from hour to hour—let alone day to day. "Who knows what I would have become if I was not forced to undergo shock—a doctor, a lawyer, a scientist?" she asks.

While it figures in the discourse less frequently and less urgently, some women additionally refer to bodily injury. For example, Wendy (Funk, 1998) reports that the seizures injured her knee permanently. And Shirley, who was given unilateral shock and so would expectably be affected more on one side than the other refers to general bodily weakness but particular weakness on the right side, stating:

It became very difficult to lift my lower spine and middle back . . . When I am tired, there are times my mouth will not form words. At times, I have lost the use of my right arm and right leg (quoted from Phoenix Rising Collective, Ed., 1984).

**Assault and Trauma.** Repeatedly, women's testimonies connote a sense of the entire process as an ongoing assault—being herded into the room, being strapped down, one's head being encased in a band, being unable to breathe, being rendered unconscious, having one's body violated by shock, being brain-damaged. "I feel like I've been gotten at, bashed, as if my brain has been abused," states one of the women in the Johnstone study. "It can feel like a brutal assault on who you are," states another (see Johnstone, 2002–2003, p. 46). Some women pointedly identify the process as torture, and urge us to understand it as such. Sue, for example, proclaims:

All the therapy in the world is not going to erase the scars of being dragged into a room, having a band on your head, and having your brains fried. People say there's no torture in Canada. That's pure bullshit. And excuse my language. There is torture being paid for by the Ministry of Health (quoted from Burstow, 1994).

Figuring in the sense of assault is the sense of being treated like an animal, a sense of being led to the slaughter. One survivor explicitly speaks of "the feeling of being led to the slaughter on

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treatment mornings and knowing when they put the needle in, it meant blackness and waking up with the splitting headache and not knowing where my room was even" (quoted from Ontario Coalition to Stop Electroshock, p. 180).

In line with survivor depictions, British researcher Lucy Johnstone (2002–2003) identifies ECT-induced trauma in all the women shock survivors interviewed in her study. The trauma, however, is more extensive than even Johnstone suggests. Testimony by shock survivors typically lays bare extreme states of terror, the feeling of being powerless, the sense of being humiliated and degraded, the subjective sense of annihilation, of dying. Why did I have "to die thirty-six times?" asks a shock survivor at a recent hearing in Toronto (Electroshock Panel, 2005). "Your heart's a muscle, and your lung's a muscle, and all of your muscles stop," points out shock survivor Connie Neil, "and each time, you feel like you are dying, and then they shoot electricity through your head, and then you don't know anything" (quoted from Burstow, 1994).

Feelings of humiliation and degradation are equally evident in survivor testimony, and as with the sense of death and doom, they are tied to the assault, to the sense of being purposefully mistreated. "I felt like an animal"; and "they strip you of your self-worth", state survivors (quoted by Baldwin and Froede, 1999, p. 185). By the same token, a woman in the Johnstone study states, "I felt as if I was a non-person" (p. 49). Statements like these, it should be noted, are hardly new to those of us in the VAW world, for they are strikingly similar to statements found in the domestic abuse literature (see, for example, Martin 1981).

As with all victims of ongoing abuse, additionally, the women typically express a sense of having no control, of being powerless. For example, a woman at a public hearing testified, "I never felt so helpless in all my life" (quoted from Baldwin and Froede, 1999, p. 185). The sense of helplessness joins with the sense of diminishment in women's depiction of themselves as being infantilized (see, for example, Baldwin & Froede, 1999, pp. 184–185).

Terror, humiliation, and sense of helplessness, significantly, stem at once from the damaging and terrorizing treatment and from the larger objective context of "a total institution"—an institution which controls all aspects of life. The context is such, correspondingly, that it mutually constitutes the woman shock recipient as powerless child who knows that she will not be heard and the presiding male as all powerful parent who knows what is best and will enforce it. Velma Orlikow's compelling description of her experiences on the ward illustrates one of the ways these different elements can come together in the traumatizing present:

I never saw him once that I wasn't afraid. Every time I saw him coming down the hall, I'd shake with fear . . . I'd say, "I can't, I can't take it any more. I don't think this is doing me any good. I feel worse." And he'd walk down the hall a little way and put his arm on my shoulder and say, "Come on now, lassie, you know you're going to do it" (quoted from Burstow & Weitz, 1988, pp. 202–204).

The patriarchal nature of such violence is not lost on women survivors. Many have used words to suggest that it is battery by men. Note, in this regard, psychiatric survivor Ollie May Bozarth's classical reference to electroshock as "a gentleman's way to beat up a woman" (Bozarth, 1976, p. 27).

As with all trauma (see Herman 1992 and Burstow 2003), the effects of the trauma remain long after the events which occasioned them pass. Significantly, women explicitly refer to the low self esteem and the sense of powerless continuing (see, for example, Burstow, 1994). As is common in trauma, however, it is the ongoing fear which is most emphasized. Note, in this regard, Connie Neil's statement, "But the biggest thing, I think, is the business about the terror and the violence. This just doesn't go away" (quoted from Burstow, 1994).

**Punishing/Controlling Women.** Not all women who experience electroshock as assault see it as punishment. Most, however, do. In this respect, Connie Neil states, "It was meant to be punishment" (quoted from Burstow, 1994). And women report wondering what they did

wrong to deserve such punishment (see Johnstone, 2002–2003, p. 49).

As with other forms of violence against women, punishment and control go hand in hand. Woman after woman has testified that the real purpose of the ECT was social control. Cognitive impairment or memory loss is frequently identified as the means. The rationale is: What cannot be remembered, cannot be acted on (see in particular Warren, 1988; Funk, 1998; and Ontario Coalition to Stop Electroshock, 1984). Correspondingly, if people are so impaired that they cannot function, behaviour seen as undesirable may be altered (see, Funk, 1998 and the Ontario Coalition to Stop Electroshock 1984).

Still more commonly, women testify to being kept in line via fear of ECT.

There was always the fear . . . that you are going to appear a little outside the norm, says shock survivor Connie Neil. "You must not be anything that is outside the norm because . . . if you are, you will be taken to a hospital, you will be strapped down, and you will be given electroshock (Ontario Coalition to Stop Electroshock, 1984, p. 90).

Connie makes the point more forcefully still in the Burstow (1994) video:

All I did was have a baby. And look at what they did to me. Now if I really did something, what would they do to me next? So you have to be very very careful . . . You fit in. You play a role.

ECT, it would seem, is effective in the way abuse is always effective—by inspiring fear of further violation. Additionally, a vicious cycle sets in, with ECT used to stop women from complaining about the effects of ECT. Significantly, many women have testified that when they spoke of the treatments making them worse, they were told in no uncertain terms that continued complaints would be interpreted as illness and result in further "treatment". Not surprisingly, women reported protecting themselves by obeying (see, for example, Funk, 1998). What is also telling, women psychiatric survivors who have not been shocked describe

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the very witnessing of shock in the institution as both traumatizing and as an everpresent threat. "It was a threat to those of us who were not to receive ECT to get our act together really quickly or else this could happen to us," stated a woman at one of the hearings (Ontario Coalition to Stop Electroshock, 1984, p. 161 ff.).

Add all this up, and what you have is battery complete with extensive injury, trauma, intimidation, danger. Put all this together, correspondingly, and what emerges is a formidable and comprehensive method of social control. The fact that such control is primarily exercised over women would raise the question of gender role enforcement even if women's own testimony did not suggest it. Women's testimony, however, blatantly suggests it.

Women have testified to ECT being used to control their sexuality (see Blackbridge and Gilhooly, pp. 45–50).

I told my shrink I didn't want to be cured of being a lesbian, writes Gilhooly. He said that showed how sick I was. He said I needed shock treatment . . . Nineteen shock treatments later, I still did not want to be cured of being a lesbian.

ECT in the interest of compulsory heterosexuality is clearly operant.

Being controlled as a wife figures particularly centrally—generally with the psychiatrist seeking this control, sometimes with the husband tricked into cooperating, sometimes with him actively instigating. British Columbia's Wendy Funk is a case in point. In 1989, states Wendy, the following conversation transpired between her husband and her doctor:

"Can't you tell her to . . . spend more time at home?" Dr. King asked.

"I try but she doesn't listen to me," Dan joked.

"So you can't control your wife's behaviour?" Dr. King asked. (Funk, 1998, p. 15).

Dr. King "explained" to Wendy that her "problem" arose from neglecting her house and being consumed by "feminist-type thinking" (p. 48). Locked in a ward, with Dan urging cooperation, and her doctor pushing

ECT and threatening to ship her far away if she refused, Wendy consented and was shocked. Wendy's psychiatrist later pressured for further ECT, telling her, "You really should have ECT for the sake of your family if nothing else. Making Dan worry about you so much is not a good thing for a wife to do" (p. 91). Patriarchal enforcement of stereotypical wife and mother behaviour is evident.

Patriarchal control is equally marked in the stories of other women who received electroshock while married. "Why don't you care for your baby? Why don't you care for your husband? Why don't you smarten up?" Connie was asked before the electrical assaults began (quoted from Ontario Coalition to Stop Electroshock, 1984, p. 87). Women saw shock's purpose as "fixing" the marriage with "fixing" *them* as the route. "Shock treatments is a helluva of a way to treat marital problems," objected one woman in the Warren study (Warren, 1998, p. 296).

A particularly extreme example of "wife control" happened in the Allen Memorial at the hands of renowned psychiatrist Alan Camera—one time head of the World Psychiatric Association. Cameron used rapid ECT to "depattern" or wipe clear the mind and reduce patients to the level of infants. On top of being given shock, taped messages played as the patients slept, with the same personally tailored message playing over and over. An example of a message given to one woman who was in conflict with her husband was "you are at ease with your husband" (quoted from Gilmour, 1987).

Another extreme example of ECT in the service of wife control is the practice of couples therapist H. C. Tien. Tien used electroshock to effect what he called "memory loosening" with women in "marital difficulty". Transcripts of dialogues between Tien and one married couple show the woman prior to shock complaining that her husband beat her and announcing her wish to leave him. After each ECT treatment, at Tien's instigation, the woman was reprogrammed by her husband, who bottle-fed her. In the end, the woman declared that she was happy with her husband and she was pronounced cured (for documentation, see Breggin, 1991). What we have here is: (a) the infantilization of women;

(b) sexist brain-washing; (c) collusion between husband and psychiatrist; and (d) battery which is both institutional and domestic. Now Cameron and Tien are extreme examples to be sure, but examining the extreme is helpful for it writes large the dynamics inherent in more everyday use of ECT on women.

### **Involvement of Male Partners**

As is evident in the foregoing, others from the women's private lives tend to be implicated in the shock experience, and not uncommonly, those others are male partners. Most men who are implicated are worried about their partners and think that they are helping. Equally significantly, however, they have been socialized to trust men in authority and to see "fixing women" as a solution to life's problems.

Collusion between husband and doctor is a slippery slope which generally begins with husbands, at the psychiatrist's behest, urging their partners to have ECT, or what is particularly common, authorizing it for them. Indeed, in many cases, if not most, as testimony reveals (see Ontario Coalition to Stop Electroshock 1984 and Electroshock Panel, 2005), married women receive ECT as a result of their husband signing the consent form, often against their own wishes. Many husbands have no idea that damage will be done. Most of the rest may have nagging doubts but are largely reassured by the doctor's insistence that ECT is new, modified, safe, effective. Still other male partners, however, are aware of and even counting on some degree of damage. And whether they knew about damage in advance or not, some relish the damage (see Warren 1988).

In the Warren study (1988), significantly, which included interviews with the husbands of women electroshocked, a number of husbands expressed satisfaction with the memory loss. In this regard, Warren (1988, p. 294) writes, "Mr. Karr commented on his wife's long-term memory loss as proof of her successful cure by ECT . . . . These husbands used their wives' memory loss to establish their own definitions of past situations in the marital relationship."

There is a continuum here, and it would be unfair to view all husbands

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who cooperate with the shocking of their wives in the same light, especially given the hegemony of psychiatry. At some point, nonetheless, the institutional abuse that is called “electroshock” decisively enters the arena of domestic abuse even where men are not battering their wives in any traditional sense.

The combination of husband plus medical establishment plus threat of further ECT is formidable in its ability to control women. Once again, Warren (1988) is instructive. Women told Warren that they refrained from expressing any kind of problems to their husbands, “for fear of reprisal in the form of ECT” (p. 296). What we have here is a medical-marital web of control which includes threats, which involves damage, and which leaves women very little room to maneuver. Ways in which husbands have been implicated in this medical-marital web of control of women include: battering their wives while treating the battery as irrelevant and their wives “mental health problems” as “the real issue”; consenting to the electroshocking of their wives; pressuring wives to consent; suggesting shock; acting as a spy for the psychiatrist; advising the doctor of “bad behaviour”; threatening to report noncompliance even while knowing that this threat will predictably result in further control and potentially further electroshock; and using their wives’ medically-induced memory problems to ensure that their own views of the marriages are accepted (see Warren, 1988, Funk, 1998, Burstow, 1994, and Ontario Coalition to Stop Electroshock, 1984).

### **Electroshock on the Heels of Other Violence Against Women**

What adds to the complexity of understanding ECT as violence against women, as is evident in the foregoing, are the complex relationships between having already been subjected to another form of violence against women and being subjected to ECT. Approximately half of the shock survivors interviewed in my video (Burstow, 1994) reported having told their psychiatrists that it was upset over previous or current sexual abuse or battery that landed them in the hospital. In all instances, the women informed me, nothing happened to the abusive relatives or partners, but the

women were electroshocked. In some cases, the women were accused of lying. Even where psychiatric staff did not deny the abuse, correspondingly, it was largely regarded as irrelevant. Consider in this regard, the following interchange with ECT survivor Usha:

Bonnie: Let me ask you something I don’t understand . . . . Nowhere did they say that your husband should stop beating you and abusing you and that [the abuse] may have something to do with what’s happening to you?

Usha: No. They didn’t even want to listen to me that my husband was doing something to me and that it’s because of that I’m so much stressed out and so sad.

Bonnie: So you told them about it and what did they say?

Usha: They just ignored it, no? (quoted from Burstow, 1994).

Consider also the fate of teenager Sue (in Burstow, 1994). Sue ran away from home because of repeated abuse. She ended up homeless, then in a psychiatric ward, where she made it clear that abuse at home was at the root of her problem. She was not believed. Subsequently institutionalized in another hospital and still not listened to, Sue was given electroshock. At best, abuse is being ignored or disbelieved and ECT is being used to control women. As its worst, ECT is being used to silence women about their abuse.

Additionally, while I am not suggesting that this is standard, as women’s testimony reveals, more blatant types of silencing can also motivate the use of electroshock. Significantly, a woman in my video who had been sexually abused by her psychiatrist was threatened with electroshock should she ever divulge the abuse. Other women reported comparable threats by abusive male relatives.

Moreover, sometimes women are electroshocked because the family as a whole finds the eradication of abuse memories in their interests. A woman in the Warren study (1988) appears to be a case in point. According to her, she was sexually abused by her maternal uncle. After the relatives denied the abuse, her mother successfully

pushed to have her electroshocked. In this regard, the woman states:

Before we left the house . . . she [mother] was explaining [to other relatives] why she wanted me up here, you know, she wants me to have the full treatment, she says . . . . She said that she thought it would make me forget all those things . . . . My mother wants me to have shock so that I’ll forget all those things that happened. (p. 294)

While the mother may well have convinced herself that she was simply sparing her deluded daughter further agony, the daughter was effectively silenced regardless.

The types of silencing suggested here, I would add, are confirmed in my own psychotherapy practice. The message that women predictably get from such invalidation, violation, and threat of violation are: Complaints are counterproductive.

What is more fundamental, and what makes the issue of prior violence particularly complex, severely violated women are in special jeopardy of ECT whether or not ECT is being used to silence them. They are also likely to be traumatized more if given ECT. In this regard, as shown in Burstow, 1994; Burstow, 1992; and Burstow & Weitz, 1988, routinely, women end up in psychiatric institutions precisely because of violence against women. Once inside, women with such a history are at greater risk of ECT not only because they are frequently depressed but also because, as demonstrated in Burstow (1992 and 2003), traumatized women more commonly cope in ways that psychiatry theorizes as dangerous—cutting themselves, starving themselves. Correspondingly, if they are given electroshock, as Johnstone (2002–2003) demonstrates, retraumatization occurs. As such, ECT constitutes a special threat to violated women and is one of the ways in which the trauma of women is compounded.

### **Women in Special Jeopardy**

Several of the populations of women at particular risk of being subjected to this medicalized assault are evident in the foregoing. They include: women who are distressed, abused women,

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women who are in conflict with others who hold power over them, women who have received ECT previously, women who have not “improved” on psychiatric drugs, women who present as “suicidal”, women who are depressed. As testimony delivered in the public hearings makes amply clear, the latter group includes women who are suffering from post-partum depression, despite how natural postpartum depression is and despite its tendency to resolve itself. Significantly, woman after woman has testified to being given shock just after the birth of her baby (see, for example, Ontario Coalition to Stop Electroshock 1984). What no doubt contributes to this jeopardy, psychiatric guidelines for giving electroshock explicitly stipulate that neither pregnancy nor post-partum are counter-indications for giving ECT (see, for example, Mental Health Evaluation & Community Consultation Unit, 2002).

One group which is not obvious but which merits special mention because of the jeopardy is now so extreme is women over 65. As ECT statistics over the last couple of decades show, old age correlates with greater electroshock. Moreover, older women are given shock considerably more than either older men or women in any other age bracket, with some statistics showing women over 65 receiving half of all electroshock given to anyone (see Weitz 2001) some showing women over 65 receiving half of all electroshock given to women (see Health Planning Division, British Columbia Ministry of Health, 2008). The targeting of the elderly is particularly worrisome, for besides that it is harder for the elderly to defend themselves, research shows that the elderly sustain greater brain injury from the treatment (see Breggin, 1991, p. 205 ff.) Moreover, given that women as a whole incur more damage from electroshock than men, older women should be the very last group subjected to this dangerous treatment; and yet this population is the primary target of electroshock. The low societal value placed on elderly women is hardly coincidental.

### Concluding Remarks

The image of electroshock which has emerged in this article is one of woman battery—battery which is highly damaging and which is unleashed on

women at their most vulnerable. It is a particularly insidious form of battery, moreover, and one difficult to mobilize against because it is done in the name of help. What adds to the problem, it is committed by professionals; its victims are automatically defined as “not credible”; it is state-sponsored; it is seen as legitimate; it is underpinned by a huge industry with vested interests; it is routinely done with the cooperation of family members; and there are no shelters to which its victims or potential victims may flee.

It is beyond the scope of this article to provide detailed suggestions about what feminists can do about this form of woman abuse, though clearly, we have a responsibility here. To highlight a few possible directions, concrete measures that might be taken include: creating and disseminating feminist critiques of ECT; getting together with others similarly situated to issue professional statements as concerned nurses, as concerned VAW workers, as concerned social workers; allying with psychiatric survivor organizations and antipsychiatry organizations to mount public educational; joining in the annual international protest against ECT on Mothers Day; lobbying government; conducting research into ECT as a form of violence against women; including work to end ECT in the mandate of feminist organizations; coming to the aid of women at imminent risk; extending the working definitions of battery used at women’s shelters; refusing to work in any way with people or organizations implicated in the shock industry; investigating what is happening to the women warehoused in geriatric units.

I would end by reminding readers of the special jeopardy of older women. I end, correspondingly, by reminding readers that we will all grow old.

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