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PPR

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# Shock Machine Scandal

**by Pat Butterfield and Alex Doherty**

**American woman, Imogene Robovit from Iowa, recently managed to get a successful settlement from MECTA Corp., one of the major ECT machine manufacturers, after she sued the company for brain-damage and being rendered unfit to work because of shocks inflicted be a MECTA Model D machine in 1989. At the trial Robin Nichol, MECTA'S President, testified that MECTA have never performed a single safety check on their machines.**

Linda Andre's newsletter, SHOCKWAVES in the US, published further information about this and also about MECTA'S failure to produce safety studies to the FDA in the required timescale. This sparked off our own investigation in this country.

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We discovered that Vickers - who are responsible for the distribution of MECTA products in the United Kingdom - were unaware of the problems in America.

Our partner in Scotland, Alex Doherty, wrote to Vickers on the 28 October 1997, bringing both articles to their attention. Vickers, on receipt of his letter, immediately contacted him by telephone, assuring him that an immediate investigation was b eing undertaken.

The spokesman for the company had already contacted the MECTA Corp., who denied that their Director gave any form of evidence at any trial. They also said that safety studies had been sent to the FDA in the required timescale.

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They promised Vickers that written evidence would be faxed that day.

Three days later the evidence still hadn't arrived. To quote Vickers spokesman, "They seem to be stalling for some reason, which leaves us concerned. We have stopped sales of this equipment from the date your letter was received. We don't need this hassle, we're out of here." To be honest, to a company as big as Vickers this is only beer money with regard to corporate sales".

Our partner contacted the press, and Vickers confirmed that sales of MECTA machines had been suspended.

Two days later an Investigative Television Reporter, Howard Belgarde, BBC Midlands, contacted the Attorney who acted for the pursuer in the Iowa case. He confirmed that Robin Givens did give evidence in a pre- trial setting, and confirmed what was said in SHOCKWAVES article.

The Attorney stated "The psychiatrist was cleared only because the pursuer was a nurse and she should have known what she was letting herself in for. If she was in any other occupation she would have won. MECTA, however, settled out of court without prejudice, and a substantial sum was paid".

The safety certificates were sent to Vickers by fax three days later. We think these safety certificates were only lodged with the FDA after the matter was raised here in the UK. We would like to know the precise date the documents were lodged!

Going back to the subject of the sales of the machines by Vickers, despite their assurances that sales had been stopped from 29 October 1997, another investigative reporter, Colin Savage, working on a BBC programme called, *Here And Now,* rang the company and was offered a MECTA machine to buy.

We believe Vickers were obviously embarrassed by the whole situation and deliberately covered up the fact that these machines were still being sold from under the counter. They were up for sale at this time and did not wish any adverse publicity. (Mecta machines are now distributed by Hillenbrand Industries (Indiana Tel.: 812 934 700 fax 812 934 1963 - President/chief exec: W Austen Hillenbrand) who also supply coffins and funeral insurance!)

In their 1996 ECT Audit, the Royal College of Psychiatrists visited 55 clinics in Wales, East Anglia and the North East Thames region, and sent postal questionnaires to the remaining 166 ECT clinics in England. Their Audit showed that 5.5% of clinics visited, and 14% of those clinics that answered the questionnaire (129 out of 166), used MECTA machines. The RCP also lists MECTA as one of the manufacturers whose machines meet their guidelines.

In the meantime people across the UK are being treated on unsafe and obsolete machines (just for the record, we believe all machines to be unsafe).

On a recent TV programme about ECT which allowed filming of an actual ECT session, one of our colleagues noticed that the psychiatrist was using a MECTA SR2 machine (this machine is the same model with a different number as the one used in Iowa on Imogene Robovit)!

The voltage read-out on the treatment parameters read 229.9 volts (mains voltage almost)! This particular machine is capable of delivering 1200mC of electric charge but IEC and TUV safety approvals don't apply above 500mC (according to RCP handbook- the one they don't read)! Imagine an untrained or unsupervised junior doctor twiddling with the knobs of this potentially lethal piece of equipment!

At a meeting set up by the Community Health Council in Salford in October last year I questioned the invited psychiatrist about the machines being used in his hospital. He said he didn't know, but they would be getting a new one in six months time.

When asked what happened when the machine they were using broke down he admitted, publicly, that they used an obsolete machine.

When asked about the safety of continuing to give ECT to the patients over the next six months he just blushed and muttered under his breath.

This disgraceful state of affairs continues as we write - and thousands of people are being put at risk across the UK every day. The cavalier attitude of certain members of this profession continues to anger me greatly.

In view of the current level of interest in ECT and the fact that this company is in the death business, we think it a good idea to discover the company's attitude to the safety of these machines and in particular whether they intend to withdraw the 70 or more 'doubtful safety' machines which Vickers have already sold to British hospitals.

**We intend to follow this up. We'll keep you posted.**

# Counterinsurgency and repression in Chiapas

by Ignacio Dobles O.

**The situation in Chiapas, in the southern part of Mexico, continues to be one of counterinsurgent warfare and repression, directed primarily at those communities and groups that sympathize with the zapatistas or other opposition groups.**

In recent years we have witnessed massacres perpetrated fundamentally by paramilitary groups, such as in Acteal, where 45 persons were killed in december 1997 and other murders in communities such as El Bosque, UniÛn Progreso and others. Thousands of people, mostly indian population, have been forced to leave their homes and belongings, and dozens of community leaders are held as political prisioners in Tuxtla Gutiérrez, the state capital.

**Harassment**

The recent zapatista nationwide consulta concerning the rights of the indigeneous people held in a national scale, demostrated considerable political influence of the zapatistas, specially in Chiapas, and this has caused concern in the dominant political and military circles. Meanwhile, the harrasment of communities continues, with incursions of the army and police forces, and the disruption of autonomous local goverments.

This situation, in the midst of a counterinsurgency policy carried out by the army, police and dominant political circles of the ruling PRI party, creates a very difficult situation for thousands of people, and profound challenges to those seeking to work with communities and the victims of repression, with respect for their cultural and group characteristics.

In additon, the mexican goverment has carried out a very distinct policy of harrasment of international observers, human rights and peace activists and in general those organizations that identifies as a threat to the implementation of this policy.

Strict, almost impossible restrictions apply to the intent of carrying out work in Chiapas, and foreigners have been expelled from the country or prohibited from entering it withou having violated mexican laws; these same restrictions do not apply, of course, to foreign investors or military advisors.

**Challenge**

The challenge to workers in the field of psychology is large. There is a need to address the psychological and psychosocial factors involved in these repressive policies and their effects, and also a need to develop strategies that work with the communities respecting their cultural and ethnic characteristics.

Some very courageous people, groups and institutions carry out work in these difficult conditions. International attention should be focused in this situation, because the causes of the conflict in Chiapas, at a distance now from the sensational uprising of 94 that marked the failure of the supposed entrance of mexico into the "first world" proclaimed by Salinas are everpresent and aggravated, while the mexican goverment refuses to comply with the accords signed with the zapatistas in San Andrés in 1996.

# The 1998 Tourette Syndrome International Conference, Washington D.C.

by Rob Evans

**Over the past year and a half my research on Tourette Syndrome (TS) has developed an alternative view of this label in collaboration with the participants I have been fortunate enough to work with. As some of you may already know, TS is a label given to people who make sudden and 'involuntary' noises and has a long list of other 'symptoms'.**

Since the mainstream fields of psychiatry and psychology took an interest in this 'disorder' it has come as no surprise that the 'prevalence' has increased dramatically, and the constructions of TS along with Attention Deficit Disorder (ADD), and Obsessive Compulsive Disorder (OCD) have become 'buzz' or fashionable labels for psychiatrists to 'diagnose'.

It is possible, in regards to TS to draw a parallel between interest in research and subsequent increase in diagnosis (See Apter 1992). For critical and introductory reading see Parker et al (1995), Fox Prilleltensky (1997), Burr (1995), Hales (1996) and for an introduction to the medical discourse see Robertson (1994,1995), Bornstein (1991), Baron-Cohen (1993).

The 1998 conference was held in Washington DC, and I planned to provide a new and alternative perspective of how we understand the nature of this label and how the people with the label manage it.

I am sure we are all familiar with the 'positive' and 'negative' consequences of labeling, more than this however I have come to understand that the method of treatment for TS, predominantly benefits people other than those with the label. This is a major issue in the research I am doing at the moment which shows in interviews that the reasons people say they consult a psychiatrist is because they are experiencing difficulties *"socially"*.

Why did I want to attend the conference? Originally I heard of the conference via the TSA (UK). The provisional program of the conference showed a dominance of a pathologising, medical way of understanding and drug treatment as the dominant 'treatment'. Discourse about the construct of TS in the USA is, at present, firmly grounded in psychiatric pharmacology, and psychological research has become stuck on its obsession for describing 'cognitive deficits'.

The provisional program of the conference, the topics and speakers were predominantly concerned with 'new developments', but these 'new' developments were only within medical science.

One important omission form the program was the voice of the very people the conference was about. With the absence of research carried out by people with the label of TS, my aims for attending were a) To challenge the medicalisation of TS and b) To provide examples of an alternative perspective in action, i.e. from my current research.

The conference was divided into five tracks; Advocacy, Adult Issues, Education, Family Issues, and the most interesting from my own position, that of Medical Research. The conference also featured a number of roundtable discussions in which I planned to participate. These enabled me firstly to put the alternative view across, and secondly to take questions and inevitably criticism from other delegates.

The conference was on a massive scale. The venue, the Radisson Hotel was a testament to building technology. With five different tracks in addition to a medical research conference, planning your way through such an event was at times quite frankly baffling. Each of the five tracks contained sessions that I wanted to attend, this was not possible though with some of the sessions running simultaneously.

**Medical symposium**

At the medical symposium developments in pharmacological intervention were reported. With an 'alternative position' to my own view of the problems faced by people with the label of TS, these sessions were lively and in addition served as a concise literature review.

The interest in genetics was also clear with a number of papers being delivered which again were useful for generating subsequent debate. The medical symposium with its propensity to pathologise difference was again focussing on the issue of 'co-morbidity' with constructs like ADD and OCD.

This kind of session provided some of the most vehement debate of the whole conference. The validity of co-morbidity and the reliability of the Diagnostic and Statistical Manual (DSM-R) is highly questionable, however within reductionist science this

method of 'diagnosis' is highly valued and life influencing decisions based upon it.

I am sure you can imagine the nature of debate with people from these very different theoretical positions in the same room! These debates are of immense value to all researchers whether they be from psychology, psychiatry, philosophy, or other Human Sciences, they provide the opportunity for you to place your views under criticism and invite you to question, critically, your own theoretical position.

One encouraging result from these debates was the interest not only from non-academic delegates but also from medical professionals.

The evening after such a debate I had conversations with people who felt unable to put questions during the session. We still agree to disagree on many points but I would hold that they are at least aware that the medicalisation of difference is just one of a number of different discourses that one may position oneself in. There were also one or two medical professionals at the medical symposium who themselves have the label of TS and together we had some productive talks.

Looking at the sessions run by advocates of the TS Association it was clear that the medical sessions fed directly the content of the sessions for 'lay people'. The strength of this reliance on medical science was very clear when I spoke with other delegates.

For instance, on one occasion I was talking with a young person who was describing the side effects of medication she "had to take" and how they "are important for stopping the tics".

After listening to this pathologised description of herself I asked her what else in her life was important to her apart from TS. We then got talking about the million and one other things in life and in each case I pointed out that the label of TS doesn't have to be the only way she could describe herself.

Then came the bombshell. Her mother had been listening to our conversation and intervened (carrying her copies of "OCD and your child" along with other frightening titles), her mother told her she had to go and do some reading and took her away.

Later on that evening the young person told me that her mother had forbidden her to talk to me. I did speak with her mother after this and every attempt I made at releasing the grip of pathologising language about her daughter was met with hostility.

**Advocacy**

Within the Advocacy track, invited speakers and round table discussions were focussed on "The law and TS" with other sessions debating how advocates of people with the label of TS can engage with teachers and parents.

This focus on the so called dis-ability of young people with the label provided another opportunity for me to pose the alternative way of looking at education with a focus on strengths in the classroom as opposed to weaknesses. The roundtable format of discussions here perpetuated a more relaxed atmosphere and were open to all delegates. It is worth mentioning here that many parents are taking on advocacy work on a daily basis when their child experiences problems with teachers.

The sessions in this track were aimed at helping a parent gain an understanding of the existing body of 'knowledge' and to participate effectively in decisions affecting the education of their children. I did at times in these sessions consider what it was that was being advocated; the person or the 'disorder'?

Occasionally these sessions described the medical view of TS with the person being somewhat left behind. Again, presenting an alternative position, one which focuses on the abilities and strengths of the person in addition to the long list of 'symptoms' was generative and initiated debate.

**Education**

The Education track focussed primarily on the difficulties faced by young people at schools. An interesting session, "Establishing a positive educational environment for children with TS and ADD" focussed on how the educational setting can be problematic for a child who may find sitting at desks, and in silence "very difficult". I found this session very innovative though, as it sought to develop alternative teaching strategies that viewed the differences in behavior *"as potential strengths"*(feeling like a breath of fresh air).

The session used a familiar insight that people familiar with the TS label would know. If you can engage a person in a task they enjoy, and in a creative atmosphere the results can be astonishing. This might seem very obvious to many but so often in the educational setting people with the label of TS are being invited to participate in a social activity that is difficult.

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Once the scenario is changed many people often show incredible talent. It is imperative to note that this talent was already there in the previous setting, the only change that has occurred in the context, not the person. This session was progressive and highly positive in its approach to education.

**Other sessions**

The remaining tracks ( Adult Issues and Family Issues) comprised of a variety of lectures and round table discussion focussing on the experiences of parents and other people who are involved with the work of the Tourette Syndrome Association.

The evenings at this conference were a great deal of fun. I had some wonderful times with people I met and had time after the conference to visit wonder into the capital - I can recommend Georgetown for a good night out!

**An important arena**

The 1998 TS conference was the first ever of its kind. Washington last October was unique; I do not know of any other event where 'lay-people', academics, psychiatrists, psychologists, educators, and social workers have come together for the purpose of an open conference on TS.

Despite the language of many of the speakers, and more worryingly family members being firmly rooted in a pathologised discourse, this conference functioned as an important arena in which such a discourse could be challenged. In addition to challenging and critiquing the medical and psychological discourse on TS, alternative perspectives were discussed and a more progressive and empowering construct of has begun to emerge.

The evenings were a good chance (usually at the bar) to talk with people from medical backgrounds and to make progress in ways other than just vehement disagreement.

Many of the members of the TSA I met were interested in my academic background (Cue: big plug for your institute and sponsors) and often appeared surprised at me 'having' TS and being 'able' to carry out research. Such can be the assumptions of a person with this label "Not being able". I argue that the label should not be an issue, and research by people has qualities that research for people could never have.

The next conference of the TSA in the United States is planned for the summer of 2000. With gradual transition already occurring in methodology and the presence of self advocates in the research community we can look forward to more debate and a focus on empowerment.

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# Tribunal on Human Rights in Psychiatry at Scarborough, England, June 23-25, 2000 by Rene Talbot

**In half of the 193 states on this globe people are being kept prisoner due to their religious beliefs, political convictions, race, or gender.**

The other half of humankind calm themselves with the moral supremacy they proclaim to have gained over non-democratic states for observance of human rights.

Indeed, much has been reached since the Universal Declaration of Human Rights was issued in 1948 and in the process of its implementation in the law of nations. But do Western societies actually live up to their self-defined ethical standards, or are the moral merits undeserved that the democratic reasoning ascribes itself?

It seems that the vertical division does not hold, and that there is tacit violation of human rights not only in remote corners but also in unsuspected realms.

**Fundamental rights**

The Universal Declaration of Human Rights ensures the fundamental right to liberty to all human beings, the right to freedom of thought, conscience and religion, as well as the right to freedom of opinion and expression (Articles 3, 18 and 19).

These are guaranteed to everyone `without distinction of any kind` (Article 2). They are inviolable and indivisible rights. No legitimate limitations may be imposed on holding a belief. Manifestation of belief may only be restricted when `it is necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others`. Unless a danger of this kind needs to be averted, no intrusion is justified.

It is, of course, also quite irrelevant whether the belief or opinion held is true or not for the individual to be entitled to the rights in question. In fact, it is one of the principles of reason that its utterances be disputable.

**Restrictions and violations**

Whence then the pressure on some to refrain from their thoughts and beliefs in the so-called open societies? Involuntary detention in mental hospitals on the allegation of insanity is, in a host of cases, a manner of imposing restrictions to the rights to liberty and to freedom of thought and belief.

The woman who believes she induced the fall of the Berlin wall and firmly states her belief, without ever presenting a danger to anyone including herself, can tell a story about the pressure to give up her convictions. Her life has been an Odyssey between section and drug treatment, with the explicit purpose of making her abandon those opinions.

As a mental patient her fundamental rights have been severely violated. Is she, in a bizarre way, a prisoner of conscience? In prevention of what crime is she locked up?

Thus, ex negativo we understand the odd necessity to conform, as it is done in the `Principles for the Protection of Persons with Mental Illnesses and for the Improvement of Mental Health Care' that `every person has the right to exercise all civil, political, economic, social and cultural rights as recognised in the Universal Declaration of Human Rights`.

Society protects itself from deviance. The line between acceptability and alleged `disorder of thought form' is rigidly drawn by the stronger party. If it cannot be, it must not be - in defence of this axiom, reason is administered through force and coercion by the medical system.

Doctors are presumed to be competent judges and authorities in matters of thought and belief, in that they are legally designated to certify whether someone is sound or not.

Drug treatment serves to blur and disrupt the belief that there is a right to freedom of thought and that, of course, is at variance with the provisions of the Universal Declaration of Human Rights.

**No evidence**

No evidence has been produced that there is such a thing as mental illness, apart from certain symptoms; hence the serious quest for a yet-to-be-discovered biological cause, like a genetic defect.

Forced conformity is an illness from which reason needs to convalesce. This is in accordance with the spirit of the UN Declaration of Human Rights, which was set forth as a response `to the barbarous acts which have outraged the conscience of mankind` in this century of war and genocide (Preamble).

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# *Politics and Psychology: An Interview with Hans Eysenck*

**The circumstances of this interview are rather unusual. Hans Eysenck approached Psychology Politics Resistance after seeing a copy of one of our newsletters and asked for an opportunity to put forward his views.**

Our immediate inclination was to refuse, but we did agree to meet for a recorded interview which would not, we emphasised, necessarily be published.

We are sure that our readers will agree that, despite our misgivings about entering into a dialogue with Eysenck, his comments here shortly before his death are surprisingly supportive of the perspectives of PPR.

~

***PPR:*** *Could we start by reviewing the reasons that led us to this interview? It is, after all, rather unusual for a radical psychology group to be talking to you.*

**Eysenck:** I can certainly appreciate that. I was aware that an interview with Noam Chomsky is due to be published by PPR [and it was, in PPR Newsletter 5], and was annoyed that such a figure should be giving support to a group that seemed to me, by the name, to be anti-scientific and destructive.

You will know that I have spent most of my life exposing abuses of science and explaining how a proper science of psychology should be developed, and I have devoted considerable time to showing how Freudian theory fails to meet any of the standards we would expect of science.

I was, in fact, revising the first draft of a new manuscript about the stupidities of psychoanalysis, provisionally entitled Freudian Charlatanry and Scientific Reason, when I read the first issues of PPR Newsletter.

The first thing that struck me was that the reasoned tone of its arguments against abuses in psychology sat uneasily with the characterisations of PPR by colleagues, and indeed what those words `Politics` and `Resistance` in relation to psychology would lead one to expect.

The most important point that has now led me to rethink my work on psychoanalysis, for example, was that the question of `abuse` was an abuse of power rather than a simple abuse of scientific reason. It hadn`t occured to me that Freud and his followers were causing misery to people by claiming to speak in the name of science, and that this was the most important issue.

Some silly students interrupting some of my lectures had shouted slogans about such things of course, and I knew that that fellow Masson had been arguing against psychotherapy using feminist ideas, but I felt I had more important things to read than Masson. I have recently looked at his work, and been astonished that it makes persuasive reading.

***PPR:*** *Many readers of PPR Newsletter will find it difficult to believe that you are changing your views at this stage. Does this mean that you are also rethinking your work on intelligence?*

**Eysenck:** I still believe in the scientific method, and I don`t think that you can simply pretend that biological processes are unimportant in human psychology. But I do want to say that I am very sorry for the unhappiness that my work has caused. You should know that it has caused myself unhappiness as well.

***PPR:*** *Do you mean your work on intelligence and race?*

**Eysenck:** My work was devoted to finding a scientific basis for intelligence and personality. The fact that it was misused was a secondary issue, or so I thought until I reflected on some of the points that were made by Billig in a Searchlight pamphlet [Psychology, Racism and Fascism, 1979].

I was genuinely shocked by the links between right wing political groups and racial studies of intelligence. But I thought that the best way to deal with it was to keep psychology away from politics altogether.

I only agreed to the interview with the National Front magazine because they told me they were completely non-political. One of them bit a piece out of one of our best china cups and urinated in a pot plant, but apart from that they were polite pleasant people.

One thing I learnt from reading Billig`s pamphlet and now, more recently, PPR literature, is that psychology and politics are interlinked. Psychology is a discipline which regulates people, as the French psychologist Michael [should be Michel] Foucault discovered in his studies which we plan to publish soon in a special issue of *International Journal of Individual Differences.* If it operates in that unscientific way it won`t be able to progress.

***PPR:*** *But does that mean that you still believe that intelligence is mainly inherited, that you would stand by Cyril Burt and...*

**Eysenck:** I don`t want to talk about Burt. I was relieved when the BPS [British Psychological Society] set up the inquiry. The question of abuse is very salient in the Burt case, and the whole issue has caused me much pain. He was an abusive man, and knew how to enforce silence.

***PPR:*** *There have been rumours about your role with respect to his imaginary assistant `Miss Conway`, beatings and so on.*

**Eysenck:** My attempts to address this history of relationships with people like Burt in psychoanalytic quack therapy only served to convince me that Freudians make problems worse, and a good scientifically-proven behavioural treatment is the only way forward.

A very well known Freudian analyst wasted my time and his on a couch in North London for several years, and it was only when the encounter took a nasty turn with some physical contact that I gave up on it altogether.

Unfortunately, well, I don`t want to speak about this. I can`t excuse my behaviour, but the historical record needs be set straight as to the reasons why I needed large amounts of money, and large corporations like BAT [British American Tobacco] were willing to provide that.

***PPR:*** *Do you mean the research sponsored by British American Tobacco on the susceptibility of extraverts to cancer linked with their greater willingness to smoke.*

**Eysenck:** I don`t want to comment specifically on BAT for legal reasons, but the research grants into smoking had to follow a direct line from company headquarters, and, despite Sybil`s warnings when we were asked to do the photo shots of us smoking a filter tip while peering down a microscope, I was willing to go along with it.

The distinction between extraversion and introversion, after all, doesn`t stand up to serious scientific scrutiny. The study on extraversion in prison was a particularly stupid mistake. We asked prisoners whether they liked parties, and, not surprisingly, got rather useless results, from which we concluded a great deal. Sybil got the blame for that when people noticed, but it was my idea.

Only the work on psychotic personality stands the test of time, but even in those cases it is possible to shock the criminality out of people.
***PPR:*** *Your comments in favour of aversion therapy would still accurately represent your position then?*

**Eysenck:** Aversion therapy has been proven to work for certain kinds of psychological problems. Unfortunately, I have many times mistakenly argued that sexual problems should be treated in this way.

On one occasion Peter Tatchell, who I viewed as a nuisance and a trouble-maker, demonstrated in one of my lectures against my statement that aversion therapy might reasonably be used to treat homosexuality.

It has only been the debates in the BPS over the creation of the lesbian and gay section that has made it clear to me that intolerence of people with different sexual orientations, such as feminists, has nothing to do with science. I voted for the section, with some uneasiness still I must say, and think back now to my encounter with Tatchell. He is a very brave man.

Unfortunately one of the conditions of my funding from the Soviet Union for saying nice things about Pavlov and the stupid research on conditioning by their scientists doing behavioural research on people with different nervous systems was also that I should condemn homosexuals.

Every favourable reference to Soviet research was rewarded by a suitcase of used notes from the embassy, but there was always a spiteful reminder about the Burt photos and a warning that I should come down harshly on deviants of all kinds.

***PPR:*** *This is unbelievable. Are you saying that you were funded and threatened by the Soviets as well as by Tobacco companies?*

**Eysenck**: The fall of the Berlin wall makes it possible for me to say this, though I am nervous about Western businesses and security services still.

Perhaps I have been silent for too long. Psychology is a dirty game. I have written to The Psychologist [the BPS house journal] supporting the gay section and offering to host the next conference at the Institute [of Psychiatry]. 15 such letters have not been published.

***PPR:*** *Would you vote for a PPR section!?*

**Eysenck:** That is a silly question. What is important is that groups like Psychology Politics Resistance work with the BPS, which is an organisation whose thinking is very much in accord with yours, it seems to me.

If you stopped the criminals and psychotics and low intelligence people from coming along to your meetings or writing for your newsletter you could do a lot of good. In fact, one of the biggest problems is that it is exactly these types of people who run the BPS at the moment.

I would like to see Psychology Politics Resistance supplements to all the journals and newsletters of the BPS so that there was a critical reflexive awareness running through the whole organisation. It makes a lot of sense and...

***PPR:*** *Your willingness to think again about issues of abuse and personality and racism and sexuality is out of keeping, isn`t it, with those comments on intelligence and mental distress. We have to say that we find those comments offensive.*

**Eysenck**: I don`t understand why you think it important to stick up for all these people and ignore differences of ability.

PPR: PPR is against abuses of knowledge and power in psychology at all levels, and for challenging oppression of people who are labelled as `mentally ill` or `psychotic`. People are categorised according to their `intelligence`, as well as their supposed personality characteristics and many people who end up in prison have been

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*systematically excluded by people who think they know what healthy psychology should look like. PPR is supportive of campaigns against exclusion of children with challenging behaviour or learning difficulties from school for example, and, in the same spirit, we would not agree with the labelling of `criminals` as if they were special excludable types of personality.*

**Eysenck:** We will have to agree to differ. I am tired now. I will think about your comments, and I want to make it clear that I believe that there is a direct link between psychology and politics in a much more direct way than Chomsky seems to believe.

It`s all very well campaigning for good social causes in the world if you don`t set your own house in order.

OK, I`m willing to learn, and I will be arranging for a sizeable donation to your organisation in the near future. In the meantime I will do what I can to advance the possibilities of resistance to abuses of power in psychology until my dying breath.

~

Unfortunately, the donation did not come through before Eysenck died, but it should be noted that, from further postcards to PPR and (as yet unpublished) letters to the prisoners support group `Black Cross` and to the magazine Asylum, it is clear that he was rethinking his unpleasant comments towards the end of the interview. Although he was counselled to withdraw his application for the MSc Critical Psychology at Bolton Institute after submitting a very poor test essay, he asked to be kept on the mailing list of events.

**We have let the interview stand as it is, unedited, to catch something of the contradictions and movement in thinking of someone who, until very recently, has been thought of as an enemy of people who use psychology. We now leave it to our readers to assess those contradictions, and how far the movement forward may have proceeded.**

~

# Tribunal on Human Rights

*...continued from page 7*

The Declaration is a document to promote liberty and tolerance while asserting the universality of the principles it advances.

If it allowed for discrimination on the grounds of reason, it would expose itself to a deep self-contradiction, for it would then restrict the validity of the principles it pronounces as universal.

Mental health legislation concentrates on the right to treatment and keeps silent about the right to freedom from fear called for in the Declaration.

The concept of mental illness and the coercion which impairs the freedom of thought have to be reconsidered in terms of violation of human rights.

**Investigation required**

This requires an investigation. An assessment of the violation of human rights in psychiatric practice and mental health legislation as its legal framework is due.

In June 2000 a Russell Tribunal on Human Rights in Psychiatry will convene at Scarborough to investigate cruel, inhuman and degrading treatment in coercive psychiatry as a crime against humanity and to break the silence that surrounds it.

The World Psychiatric Association will be strongly encouraged and requested to present evidence in defence of its policy. Mental health legislation will be accused of violating elementary rights.

Individual cases will be brought before the Tribunal. It will examine the evidence emerging from hearings and interrogations of the witnesses and pass judgement on it.

The American writer Kate Millett will be part of the Accusation, as well as the critical psychiatrist Thomas Szasz who has devoted a lifetime to the cause. Member of the European Parliament Ken Coates, former President of the Russell Peace Foundation, will be on the Jury. A number of British psychiatrists, philosophers, writers and artists will also join in the trial.

**To be involved contact**
**Rene Talbot,**
**Vorbergstr. 9a,**
**10823 Berlin, Germany.**

# Evidence from the Bradford Group

**At a meeting held in Bradford on the 8th January, 1999, a group of psychiatrists met to launch a campaign opposing any extension of the legal powers of psychiatry.**

They expressed concern that public debates about mental health have been distorted by a media pre-occupation with issues of safety and risk.

In a paper representing their views - which is their response to the Scoping Group's call for evidence, they said:

" We believe that it is wrong that the government should make changes in the legal framework for mental health practice that are driven by inaccurate and distorted media reports."

"We are particularly worried about government proposals for community treatment orders (CTOs) and the notion of reviewable detention."

"We believe that the introduction of such legislation would result in unacceptable violations of patients' civil liberties and human rights, as well as bring about an unacceptable shift away from the value of care to a principle of coercion."

The Bradford group's statement of evidence outlines their objections to CTOs and the proposal to introduce reviewable detention under the mental health act.

The evidence looks first at ethical and practical objections to community treatment orders. It then turns to reviewable detention, describing ethical and human rights objections, as well as problems with the whole concept of personality disorder.

The position on reviewable detention is summarised on the basis of the following beliefs:

* reviewable detention is a political matter, not a medical one;

* psychiatry does not possess a special knowledge which is valid in terms of medical science, and which allows it to predict dangerousness or the risk of reoffence;

* there are no effective psychiatric interventions for these offenders.

The group believe that many psychiatrists share their concerns, and they will be doing all they can in the months to come to stimulate a public debate in a campaign to resist the introduction of CTO's.

The group's evidence concludes with the following statements:

"We object strongly to the government's calls for the introduction to CTO's. There are strong ethical arguments and practical difficulties which, in our view, make such legislation unconscionable."

"The proposal to introduce reviewable detention raises profound human rights issues, and if introduced would turn psychiatrists into jailors. The issues here are of such importance that in our view our society must engage in a very full and thorough debate so that this difficult area can be thought through carefully."

"The government should use this review of mental health legislation to implement measures, such as advance directives and advocacy, that will place more control in the hands of people who use mental health services."

**The Bradford Group**

Those attending the meeting on 8th January, 1999 were:

Simon Baugh,
Consultant Psychiatrist,
Bradford Community Health Trust

Mike Basher,
Trainee psychiatrist,
The Maudsley Hospital

Pat Bracken,
Consultant Psychiatrist,
Bradford Community Health Trust

Duncan Double,
Consultant Psychiatrist,
Norwich

Claire Henderson,
Research Psychiatrist,
Institute of Psychiatry

Steve Hopker,
Consultant Psychiatrist,
Bradford Community Health Trust

William Hopkins,
Consultant Psychiatrist &
Lead Medical Clinician,
Barnet Health Care Trust

Rhodri Huws,
Consultant Psychiatrist,
Sheffield

Joanna Moncrieff,
Research Psychiatrist,
Chelsea & Westminster Hospital

Marcellino Smyth,
Consultant Psychiatrist,
N Birmingham Mental Health Team

Phil Thomas,
Consultant Psychiatrist,
Bradford Community Health Trust

# PROZAC - the arrival of a Messiah?

by Kevin Brewer

**The claims for Prozac since its arrival in 1987 have been astounding.**

Not simply does it combat depresssion, but "it can transform pessimists into optimists, turn loners into extroverts, improve business acumen and emotional resilience - in short, that it can fundamentally alter personality" (Kramer 1993).

The story of Prozac is even more a media event in the USA, including the Church of Scientology claiming an evil conspiracy to control people with it. Typical of media events in the USA, it reached the cover of "Newsweek" (March 1990), and the "Oprah Winfrey" talk show.

### Key questions

The whole episode with Prozac, which is still continuing, opens up a number of key questions. What is the place of drugs in dealing with mental disorders? But furthermore, is there a place for "cosmetic psycho-pharmacology" ie a drug to simply help make living better?

The treatment of depression is always difficult because depression has many causes, and takes many forms. It may be a reaction to a life event, or it may be apparently unconnected to any event. It may even be a "normal" part of the human condition.

### The "first generation"

When anti-depressants arrived with iproniazid in the 1950's, so began the opportunity to "cure" depression. Certainly anti-depressants do work for some people. But along with the drugs came the view that was to dominate psychiatry.

Depression is caused by a neurochemical imbalance - the brain's own chemistry is a little off. I may be living in poverty and a close relative has just died; I am depressed - whatever, the answer is to "attack" my brain's chemistry.

The "first generation" of anti-depressants (tricyclics) have been shown to be highly effective for "classically" depressed patients. So there are many "non-classically" depressed patients who do not improve. But there are side effects. For example, imipramine can result in sweating, heart palpitations, a dry mouth, and constipation. The biggest side effects are addiction, or more particularly death from overdose.

The traditional feeling is that anti-depressants are not addictive, but they certainly are toxic. Giving a potentially toxic substance to a depressed patient with a time lag (of 2-3 weeks) before it works, it is not surprising that overdoses occur.

Since the arrival of the "first generation" of anti-depressants, the search was on among pharmaceutical companies to find alternatives. They found mono-amine oxidase inhibitors (MAOI); and then the pharmaceutical company, Eli Lilly, produced selective serotonin reuptake inhibitors (SSRI) (and particularly, fluoxetine hydrochloride - the chemical group of Prozac).

### Side effects

Then came the claims of a "new Messiah". Kramer(1993) points out that the "relative" lack of side effects encouraged its use. Certainly compared to the older anti-depressants, the side effects are less obvious. But there is a difference between relatively less side effects and no side effects as some claim.

Fieve(1994) lists the side effects detected among 3000 patients on clinical trials - nausea (21%); headaches (20%); nervousness and anxiety (10-15%); insomnia (14%); drowsiness (12%); anorexia (9%); diarrhea (12%); dry mouth (9.5%); sweating and tremors (8%); rashes (3%).

Also "Prozac overdoses are relatively benign" (Kramer 1993 p66). The writers talk about "dirty" and "clean" drugs in terms of their ability to solve the particular problem that they were made for, without too much other damage (ie side effects).

### Extended use

Prozac was of course "clean". Its supporters suggest it is less toxic than salt. The move to use Prozac for other problems than depression began. And more than that - to use with patients who would not traditionally be viewed as having mental problems.

Kramer(1993) quotes the example of rejection-sensitivity (the fear that events will produce sensations of loss and inadequacy) - not an illness nor personality disorder, but a personality characteristic. "It is one thing for a doctor to be able

to transform a patient with medication, quite another for the doctor to be able to sculpt the patients' personality trait by trait" (Kramer 1993 p97).

Kramer admits that he looks for signs of rejection - sensitivity in all patients, and sees it everywhere. From a young person who has never had a romantic relationship, to another stuck in an abusive relationship.

Not only do we have the creation of a new category of "problem", but it is so general that it can be applied to almost any social difficulty. Certainly unhappy individuals who seek help probably have social difficulties, or feel that they do.

Take the example from above of a young person "in the usual age of courtship" who has not had a romantic relationship. What are we saying about society, if we decide that this type of person needs treatment. There may be individuals in such a situation that need help, but what about individuals who are just different to the majority.

It is worrying that psychiatrists are moving out of their field of "mental disorders" to attempt to "create" the correct personality, and define any behaviour other than a thin band of "normality" as a "problem". Individuals that seek help from psychiatrists are usually unhappy with their lives, but this should not be the criteria for prescribing Prozac.

The modern world of capitalism is not a happy place. Peter Breggin, the well known psychiatrist and critic of drug use in psychiatry, points out that life is hard, and to call it depression trivialises it. Ultimately we are looking for a "heaven on earth", and Prozac is the latest "Messiah" to bring this. Nigel Cassidy on "Shelf Life" calls Prozac the "psychoactive Mars bar" - it will help you work rest and play.

**Flavoured for children?**

Taking the use of Prozac further, Hampshire(1998) reports attempts by Eli Lilley to get clearance for peppermint and orange flavoured children's versions. There are around 400 000 under 18s in the USA taking Prozac. The figures for the UK are lower, but difficult to establish exactly.

It is important to note that children's psychobiology is very different to that of adults. "Listening to Prozac" (Kramer 1993) is full of biographies of individuals helped by Prozac. But it is written as if each individual experienced a "religious conversion", and Kramer is the evangelist with the goal of removing "mental disorders" and "chronic low-level unhappiness or recurrent minor periods of demoralization" (p125).

Other authors, though, are more controlled in their enthusiasm (eg Fieve 1994), accepting that less than 10% of patients experience personality transformation.

**Where does it stop?**

We are faced with the issue of what is treatment, or more correctly, where does treatment stop? Prozac is a "mood brightener", but it is different to other anti-depressants in that it interferes with an individuals relationship to reality. Particularly, the ability to "stand to feel what you feel" ("affect tolerance" - Schwartz 1991). "Schwartz is afraid that mood brighteners will rob life of the edifying potential for tragedy"(Kramer 1993 p258).

Finally, we have to look at the manufacturers of Prozac, Eli Lilly. They are not philanthropists. Under capitalistic economics, the aim is to maximise profits, and they certainly have profited from the sale of Prozac. Estimates of sales of 1 billion dollars a year by 1993, which is now up to 2.2 billion dollars.

It has been suggested that they are trying to play down the "hype" and claims of Prozac. Whatever, any publicity is good publicity for them. Is it possible that integrity will predominate when such large amounts of money are available?

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# 25 Good Reasons to Abolish Psychiatry by Don Weitz

1. Psychiatrists are more harmful than helpful.

2. Psychiatrists are more unethical than ethical .

3. Psychiatrists do not empower - they disempower people.

4. Psychiatry is not a medical science.

5. Psychiatry is quackery, a pseudo-science which lacks independent diagnostic tests, testable hypotheses, and cures for "mental illness".

6. Psychiatrists can not accurately and reliably predict dangerous-ness,violence or any other type of human behaviour, yet make such claims as "expert witnesses".

7. Psychiatrists have already caused a worldwide epidemic of brain damage by prescribing brain-disabling treatments such as the neuroleptics, antidepressants, electroconvulsive brainwashing (ECB or electroshock), and psychosurgery("lobotomy").

8. Psychiatrists mnanufacture hundreds of "mental disorders" classified in its bible titled Diagnostic and Statistical Manual of Mental Disorders(DSM). The DSM is not a scientific work but a catalog of negative moral judgements which psychiatrists use to medicalize, target and stigmatize dissidents and alternative ways of perceiving, interpreting or being in the world.

9. Psychiatrists fraudulently diagnose people's life crises as symptoms of "schizophrenia" or "mental illness".

10. Psychiatrists falsely claim, without scientific proof, that "schizophrenia" is not only a real disease but caused by a "biochemical imbalance in the brain", genetic factors or a "genetic predisposition"—in fact, there are no scientifically-established biochemical and genetic factors in "schizo-phrenia" or any other "mental illness".

11. Psychiatrists routinely misinform psychiatric prisoners ("involuntary patients"), their families and the public by claiming that bain-disabling rocedures as the neurotoxins (e.g.,"anti-psychotic medication","antidepressants"), electroconvulsive brainwashing (ECB), sychosurgery and other behaviour modification or ind-control procedures are "safe, effective and lifesaving"—the exact opposite is the case.

12. Psychiatrists routinely deceive or lie to psychiatric prisoners, other prisoners, their families and the public.

13. "Psychiatrists routinely misinform or not inform psychiatric prisoners and other prisoners about their treatments' many toxic and permanently disabling effects such as memory loss, tardive dyskinesia, parkinsonism, dementia (all signs of brain damage), and death.

14. Psychiatrists routinely threaten, intimidate and coerce psychiatric prisoners and other prisoners into consenting to health-threatening treatments such as the antidepressants, neuroleptics, ECB, and hi-risk experiments.

15. Psychiatrists routinely violate the ethical and legal principle of "informed consent" by failing to inform psychiatric prisoners and others about non-medical alternatives such as safe survivor-controlled crisis centres, drop-ins, self-help/advocacy groups, holistic/naturopathic medicine, and affordable supportive housing.

16. Psychiatrists are sexist in frequently stereotyping women in crisis as "hysterical" or "overemotional", overdrugging, electroshocking and blaming women whenever they voice real complaints or openly express their feelings and emotions such as sadness pathologized as "depression".

17. Psychiatrists are homophobic; the American Psychiatric Association once officially labeled homosexuality as "mental illness", later voted not to classify it as an illness.

18. Psychiatrists are ageist in targeting elderly people, especially women, for antidepressants and electroshock - a form of elder abuse.

19. Psychiatrists are racist and classist in disproportionately drugging African-Americans, African-Canadians and poor people, labeling them "schizophrenic" or "psychotic", and subjecting children of colour to experimental drugs or hi-risk experiments.

20. Psychiatrists routinely violate people's human rights and constitutional rights such as incarcerating innocent people without trial or public hearing ("involuntary commitment" or preventive detention), and subjecting them to cruel, degrading and inhumane punishments or tortures such as forced drugging, forced lectroshock, psychosurgery, solitary confinement and other "restraints".

21. Psychiatrists masterminded the mass murder of hundreds of thousands of psychiatric prisoners, disabled children and elderly people in hospitals during The Holocaust in Nazi Germany and "selected" hundreds of thousands of concentration camp prisoners for death. There is still no mention of this psychiatrically-administered, mass murder program code-named "T4/euthanasia" in psychiatric textbooks and histories. In Canada, very few medical schools provide lectures on "T4".

22 Psychiatrists have participated in mind-control experiments in the United States, Canada and other countries since the early 1950s.

23. Psychiatry, particularly involuntary-biological psychiatry, is inherently coercive and based on three Fs: Fear, Force and Fraud.

24. Psychiatry is essentially fascist.

25. Psychiatry is a direct threat to democracy, human rights and life.

# Letters

## A letter to PPR

Dear Ian,

I want to thank you for the Newsletter. I found it very interesting and, I must say, provocative. It never ceases to astound me about just how different `we on the left` are in regard to fundamental philosophical issues.

A case in point is the recent interview with Noam Chomsky. According to him, both behaviorism and Marxism are dead. In their place he offers us `libertarian humanism` and cognitive theory.

I find this position challenging to say the least in that I have a chapter on the relevance of radical behaviorism for Marxism in your edited book, *Psychology and Society: Radical Theory and Practice* as well a chapter on the relevance of Marxist theory for behaviorists in Theories in Behavior Therapy. I also wrote a piece entitled `Toward a Synthesis of Marx and Skinner.`

In my view, Chomsky's `libertarian humanism` is just another name for liberal reformism, that is an apologia for capitalist politics. As for Chomsky's cognitive theory, specifically `transformational grammer`—I find it to be of the worst kind of nativism.

Cognitive theory in general, and his theory in particular, are too easily employed to promote the notion of inner agency, that is, the problems of society are located in the psyche of the person, not in an economic system that puts profits ahead of human needs.

The point I am making here is not to condemn Chomsky, but to illustrate how really different `we on the left` are. What is most important at this time in history is that we find ways to build united fronts against imperialist aggression around the world.

We must struggle TOGETHER to oppose U.S. attacks on Iraq, continued aggression, against revolutionary Cuba, and the expansion of the UN against the East European nations and the former Soviet Union. These among a multitude of other struggles—anti-racism, anti-sexism, anti-homophobia, and in general anti-working class.

In struggle,

**Jerry Ulman**

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## An Equitable NHS? Wouldn't That Be Nice!

Although it is hoped that Lewis Wolpert will enjoy a permanent and happy recovery from his bout of depression it is a shame that the majority of users of the mental health services cannot share his gratitude for the quality of treatment received, especially in areas of the country where psychiatrists seem to have little understanding of the psychological needs of individuals.

Unlike Lewis W., unless they can pay privately, people are highly unlikely to be offered any choice of treatment, including the cognitive therapy he found so invaluable.

At the same time his book came out, the scandal of the abuse of psycho-geriatic people at University College not 2 miles down the road, broke out. This is a hospital which runs a psychotherapy department sickenly enough, but it received nowhere near the publicity that Lewis Wolperts roadshow is receiving. ie a high status, professional man/scientist with access to the media.

As well as high doses of medication other elderly people receive high levels of ECT, depending which psychiatrists in which part of the country is in control of the services. Most members of the public are unaware that this can still be given against their wishes despite the risk of permanent memory loss and other horrendous consequences.

These elderly people are extremely vulnerable once hospitalised, it is therefore vital that their wishes are put on file by themselves or their relatives/advocates.

It could still be given as the law now stands but there would be a better chance of bringing legal proceedings to prevent it if a Living Will/Advance Directive is on file.

Although Lewis Wolpert asserts ECT saves lives, we can take it as read that somebody whose intellect is as admired as his would not take the risk - why should anybody else?

**Sue Stevens**
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