

TO SEE OR NOT TO SEE “SCHIZOPHRENIA” AND THE POSSIBILITY OF FULL “RECOVERY”



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The inspiring individuals presented in this article as exemplars of creative emergence from psychiatric labels and treatment are participants in electroshock coalition activity. Dr. Breeding is the author of four books, including *The Wildest Colts Make the Best Horses*, and *The Necessity of Madness and Unproductivity: Psychiatric Oppression or Human Transformation*. His Web site, www.wildestcolts.com, is a great resource on psychology, parenting, and issues of psychiatric oppression.

Summary

Since the beginning of modern psychiatry, the diagnosis of “schizophrenia” has epitomized the idea of chronic, severe mental illness. This engaging article looks at the beliefs and practices of biological psychiatry regarding “schizophrenia.” Guiding beliefs, however flawed they might be, determine perception and action, and this is very true in psychiatry. There are, however, significant differences between belief and fact in psychiatric theory. The author examines these differences, and presents research about the safety and efficacy failures of treatment, especially regarding the antipsychotic drugs. He reviews important dissident literature from both psychiatric survivors and professionals showing that recovery from extreme states, from “schizophrenia,” is quite possible. Although the standard psychiatric outlook for recovery from schizophrenia is virtually nil, the essay concludes with an inspiring story of musical artists who have demonstrated a reemergence from diagnoses of severe mental illness and treatment with antipsychotic drugs and electroshock.

Keywords: *psychiatry, mental illness; psychiatric drugs; antipsychotic drugs; schizophrenia; electroshock*

We see the world not as it is, but as we are. Talmudic adage also attributed to Anais Nin.

And we act according to our understanding.

For the mainstream psychiatric industry today—the government, big pharma, the courts and the psychiatric professionals—one thing is said to be clear: Schizophrenia is a chronic, progressive, incurable, genetic defect of the brain. To wit, consider this excerpt from schizophrenia.com, an industry Web site:

Schizophrenia is a chronic, severe, and disabling brain disease. Approximately 1% of the population develops schizophrenia during their lifetime—more than 2 million Americans suffer from the illness in a given year. Schizophrenia is a disease of the brain. (Overview of schizophrenia, 2008)

With such a definitive belief, the seeing is inalterable—people in extreme states of mind are schizophrenic.

The belief is the thing (Breeding, 2006). Stating this belief as a scientific fact lends credibility and gains power from its connection to another popular belief—that it is good to defer to medical authorities who know best about these things.

VALIDITY OF SCHIZOPHRENIA DIAGNOSIS

It is a fact that psychiatry calls schizophrenia a brain disease. Also fact is that the extensive body of evidence pointing out that the diagnoses of various “mental illnesses” is entirely subjective. One of the clearest expositions of the problems with psychiatric diagnoses is provided by Mary Boyle in *Schizophrenia: A Scientific Delusion?* (2002). She explains that the identification of psychiatric illnesses is a two-stage process: “a researcher or clinician first identifies a cluster of features which they believe ‘hang together’” (p. 13). Second, it is necessary to “show that this cluster is reliably associated with another feature which can be measured independently” (p. 13). It is this *independent* feature that is the rub, just as much for schizophrenia as for any of the other psychiatric labels. She concludes that “the entire enterprise of defining mental disorder is pointless, at least in so far as the goal is to allow us to

recognize ‘genuine’ or ‘true’ disorders” (p. 231). Boyle asserts that such an enterprise “can be seen as attempts to prove that we ought to respond to certain behaviors and experiences as if they were unwanted bodily phenomena *in the absence of evidence that this is a valid and useful way of proceeding*” (p. 231). Peter and Ginger Breggin (1994) conclude that it is scientifically incontrovertible that there is no convincing evidence that any condition routinely seen by psychiatrists has a genetic or biological origin.

The *Journal of Humanistic Psychology* has been remarkable in providing a place of publication for ongoing, spirited exposition and dialogue on this subject of “mental illness” and extreme states of mind, a rare venue for humanistic, psychological challenges and alternatives to the dominant biopsychiatric model of our country’s mental health system. To cite just one recent example, psychiatrists Thomas Szasz and E. Fuller Torrey loom as great archetypes of the controversy presented above in the juxtaposition of the views aired on schizophrenia.com and Mary Boyle on so-called schizophrenia. In 2004, *JHP* published Szasz’ critique of Torrey’s work. Torrey’s response followed the next year (2005), along with a commentary by Schwartz and Wiggins (2005).

There is, of course, a long history of pathologizing human experience, and a pretty decent history of challenging that practice. Jeff Rubin (2000) wrote in *JHP* about a very famous early psychologist, William James, who worked hard to depathologize the language trends present in the mental health field even in his day. In this author’s view, it is still best to turn to the incisive words of Thomas Szasz, who lays bare the true dynamic:

The point is not that psychiatric diagnoses are meaningless, but that they may be, and often are, swung as semantic blackjacks: cracking the subject’s respectability and dignity destroys him just as effectively, and often more so, as cracking his skull. The difference is that the man who wields a blackjack is recognized by everyone as a public menace, but one who wields a psychiatric diagnosis is not. (1970, p. 206)

Nevertheless, when one “sees” a brain disease, one wants to treat it. The industry is very reassuring about such treatment:

This is a time of hope for people with schizophrenia and their families. Research is gradually leading to new and safer medications and unraveling the complex causes of the disease. (Overview of schizophrenia, 2008)

RESEARCH AND LITIGATION ON ANTIPSYCHOTICS

What about this research? We know that the so-called antipsychotic drugs have caused perhaps the largest epidemic of neurological disease in history—tardive dyskinesia. The industry now offers “newer, safer” so-called atypical antipsychotics. The two most popular and profitable are Eli Lilly’s Zyprexa and Janssen’s Risperdal.

The country is now awash in state attorney generals suing makers of the antipsychotics for false advertising. In my home state, attorney general Greg Abbott added Texas to the list in December of 2006. Attorney Jim Gottstein has been in the news this past year in regards to his being sued by Eli Lilly for allegedly disclosing documents showing the company’s suppression of important data about the clinical trials of Zyprexa. See Gottstein’s Law Project for Psychiatric Rights Web site (www.psychrights.org) to access information about his legal challenge to Eli Lilly, the Texas attorney general document, and a host of related articles.

The country is also awash in class action lawsuits filed by users of the antipsychotics. For example, Eli Lilly has faced thousands of lawsuits over Zyprexa, claiming that drug labels failed to warn users about risks of diabetes and high blood sugar. Tim Murphy reports that,

The drug maker has spent about \$1.2 billion to settle roughly 28,000 Zyprexa claims since 2005. Lilly said Tuesday it had settled an additional 900 claims but did not disclose a settlement amount. The company still faces product liability lawsuits from roughly 750 patients. (2007)

Given that Lilly generated \$4.4 billion in sales from Zyprexa last year, they can afford hundreds of millions in settled claims. As Leonard Frank (2005) reports in his revealing article about Zyprexa, the math was well covered on a lawsuit settled June 8, 2005:

On July 21, [2005] Eli Lilly came out with its second-quarter financial report showing that \$1.07 billion was allocated to cover its liabilities in these lawsuits. That amount exceeded the \$690 million settlement by \$380 million. The additional sum was the company’s estimate of its liability and defense costs for the unsettled claims [reported in *Forbes.com*, July 21, 2005]. News of the settlement may generate more damage claims, in which event the cost to Eli Lilly may be greater than the \$1.07 billion already set aside.

The human story is about damage and death, although the following quote also reveals industry and governmental regulatory collusion:

Based on the results of a six-week clinical trial sponsored by Eli Lilly, the FDA granted the company permission to manufacture and distribute Zyprexa on September 27, 1996. The trial involved 2,500 subjects, and two-thirds of them didn't even successfully complete the trial. Among those who stuck it out, 22% of the Zyprexa subjects suffered a "serious" adverse effect, compared to 18% in the group taking Haldol.

The FDA reviewers found there was an average weight gain of almost 1 pound a week during the 6-week trial period and 26 pounds over a year-long period for the Zyprexa subjects who remained for the extension trial. Other drug effects included shaking, spasms, sedation, diabetic complications, rapid heartbeat, restlessness, constipation, seizures, liver problems, white blood cell disorders, and decreased blood pressure.

In addition, there were 20 deaths, including 12 suicides, in the Zyprexa group. Shockingly, these deaths went unreported in the scientific literature. The death cover-ups also took place in reporting trial results of several other atypicals during the 1990s.

Information concerning these deaths was obtained from FDA documents through the Freedom of Information Act by science writer Robert Whitaker, who wrote that one in every 145 subjects who entered the trials for Zyprexa, Risperdal, Seroquel, and Serdolect had died. (Frank, 2005)

The industry marketing is so highly effective that Frank's statement is regrettably still too true: "Potential and current users of the drug, doctors, and the public are still almost totally in the dark about Zyprexa's shameful history." (Frank, 2005)

The industry is also quite adamant about making sure treatment happens:

Because relapse of illness is more likely when antipsychotic medications are discontinued or taken irregularly, it is very important that people with schizophrenia work with their doctors and family members to adhere to their treatment plan. *Adherence* to treatment refers to the degree to which patients follow the treatment plans recommended by their doctors. Good adherence involves taking prescribed medication at the correct dose and proper times each day. . .

Treatment adherence is often difficult for people with schizophrenia, but it can be made easier with the help of several strategies and can lead to improved quality of life. (Overview of schizophrenia, 2008)

What are these strategies?

COERCION

I have written about a strategy of coercion, psychiatric incarceration, in previous pages of this journal (Breeding, 2006). Astounding numbers of U. S. citizens are deemed “mentally ill” and face psychiatric coercion every day. Extrapolating from California data, psychiatrist Lee Coleman states, “Since California has one-tenth of the nation’s people, we arrive at a national figure of 1.5 million to 2 million involuntary admissions per year in the United States” (Citizens Commission on Human Rights, 2005). Almost all states have now yielded to the growing coercive practice of so-called involuntary outpatient commitment (forced psychiatric drugging) on an “outpatient basis.” This is enforced by mental health professionals who form designated Assertive Community Treatment teams. For those readers who have only been exposed to relatively new versions of psychology education that censor the profound and prolific work of leading American ideological challengers of psychiatric coercion, I refer you to the works of psychiatrist Thomas Szasz, available at www.szasz.com, for a ringingly clear reminder that these massive assaults on liberty typically involve no criminal violations whatsoever.

OUTCOMES AND EFFECTS

Psychiatry today sees brain disease and insists on drug treatment. Here is a representative industry self-congratulation:

The outlook for people with schizophrenia has improved over the last 25 years. Although no totally effective therapy has yet been devised, it is important to remember that many people with the illness improve enough to lead independent, satisfying lives. As we learn more about the causes and treatments of schizophrenia, we should be able to help more patients achieve successful outcomes. (Overview of schizophrenia, 2008)

Here is a translation:

The outlook for “schizophrenia” has improved in that the sales and administration of so-called antipsychotic drugs has mushroomed. A particularly impressive expansion in the market for young people has garnered considerable media attention (Elias, 2006; Harris, Carey, & Roberts, 2007). Although there is no cure, many people are good patients, stay under control, live in group homes, and participate in day treatment. We don’t understand much about cause or treatment, but we are treating many and plan to treat even more as we implement universal mental health screening (see www.mentalhealthcommission.gov).

The real challenge for anyone attempting to understand the truth about psychiatry and so-called mental illnesses such as “schizophrenia” is to discern fact, theory, and opinion. The industry presents theory (e.g., schizophrenia is a brain disease consisting of a chemical imbalance regarding dopamine) and opinion (e.g., that mentally ill patients need to take their “medicine”) as fact. The actual fact is that the chemical imbalance theory has never been proven and that scientific research evidence suggests it is flat out wrong. I cite just two recent articles (Lacasse & Leo, 2005; Moncrieff & Cohen, 2006) that address these facts. I choose them because they are published in a free, peer reviewed journal that anyone can easily access without cost on the Internet.

As to outcomes, one of the best sources on the subject is Robert Whitaker’s 2002 book, *Mad in America*. The data is actually quite clear. In today’s world of psychiatry, recovery rates for “schizophrenia” are virtually nil. The industry justifies this massive failure with the beliefs outlined above that schizophrenia is a chronic, severe, and disabling brain disease. Therefore, the best one can hope for is to keep it under control with neuroleptic drugs. Whitaker lays out the contradictory facts that prior to the advent of the “miracle” antipsychotics, recovery rates tended to be about 60%. Furthermore, he points out that recovery rates are still about 60% in “undeveloped” countries that do not rely on neuroleptics. Whitaker also lays out some of the science pointing to the apparent fact that the drugs actually damage the brain in such a way that makes eventual recovery less likely.

Ron Bassman, psychiatric survivor and psychologist, wrote about his passionate views on survivor/consumer empowerment in the pages of this journal in 2001. In his new book, *A Fight to Be* (2007), Bassman lays out the reality of psychiatric oppression. He

presents strong research evidence, similar to the data Whitaker cites, of a good percentage of recovery of people considered severely mentally ill. Regarding the neuroleptics, Bassman refers to the work of his friend and fellow psychiatric survivor, Soja Kraer, who also suffers from a severe case of neuroleptic induced tardive dyskinesia. In 1988, Kraer cofounded the Tardive Dyskinesia/Tardive Dystonia National Association and offers a personal account of what it is like to live with a body that responds not to your requests but to its own unfathomable rhythms. Members of the Tardive Dyskinesia/Tardive Dystonia National Association can tell story after story of pain and suffering because of permanent neurological damage caused by antipsychotic drugs. Bassman cites the 2006 Clinical Antipsychotic Trial in Clinical Effectiveness study of 1500 patients that confirms the dark truth about these drugs, both old and new:

This sixty-seven million dollar federally funded study . . . paints a sobering picture of the state of treatment of schizophrenia, . . . Every drug, old and new, caused serious side effects, and the vast majority of patients stopped taking each of them. (Lieberman et al, 2006; quoted in Bassman, 2007, p. 217)

The industry calls it a problem with treatment adherence. David Oaks, psychiatric survivor and founder/director of the psychiatric liberation support and activism coalition called Mind Freedom has a different interpretation. Oaks says that the fact that three-fourths of patients stopped taking the drugs because of side effects or lack of benefit shows that these individuals “trying to say no to forced neuroleptics (drugs) have had a better grip on reality than the medical community.” (Vedantam, 2006, p. A1).

VOICES OF THE SURVIVORS

A wealth of literature points to a reality of recovery or reemergence from extreme states of mind that are often diagnosed as schizophrenia. The biggest part of this actually comes from those who have survived harm suffered at the hands of psychiatry. David Oaks’ organization, Mind Freedom (www.mindfreedom.org) is one great source on this movement and literature. Oryx Cohen (2005) summarized the oral testimonies of 36 psychiatric survivors who participated in the Mind Freedom Oral History

Project. Not surprisingly, no magic bullet was found; rather, participants used a variety of strategies they designed themselves to rebuild their lives.

Some professionals also emphasize relating to those diagnosed “mentally ill” as people. For example, Larry Davidson’s (2003) book on qualitative studies of recovery underscores the importance of listening to what people have to say about their own experience. Alexandra Adame and Roger Knudson (in press) have added the latest contribution on alternative narratives of recovery. Their important article in the spring 2008 pages of *JHP* is based on interviews with four self-described psychiatric survivors who found that becoming activists in challenging psychiatric oppression is a key factor in recovering a good life.

John Modrow (1992) and Clover Greene (1999) are two of many survivors who have written powerful books about their stories, about how they were able to recapture their broken lives. Modrow’s book, *How to Become a Schizophrenic*, offers an enlightened description of the physical and psychological dynamics causing extreme states of mind, including hallucinations. Sleep deprivation is a big factor. Modrow’s declaration that “my hallucinations were a meaningful and purposive attempt on my part to cope with feelings of guilt and low self-esteem, and can be explained wholly in terms of the events which preceded them,” (p. 153) is a far cry from the doctrine of brain disease.

Psychologist Al Siebert, himself an author and psychiatric survivor, is curator of the Kenneth Donaldson Archives for the Autobiographies of Psychiatric Survivors on the Web site Successful Schizophrenia (www.successfulschizophrenia.org/kdarch). *JHP* published a case study by Siebert (2000), telling how nondiagnostic listening resulted in a dramatic recovery from paranoid schizophrenia. Jason Pegler, author the autobiography, *A Can of Madness* (2002), is also head of Chipmunka Publishing, which specializes in psychiatric survivor publications.

An alternative professional literature is becoming quite extensive. Besides Thomas Szasz, the work of Peter Breggin is most notable (e.g., 1991). Grace Jackson (2005) offers a rethinking of psychiatric drugs. I recommend Seth Farber’s (1993) book, *Madness, Heresy and the Rumor of Angels*, which gives side by side translations of the stories of seven psychiatric survivors comparing psychiatric jargon with plain speech. I have already mentioned Ron Bassman’s (2001) excellent new book.

PROFESSIONAL VOICES

There is a well-established legacy of caring and successful support for those in extreme states of mind. The work of British psychiatrist R.D. Laing (e.g., 1967) played a significant role in opening many minds to the possibility of recovery for those labeled severely mentally ill. In the United States, John Weir Perry (1989) has been a significant figure. Both Laing and Perry echo Modrow's words cited above, that meaning and purpose lie within the experiences of people in extreme states of mind.

One big reason that this meaning and purpose remains hidden is because, as suggested in this article, the preconceptions of the observers preclude a real search for meaning. Once explained as brain disease, the search is over. Another important contributor to the work of supporting recovery for people in extreme states is Edward Podvoll (1990). Like Laing with his Tavistock Institute and Perry with Diabasis, Podvoll was involved with the development and implementation of residential services for individuals needing intensive support. Podvoll's group calls itself the Windhorse Project, and though Dr. Podvoll died not long ago, Windhorse continues. All three of these projects demonstrated that with authentic support and genuine asylum, people who tend to get labeled as "schizophrenic" can and do recover.

Psychiatrist Loren Mosher provides an example of successful residential alternatives to standard coercion and drugs for people in extreme states of mind (Mosher, Hendrix, & Fort, 2004). Mosher directed the Soteria Research Project for the National Institute of Mental Health from 1969 to 1983, when the project ended because of lack of funding and industry priority choices. Mosher (1999) reports:

Two random assignment studies of the Soteria model and its modification for long-term system clients reveal that roughly 85% to 90% of acute and long-term clients deemed in need of acute hospitalization can be returned to the community without use of conventional hospital treatment. Soteria, designed as a drug free treatment environment, was as successful as anti-psychotic drug treatment in reducing psychotic symptoms in 6 weeks. (p. 142)

Long term results were also favorable. Mosher's conclusion underscores the disconnect between industry beliefs and practices and the evidence of what really promotes well-being: "Despite

these clinical and cost data, alternatives to psychiatric hospitalization have not been widely implemented, indicative of a remarkable gap between available evidence and clinical practice” (Mosher, 1999, p. 142).

Mosher’s book lays out the key requisites of the Soteria program, based on what Mosher called the four threatening *Ds*: demedicalized, dehospitalized, deprofessionalized, and dedrugged (Mosher et al., 2004).

Ty Colbert (1996) and John Breeding (2000) offer syntheses outlining models of varying levels of genuine care. The difference between support for someone who can benefit from a little individual counseling and an individual in an extreme state of mind is mostly a matter of degree and resource.

People get committed and forcibly treated for a variety of reasons. These include the false beliefs and dangerous practices of biological psychiatry and the institutionalized means of judicial psychiatric incarceration. It is still true, however, that people do experience severe distress and extreme states of mind. Our society’s breakdown of community is a huge factor, as is the depressing dearth of authentic, safe asylum like Soteria for people who need intensive help. This lack should not be denied by holding on to the belief that sending someone to a psychiatric facility is a therapeutic act; as a long-time “mental health professional,” it was a big step in this author’s own maturation to be disillusioned of the notion that he could feel satisfied about discharging his professional duties by referring “treatment failures” to psychiatrists and/or psychiatric institutions. Nor should this void be confused with hopelessness for “recovery.” Instead of hopelessness, a more realistic feeling would be grief at the failed possibilities, and righteous outrage that can be used to fuel ongoing efforts to create and provide genuine asylum and safe alternatives. Jim Gottstein’s yeoman work in fighting for the creation of Soteria-Alaska is an inspiring example (see www.soteria-alaska.com).

FACING TERROR

It is important to clarify here that I do not intend to say that someone in an extreme state always requires residential asylum to recover. That may be necessary, and it may not. Psychologist Bertram Karon has devoted a significant part of his life to working

with "schizophrenic" individuals on an outpatient basis. In an important work, *The Tragedy of Schizophrenia*, Karon (1999) reviews the research showing that individuals do tend to recover with psychotherapy, and at a better rate than with antipsychotic drugs. Based on decades of personal experience, Karon tells us that: "Fundamentally, we do not want to know about schizophrenia because we do not want to feel terror at that intensity" (1999, p. 7).

People in extreme states of mind are usually dealing with intense and overwhelming fear. As Karon says, "Human beings are not easily able to tolerate chronic, massive terror" (1999, p. 6). This not only helps explain so-called schizophrenic symptoms, but also the reactionary and oppressive psychiatric treatment of those so labeled. It is not only about resources in the sense of more people and more time and space. It is also about inner resource and presence. To be helpful, the helper must be able to sit with terror and stay present and connected.

Whenever one challenges the standard practices of modern day psychiatry—be it the drugging of children and elders, or electroshock, or forced incarceration and drugging—the challenger is inevitably met with a question, "What are your solutions then?"

The material just above speaks to this question in general terms and suggests resources that go into much greater detail. In this author's experience, most important is snapping out of the spell that says people's troubled or troubling experience is a brain disease necessitating biological and/or electrical "treatments." The simple truth is that there are much gentler, benign alternatives that often really help—loving support, listening, a safe space to go through psychic opening and transformation, being allowed to challenge and think about false beliefs and be disillusioned. As psychiatric survivor, activist and author Leonard Roy Frank, in a video commentary with John Breeding, speaks to the subject of this article: It is tough to overcome the enormous psychiatric propaganda, the abuse of language, and the abuse of people through procedures that are often violently imposed by coercion and force. Frank closed with the words: "That kind of thing should never take place in a free society" (Breeding & Frank, 2007).

The evidence above strongly points to a mental health system of false beliefs and damaging practices. To complement and make more personal the very real possibilities for genuine reemergence from extreme states of mind, I will share my recent experience with a group of remarkable individuals.

ARTIST SURVIVORS

In my hometown of Austin, Texas, we are blessed that several members of our city's outstanding musical arts community have joined in alliance with the efforts of the Coalition for the Abolition of Electroshock in Texas (CAEST) to abolish electroshock. On March 15th, Threadgill's World Headquarters hosted the Fifth Annual Roky Erickson Ice Cream Social Celebrating Electroshock Survivors. CAEST cosponsored the event (see www.endofshock.com). Austin music icons Roky Erickson and the late Townes Van Zandt survived shock. Other shock survivors include local legendary artist Jim Franklin. We know that artists frequently get involved in one way or another with psychiatry. Think of Judy Garland, Frances Farmer, Ernest Hemingway, Lou Reed—the list goes on and on. Artists often represent the edges of nonconformity, and also often get caught up in drug and alcohol use. Members and supporters of CAEST are aligned in the intention to make Austin, and the world, a safe space for artists.

Though this particular event focused on electroshock, the relevant point here is the reemergence and outstanding works of a group of artists who had all been labeled and treated as severely mentally ill, mostly with “schizophrenia” included in their labeling history. It is also worth noting, as Leonard Frank says, that electroshock is the treatment of next resort. Most everyone who is electroshocked has and is taking a plethora of psychotropic drugs. This particular group of artists just happened to get their shock treatments when it was equally likely to get it for so-called schizophrenia as it is today to get it for depression.

This music event set an historic precedent of musicians and artists coming together with electroshock activists, calling for an end to electroconvulsive therapy and a safe haven for creativity, growth and transformation. Austin artist, Jim Franklin, created the poster for the event (see the home page of www.endofshock.com). Franklin designed a poster featuring an original painting that radiated the loving presence of Roky Erickson right through a clear, symbolic representation of electroshock. A man of sardonic wit, Franklin said from the stage, “I had an elaborate statement prepared in my mind, but in 1965 they erased it with an electric eraser.”

Although the extremely talented singer/songwriter Townes Van Zandt unfortunately died from the effects of excessive alcohol consumption, he had an intensely creative and successful

music career after he had been "treated" by psychiatry as a young man for allegedly severe mental illness. Townes was represented at the concert by his musician son, J. T. Van Zandt, who shared his thoughts on his father's electroshock, informing the audience of more than 500 people about the profound memory loss that caused him to forget the mother of his children. J. T. also said that electroshock should be abolished:

Is it necessary that human beings destroy all things which they do not understand, including the unique mind of the artist? Why not examine our past, learn from our mistakes and actually make positive changes in our behavior. How long does it take to discontinue practices that have been proven to be absolutely detrimental to society and produce only negative consequences? Let us unite to put an end to the barbaric practice of shock therapy. (Report on the 5th Annual Roky Erickson, 2007)

Michelle Shocked gave a magnificent performance at the concert. Not only is her music terrific, but her presence is intensely alive and passionate. Whatever the implications of her chosen name, Shocked is not an electroshock survivor. She is, however, an outspoken survivor of psychiatric abuse. I was moved to tears when she engaged onstage with Leonard Roy Frank and shared a little of her story about being forcibly incarcerated in a psychiatric institution and repeatedly injected with Haldol, one of the worst of the psychotropic drugs. Michelle described Haldol as a mental straitjacket. She strongly supports our effort to stop electroshock, but she and Leonard also made it clear that for every electroshock survivor, there are hundreds of people hurt by brain-disabling psychiatric drugs.

Leonard Roy Frank was our special guest for the Ice Cream Social. In 1962, Leonard was incarcerated by his family and a cooperative psychiatrist and subjected to 50 insulin coma shocks and 35 electroshocks, destroying memories of a period of 2.5 years of his life (Frank, 1990). After a few years of recovery (from the shocks), Leonard became a leading activist against psychiatric assault and the brutal physical methods of treatment, especially electroshock. Leonard spoke eloquently to the crowd about his experience and about electroshock. He was honored at the event, along with fellow electroshock survivors, Roky Erickson, Townes Van Zandt, and Jim Franklin. It is an astounding thing to consider that if you add Michelle Shocked to these four, you have five incredibly competent and outstanding individuals, all of whom

psychiatrists regarded at one time as being very severely mentally ill. I consider this a profound wakeup call to all who today are thoroughly conditioned by the incessant propaganda that leads us to believe—as if it were a proven scientific fact (NOT)—that so-called schizophrenia and other serious “mental illnesses,” like clinical depression and bipolar disorder, are genetic defects and biologically based brain diseases. And incurable.

The headliner for the Rock to Ban Shock event was Roky Erickson, psychedelic rock n’ roll pioneer extraordinaire. Roky himself has a lot to celebrate. The new documentary, *You’re Gonna Miss Me*, directed by Kevin McAlester, shows the extent of Roky’s tragic decline and the beginnings of his recovery up to 2002. The following 5 years have been nothing short of astounding. Not only is he in the midst of perhaps the greatest rock n’ roll comeback ever, not only is he completely free of all drug use, including all psychotropic drugs, not only has his health continued to improve dramatically, but as of February 23, 2007 the guardianship of his brother, Sumner, set up in June 2001, has been dissolved. Roky is back, a free agent, and the rock n’ roll muse he was born to be. The keys to his reemergence were loving care, genuine support, an overall physical and emotional wellness program, and a reclaiming of his music. About electroshock, Erickson said: “I wish I hadn’t had it and it didn’t help me.” His performance at the concert was absolutely awesome.

There are, of course, a number of less famous survivor activists in our coalition. Space here does not allow for an honoring of courageous and creative individuals like Kathy Scogin, Don Erickson, and Mimi Greenberg, whose lives were also celebrated at the concert. See the CAEST Web site (www.endofshock.com) for a full report.

I end this essay with a statement from a woman I deeply admire. Dottie Curry has lived all of her 70 years in Austin and is an activist leader in the community on various issues of oppression, including our CAEST. Dottie was called schizophrenic and suffered electroshock as a young woman. She testified to the Austin City Council at an April 3, 2007 hearing on electroshock in Austin (for full report, go to the progress section of the CAEST Web site).

I have suffered many indignities as a Black woman over the course of my life in Austin, and I have rejoiced at many examples of liberation from oppression. As a child, for example, I could not go to the Austin public library. I am here to tell you, however, that of all the hurts and indignities, by far the worst was electroshock. My prayer is that just as my own children and grandchildren are

spared some of the racist actions I endured, they will also never be in danger of being assaulted by psychiatric electroshock. (Report on Austin City Council, 2007)

May the same be true for disparaging labels and brain and body damaging drugs.

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