

# Diminished: Canadian Women's Experiences of Electroshock

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## Abstract

"Diminished" is the result of a two-year feminist inquiry into the gendered experience of electroconvulsive therapy (ECT) in Canada. This paper focuses on seven women's experiences with electroshock and how it affected their lives. It raises pressing questions for Canadian feminists about the apparent dispensability of women's minds, with the purpose being to re-ignite feminist interest in women's experiences of psychiatry in general and the damaging effects of electroshock in particular.

## Résumé

L'article intitulé « Diminished » est le résultat d'une enquête féministe de deux ans sur l'expérience de la thérapie électroconvulsive (TEC) basée sur le genre au Canada. Cet article met l'accent sur l'expérience de sept femmes qui ont subi la TEC et la façon dont cette thérapie a eu un impact sur leur vie. Il soulève des questions pressantes pour les féministes du Canada au sujet du caractère apparemment superflu de l'esprit des femmes, dans le but de raviver l'intérêt féministe envers l'expérience des femmes avec la psychiatrie en général et les effets néfastes de la thérapie électroconvulsive en particulier.



## Introduction: The Pathologizing of Women's Minds

For decades, feminist women's health scholars have documented countless examples of the medicalization and pathologizing of women's minds. Barbara Ehrenreich and Deirdre English (1973) provided vivid examples of the "treatments" and "rest cures" imposed on upper and middle-class women in the United States at the turn of the twentieth century, and exposed the inherent sexism in the biomedical rationale used to justify women's discrimination in jobs, society, and the family. Phyllis Chesler (1972) also explored historical and structural examples of women's minds being pathologized in her seminal text, *Women and Madness*. Paula Caplan (1985) named and challenged notions of women's apparent intrinsic masochistic tendencies and later (1995) called into the question the Diagnostic and Statistical Manual's (the DSM) propensity to categorize almost any woman as mad. Carol Tavris (1993) proposed that gender-based bias has been at the root of women's supposed proclivity for madness and argued that women are *always* going to be so evaluated—or 'mismeasured', as she called it—as long as maleness and masculinity remains the unquestioned standard for normalcy. Jane Ussher (1991) invited us to wonder whether it was misogyny, and not madness, that led to thousands of women annually being prescribed dangerous psychoactive drugs or undergoing dangerous procedures in the name of treatment. In addition, concerns about women's assumed propensity for depression as an almost rite of passage have gained significant momentum (Jack 1991; Stoppard 2000), as have various critiques of the excessive prescribing of psychotropic medications to women (Cooperstock 1976; Stoppard and Gammell 1999).

While many authors have been critical of the ways in which the biomedically-oriented mental health system has been pathologizing women's minds since at least the late nineteenth century, there has also been growing concern about the extent to which women's minds have been shocked and 'treated' with electroconvulsive therapy (ECT) or electroshock in the past few decades. This psychiatric procedure involves passing electricity through a person's head in order to cause a convulsion or grand mal seizure. It can be performed either bilaterally or unilaterally, with the bilateral form being the most commonly used and most destructive

to autobiographical memory (Breggin 1997). While the voltage used to induce a seizure varies with the age and gender of the individual, current "improved" procedures now involve a general anesthetic, a powerful muscle-paralyzing agent to prevent fractures, and artificial respiration with oxygen because the muscle paralysis renders the individual unable to breathe independently. According to Dr. Peter R. Breggin (1997), these improvements raise the seizure threshold, which in turn requires increased electrical energy in order to cause a seizure. A typical course of electroshock for adults is six to twelve treatments, administered two to three times a week, followed by what is termed *Maintenance ECT* in order to prevent a relapse of the presenting depression (Gomez 2004). Many theories about electroshock's mechanism have been proposed over the years, with estimates suggesting that there are seven being considered, but none have been conclusively proven (Challiner and Griffiths 2000).

One deeply troubling trend is the extent to which ECT is administered primarily to women and the elderly. In Canada and the US, approximately 70 percent of shock survivors are women and 45-50 percent are over 60 years old, with 10-15 percent being 80 years and older (B.C. Ministry of Health 2008; Ontario Ministry of Health 2007; see Breggin 1997). In fact, according to the Ontario's Ministry of Health (2007), women receive electroshock two to three more often than men. Seventy-one percent of the patients given ECT in Canadian provincial psychiatric institutions are women and, regardless of setting, 75 percent of the total electroshock procedures were administered to women. In addition, as recently as March 2013, ECT was proposed in North America for "treatment-resistant" depression and eating disorders in women (Lipsman et al. 2013).

In light of these trends, this paper focuses on the gendered contours of electroshock with a particular focus on the stories of seven Canadian women who underwent ECT treatments during the past forty years. Drawing on qualitative interview data gathered over a two-year period, we present their individual narratives, which illuminate the trajectory of their lives prior to, during, and after ECT. The purpose of bringing this study's findings to *Atlantis* is to re-ignite feminist interest in women's experiences of psychiatry in general and the damaging effects of electroshock in particular.

## The Sole Intent: The Brain Damaging Effects of Electroshock

While proponents of ECT argue that applying a certain amount of electricity to the brain in order to create a grand mal seizure is safe and indeed therapeutic, electroshock is, in reality, a psychiatric procedure whose sole intent is to injure and disable the brain. The result is often a temporary flat lining of brain waves on an EEG where, after several applications, the patient always becomes significantly brain damaged with signs of confusion, generalized cognitive impairment, loss of judgment, and emotional instability. In fact, sometimes a patient's brain is driven into persistent seizures, so that attending anesthesiologists have IV push meds at the ready to undo induced seizures that do not stop on their own. According to Dr. Peter R. Breggin (2008), the world-renowned expert on the acute injury and brain-disabling principle of psychiatric treatment, the induction of multiple grand mal seizures during ECT disrupts, disables, and damages brain cells by (i) overheating brain tissue; (ii) causing severe intracranial hypertension; (iii) breaking down the indispensable blood-brain barrier; (iv) causing blood vessels to spasm and close; and (v) starving neurons of oxygen and other essential nutrients.

Dr. Breggin (2008) further argues that this type of acute injury and resulting brain damage is the very principle behind ECT treatments. He has, for example, demonstrated that brain dysfunction is considered therapeutic by psychiatrists who administer ECT. The subsequent euphoria (usually temporary) and the lobotomy-like apathy and disinterest (usually persistent) are mislabeled as signs of improvement, rather than as actual symptoms of brain injury. Breggin's fulsome examination of the psychiatric literature cites both electroshock pioneers and current proponents who measure success based on craniocerebral trauma, the need for induced trauma, and the necessity to induce cell death and apathy. Psychiatrists Edward Shorter and David Healy (2007) are modern proponents of ECT, who speak positively about the most damaging extremes of the treatment in the form of repeated ECTs administered daily or several times a day (intensive, regressive, depatterning, and annihilation ECT). This intensive ECT regime results in neurological and mental dilapidation where "patients were sufficiently injured to become incontinent, mute or babbling and needing to be spoon fed" (134).

A review of the literature that exposes the sole intent of and damage associated with ECT leads many to question how it is possible that the practice of electroshock still exists. In fact, Dr. D. Ewen Cameron's (1957) work that is considered pioneering by ECT proponents, for example, used multiple ECT treatments in order to erase an individual's memories and personality. Follow up studies to Cameron's work exposed that 75 percent of his patients had memory loss up to ten years later and experienced impoverished and unsatisfactory social adjustment (Breggin 2008). North America's best known author-psychiatrist Dr. Harold Sackeim acquiesced to pressure and embarked on a multi-site study, which sought to debunk assertions that ECT produced lasting brain damage. Sackeim and his colleagues (2007) followed up with 347 patients given ECT in routine outpatient practice at multiple sites and evaluated them using neuropsychological testing up to six months later. For all types of ECT, they found persistent and significant detrimental effects on mental function, in such areas as memory retention, attention, and autobiographical memory. The authors also found that, although all patients demonstrated impairments in mental functioning after the common bilateral application of electrodes over a patient's temples, the female ECT patients experienced the most impairment.

Perhaps not surprisingly, given the growing evidence that ECT is associated with mental impairment, various community activists have lobbied to have ECT banned. For example, according to Don Weitz (2008), on 17 January 1984 at a public meeting of the Toronto Board of Health, seven members of the Ontario Coalition to Stop Electroshock tried to convince the Board to call a moratorium on electroshock in Ontario. The Board's decision to support this request marked the first time in Canada that a board of health or any health body tried to restrict electroshock. In 2005, leading anti-psychiatry scholar Dr. Bonnie Burstow hosted a two-day, Toronto-based "Inquiry into Psychiatry," where psychiatric survivors were invited to testify about the impact of electroshock, psychiatric drugs, and engagement with the psychiatric profession (CAPA Canada 2005). One of the spin offs of this historic two-day hearing has been the Coalition Against Psychiatric Assault's "Stop Shocking our Mothers and Grandmothers" events held every Mother's Day in several cities in Canada (see [Atlantis 37.1, 2015](http://coalitionagainst-</a></p></div><div data-bbox=)

psychiatricassault.wordpress.com). While the Ontario Ministry of Health refused to enforce the moratorium resolution presented by the Ontario Coalition to Stop Electroshock, these and other examples of public outcry about the dangers associated with ECT counter the common public perception that electroshock is no longer being used. This has been the experience of the authors—wherever we go, we are met with the question: “They still do that?” Indeed, many Canadians would find it hard to believe that electroshock is back in vogue and its use is increasing.

### Previous Research on Experiences of ECT

Amidst the research questioning the safety of ECT and lobbying efforts to have the use of ECT reduced (or stopped), there is a growing body of research literature that documents people’s experiences and perceptions of ECT. Perhaps not surprisingly, the research literature is divided. Psychiatrists and/or biopsychiatric researchers who are pro-ECT publish research articles (in biopsychiatric research journals) that claim that ECT patients find it to be both safe and effective and as having minimal and transitory side-effects. For example, the Royal College of Psychiatrists (1995) published a “factsheet” that claimed that 80 percent of people who received ECT (mostly women) were satisfied with the procedure. Other pro-ECT reviews of the literature (Rose et al. 2003) found that up to 90 percent of ECT recipients reported it as helpful.

Other researchers who are not affiliated with psychiatry tend to publish research articles (in non-psychiatric journals) that maintain that people have a range of attitudes towards ECT (for example, Chakrabarti, Grover, and Rajogopal 2010). These include many people who report that electroshock was not helpful, that they received inadequate information about ECT (or its risks) during the informed consent process and felt coerced into undergoing the procedure, and found the experience frightening and/or demeaning; they also indicated that ECT resulted in persistent and distressing memory loss (particularly autobiographical memory loss). In particular, a number of qualitative studies of people’s experiences with ECT—which typically allow participants to speak at greater length and more freely—have, almost without exception, indicated that most participants found that ECT did not reliably help their depression and that the experience was a very negative

one (Fisher, Johnstone, and Williamson 2011; Froede and Baldwin 1999; Johnstone 1999; Smith et al. 2009). Some qualitative studies have also specifically examined women’s experiences of ECT, who reported that they received little or no balanced information prior to ECT, felt coerced into and fearful of the procedure, found the procedure to be disempowering and demeaning, and suffered from persistent and distressing memory loss after ECT (Orr and O’Connor 2005; van Daalen-Smith 2011; Edjaredar and Hagen 2013, 2014). The experiences of the seven Canadian women we interviewed provide further evidence of these trends and the diminished lives that resulted.

### Methodology

“Diminished” is the result of a two-year long feminist qualitative Canadian study that explored women’s lived experiences of ECT. After ethics approval was obtained from the York University Research Ethics Review Panel, prospective interview participants for this project were recruited via the distribution of a poster and through word of mouth. Women who were in the midst of ECT treatments were recruited by staff at an outpatient ECT clinic. Nurses involved in the provision of electroshock were also interviewed for this study (see van Daalen-Smith 2011). Of the seven women interviewed, two were in the midst of ECT treatments and five had received them in the past. The seven participants were all English-speaking, ranged in age from 44 to 65 years old, and received ECT in Ontario, Alberta, and Saskatchewan between approximately 1975 and 2010. Six were white, one identified as First Nations, all were heterosexual, and while all were able-bodied at the time of their ECT treatments, three of the seven now self-identify as disabled. Five of the seven women received unilateral electroshock; one received both types and one was the recipient of bilateral electroshock. Informed verbal and written consent to participate in the research was obtained from all participants.

Rooted in principles of feminist emancipatory research, semi-structured interviews were conducted, all of which were recorded on a digital voice recorder. The women were asked to discuss the following topics: what their life was like before receiving electroshock; their experiences with and perspectives on ECT, including what series of events lead them to be prescribed the treatments; what they were told about

ECT; the effects of electroshock on their lives; and their recommendations for the future. The women's stories of distrust, coercion, and powerless invisibility were compelling to hear. They felt damaged by the experience and had great difficulty 'going there' during their interviews, but they pushed themselves as they wanted to tell their truths. The women were free to add anything else they wished to share.

The study's epistemological and methodological ethos was derived from feminist standpoint theory, as outlined by Dorothy E. Smith (1997). She suggests that "women's standpoint as a method commits us to beginning in the local historical actualities of one's experience, and as such makes ruling relations visible from a standpoint located in an embodied subject situated in the everyday/every night actualities of her own life" (128-9). Because women's and especially psychiatrized women's truths are at significant risk of being discounted and dismissed, standpoint theory is both a methodology and a politics that values lived experience and validates it as a legitimate source of knowledge. These principles guided our analysis of the stories shared by the seven women who participated in this study. In addition, the process of data analysis involved the constant-comparison method whereby codes, themes, and proposed relationships between data are proposed (Lincoln and Guba 1985). The data were divided into manageable portions called bibbits and were then coded to identify themes (Chenitz and Swanson 1986). Periodic check-ins with interested participants occurred during the process of data analysis to determine validity.

## Results

The two years devoted to seeking out and listening to women's stories about electroshock was a journey of grim privilege, given that ECT is *not* an isolated treatment of last resort as many would assure us. It is currently being scheduled or performed all over Canada in both community and psychiatric hospitals through both inpatient and outpatient programming. In this section, the overall themes from the interviews are presented, including the women's journeys to receiving ECT, problematic practices employed in obtaining informed consent, the experiences of being blamed and shamed, and the maleficent impacts of electroshock on these women.

## *It's You: The Path to Electroshock*

The journeys of the seven women—Ruth, Sandra, Linda, Celeste, Fran, Lee and Cathy (all pseudonyms)—to ECT shared many similarities. Almost all of the women asked a health care provider for support during a period of distress. Almost all. When Fran visited her family doctor for a stubborn throat infection that left her feeling drained and exhausted, she was receiving electroshock within a month or so. She explained that, while telling her doctor that she was feeling tired and sick, two tears fell from her eyes. Her doctor reached for his prescription pad and prescribed Prozac. For the next ten days, she "didn't eat or sleep on that drug" and was subsequently admitted to hospital with a diagnosis of both bipolar disorder and depression. Fran reported being told: "You're not responding adequately to any of the drugs we've given you Fran. We're going to try electroshock." She was deemed incompetent to make treatment decisions and so her husband was approached and convinced of its necessity. By this time, she was in such a fragile and unrecognizable state that her husband reluctantly agreed. As Fran noted: "even though they told him it was my only chance...his only chance to get me back, my husband stills feels guilty." Years later, after fighting for the right to view and obtain her hospital records, Fran discovered that her fourteen-month stay in a psychiatric unit involved over thirty psychiatric diagnoses and forty-three shock treatments.

Lee's journey started with insomnia following the devastating loss of her mother. She was prescribed strong sleeping pills that were then changed to Benzodiazepines to which she (predictably) developed debilitating anxiety. She was also diagnosed with several psychiatric conditions and each cocktail of powerful drugs she was given made her worse. Lee asserted that she was medicated *to* insanity. She too was told that she was not responding adequately to the prescribed drugs and that there were no others physicians could try. Lee recounted that she was told that ECT was a treatment of *last* resort, but she supposedly reached that juncture fairly quickly. Her husband was also convinced of electroshock's urgent necessity and was asked to provide consent.

At the time of her interview, Ruth was in the middle of a series of shock treatments, but she could not remember if she was scheduled for her fifth or seventh treatment the following morning. She was very

weak, her mouth was dry, and her color was ashen. Ruth explained that she had experienced varying degrees of depression since childhood and that pills did not help. They “made me worse, but I’m afraid to come off them.” Despite ardent opposition from family and friends, Ruth explained that she tried ECT (again), even though she had experienced severe “mania” when she underwent electroshock several years prior. At that point, Ruth noted: “I signed myself out of the hospital then...I’ve never been the same.”

Sandra, equally fragile, was in the midst of a series of outpatient ECT treatments. She explained that she had also experienced depression since childhood. Like other participants, Sandra was told that, because so many drugs had been “offered to her, and nothing worked,” ECT constituted the ‘last resort’ treatment. While she felt as though she was taking a risk undergoing electroshock, Sandra proclaimed that she would “try anything to feel better.” Because of her vulnerable state at the time of the interview, we did not probe further into the source of her lifelong sadness and distress.

Celeste described a history of childhood sexual abuse starting at the age of four and of physical and mental abuse in her home until she was seventeen. She disclosed her situation to a guidance counselor—exactly what adults tell children to do—and underwent an assessment in the emergency department of her eastern Ontario town. Without undertaking an investigation into other options or providing her with adequate information about ECT, Celeste was offered electroshock treatments. As she indicated, “they told me it would cure my depression...no one cared why I was depressed.” Celeste went on to explain that it was then that her ‘psychiatric career’ started; she was admitted, “held for months at a time, drugged, restrained, shocked” (despite flatly refusing consent countless times including in the OR, while strapped down on a gurney and wheeled to the treatment room), and blamed for not getting better. She indicated that her parents were the ones who consented to the electroshock and that this was an injustice: “My abusers got the right to consent to more abuse of me.”

Shortly after her fortieth birthday, Cathy told her physician that she experienced severe depression the day before her period and asked him if this was normal. He diagnosed her with “Premenstrual Dysphoric

Disorder” and prescribed several medications—some to treat PMDD and others to counter the side effects of the preliminary drugs. Cathy reported that her mood worsened significantly, and she was eventually told that the medications could no longer help her and that she needed electroshock. After receiving thirteen outpatient ECT treatments, EEGs revealed organic brain syndrome and dementia. Cathy was no longer able to work and reported losing nearly twenty years of autobiographical memories.

Linda told the story of being a twenty-eight year old mother of two children under the age of six years who was working at two jobs, trying to survive in a ‘rocky’ marriage, and feeling overwhelmed. She too, went to her family physician to discuss her feelings and to get support. She was told that she needed ‘a rest’ and was admitted to the hospital. Linda explained that, within forty-eight hours, she had been prescribed eight psychoactive drugs; within two weeks, she was sent for inpatient electroshock, despite being neither depressed nor suicidal. As Linda stated, “I asked for help and was given ECT. That’s not what I needed.”

In learning about the seven women’s pathways to receiving electroshock, it became evident that the main rationale for ECT being prescribed was the conclusion that *they* had each ‘failed’ to adequately respond to other treatments, thus individualizing its necessity. Once they were labeled “treatment-resistant,” the women were told that *they* had ‘failed’ to respond to (any number of) psychiatric drugs and hence, they had reached an assumed point of no return; in other words, electroshock was their only recourse and their only opportunity to regain some semblance of a normal life. They were also informed that they would need to periodically undergo maintenance ECT in order not to slide backwards. This idea of ECT as a last resort seemed to resonate with Ruth and Sandra who were undergoing treatments at the time of their interviews. While they indicated that drugs did not help “their” depression and that they knew little about ECT, they very much hoped that it would help them: fingers crossed, eyes closed, and futures held in the palm of someone else’s hands. However, ECT did not help most of the women and it was not what they needed. As Celeste explained, “I was just an abused girl who just needed to be heard. But all those drugs and then electroshock? That’s not what I needed.”

### *"Don't worry": Consent in a Fog*

The women were asked to recount (if they could) what they were told about electroshock at the time of consent. All of the women remembered being told, "don't worry," and that ECT would "be helpful, was necessary, safe." They were also told that they were "good candidates for ECT" and that "other women just like you got better." Sandra noted that, "I didn't really understand it...how it works. Just that they say it helps women like me." Ruth and Sandra, who were in the middle of their ECT series, explained being shown an information video during their consent process. The video was produced, funded, and distributed by the manufacturer of the ECT machine, which downplayed the potential risks. As Ruth indicated, "I reluctantly agreed to this procedure being ignorant about the risks." When other participants were asked if they were made aware of any risks, many recalled that they were told that they would experience "some fatigue" and "mild temporary memory loss." Celeste, Linda, Lee, and Fran, however, shared that they were so incapacitated by the powerful psychoactive drugs they were expected to take daily, comprehension of what was involved was next to impossible. As Cathy maintained, "I was so drugged, there was no way I could have properly consented."

In each situation, psychiatrists approached parents or partners and convinced them of the necessity of electroshock and of the need for ongoing psychiatric hospitalization. Lee explained that doctors lied to her and her husband about ECT. While she was in no state to be able to ask questions, argue, or refuse, "my husband believed what they told him—that ECT was the last resort, and that there would only be some minimal and temporary memory loss. Nothing else. It was a soft sell. But they lied. They lied by omission." Celeste, whose parents consented to the procedure, remembered screaming and pleading to be let out of the restraints, to not be wheeled into "the torture room," and to "please don't do this to me." Both recalled the far away eyes of the health care team, seemingly detached and patently absent.

### *Tamed, Blamed, and Shamed*

Despite spanning different decades, provinces, or healthcare settings, the women's descriptions of their experiences with electroshock shared many similarities. Aside from healthcare providers' individualization of its

necessity and the questionable procedures used to obtain consent, the women who were post-ECT recalled their sense of powerlessness in the face of indifferent professionals. Lee, for example, described the terror she experienced prior to ECT: "These treatments were handled like an assembly line, with a row of gurneys ready in the hallway. I shook in terror as I looked at the matter-of-fact faces above me. I thought I was going to die." She also maintained that she eventually realized that things would go far more smoothly and that she would likely "get out of the hospital sooner" if she didn't resist and "simply surrendered." For the women in the midst of treatment, their real-time experience included a combination of hope and desperation—of blind, yet powerful, trust and faith in a system that promised to help.

The women further explained that an overlooked part of the ECT experience involved isolating stigma that stemmed from being blamed and made to feel ashamed. They felt ashamed for "needing" ECT and this was reinforced via psychiatric labels like "treatment-resistant." Some family members had already considered the women to be "whack jobs" or "mental cases," and when they learned that the women had received electroshock, the stigma increased ten-fold. In other instances, family or friends blamed them for getting themselves into their predicament. The women recounted painful stories of lost relationships following (and, for some, during) electroshock as people lost patience with them or grew increasingly uncomfortable; as a result, the women became more isolated. Lee, for example, recounted how she felt betrayed by friends who abandoned her after they found out about her many ECT treatments: "most of my old friends are gone...they disappeared when they saw me trembling and spasming and muttering after twenty-five shock treatments." However, unlike current anti-stigma initiatives, such as the Mental Health Commission of Canada's (2014) "Opening Minds" campaign or Bell Canada's (2014) nation-wide "Let's Talk" campaign, the post-ECT women did *not* believe that erasing stigma so more women would agree to electroshock treatments was the answer.

Whether the women were post-ECT or undergoing treatments at the time of the interviews, they *all* discussed a profound change in their affect, motivation, and selfhood. They described being flat with no drive and little emotion; with each shock 'treatment,' their will

to fight eroded away like sand on a beach at high tide. Linda explained that it felt like pieces of her never made it back to her hospital room and even though she had searched for those pieces, she never found them again: “my life is like I’m looking through a window. I see life, but can’t touch it. I have no deep, no true emotion in me anymore. I just go through the motions. I miss the person that got away from me.”

### *The Maleficent Impact: Hope Dies*

At the heart of the women's decision to undergo electroshock treatments was hope and the promise thereof. Believing they were out of options, they hoped that things would be different; that they would adequately respond to a treatment (finally); that it would work; and that the distress that had taken hold of their lives would subside—or be permanently extinguished. During the latter portion of the interviews, the women were asked about the *impact* of electroshock on their lives.

Ruth and Sandra, who were in the midst of ECT treatments, described feeling exhausted, yet less anxious, “lighter, closer to feeling like themselves, not up, not down, just blah; numb; flat; and forgetful.” Sandra did note that memories just ‘floated’ by her after her ECT treatments: “I can’t hold onto memories anymore...they kinda just float by.” They also indicated that when the feelings of lightness and reduced anxiety waned, they were told that they would always need maintenance ECT.

Regardless of whether their ECT was bilateral or unilateral or was prescribed in the 1970’s, 1980’s, 1990’s, or during this millennium, the five remaining post-ECT participants were unified in their assessment of electroshock’s impact. It devastated them cognitively, emotionally, spiritually, financially, and socially and, in so doing, killed any last morsel of hope they had. They described physical symptoms (e.g. leg pain, arrhythmias, cracked teeth, poor co-ordination, fatigue, joint and back problems, tremors, headaches), cognitive effects (e.g. amnesia, dementia, confusion, disorientation, un-relenting memory loss, inability to think or focus, forgetfulness, loss of attention span), and emotional consequences (fear, anxiety, flashbacks, apathy, embitterment, shyness, nervousness, decreased or flat effect, loss of self-esteem or the self they knew). Fran described her life as being ‘wiped out’ by ECT: “my life as I knew it has been wiped out. I don’t know who I am

anymore. I’ve had to re-create myself.” Similarly, Lee described her life as “joyless striving” since her ECT, trying to make it through each day by compensating for her post-ECT losses.

In total, the women described sixty-four adverse effects of electroshock, which demonstrated that the shared hope that accompanied each of the seven women’s journeys to the electroshock room had all but died. Electroshock affected every aspect of their lives (see Table 1.). In addition, all of the women were no longer able to work and survived on disability pensions for a portion of or the entire time since receiving electroshock. Celeste explained why she was sobbing during the interview: “I live in sheer poverty. ECT and the drugs cheated me of a life. To this day, I wonder what I would’ve become if I wasn’t forced to have electroshock.”

### **Discussion**

This study adds to the growing body of qualitative research on women’s experiences of ECT. In particular, it adds further weight to growing evidence that women’s experiences of ECT are characterized by the following: a lack of knowledge about ECT; a fear of the procedure; being told that ECT was their only hope or the “last resort”; a sense of generalized powerlessness and humiliation; cognitive side-effects; and severe and persistent autobiographic memory loss (Ejaredar and Hagen 2013, 2014; Fisher, Johnstone, and Williamson 2011; Froede and Baldwin 1999; Johnstone 1999; Orr and O’Connor 2005; Smith et al. 2009; van Daalen-Smith 2011). Given the disturbing picture that is emerging from this qualitative research, it is not surprising that feminist critics, like Dr. Bonnie Burstow (2006a), argue that ECT is a form of violence and power over women, and are calling for an end to publicly-funded ECT.

### *Empathy, not Apathy*

The women, whose narratives are centred in this feminist inquiry, sought support from a health care professional during a period of distress. Celeste was an abused girl who wanted and deserved to be heard, believed, and made safe. Lee was bereaved and bereft—for mother loss can leave an irreparable void in many women’s lives. Linda was overwhelmed with work and home life and simply wanted to talk. Fran had a mere throat infection. Rather than addressing the underlying

causes of the women's distress and listening empathically, medical professionals prescribed medications that made their mental conditions worse. To a health care practitioner who views women's distress 'symptoms' through a *bio-psychiatric* lens, the women's modes of "coping" become pathologized and medicalized.

In other words, they were blamed for any undesired side-effects of what have been identified as harmful and ineffective psychiatric drugs. It was them. It was *their* depression. It was *their* response to the drugs, which served as a key justification for more aggressive psychiatric intervention like electroshock. Such psychiatric modalities fail to address the social phenomena that contribute to women's gender-based depressive responses to trauma, oppression, poverty, and misogyny. This response is not rooted in empathy, but rather seeks to achieve quick and lasting apathy in those receiving ECT. With all that is anecdotally and scientifically known about the resultant brain damage, how it is that the application of electricity to the brain can possibly be viewed as therapeutic?

An analogy could be drawn to cancer treatments, which have been described by feminist women's health activist Dr. Susan Love (2000) as *slash, burn, and poison* (surgery, radiation, and chemotherapy) for the purpose of killing the 'bad cells' and leaving the 'good cells' alone. It is suggested that electroshock might work to extinguish some of the painful memories or sources of women's sadness and distress or somehow attack and disable *only* the brain cells responsible for "medication-resistant" depression. However, this precarious cure is akin to taking a sledgehammer to kill a flea and hoping the dog will be okay. Might we value the dog more and seek to prevent its distress in the first place? Might we value women's brains more?

The notion that there is nothing left for women, except the application of electricity to the brain, is unimaginative at best and carelessly maleficent at worst. Many feminist scholars argue that, through chemical and then electrical manipulation, psychiatry seeks to induce apathy, labeling this outcome therapeutic. In fact, early electroshock proponents wrote about a desired taming effect (see Breggin 1979, 2008). When women experience gender-based oppression and/or trauma, the psychiatric process of blaming women through a sophisticated process of diagnostic labeling *IS* a form of violence. Dr. Burstow (2006a), Canada's leading feminist critic of psychiatry, is right. It is abuse. It is answering trauma with trauma, abuse with abuse. It renders those who seek support all the more diminished. If being ignored, ill-treated, abused, dismissed, or devalued is not enough—is not diminishing enough, psychiatry responds with further diminishment erroneously re-

Dementia	Forgetfulness (& resultant safety risks)
Confusion	Erased education
Disorientation	Loss of friends
Decreased emotion	Unemployed/unemployable
Changed personality	Unable to complete tasks
Don't recognize people who know them	Unable to complete schooling/courses
Significant short-term memory loss	Low attention span
Weight gain	Get lost in house/neighborhood/plaza
Poor coordination	Apathy
Unable to manage household tasks	Flashbacks
Unable to schedule things	Embarrassment
Unable to remember or keep appointments	Labeled
Disorganization in life & surroundings	Stigmatized
Live in fear it will happen again	No longer believed/seen as credible
Creativity stunted	Learning disability
Back problems	Poverty/living on disability
Joint problems	Loss of imagination
Forced to re-learn how to dress, brush teeth	Numbing of emotions
Barely know children/husband/family	Shy now
Not believed	Forgets things from one day to the next
Written off/categorized/demoralized	Amnesia
Paranoia	Memory disability
Cracked teeth/dental problems	Can't think the way I used to
Constantly shaky	Forget what read almost immediately
Not grounded	Headaches
Arrhythmias	Tremors
Guilt for impact on family	Nightmares
Embittered	Hands/feet tingle
Anxiety	Leg tremors/twitches
In a stupor/fog	Constantly lose track of what I'm doing
	Loss of self confidence
	Loss of Self

Table 1: Reported Impacts of Electroshock (van Daalen-Smith 2011<sup>1</sup>)

ferred to as therapeutic treatments. For at least five of the women interviewed for this study, engagement with psychiatry in general and with electroshock more specifically left them less-than they were prior to asking for assistance. As Lee noted, after ECT, “you become a permanently diminished human being.”

*“What difference does it make?”: A Call to Canadian Feminists*

When Fran was interviewed, she was living in the Yukon and re-creating a life. During her hospitalization, Fran kept a secret journal. Thankfully, her husband smuggled it out of the psychiatric hospital before it was discovered. Had it not been for that journal, Fran would not have remembered most of her experiences during her electroshock treatments and psychiatric hospitalization. She recalled that, while undergoing her treatments as an inpatient, she pleaded with her physician to stop them because of frightening memory loss. She vividly recollects that her physician, standing in her hospital room doorway, responded by asking: “What difference does it make?” For her, she was rendered less of a person in that moment: “Maybe I always was less of a person to him...to psychiatry.” She felt defeated, devalued, and diminished. It wasn’t that she did not want to feel—it was that she wanted to feel *better*. It wasn’t that she wanted her life to stop—she wanted it to start.

Through this study that has explored seven Canadian women’s experiences with ECT as well as other Canadian studies (Ejaredar and Hagen 2013, 2014; Froede and Baldwin 1999), we have learned that so much needs to be called into question and changed. That ECT damages the brain should be enough for Canadians to collectively call for a global ban on electroshock (see van Daalen-Smith et al. 2014). In addition, it is evident that the types of responses that the women who participated in this study received lacked empathy and any socio-political understanding of women’s lives. The mechanisms through which consent was sought were fraught with violations of human rights and the rights of hospitalized persons, especially given that fulsome and balanced information was not provided and consent was often obtained from others after the women became mentally incapacitated by the very treatments prescribed to help. The women entered the psychiatric facility as thinking and feeling individuals—but they left both foggy and

flat. The notion that electroshock is a therapeutic modality of last resort is a dangerously fallacious myth.

Given women’s experiences of electroshock discussed in this paper, Canadian feminists should consider the following questions:

1. Why are so many women and elder women more specifically given electroshock? What do the disproportionate statistics tell us? Do they speak about the continued pathologizing of women’s minds?
2. Why is the response to women’s trauma more trauma?
3. What role does Big Pharma play in the unquestioned prescription of psychoactive drugs among women in general and among those experiencing distress more specifically?
4. Why did mostly white heterosexual able-bodied women step forward and participate in this study? Is it that psychiatry is disinterested in investing in marginalized women? Is it that in confronting systemic racism, ableism, classism, or homophobia (to name but a few) on a daily basis, most marginalized women are fearful of further oppression and dismissal?
5. Why is apathy considered a therapeutic outcome? Does psychiatry perpetuate itself through its use of a *drug, shock, and lock* treatment plan? Who exactly is served by the inducement of chemical or electrical apathy?
6. Are women’s minds so dispensable that electroshock is (again) increasingly prescribed despite the scientific evidence of its destructive impacts?

The continued practice of medicalizing and pathologizing women’s minds has been shown to have devastating outcomes, some of which are discussed in this paper. Electroshock is not prohibited as many perhaps had hoped, and the troubling ageist and sexist applications of this procedure is of urgent concern. The voices of the seven women who participated in this study urge us, all of us, to place this issue back on our collective activist agendas. The Ottawa-based activist and electroshock survivor Sue Clark-Wittenberg, who despite being rendered “un-employable” because of her “psychiatric incarcerations”—used her own meager funds to create a poster wherein she asks us to “Please help stop the abuse.” Shall we?<sup>2</sup>



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## Endnotes

<sup>1</sup> The authors secured permission of the editor of *Issues in Mental Health Nursing* to draw on the narratives presented in van Daalen-Smith (2011).

<sup>2</sup> Post Script: Readers of *Atlantis* are directed to the recent groundbreaking publication by Canada's leading feminist critic of psychiatry Dr. Bonnie Burstow (2015) entitled, *Psychiatry and the Business of Madness: An Ethical and Epistemological Accounting*.

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