

Multiple truths and contested identities:  
Power, gender, and governance in first-hand accounts of shock therapy

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## **Abstract**

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Abstract: This thesis explores relationships of power and resistance, and the production of truths and subjects in first-hand accounts of electroconvulsive therapy (ECT). Using a feminist poststructuralist approach and Foucauldian genealogical methods, I analyse texts from ECT professionals and former patients in order to destabilize dominant understandings of “mental illness” and ECT. I investigate patterns, contradictions and consistencies within and between dominant and obscured knowledges in these texts. Connections between electroconvulsive therapy, gender and class relations, and governmentality—including processes of reponsibilization and individualization—are highlighted. I discuss evidence of the production of particular subjects, specifically the “still mad” former patient, and active citizens.

December 5, 2013.

To Two Mum, John, and everyone with a story about psychiatry.

## **Acknowledgments**

First of all, thank you to all my fellow former-patients-turned-critics of psychiatry. Your resistance inspires and comforts me. Thank you also to mental health service users who benefit from services. You remind me not to generalize my own experience. Thank you to critical mental health workers and educators for trying to understand different perspectives and bring compassion to the mental health system.

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## Table of Contents

### **Chapter 1:**

Introduction .....	1
◦ Established narrative of electroconvulsive therapy (ECT) .....	6
◦ Explanation of terms.....	7
◦ Research questions and why this is worthwhile .....	10
Methodologies .....	12
◦ Genealogy—A history of the present ECT .....	12
◦ Uncovering my primary sources .....	14
◦ Genealogy, governance, and critiquing the mental health system.....	23
Theoretical framework .....	25
◦ Foucault-inspired feminist poststructuralism – the (re) constitution of truths and subjects ...	26
◦ Foucauldian toolkit .....	32
· Power .....	32
· Subjugated knowledges .....	35
· Governmentality .....	36
Literature review.....	38
◦ Critiques of psychiatry and mental illness.....	38
◦ Feminist critiques of psychiatry and the medical model of mental illness .....	39
◦ Feminism and women’s diagnoses-depression and hysteria .....	41
◦ Histories of electroconvulsive therapy .....	43
◦ Feminist work on ECT .....	47
◦ First-hand accounts: Patients’ perspectives .....	49
A map of my research .....	49
Limitations.....	50

### **Chapter 2: The simultaneous construction of truths and subjects**.....52

A note on the texts.....	52
Expert knowledges and truths .....	53
Professionals’ version(s) of the truth.....	55
◦ Gender neutrality .....	57
Changes and contradictions throughout the professional narrative.....	60
◦ Should ECT be replaced? .....	60
◦ Suicide.....	60
◦ The extent of “improvements” .....	61
◦ “Last Resort” .....	62
◦ Memory loss and brain damage .....	64
Accounts chosen by professionals to reinforce their version(s) of the truth .....	65
Alternative truths.....	66
◦ More truths about memory loss and brain damage .....	70
Producing subjects .....	75
◦ Hysteria and the construction of the “still mad” former patient .....	77
◦ Power of suggestion .....	81

### **Chapter 3: Governing through mental health**.....83

Active citizenship .....	86
◦ Recognition of symptoms – acknowledgement of illness, getting help, and working towards wellness.....	87
◦ Building relationships with mental health professionals .....	96
◦ Choice and informed consent.....	104
◦ Managing the risks of treatment .....	109
◦ How to criticize shock therapy .....	110
<b>Chapter 4: Conclusions</b> .....	114
Practical concerns and a need for further critique .....	114
Former patients’ accounts of shock as bibliotherapy.....	116
The contradictory nature of a critique of active citizenship .....	119
<b>References</b> .....	120

## **Chapter 1**

### **Introduction**

More than a decade ago, I was hospitalized for a psychiatric illness. My behaviour and “symptoms” were managed with drugs, and eventually electroconvulsive therapy. My experience is typical in some ways: for example, I am a white woman who was diagnosed with depression. Severe depression is one of the main illnesses treated with shock, and research shows that, at least since the 1970s, a majority (about 70%) of the patients treated with shock are women (Andre 2009, p.177; Burstow 2006, p.278; Kellner et al 2005, p.978; Morrissey, J., Burton, N., & Steadman, H. 1979, p.103; Rapoport, M., Mamdani, M., & Herrman, N. 2006, p.617; Shorter, E. and Healy, D. 2009, p.145; Ussher, J. 2011, p.1; Warren, C. 1987, p.129). Shock therapy is treated as a gender-neutral practice, ignoring the power differential between (usually) male doctors and female patients, and research from a variety of sources confirming that shock is used disproportionately to treat women. Despite this consistent pattern, gender-neutral language is used in most scientific and popular accounts.

Bonnie Burstow calls on feminists to re-frame shock as violence against women: “It controls women and, indeed, is used to control women. It combines with other forms of violence against women. It is a special threat to women who are severely violated. And is used to silence women. As such, its very use is a feminist issue” (Burstow 2006a, pp.389-90). I will not argue that Burstow’s characterization of ECT should replace dominant understandings of ECT; however, I do consider this to be one of multiple understandings of the practice, and I take up her challenge to make ECT a feminist issue. What is more, my thesis will show that there are multiple knowledges

about shock therapy, and that these knowledges are unstable, while underlining gender and class power relationships involved in ECT.

Aspects of my story are different than the representations of shock therapy that I have encountered in the popular media as well as in professional and academic accounts, which tend to simplify the ECT process in contrast with the complexities of lived experiences of ECT. A psychiatrist treated me with shock when I was seventeen, which complicates the consent process—I was a voluntary patient, but because of my age, my parents were ultimately in charge of making treatment decisions. My parents consulted my doctors and me constantly throughout the treatment process and made decisions based on what seemed to be best for my mental health. I was discharged from the hospital without completing all the doctor-recommended ECT. Nevertheless, I experienced long-term memory loss that has been impossible for me to understand and describe, as well as changes to my learning abilities including what I perceive to be a diminished vocabulary and capacity for storing knowledge.

I have struggled to find my experience in media representations, academic discussions, and of course others' first-hand accounts of shock therapy. What I have found is that although shock treatment and its outcomes are deeply personal, common patterns throughout the stories recur, and while some of these patterns dominate, others are obscured by more acceptable and easily digestible ways of portraying ECT. As a result, I have come to understand that broader power relationships and practices of governance constitute particular truths about ways of knowing and being in relation to mental health and ECT.

Through my research process, my view of what ECT research and representations are lacking has changed. I used to argue that more negative experiences need to be available to the public and



potential ECT patients. I understand now that the distinction between negative and positive experiences is not as clear as I originally had assumed. For example, first-hand accounts where a patient considers their treatment to be positive often still describe periods of memory loss that interfere with their day-to-day lives and require extra care (Dukakis and Tye 2006, pp.156-164; Manning 1994, pp. 130-132, 144). In one case that I studied, a former patient reports memory loss to be one of the major positive effects that ECT provides (Nuland 2004, p.8). Uncovering and analysing the complexities of the accounts and people's understanding of their own shock therapy and others' has made me aware that there is not just an absence of depictions of negative experiences at the moment when the choice is made to have or administer ECT. Feminist thinkers have explored the problem of scientific objectivity and the exclusion of embodied knowledges from the sciences (Haraway, D. 1988; Smith, D.E. 1990), and these embodied knowledges are often absent from discussions of ECT. Representations of multiple ways of knowing ECT, and of a diversity of ECT patients are missing from professional and popular accounts.

I recognize that many people have positive experiences of electroconvulsive therapy, and that these should be reflected in discussions about the practice, but I also know that different outcomes are obscured in the medical context. In the decision-making process for my treatment, doctors downplayed the potential for negative side effects by offering statistics that assert a high success rate (without discussing how success is measured), and a low rate of longer-term memory impairment (see Andre 2009, Cott 2005, Funk 1998, Donahue 2000, Roueché 1991 for accounts of extensive memory loss). Professionals who view ECT positively and describe long-term memory loss as rare suggest that presenting post-ECT memory loss as a possibility may, in

fact, exacerbate these complaints (Fink 2009a, p.12; Shorter & Healy 2007, p.244). Such an assumption may affect what doctors say about memory loss to potential patients.

It is not only during the treatment process that particular knowledge about ECT is presented, reproduced and circulated. Popular discourses of shock also lack representations of varied experiences; I rarely see or hear of an experience that looks like mine. While at first I thought it was possible that negative experiences are rare, as I reviewed psychiatric survivor literature, and even accounts where people identify their overall experience as positive, these revealed many aspects that are not openly discussed and debated in popular discourses. I have become aware of this absence on a number of occasions: in an introductory psychology class that presented shock as just like any other treatment, but with a negative connotation because of films like *One Flew Over the Cuckoo's Nest*; in the reactions of people who are convinced that it no longer exists when they learn that I have had it; in contemporary representations on television shows wherein the choice to have ECT is presented as empowering (eg. *Six Feet Under*, *Dr. Oz*), and its involuntary use is confined to extreme cases of illnesses characterized by violence (*Six Feet Under*); on the comment sections of websites where people who have no experience with the practice assert that it used to be barbaric, but is now well-researched and modernized, and that the problem that remains with electroshock is the stigma faced by patients who have had it.

I began my academic career hoping to bring more attention to the topic of electroconvulsive therapy, especially aspects of the practice that are usually ignored and glossed over. I do not think of myself as an “expert” on shock therapy, but this is because there are too many ambiguities around how shock works, how memory works, and what counts as expertise, not because professionals know more about shock than me or any other person who has

experienced shock. My analysis of first-hand accounts of shock therapy highlights some of the troubling issues related to the use of shock therapy as a therapeutic treatment: the unknown method of action; the shakiness of the meaning of improvement or “recovery”; the sheer quantity of experiences, good and bad; the connections between shock therapy and the governance of citizens; the contradictions and consistencies within and between discourses, institutions, and groups of people with different understandings of shock.

I consider my own experience with shock as negative and harmful; my understanding is that it created more obstacles for me than it solved. However, I was discharged from the hospital shortly after having ECT, and I have never been re-admitted despite experiencing the same “symptoms” that resulted in my diagnosis and hospitalization. The psychiatrists who treated me, and others who know me or my story, may count my treatment as a success. I have been out of the hospital for over a decade, and free from medication for a number of years. This seems like a long time, but I still deal with negative effects on my memory and learning (especially retention of knowledge) that I associate with ECT, as well as a general fear that I will be subjected to the treatment again, that manifests itself in nightmares or whenever I feel as if I should talk to someone professional about feelings of distress. In other words, I am not comfortable engaging with the mental health system and as a result, I am compelled to manage these issues on my own.

I have wondered whether my response to shock is a form of responsabilization. Processes of responsabilization and the production of autonomous active citizens who are “encouraged to strive to optimize their own quality of life and that of their families” (Miller & Rose 2008, p.79) are broad strategies that reinforce a shift away from reliance on social services and onto the

expectation that we must actively govern ourselves in ways that benefit us. In other words, the problems that we face in our lives that previously may have been considered social issues, or the effects of social conditions, are continuously framed as personal problems that we are responsible for and must deal with privately (Miller & Rose 2008a&b; Rose 1996; 2000). My experience, further informed by theories of governmentality, has led me to view the mental health system as a system designed to transform an individual's understanding of distress caused by external sources into a personal failure that requires people to work on and improve themselves rather than work towards understanding and changing circumstances that contribute to their distress. I may be considered a "success" of the mental health system because I am no longer accessing public resources, and I treat my problems as personal ones that I manage by myself and with others who accept some level of responsibility for my wellbeing.

#### *Established narrative of electroconvulsive therapy (ECT)*

Many aspects of ECT are highly contested, but there are some commonalities that exist throughout historical accounts, even when these accounts are written from very different perspectives. Electroconvulsive therapy is a treatment option for various severe mental illnesses. Although it is not the first treatment that produced convulsions in patients in order to relieve psychiatric symptoms, over the span of a few decades, it was the one that persisted alongside psychiatric medications. The theory that epilepsy and particular mental illnesses could not exist together was the basis for the development of the practice of inducing convulsions in psychiatric patients (Berrios 1997, p.106; Frank 1978, p.5; Kneeland & Warren 2008, p.xxv; Shorter & Healy 2007, p.25), initially through the administration of insulin or metrazol by psychiatrists. This theory was quickly abandoned, but doctors continued to see benefits to convulsions.

An Italian psychiatrist, Ugo Cerletti, is credited with inventing the technique that uses electricity to produce seizures and treat mental illness after learning about the use of electrical currents to stun pigs so that they could be slaughtered easily (Shorter & Healy 2007, pp.36-7; Kneeland & Warren 2008, p.48; Frank 1978, p.9). Since Cerletti's first electroshock patient in 1938, the treatment process has been modified, specifically to add anaesthesia and muscle relaxants to reduce physical side effects (bone fractures were common at first), but the extent of the changes and the reasons behind them have been continually contested over the decades and into the present.

### *Explanation of terms*

Electroconvulsive, or shock therapy, is defined simply by the Mayo Clinic website as

a procedure in which electric currents are passed through the brain, intentionally triggering a brief seizure. ECT seems to cause changes in brain chemistry that can quickly reverse symptoms of certain mental illnesses. It often works when other treatments are unsuccessful. Much of the stigma attached to ECT is based on early treatments in which high doses of electricity were administered without anesthesia, leading to memory loss, fractured bones and other serious side effects. ECT is much safer today and is given to people while they're under general anesthesia. Although ECT still causes some side effects, it now uses electrical currents given in a controlled setting to achieve the most benefit with the fewest possible risks.

(Mayo Clinic 2012).

The simplicity of this largely positive definition by a prominent medical institution contrasts with the complexity of the meanings that come from lived experiences of ECT.

There are a number of presumptions underlying this understanding of shock therapy. It assumes, first, that different "mental illnesses" are individual biomedical conditions that can be managed medically. Second, it asserts that the application of electric currents to the brain can alleviate, to

an extent and for a limited period of time, the suffering caused by symptoms of these illnesses. However, people's accounts provide different understandings and experiences of shock. In professional accounts as well as media representations, the struggles that take place between alternate truths about ECT concerning whether it works, what it does, and its consequences are generally obscured. Like the above definition, they are simplified.

It is not only ECT as a practice that is simplified. In above definition, potential ECT patients are reduced to pathological brain chemistry. Individuals are subject to a cost-benefit analysis based on theoretical assumptions about the brains of people diagnosed with a mental illness, while other aspects of their (our) lives are ignored.

Throughout my thesis work, I will use the terms ECT, electroconvulsive therapy, electroshock, shock therapy, or just shock. As I discuss specific findings that emerge, I will use the term preferred by the author of the evidence I am referring to. At other points in my thesis, I intentionally substitute terms to emphasize that the knowledge about the practice is unstable.

The term "mental illness" is equally as contentious (see, for example, Andre 2009; Foucault 1998; Szasz 1960; Ussher 2011). Although an in-depth exploration of this concept is outside the scope of my research, I do wish to emphasize the instability of the image of the "mentally ill" person in my work. Although we associate particular words with what we know as "mental illness", there is no universal dominant understanding or image of a "mentally ill" person. Many people who resist this term, or the biomedical understanding and pathologization of emotional and psychological distress or behaviors that seem to cross the bounds of what is socially acceptable, also reject associated terms like "symptoms" and "treatments". However, I use these terms as

they provide a recognizable way of speaking about the distress of people who are identified as mentally ill and access mental health services.

ECT is variously described as: the “most effective” treatment for certain illnesses (Ottoson & Fink 2004; Shorter & Healy 2007, p.2); the subject of a successful public relations campaign (Andre 2009); positive and beneficial (Dukakis & Tye 2006); and “a crime against the spirit” (Frank 2002). These are only a few of the multiple truths about shock. Exploring different perspectives regarding particular knowledge can highlight the unstable nature of “truth” (Foucault 1980a, pp.93-4; Foucault 1980c, pp. 112, 118; Haraway 1988; Saukko 2003a, pp.17-19). I use the term “truth” or “truths” throughout my thesis to mean an understanding (or set of understandings) about objects or ideas that are believed or known to be real by any number of people. Different truths have wider or lesser acceptance and circulation socially depending on factors such as who makes the truth claim, what sort of evidence is involved, and whether the truth is consistent with other knowledge and beliefs held by the person or groups involved in representing or evaluating the truth. The establishment of a particular truth requires the exercise of power. Some truths, such as those that constitute and are exercised through psychiatry, are dominant in comparison to alternative understandings. Offering alternative truths is a way of exercising power through resistance.

There is little consensus over any aspects of shock treatment. However, even experts who advocate for wider ECT use agree that no one is sure how it works (Fink 2009a, p.94; Shorter & Healy 2007, p.6). Advocates describe theories about how shock therapy may work that have not been proven, but these change along with what is acceptable within psychiatric practice more

generally.<sup>1</sup> Professionals and patients who claim both positive and negative experiences all agree that some memory loss is a side effect, but according to different accounts, ideas about the extent of the loss vary in length from the period of treatment to decades. At the same time, accounts of shock that appear oppositional at first have similar themes and draw from and reinforce particular discourses or ways of knowing and being.

*Research questions and why this is worthwhile*

The goal of my thesis is not to reinforce one set of truths about ECT as superior to another. However, I show how knowledge about electroconvulsive therapy is not as straightforward as it appears in psychiatric and popular discourses. I explore the history of ongoing struggles over the construction of these knowledges, and illuminate how these connect to broader power relations as well as produce particular gendered subjects of governance. The research questions that frame my work are as follows: since the patients' rights movement politicized the practice in the 1970s, how do ECT experts and patients produce particular medical, historical and personal accounts of the shock process in relation to other truths? How are these constructions involved in shaping the subjectivity of former ECT patients? Further, how do relationships between subjects and truths connect to other power relationships? Because I have found that mental health and ECT are sites of gendered and class-based power struggles, I highlight these aspects in particular.

In current professional accounts of ECT, there is an emphasis on concepts like informed consent, patients' rights and choice, and medical ethics. In professional accounts, the struggle over whether or not electroconvulsive therapy should remain a treatment of "last resort" appears to

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<sup>1</sup> For an overview of theories about how ECT works, and how these look different over time according to professionals, see Fink 1979 Chapter 13, Fink 2001, and Fink 2009a Chapter 10; Shorter & Healy 2007.



be the most important question in the debates over the use of ECT currently (Fink 2009a, p.6; Morrison 2009, p.164; Ottoson & Fink 2004; Shorter & Healy 2007, p.4). This is reductive. There are innumerable problems with the practice itself that are obscured by this discursive move. Multiple knowledges and experiences have gone into developing how professionals, patients, and the general public think and talk about shock therapy, and though simplified versions of the truth obscure these various perspectives, they are more visible in first-hand accounts of ECT. The creation of particular truths and the struggles between these truths provides the context for the emergence of particular ways of knowing about and challenging shock therapy, and analyzing the processes involved in this work is important.

Uncovering and exploring the existence of multiple and competing truths can provide insights into the construction and maintenance of unequal power relations and provide a basis for criticism and a challenge to the status quo. Examining how a specific power relationship, like the ECT doctor/patient relationship, is constructed in texts written by people with different understandings of this relationship and the practice of ECT itself, can illuminate how acceptable knowledges are formed through discursive practices. Highlighting processes involved in knowledge production can denaturalize accepted knowledge (Reed 2011, p.60) in common sense or dominant discourses and create opportunities for criticism of and changes in power relations. Looking for how truths and knowledges related to electroshock connect to practices of governance allow for a critique of broader power relationships that on the surface appear to be disconnected from the exercise of power in the context of mental health.

As a feminist researcher, locating myself in relation to my research as I do above, and acting on the recognition that my personal experience is political is central to my thesis. My general

purpose is one of critique and I am specifically focused on the gender work that gets done both in the mental health system and in written accounts of ECT. I want my work to offer a space to consider different ways of knowing.

My thesis contributes to both ex-patient produced literature as well as critical feminist literature on shock. With insights from feminism and poststructural theory and method, as well as my own experience of living with the effects of shock treatment, I offer a unique perspective on the issue. I attempt to do more than provide a narrative of my experiences, though these are necessary if the goal is to resist a dominant truth. I highlight how power relations and practices of governance and responsabilization continue after shock, and shape our accounts of our experiences and ourselves.

### **Methodologies**

#### *Genealogy - A history of the present of ECT*

It is necessary to emphasize that my methods and theoretical standpoint are interconnected and not distinct. In this section, I outline the basic strategies and goals of a genealogical approach to research, and describe my research process, but my methodological process is informed by and intricately connected to theory, which I discuss in the following section.

A genealogical approach denaturalizes widely accepted truths by highlighting processes involved in producing knowledge (Reed 2011, p.60) and the power relations (re)produced by knowledge. It offers a means of critique by exploring how taken-for-granted truths are historically constructed and rooted in power struggles (Saukko 2003b, p.115). Rather than starting with the assumption of a stable subject, it investigates how subjects are produced within a particular

historical context (Foucault 1980c, p.117). A genealogical analysis pays close attention to documented struggles and voices that often are ignored or obscured (Foucault 1977; 1980a, p.83). As such, it is an appropriate method for exploring accounts written by people who are often excluded from professional discourse about ECT—dissatisfied former patients. Further, this approach allows me to problematize what are normally considered positive accounts and accounts written by satisfied patients which are often called upon as proof that shock therapy is therapeutic. This destabilizes presumptions about the meanings of positive or satisfied in this context.

This type of analysis attempts to uncover how localized relations of power (such as the struggle over the truth about ECT) are embedded in more widely dispersed and encompassing power relations. How do power/resistance relationships work to produce a particular, widely circulated understanding of ECT as improved and effective while obscuring possible alternatives? How are these connected to other practices of governance? I explore these questions by analyzing accounts written by leading ECT professionals and those by people who have had ECT to see how they (we) construct multiple truths about ECT and how they (we) construct and govern them (our)selves in relation to multiple truths.

At this time in the history of electroconvulsive therapy, there are disagreements over how it should be used, and its repercussions, even between psychiatric professionals. Despite opposition to shock in general by many former patients and their supporters, the question of stopping ECT altogether is not part of the discourse of the “ECT specialists” and advocates.

Rather, there has been a shift in language from using shock as a “last resort” in-hospital treatment providing temporary relief from symptoms of “emotional disorders” (Fink 2009a, p.4)

to an option that should be considered earlier, (Fink 1999a, p.1; 2009a, p.6; Shorter & Healy 2007, pp.2-4) with longer-term “maintenance” or “continuation” treatments (Fink 2009a, p.4; Ottoson & Fink 2004, pp.62-63). Although this is presented as a new idea (Fink 2009a, p.viii), maintenance electroshock has been performed for decades in order to keep patients functioning at a certain level (Fink 1979, p.231; Shorter & Healy 2007, pp.99-100).

The emergence of the emphasis on this idea to the exclusion of others in debates over shock is made possible by, among other contextual factors, the widely accepted truth that ECT is a modern, improved, safe and effective, and gender-neutral psychiatric practice. I attempt to destabilize this understanding by examining how these terms are used in the accounts that I study. I problematize the assumption that “improvements” are the necessary outcome of the continual progression of psychiatry (Foucault 1980c, p.112). I show how, despite discourse that suggests that technological and medical advancements drive an evolving mental health system that consistently improves the lives of service-users, the same problems with the mental health system, and ECT in specifically, recur at different times, and so claims to advancement cannot be accepted uncritically.

#### *Uncovering my primary sources*

My research process began with reading a selection of writing by Max Fink, a widely influential “ECT specialist” (Shorter & Healy 2007) who has been practicing, researching and writing about ECT since the 1950s. Fink’s work directed me to Shorter and Healy’s *Shock Therapy: a History of*

*Electroconvulsive Treatment in Mental Illness*.<sup>2</sup> He is the first person listed in the

“Acknowledgments” section of their text:

This book owes a special debt to Max Fink.... [A]t every step Max helped us by drawing from the depths of his own enormous experience and wisdom. He opened a number of doors for interviews with other pioneers of the field, and, finally, he gave the manuscript a critical reading. This is in no sense Max's book, because we have told the story from our own point of view. But if Max had not said that one of the great untold stories of medical history was out there, just begging to be written, we probably would have glanced elsewhere

(Shorter & Healy 2007, p.xi).

Along with this acknowledgment, the authors' frequent references to Fink throughout the book include numerous personal communications and interviews with him, and inclusion of material from his “personal archives”. This expression of gratitude and acknowledgment of Fink's important role in the creation of this book suggest that Fink has authority to speak the “truth” about a subject (shock) despite being a long-time open advocate of it. This introduction to the history of ECT provides evidence about the type of expertise that is taken for granted as objective. In this particular account, it appears from the beginning that the information within is valid because it comes from the professional expertise instead of personal experiences of former patients.

Max Fink's advocacy of shock therapy is extensive and spans decades. He is listed as responsible for the 1989 film “Informed ECT for patients and families” which has been distributed through Somatics, Inc., an ECT machine manufacturer (Somatics, LLC, 2010). This video was sold to health

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<sup>2</sup>Max Fink's faculty biography as a professor emeritus of psychiatry and neurology at Stony Brook School of Medicine states that he is “working on” a history of ECT with Shorter and Healy (the biography was published prior to 2005 and is available at [http://medicine.stonybrookmedicine.edu/psychiatry/faculty/fink\\_m](http://medicine.stonybrookmedicine.edu/psychiatry/faculty/fink_m)). However, he is not listed as an author, either in this bio or in the final publication. Later, Fink (with Dr. Charles Kellner, 2010) co-authored a review of three histories of ECT for *Psychiatry Times* that included the Shorter and Healy history without mentioning his own input into the book.

professionals in a set with a video called “Informed ECT for Health Professionals” for \$350 in 1989, and has been called “ideal for teaching families about ECT treatments and health professionals and students about the various depressive categories that ECT can affect” (Keane 1989). Fink was also a member of the American Psychiatric Association’s task force on ECT, both in the 1970s and 1980s. In 2001, Daniel Smith relied heavily on Fink’s knowledge about ECT in his article “Shock and disbelief” for the *Atlantic Monthly*, which framed ECT as a modern, safe and fairly mundane procedure and generated a heated “Letters to the Editor” section in the May issue of the magazine. Fink is the author of 1979 textbook *Convulsive Therapy: Theory and Practice*, and founded the *Journal of Convulsive Therapy* (now the *Journal of ECT*). He is the subject of criticism from prominent figures associated with the anti-ECT/ regulated ECT movements (Andre 2009; Breggin 1991). Thus Fink’s work is a practical starting point. His authority over time extends beyond the boundaries of academia or the hospital and helps to shape a more general understanding of electroconvulsive therapy.

I focus mainly on Fink’s books and articles that are accessible to the general public and specifically discuss patients’ experiences of ECT in order to analyze how he interprets and utilizes their truths (Fink 1999a; 2000; 2007; 2009a; Ottoson & Fink 2004). I have chosen these texts because I am interested in the negotiation of knowledge and subjectivity within and through the doctor/patient relationship rather than more specialized forms of knowledge that do not circulate as widely outside of the scientific community, although the truth constructed within this community is involved in shaping all of the texts concerned with electroshock.

I do not include research articles in academic journals with the exception of an article Fink wrote for *Psychosomatics* (Fink 2007). I have chosen to include this article because it is a “Perspective”

rather than research article, and it directly addresses, and outlines his opinion of, people who have complaints after receiving ECT. I am interested in his response to criticism of ECT by people who have already undergone the treatment, how he frames these people, and how they work to present themselves in relation to the truths he presents about them and the treatment.

Shorter and Healy's (2007) text will also be a source of primary data because it is a widely available historical account of electroshock written by a psychiatrist (Healy) and a prominent medical historian (Shorter). An historical approach to the truth about ECT provides a version of the truth, and one of the authors is also a psychiatrist, thus this book can provide me data about doctor/patient /truth relationships.

While reading a selection of Fink's work, I found a number of books and articles where Fink refers to specific patients or patient groups to reinforce the truth about ECT that he proposes. Fink's earlier work (1974; 1979) mentions behaviour of patients, but does not name individual narratives of successes or failures. Although he does not address potential patients directly, I consider how he suggests doctors interact with patients during the treatment process (1979). There is a tendency in Fink's later writing to emphasize the positive aspects of specific patients' ECT and the rights of patients to choose the treatment to the exclusion of negative aspects or side effects. He uses examples of appreciative ECT consumers to support his arguments (1999a; 2000; 2009a; Ottoson & Fink 2004) while calling out and discrediting ex-patients who identify as survivors or criticize ECT as a treatment option (Fink 2002; 2007). Much of my primary data comes from Fink's discussion of these patients and their accounts of shock therapy. My interest in the psychiatrist/ex-ECT patient relationship emerged from reading how Fink described the patients' experiences and how he explains their own understandings of their experiences.

As I gathered published accounts written by people whom Fink referred to in his work, both as supporters and “irrational” anti-ECT activists, I found that the categories of ECT critic, consumer and practitioner were not as well-defined as Fink suggests, or as I had assumed. Although ECT critics and specialists both claim an oppositional stance in relation to the other, they draw on common discourses to support their truth claims and to discredit others. For example, all the groups assume a biomedical understanding of mental health issues (or at least speak about it in biomedical terms), and their claims are guided by this discourse and context. However, different understandings of the reasons for and effects of ECT by psychiatrists and former electroshock patients demonstrate the “contested nature” (Hill 2009, p.314) of how the practice is represented over time, and counter-discourses have emerged (Tamboukou 2003, p.7). ECT as a site of struggle is not new, nor is it resolved despite the prominence of particular ways of knowing about ECT. Identification of both what is generally accepted by all groups as well as aspects of the practice that are contested can help bring attention to the instability of knowledge about ECT and repoliticize even the truths that appear concrete.

In addition to professionals’ accounts, I draw data for analysis from the relationships documented between and within representatives from two other groups of people who understand and act on different truths about ECT: people who experienced ECT as helpful or valuable, and people who experienced it as damaging. With the exception of one journal article that is also available online (Donahue 2000), a guide for potential ECT patients that is available online (Donahue 2007), and one online magazine article (Rosenberg 2002), data from the former patient groups comes from print books published between 1978 and 2009 and feature accounts of their experiences of ECT in psychiatric facilities in Canada or the US. The wide range of sources



is a reflection of the accounts that are prominent in the debate over ECT, but it will also allow me to note the continuities and differences in the struggles over the truth of ECT over time.

Four books that Fink refers to as positive accounts of electroconvulsive therapy are psychotherapist Martha Manning's (1994), psychologist Norman Endler's (1982), surgeon Sherwin Nuland's (2004) and celebrity politician's wife Kitty Dukakis' account, co-written by a journalist (Dukakis & Tye 2006). Fink refers to molecular biology Professor Leon Rosenberg's (2002) article in the online magazine, *Cerebrum*, as well as US politician Anne Donahue's (2000) account from the *Journal of ECT*.<sup>3</sup> In these texts, I looked for specific points where the writers discuss their relationships with other groups (experts, ex-patients) to see how they position themselves and others. I drew out and analyzed common themes in the data that I will discuss in chapters two and three. I explore their relationships with the truth about ECT, what this means to them, and how the construction of selves and these truths are connected to each other and other practices of governance.

Fink, for the most part, does not name individual people who argue that shock did not benefit, or actually harmed them—he more often reduces them to a category of extremists who he claims benefit from the antipsychiatry movement. However, Daniel Smith's magazine article, "Shock and disbelief" describes an animosity between Fink and Linda Andre, the Director of the Committee for Truth in Psychiatry. Smith (2001) writes, "I was directed to CTIP by Max Fink, who has had numerous run-ins with Andre. At a talk Fink gave some years ago in New York, Andre stood up in the audience and loudly protested his association with Somatics, one of the two

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<sup>3</sup> These patients' accounts are referred to by Fink in the following places: Manning in Ottoson & Fink 2004, pp.52-3; Fink 2009a, p.32; Endler in Ottoson & Fink 2004, pp.52-3 and Fink 2001, p.31; Nuland in Ottoson & Fink 2004, p.53; Dukakis & Tye in Fink 2009a, p.41 and Fink & Kellner 2010; Rosenberg in Ottoson & Fink 2004, p.51; Donahue in Fink 2001, p.31 and Fink 2007, p.290.

largest US manufacturers of ECT devices. (Fink says he has no ties with any ECT-device manufacturer)" (p.4). Smith's article led me to Andre, who describes her memories of encounters with Fink: "Fink has literally grabbed the microphone away from me at meetings when I tried to speak" (Andre, p.345 [Note 3]). This struggle between Andre and Fink made Andre's book *Doctors of Deception* another practical entry point for gathering resources on people whose experiences do not fit with positive examples set out by Fink. Andre's text referred me to Janet and Paul Gotkin (1992), Leonard Roy Frank (1978; 2002) and Jonathan Cott (2005) for primary sources that provide alternative truths to Fink's.

One problem I have encountered by gathering data in this fashion – through references to accounts by two of the most prominent, polarized, figures in the struggle over the truth about ECT—is that these accounts are unrepresentative of the population most likely to be treated with ECT. Although there are no official statistics on the ethnicity of people most likely to be treated with shock, it is generally agreed that ECT patients tend to be higher-educated, white people with class privilege, which is consistent with my primary source material. There is also consensus from various sources discussed previously that women are consistently more likely to receive shock treatments. Despite this, Fink refers mostly to men's accounts, which do not represent the typical ECT patient, to support his own arguments. Andre (2009) incorporates more accounts of women who identify as ECT or psychiatric survivors in her own book, including letters written by them to the FDA as an appendix to her book (pp.306-315), and their descriptions of relationships to psychiatrists. I do not include these letters in my analysis, mainly because of time constraints.

There appear to be fewer women's than men's published accounts of experiences with ECT.

However, this is not to say that women-written literature on psychiatry more generally does not

exist. It may be that fewer accounts of ECT by women are written or published, or that electroconvulsive therapy is not emphasized in works written by women about their own experiences of with psychiatry, that shock is not central to their experiences of the psychiatric system, or that their experiences are ignored. I have added Wendy Funk's (1998) book about her experiences as a source of data because as a middle-class professional woman, she is representative of the average shock patient.

Because I am examining the construction and governance of the self in relation to truths about shock in texts of first-hand experiences of shock, I consider exclusively texts that are authored directly by the former patients themselves, rather than narratives that are written by others. This excludes Marilyn Rice's story. Rice is an exception to Fink's rule of avoiding naming people who have had negative experiences (Fink 2007, p.219; Ottoson & Fink, p.74). She is the subject of Berton Roueché's (1974) article "As Empty as Eve" and the founder of the Committee for Truth in Psychiatry, a group whose purpose is to "advocate for truthfully informed consent to ECT" (Andre 2009, p.227). Creating an interesting parallel with Fink's Acknowledgment (Shorter & Healy 2007), Rice is the first person acknowledged in Andre's *Doctors of Deception*: "I would not, could not have written this book if I hadn't had the good fortune to have known Marilyn Rice (1923-1992) and to have inherited her voluminous archives of published and unpublished material on shock" (Andre 2009, p.ix). Fink has an ongoing interest in constructing the truth about Rice's experience. In contrast to Roueché's article, Fink says Rice was "successfully treated" (2007), and that her experience could not have been that bad if she was able to be so involved in the anti-ECT movement (Ottoson & Fink 2004, p.74). So, although I exclude Roueché's account of her experience from my analysis because it was not written by her, I do include Fink's account of her.

Women who identify as ECT survivors are of great interest to me because while women are disproportionately prescribed ECT (Andre 2009, p.177; Burstow 2006, p.278; Kellner et al 2005, p.978; Morrissey, J., Burton, N., & Steadman, H. 1979, p.103; Rapoport, M., Mamdani, M., & Herrman, N., 2006, p.617; Shorter & Healy 2007, p.145; Ussher 2001, p.1; Warren 1987, p.129), the truth claims they make are largely ignored or aggressively denied if they reject or resist dominant understandings of the consequences of shock therapy. Why do professional texts rely so heavily on descriptions of men's experiences for legitimacy when they are not the typical patient? I examine the actual practices involved in producing a gender-neutral understanding of ECT while simultaneously producing a gendered ex-patient subject. I show how accounts provide clues about the governance of gender performances, both before and after ECT, by authority figures who transmit psychiatric discourses and by the patients themselves.

I have chosen the texts outlined above for a number of reasons. First, I have chosen accounts written by two prominent advocates of polarized understandings of shock, and accounts that these people refer to in order to reinforce their own arguments or counter others'. Second, these are all accounts that are accessible to the general public, both in terms of their availability and their non-academic (popular, personal or autobiographical) writing style, and so could be made available to potential ECT patients. My focus is on work written by professionals, but also by people who have had ECT, because although there is a rich history of these accounts being written and acknowledged in the psychiatric survivor and feminist movements, they rarely enter into official psychiatric discourse or mainstream media. In other words, these are not necessarily the accounts that are relayed to patients when the choice about undergoing ECT is made.

Published accounts by ECT patients describe being shown videos and provided anecdotes that frame ECT positively when presented with ECT as an effective treatment option (Funk 1998, p.48;

Dukakis & Tye 2006, p.3; Rosenberg 2002, p.4) but they do not describe being told of negative outcomes, or they argue that such experiences should be included in the informed consent process (Andre 2009, p.297; Donahue 2000).

*Genealogy, governance and critiquing the mental health system*

*Let's suppose that madness does not exist. If we suppose that it does not exist, then what can history make of these different events and practices which are apparently organized around something that is supposed to be madness?*

(Foucault 2008, p.3).

One aspect of genealogical research is tracing obscured knowledges to highlight their role in struggles to produce truths: "through the retrieval of subjugated knowledge one establishes a knowledge of resistance and struggle" (MacLeod & Durrheim 2002, p.56). The apparent powerlessness of people who have been identified as severely mentally ill and in need of a treatment of "last resort" like ECT contrasts with our determination after treatment to resist dominant understandings and spread alternative truths about shock. A feminist genealogical inquiry treats subjects as constituted through discursive practices, "but at the same time, able to reflect upon these very discursive relations that constitute [them], capable of resistance and able to choose from the options produced out of the clash between contradictory subject positions and practices" (Tamboukou 2003, p.6). It also requires a specific focus on the role of gender in constituting subjects and truths.

A number of projects use genealogical methods to illuminate the relations between gender, sexuality and mental illness, and to destabilize common knowledge about these categories (Foucault 1990; Saukko 2003b; Harwood and Rasmussen 2007).

Others employ the concept of governmentality to demonstrate how the “self-esteem” (Cruikshank 1996) and “self-help” (Philip 2009) movements are techniques of governance deployed in the production of liberal rational, active citizens. These examples problematize common sense definitions of mental health and illness, as well as strategies to define, prevent and treat these illnesses. They also highlight how these specific relationships are tied to broader practices of governance. One way they do this is by pointing out effects that go against the stated goals of eradication or reduction in symptoms. This kind of work shows the complexities involved in simple, taken-for-granted concepts. For instance, previous work has shown how the emergence of “new” mental illnesses can be a new way of speaking about old problems (Foucault, 1990; Saukko 2003b; Harwood and Rasmussen 2007).

An interesting example of the (re)classification of old problems is seen in Fink’s (1999b) “Delirious Mania”, where he reintroduces the concept and argues that “delirious mania warrants specific identification in the diagnostic nomenclature” (p.54). He cites reports of its occurrence in the eighteenth century, distinguishes it from other types of mania, and argues that it deserves its own category instead of being known as a subtype of illness. Through case studies, he demonstrates that he has found a solution to an old problem—“electroconvulsive therapy was found to be quick and rapidly effective” (p.54). At the same time as Fink offers a new diagnosis, and even before it is necessarily accepted, he offers a solution in the form of ECT, positioning this “new” diagnosis as a classification that could possibly legitimize the use of ECT for something other than a “last resort”. By 2012, although delirious mania was yet to be included in the *Diagnostic and Statistical Manual of Mental Disorders*, other psychiatrists were following Fink’s lead, using case study findings to show that “early recognition and aggressive treatment, especially with electroconvulsive therapy, can significantly reduce morbidity and mortality” (Lee

et al. 2012, p.65) in cases of delirious mania. Fink offers the same argument for treating catatonia as its own category, and with ECT as an earlier choice due to it being “unique in the immediacy of its response to ECT” (Fink 2009b, p.443). Contrary to the repeated assurances that ECT is a “last resort”, (often coupled with the contradictory sentiment that it should not be), such case studies demonstrate that the meaning of “last resort” depends on the situation, diagnosis, and the doctor’s treatment choice.

These new categories or reformulations of illnesses or pathologies correspond with different forms of treatment, and the individual whose behaviour falls into these categories is responsible for learning different ways of being and improving themselves (Cruikshank 1996). This kind of evidence resists the assertion that certain differences are correctly understood as biomedical illnesses that require individual treatment. It requires us to question the distinctions between normal/abnormal and mental health/illness.

The concepts of responsabilization and privatization (Miller & Rose 2008a&b) have informed my data-gathering process and analysis, as related themes emerged from my data.

To incorporate this critical theory and research into my data analysis, I consider evidence that helps answer questions that challenge the understanding of psychiatry as a helping profession: What are signs of a serious illness and when does the “last resort” become necessary? What counts as improvement? How are these connected to constructed gender identities and other aspects of individual identities, and how do these individual aspects of identity relate to practices of governance?

## **Theoretical Framework**

My original theoretical starting point for critical research into mental health was based on feminist standpoint theory, and particularly Dorothy Smith's understanding that critical inquiry should start from a point of "disjunction" between lived experience and social theories and concepts (Smith, D.E. 1990, p.13). The influence of standpoint theory necessitates that I locate myself in relation to the research and use my own embodied experience of the mental health system to ground my theoretical knowledge (Smith D.E. 1990, p.22). However, standpoint theory became insufficient for my work when I came to understand the continuous (re)production of power relations, subjects and truths in relation to ECT. Standpoint feminism implies a fixed starting point and perspective. It assumes that marginalized groups of people are more likely to discover and know an objective truth and reality. In contrast, I understand my research process and my multiple positions as a former patient, researcher, and analyst to be fluid and constantly (re)shaped.

A limitation of standpoint theory is that it assumes a group of people with a common identity embody a worldview that opposes a dominant perspective, and has the potential to overthrow and replace this perspective with something better (Hill Collins, 1990; Smith D.E. 1990). It is important to note that my status as a former shock patient and researcher does not make me representative of an entire social group, nor does it make my own analysis and conclusions about electroconvulsive therapy more "correct" than any other account of shock therapy, especially as I try to emphasize the need for the availability and legitimacy of multiple truths.

### **Foucault-inspired feminist poststructuralism – the (re) constitution of truths and subjects**

Broadly, I take a poststructuralist feminist approach to my thesis research. This approach assumes that, rather than being static, people and knowledges are unstable, constantly



constituted and re-constituted by and through discourses (Weedon 1987, p.21). Subjects exercise power through discourses, and in doing so, are able to (re)shape discourses, others and ourselves. Individuals have agency, but are never completely free, as we are constrained by the socially-constructed discourses available to us within particular circumstances that constitute unequal power/ resistance relationships within a political context (Jenson 1986, p.25). From this perspective, it is not possible to be free from the discursively-constructed social world in order to discover a fixed “reality” about electroconvulsive (shock) therapy, the intentions of doctors or the outcomes of the patients involved. I want to disrupt the assumption that such a reality can be known. I am not searching for the “truth” about electroconvulsive therapy; instead I investigate the work that goes into producing multiple truths about the practice, how this work is connected to broader power relations, such as unequal gender and class relations, and how individuals negotiate power relations in a way that shapes themselves and others as subjects.

The debate over ECT and the struggle over the identity of ECT patients are sites of discursive struggles. On the surface, it appears that there are only two subject positions that can be taken up as an ECT patient: you had a positive experience or a negative experience. An analysis of a variety of accounts of electroshock illuminates a wider range of possible subject positions in relation to shock, as well as commonalities shared by multiple subjectivities. It shows that the ways people have of knowing about shock and about them (our)selves are constrained by the discourses available to them (us). These discourses compete with, complement and contradict each other, like the discursively-produced subjects themselves as they work to construct their own subjectivity within the texts.

Discourses

are ways of constituting knowledge, together with the social practices, forms of subjectivity, and power relations which inhere in such knowledges and the relations between them. Discourses are more than ways of thinking and producing meaning. They constitute the 'nature' of the body, unconscious and conscious mind and emotional life of the subjects which they seek to govern. Neither the body nor thoughts and feelings have meaning outside their discursive articulation, but the ways in which discourse constitutes the minds and bodies of individuals is always part of a wider network of power relations, often with institutional bases

(Weedon 1987, p.108).

Losing large amounts of memory (in terms of linear events, not necessarily memory of emotions) has raised my awareness of the constructed-ness and temporary nature of my self and the processes involved in (re)constructions of my self. I accept and (try to) welcome that what I know about my self is always changing in relation to knowledges (this is difficult when I feel really strongly about something and do not think my mind or my self can be changed--it/I can).

Soon after I was discharged from the hospital, I thought of myself as "recovering" and was concerned about the possibility of recurrence of my illness, since I was told that the majority of people with a diagnosis similar to my own are readmitted to the hospital within ten years. My diagnosis was a major part of my identity that factored into most of my decisions. I found employment and eventually went to university despite my illness (my doctor suggested my illness would make school difficult). Around the time I entered university and became more familiar with (basic) psychological texts, I became aware of and identified with the term "mental health consumer". To me, this meant I wanted to continue to learn about my diagnosis, possible treatment options, and the risks posed by my illness as well as treatments. I was getting older, and beginning to understand that my health was ultimately my responsibility. However, it became clear that the costs of being medicated on a long-term basis were outweighing the benefits. I was dealing with long-term memory and learning-related side effects I attributed to

ECT, and trying to manage the side effects of anti-depressant and anti-psychotic medications that I was told I would need to consume indefinitely to correct a chemical imbalance. As I was coming to recognize my dissatisfaction with my relationship with psychiatry, I was also reading accounts of people who had similar negative thoughts. I briefly identified as a “victim of psychiatry”. Around this time, I discontinued visits to my psychiatrists and weaned myself off medication, even though I had heard this was dangerous. I did have negative physical and psychological effects, but thought it was worth it in comparison to the effects of the drugs.

My diagnosis was part of my identity for a long time, and I related to it even after rejecting psychiatry generally. While researching my undergraduate thesis, I came across antipsychiatry and psychiatric survivor literature and finally felt like I was complete—I was a psychiatric survivor. I also began to see how my identity as a young woman was linked to my experience of hospitalization.

But it was not that simple, and it never will be. Identity construction is confusing and complex (Cerulo 1997; McLaren 2004, p.227). I no longer identify myself in such neat, simplified terms, though I understand that others put me in various categories (eg. Survivor, recovered, misdiagnosed). I see problems with these categorizations, and I have tried to wade through the complexities of all these simplified terms to understand my changing identit(ies). I want to highlight how complicated it is to be a person who has been identified as mentally ill and treated. As I gained knowledge about different subject positions that were open to me, the way I presented myself to others shifted. However, as I have attempted to describe, my identity was and is constrained by ways of knowing that are available to me at particular times in my life.

Understanding this about myself has shaped how I approach my research. A feminist poststructuralist perspective recognizes the value of analysing processes involved in the construction of selves and truths. I included this representation of my self as an always-changing “subject in process” (Kristeva 2004, p.204) to show how I came to work from a feminist poststructuralist feminist approach, to emphasize the necessity of ongoing reflection throughout my work, and to give an idea of my (changing) location in relation to my research. It also provides a brief description of the processes involved in coming to understand myself as responsible for my own wellbeing. How I view my own diagnosis (I try to resist a biomedical understanding of what psychiatrists call my “symptoms”) is up to me, as long as I employ acceptable language and do not require excessive resources. I have found I can criticise the effectiveness of the forms of help available to me using existing discourses, as long as I continue to maintain responsibility for my own mental health, govern myself in a way that allows me to be a productive, active citizen and my resistance is minimally (and only locally) disruptive.

Chris Weedon (1987) developed an explanation of feminist poststructuralism that helps clarify my theoretical stance. Weedon’s stance challenges the humanist assumption of a fixed, rational subject with a particular essence that is reflected in language and replaces it with an unstable subject that is (re)constituted in language. She then adds Foucault’s understanding of discourses as historically-situated ways of knowing that shape subjectivities and power relations within a discursive field (p.20). She argues that this emphasis on the historical aspect is valuable for feminism because it clarifies that dominant discourses of femininity and masculinity (and related dominant discourses) exist within a particular context and are not separate from discursive practices (and therefore power relations). This means that they can be resisted and that change is possible (McLaren 2004, pp.220-3).

Foucault's ideas offer a challenge to popular understandings of the goals of feminist work: "It is not evident that under Foucault's influence, feminism is deprived of elements absolutely indispensable to its liberatory aims as long as one is willing to jettison the utopian humanist notion of total emancipation" (Sawicki 1996, p.166). Instead of seeking emancipation, Foucault (1991b) urges us to think differently about what counts as political. He suggests we can live politically with a focus on developing ways of governing ourselves that emphasize and disrupt the constructed distinction between true and false that guides practices of governance (Foucault 1991c, p.82).

Foucault's work has many similarities with feminist goals, including a focus on analysis and critique of existing power relations, the capacity for resistance within power relations, and the acknowledgement that power struggles happen everywhere (McLaren 2004). Foucault's "analysis of how power is installed in everyday (including domestic) interactions has allowed feminists to theorise exactly how the personal is political" (MacLeod & Durrheim 2002, p.44). MacLeod and Durrheim (2002) suggest that a Foucauldian feminist might "stress the variety of ways in which effects of male domination are produced and gender identities are constituted" (p.44). Gender relations are often obscured or mentioned only in passing in the struggle over knowledge about ECT, with the exception of works by feminist writers who have described ECT as a tool of oppression or violence against women. I will return to these later.

With these points in mind, my intention with this research is not to overthrow the psychiatric system and replace the dominant narrative about "mental illness" and ECT with one that is more aligned with the emancipated psychiatric survivor, since, despite the romantic image, there is no essential survivor identity or one way of knowing ECT that could account for all patients'

experiences, nor is there any way to build a new system outside of unequal power relations. My aim is one of critique (McLaren 2004, p.218; Saukko 2003b) to highlight the power struggles involved in the constitution of subjects and dominant knowledge about ECT, and destabilize what counts as truth. My research includes a specific emphasis on how gender work gets done in these discourses, and how this work ties into other broad power relations, like those that make up psychiatric, medical and scientific power, and liberal practices of governance.

### **Foucauldian toolkit**

Locating myself as a Foucauldian feminist means I use concepts and strategies developed throughout Foucault's work as a "toolkit", instead of a fixed overarching theoretical framework (Foucault 1980b, p.145). Some of the conceptual tools I use to guide an analysis of my findings include his understanding of power, the role of subjugated knowledges and ideas about governmentality that draw from and expand upon Foucault's later work (Cruikshank 1996; MacLeod and Durrheim 2002; Miller & Rose 2008a&b; Rose 1996, 2000; Rose, O'Malley and Valverde 2006). A summary of these concepts is meant to provide a basic sketch of broad theoretical concepts that I filter my data through. As Foucault suggests, these are starting points to help me explore how truths about ECT and the subjects involved in struggles over these truths are constituted.

### *Power*

To begin with, Foucault (1980c) argues that we must think of power as everywhere, and as productive instead of just repressive. Power "traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is

repression” (p. 119). The doctor/ ECT patient relationship may be considered a relation of domination at some points during the process of accessing mental health services. At other points (like in post-ECT accounts), it is a power-resistance relationship that helps produce particular subjects and ways of knowing. The (re)construction of accounts of ECT after the act, and the ECT patients who are produced in text are constituted in power relations.

My understanding of Foucault’s conceptualization of power is guided by a synthesis of his “propositions” about power taken from *The History of Sexuality* (Foucault 1990, pp. 94-8) and how he talks about power in lecture two of “Two Lectures” (1980a, pp. 96-102). Power relations “permeate, characterize and constitute the social body” (1980a, p.93). Power is exercised at different points. In order to critique modern forms of governance, we must look at these specific points, or “extremities,” instead of those assumed to be a central power source, like the state or the law (Foucault 1980a, p.96). My analysis of particular power relationships (the ECT doctor/ patient) can help illuminate how these relationships connect with others in discursively-constructed personal, social and political worlds, and how these worlds are never completely separate and are always made up within a historical context.

Power circulates, but not freely. Power relations are not egalitarian (Foucault 1990, p.94). Circulation is constrained by different contextual factors. In the case of shock therapy, practitioners’ decisions and practices are reinforced in popular discourses by widely circulating, authoritative psychiatric discourses which tie in with scientific discourses, while patients have first-hand accounts and a psychiatric label that can have the effect of discrediting them. On the other hand, Foucault (1990) acknowledges there is no binary between the ruler and the ruled (p.94). The inequality of this relationship is unstable. We have, for example, evidence of the

disruption of psychiatric power/knowledge through antipsychiatry movements and the role they have played in constructing an environment where widespread deinstitutionalization of psychiatric patients in North America was possible (Shorter & Healy 2007, pp.181-209). Of course, I do not wish to suggest that they were the main cause of this historical event. A combination of academic influences (Foucault 1988; Goffman 1962; Szasz 1960), the mobilization of survivors (Dain 1989), and the publication of negative experiences of psychiatry (Frank 1978; Gotkin J. & P 1992; Roueché 1991) were all contributing factors to a shift in power within a context where civil rights, and later patients' rights, were considered important social and political issues alongside a re-organization of the welfare state. This is a good example of the ebb and flow of power and resistance since the effects of deinstitutionalization, including individualization, privatization and responsabilization of social problems, have faced ongoing criticism.

A related Foucauldian principle is that there is never power without resistance (Foucault 1990, p.95; McLaren 2004, p.217). This allows for the possibilities of coordinating different techniques of resistance at multiple points, offering the potential for meaningful social change, without the expectation of a complete revolution or "total emancipation" (Sawicki 1996, p.166). Because power is everywhere and it "coexists with resistances to it" (MacLeod and Durrheim 2002, p.55), there is room for a variety of strategies against dominant ways of knowing through multiple sites, and within and between multiple subjugated knowledges.

Consistent with Foucault's understanding of power and resistance as never separate from each other, and certainly not opposites, I will work to show that the problem of struggles over the "truth" or knowledge of ECT is more complicated than a relationship of domination between a



representative of psychiatric power, the psychiatrist or “ECT specialist” (predominately male), and a vulnerable victim of psychiatry or disgruntled consumer who chose the wrong product, represented in discourses and popular literature as the antipsychiatry advocate (usually a woman). This simplified picture that assumes the stability of subjects (and imagines them as disconnected from a historical context) obscures other relationships in the production of knowledge about shock and the analysis of how this knowledge is used in practices of governance that constitute subjects and knowledges.

### *Subjugated Knowledges*

According to Foucault, subjugated knowledges can mean two things. First, these are knowledges that are buried because they give the impression of discontinuity, or a lack of continuous progress, and so are obscured (1980a, p.81). Second, they can be knowledges that are “disqualified as inadequate” or “naïve knowledges located low down on the hierarchy, beneath the required level of cognition or scientificity” (1980a, p.82). Here he includes knowledges produced by psychiatric patients and ill people (Foucault 1980a, p.82). Truths about ECT are formed and reformed over time by various individuals and competing knowledges, but subordinated knowledges of shock often get excluded from medical and historical narratives. What points of view, information, and images or conceptualizations are included and obscured in a range of truths about electroconvulsive therapy?

It is important to look for these knowledges in the struggles over the truth about shock therapy because the idea of ECT as improved over time or progressed is built into the official (authoritative) contemporary discourse of shock therapy. Although this discourse is widely circulated, accepted and reproduced in popular representations of shock, if we look below the

surface to the struggles involved over time, the same arguments re-surface at different times, both in terms of criticism and reassurances concerning electroshock. Experiential knowledge is consistently subjugated when it offers a counter-discourse to the dominant narrative. For example, psychiatrists have been asserting improvements in ECT since the 1970s after modified ECT (ECT with the use of muscle relaxants and anaesthesia) had been widely established (Shorter & Healy, p.130; Fink 1979, p.210; Fink 1999a, p.93). In 1979, Fink wrote that shock “has been modified since its introduction more than 40 years ago and now bears little resemblance to the early procedures” (p.1). Despite the acknowledgement that most of the changes were in place by the 1950s (Shorter & Healy, p.140), these remain the improvements that are called on more recently as evidence of the progression of ECT in professional and popular accounts, (Fink 1999a, p.1; 2009, p.1; Smith 2001).

### *Governmentality*

The previous discussions of subjectivity and power are the background for understanding governmentality. An analysis of governmentality is concerned with power relations and how the conduct of subjects is governed. This type of analysis goes beyond the state or what is considered the official domain of politics (Foucault 1991a; Rose 1996), since a central concern with liberal rationality is the question of how not to govern too much (Foucault 2008, p.13). Governmentality is therefore concerned with the practices involved in governing the self and others outside the traditional state. Liberal political rationalities—the conceptualizations, rules, and justifications for the exercise of power (Miller and Rose 2008a, p.55)—require that we, as liberal citizens, subject ourselves to government (Cruikshank 1999). People both exercise and are

subject to the power to govern in relation to others and themselves as they continually come in contact with these practices of governance.

In a liberal society, practices and techniques are continually (re)developed to ensure the production of proper liberal citizens participating in governance and exercising constrained freedoms. Liberal governance is associated with the “maximization of individual liberty, and in particular, with the defence of that liberty against the state” (Hindess 1996, p.65). Even though we are not being excessively governed by the state specifically, we must also participate in self-government (Cruikshank 1999). Governmental power continuously produces objects and subjects of governance. It “is not so much a matter of imposing constraints upon citizens as of ‘making up’ citizens capable of bearing a kind of regulated freedom” (Miller and Rose 2008a, p.53). We continually submit to acceptable ways of knowing and being within an ongoing “civilizing project” (Rose 1996, p.58). One aspect of self-governance is our engagement with expert knowledges (like psychiatry or psychology) that help shape and supposedly improve us.

Miller and Rose (2008a) argue that neo-liberalism “reactivates liberal principles” (p.79). In a neo-liberal context, processes of privatization and responsabilization, and discourses that emphasize personal responsibility, choice, efficiency and active citizenship (which includes engagement with expertise) are part of this ongoing governing project and surfaced repeatedly throughout my research.

Foucault’s concept of governmentality allows a disruption of the distinction between the personal and the political. It “provides feminists with a broad-ranging and incisive theoretical tool for the analysis of gendered relations on a micro- and macro-level” (MacLeod and Durrheim 2002, p.42). It also allows us to think of gender norms and other differences as produced

strategically, compelling us to govern ourselves in ways that (re)produce particular power relations. Even though first-hand accounts of ECT are different in terms of details, patterns recur that provide evidence of the production of gendered liberal subjects through mental health and ECT specifically.

## **Literature Review**

My goal of a critique of knowledge about ECT draws from and is part of a broader group of struggles within and against psychiatry as a whole, and specific practices it involves.

### *Critiques of psychiatry and mental illness*

While there are innumerable criticisms of psychiatry and the concept of “mental illness” and its corresponding treatments, three central figures, all notably male, emerge in popular representations of the antipsychiatry movement. Some of their ideas were adopted by the antipsychiatry and patients’ rights movements that played a role in the widespread deinstitutionalization of psychiatric patients in the 1960s and 1970s in Canada and the United States. Erving Goffman’s (1962) *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* outlined the dangers of segregation within total institutions for people who lived in them. Thomas Szasz, a psychiatrist and a co-founder (with the Church of Scientology) of the Citizens Commission on Human Rights attempted to challenge human rights violations in the field of psychiatry. Szasz understands mental illness to be a myth, either diagnosed according to faulty medical science or based on arbitrary social norms (Szasz 1960). Michel Foucault’s *Madness and Civilization* (1988) is an archeology of madness, showing how what we know about the phenomenon named mental illness and the practices used to deal with it have been (re)constructed and changed over time in relation to what is widely understood as “reason”. The

general understanding among this group is that there are problems with diagnoses of mental illnesses, either in the categories of illness, how these categories are applied to behaviour and people, or in the practices in place to deal with these illnesses.

Like Szasz, more recent psychiatrists have begun to challenge particular aspects of psychiatry publicly. Co-author of *Shock Therapy: A History of Electroconvulsive Treatment in Mental Illness*, David Healy (2003) criticizes the unregulated pharmaceutical industry, arguing that powerful drug companies are able to obscure negative side effects of medication used to treat mental illnesses. Peter Breggin (1991, 2008) criticizes psychiatry's biological emphasis and subsequent reliance on physical treatments, saying that a "psychiatrist will explain that their [a patient's] problems are biological and treatable with drugs, electroshock and hospitalization," while a focus on "caring about or loving their patients in the process of helping them heal" (Breggin 1991, p.11) is largely excluded from formal training for psychiatrists and other care workers.

This brief review of these representatives of critical approaches to psychiatry gives the impression that white, educated, powerful men have control over both the discipline that defines and diagnoses illnesses that disproportionately affect women, as well as critiques of it. Although the names of these men seem to surface more often in academic and public understandings of antipsychiatry and especially the history of deinstitutionalization, there are actually many voices involved in the struggle over the truth about psychiatry and ECT. These voices resist the image of the genderless mentally ill patient common in both mainstream representations of psychiatry, and in many critiques of them.

*Feminist critiques of psychiatry and the medical model of mental illness*

Despite a feeling by some that “the feminist movement has not yet embraced ‘madwomen’, homeless women, women in psychiatric facilities—those among us most considered ‘other’” (Mcinnis 2000), the mental health system and diagnoses of mental illness have been recognized as a feminist issue:

Feminists... should be especially concerned with the increasing medicalization of mental health. Currently in the United States, women on prescription antidepressants far outnumber men. While antidepressant medication undeniably has some positive effects, its widespread use and the gender gap between the number of women and the number of men on antidepressants should cause some concern. It raises a number of questions, the most obvious being ‘Why are more women diagnosed as depressed than men?’ But more significantly, the medical model of mental health may obscure some important issues. Antidepressants individualize and psychologize depression when, in fact, it may be the appropriate response to the current social and political situation for women. Individualizing and psychologizing this problem forestalls the possibility of political action and social change.

(McLaren 2004, p.217).

Feminists have shown how expert knowledges from medicine, psychiatry, and psychology intervene into the lives of women by medicalizing women’s bodies and pathologizing what is traditionally women’s work, like mothering and domestic labour (Ehrenreich & English 1978), as well as under-valuing this work and ignoring how it may contribute to women’s mental health issues (Ussher 2011; Lafrance 2009; Appignanesi 2007). Feminist research tends to highlight the overrepresentation of women receiving mental health treatment and the constructed nature of mental illness. It also emphasizes power differentials in the psychiatrist/patient relationship (Showalter 1987, 1993, 1997; Appignanesi 2007; Warren 1987). Some feminist research focuses on the work that goes into framing a mental health problem and diagnosis, ultimately producing a sick woman (Showalter 1997; Smith, D.E. 1978).

Additionally, feminist research has explored the relationships between women who are being treated for psychiatric issues and the men--doctors, husbands and fathers-- in their lives (Appiganesi 2007; Warren 1987). These studies have found different that these different relationships affect women's diagnoses, treatment, and what counts as a successful outcome. Typically, improvement means embodying what are understood to be proper "feminine" roles. At different periods in history, women have been psychiatrized for being viewed as a bad wife, mother or daughter (Appignanesi 2007; Showalter 1987; Warren 1987; insufficiently (within the marital relationship) or overly (outside of this relationship) sexual, subverting a particular gender identity (Harwood & Rasmussen 2007), or not being a productive enough worker able to fulfill the obligations of the liberal citizen (Blum & Stracuzzi 2004; Swenson 2011).

#### *Feminism and women's psychiatric diagnoses- depression and hysteria*

The psychiatrization of female biology through the identification of illnesses like peri-and post-partum depression and premenstrual dysphoric disorder suggest that women's bodies are in need of medication. Other psychiatric illnesses, like depression, are spoken about in gender neutral terms, but disproportionately affect women. Feminist psychologist Michelle Lafrance (2009) analyses women's narratives of their experiences of depression and argues that "a biomedical understanding has the effect of pathologizing women's unhappiness and obscuring from view the depressing conditions of their lives" (p.54).

Blum and Stracuzzi's (2004) content analysis of stories about antidepressants in popular magazines shows that while discussion appears gender neutral, "mental illness is not only gendered in biomedical terms, with disproportionate cases of particular disorders among male or female individuals; mental illness is also constructed and understood in terms that convey

femininity or masculinity, that produce and police their boundaries” (p. 271). They find that Prozac has been marketed to women to make them competitive, productive and efficient in their personal and professional lives—constructing a newer version of femininity contrasted with the Valium prescribed to many full-time housewives in the 1960s (p. 271). More recently, Swenson (2011) argues that Prozac is a “productivity drug” that “transforms the depressed person into an energetic, enthusiastic and productive subject” (p. 134). She argues that the labour force has been feminized—“unstable, flexible, amorphous, ungrounded, and based on service and social relationships” (p.145) to meet the needs of a postindustrial economy. She concludes:

The only stability the depressed person has is the internalization of the unstable relations in which he or she lives. This condition allows for a particularly intense form of self-governance; whereas the depressed is diagnosed as ‘sick’ he [sic] is, nevertheless, because of the self-blame for his own instability, arguably, the most willing and able worker in this economy

(Swenson 2011, p.151).

Hysteria, which has historically been associated with feminists by critics of feminist activism (Showalter 1993, p.289; 1997, p.10) has been the subject of in-depth research and heated discussion. Foucault investigates the “hysterization of women’s bodies” (1990 p.104) that he argues was part of larger processes, an effect of which was the production of sexualities that were pathologized and in need of intervention. Ilza Veith’s *Hysteria: The History of a Disease* (1965) traced women’s relationship to hysteria from ancient Egypt to its connection to modern psychoanalysis. A diversity of feminist interpretations of hysteria followed. Some feminists claim hysteria as a revolt against patriarchy (Showalter 1997, p.10). Appignanesi (2007) writes that during the late nineteenth century, “hysteria, with its fluctuating symptoms, is par excellence the disorder that best expresses women’s distress at the clashing demands and no longer



tenable restrictions placed on women in the fin-de-siecle” (p.126). Showalter (1987, 1993, 1997) connects the changing nature of hysteria in different contexts, and draws attention to hysterical men and masculinity. I will discuss the links between gender, feminism, hysteria, and my present research in greater depth in chapter two.

Mental illness discourses, which include strategies to define, prevent, and treat biomedical illnesses, have a gender dimension that can be addressed with a Foucauldian feminist approach. By choosing the struggle over the truth about shock therapy as a starting point, I provide another feminist perspective on how gender work happens within and through psychiatric discourses.

#### *Histories of electroconvulsive therapy*

There are a number of histories of shock therapy written from very different perspectives. A recent narrative of the treatment strives to provide some background for people who are curious about its history. Shorter and Healy’s (2007) text (discussed above, and which I use as a data source), is a historical account of electroconvulsive therapy that outlines a progression of different forms of shock that emerged in the 1930s, from metrazol and insulin coma therapy to the present form of ECT (including variations in how this is carried out) and future possibilities like surgical implants. The authors argue “for the foreseeable future, although these new therapies may secure a place for themselves, they will not be a replacement for ECT” (p.288). They describe the global reaction to and research into shock (Chapter 4). They also provide information about the psychiatrists involved in ECT research and practice, and anecdotes of successful ECT at the beginning of most of the chapters of this book.

It is clear where the authors stand on the question of ECT use: "Our research convinces us that ECT is an important, responsible, and reliable therapy that deserves to be more widely used. Indeed, so clear are the benefits of ECT for patients who might otherwise commit suicide, or languish for years in the blackness of depression, that there should be little controversy over whether it is safe or effective" (Shorter & Healy 2009, p.3). At the same time, they use a historical stance to excuse themselves from stating an opinion on agreed-upon common side effects of ECT: "This is a history, not a chapter in a task force report, and hence it is not our goal to establish whether ECT causes memory problems beyond the relatively short-term difficulties that everyone agrees can arise for some people immediately after treatment" (p. 214). Despite refusing to comment on memory loss, the authors state "it would be fair to say that ECT has been better analyzed with controlled studies than almost any other procedure in American medicine" (p. 96).

Interestingly, Shorter and Healy are clear that they do not believe ECT has changed much over time, and to some extent this challenges the popular view that ECT now contrasts with its old, "barbaric" image as "'unmodified' ECT, which is to say, before the introduction of muscle relaxants,... oxygen supplementation, and a short-acting barbiturate anesthetic" (p. 101). However, they do say that by 1952, with these changes widely established, "The modification of ECT was complete. Yet in retrospect it is possible to wonder if much of the modification was really necessary or rather if it reflected mainly cosmetic changes rather than therapeutic progress" (p.130). They summarize,

the history of the past sixty years has been a history of successive attempts to improve ECT. All have failed, even if individual lives were helped along the way. The treatment that Cerletti [who developed the form of ECT currently practiced]

described in 1938, plus a few modifications involving muscle relaxation and wave form, is still with us today,

(p.289).

Shorter and Healy reinforce their position of authority over patients, saying that from a psychiatrist's perspective, "A gut feeling or common sense may suggest that a weak or inappropriate course of drugs carries greater risk to the patient than modified ECT ever would," (p.297), abandoning the language of scientific objectivity and inserting the opinions that from their positions as experts, psychiatrists can trust their own feelings about the treatments they choose to offer. On the other hand, patients' feelings about the treatment are not to be trusted: "self-assessment is a problematic tool in psychiatry... What does it mean if a treatment produces benefits readily apparent to the disinterested observers but not apparent to the patient, and what are the implications of this for informed consent?" (p.297).

Kneeland and Warren (2008) connect shock as we know it now to earlier forms of electrotherapy. This differs from Shorter and Healy's attempt to focus attention on the "convulsion produced" and distance ECT from "the history of medical electricity" (Shorter & Healy 2007, p.270). By connecting ECT to a wider group of medical practices, Kneeland and Warren find themes that re-emerge over time, like power differentials in terms of gender and class that play out in the application of medical electricity. Their approach shows the problem with assuming that there is one coherent and linear picture of the discovery and evolution of electroshock.

Two survivors provide accounts of the history of ECT that attempt to offer more alternatives to the dominant narrative of the progression of ECT. Both of these are primary sources of data for my thesis. Frank's (1978) self-published textbook-style collection of images, lists of ECT doctors

and information on the antipsychiatry movement, is dedicated “To all those engaged in the struggle against psychiatric tyranny” (n.p.).<sup>4</sup> His history also begins with a brief pre-convulsive therapy section, and compiles summaries of research conducted on convulsive therapies and a glossary of language used in psychiatric practice up until the time he published his book.

Andre’s (2009) work is not explicitly a history of ECT, but it reads like one, beginning with her own experience of shock, but then falling into a linear narrative structure like that of Shorter and Healy’s. She provides different scientific evidence to counter others’ truth claims and reinforce her own, and keeps a specific focus on what she calls deceptive practices of ECT doctors alongside the changing truths about shock. Andre, the current Director for the Committee for Truth in Psychiatry, highlights work done within the movement for truthful informed consent and describes her own interactions with ECT advocates. She thinks of ECT as a public relations success story that survives only to perpetuate money and power in the hands of a small group of men.

Andre and Frank’s works are both more critical of psychiatry and shock, and they attempt to show that the truth that they present is more valid. However, the debate is polarized and accounts like these can be framed as “irrational” or exceptional cases when they do not fit with the expert knowledge about ECT which has more influence in the popular image of shock. This statement by Fink (2002) shows how easy he believes it is to discredit this type of account: “We can ignore the few former patients who make a career in the antipsychiatry movement. Their complaints have been answered by sober assessments that find no evidence for brain damage in ECT” (p.12).

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<sup>4</sup> Frank edits the book, which includes his own accounts.

### *Feminist work on ECT*

Feminist studies on shock and shock patients bring attention to why women are given shock therapy, the effect it has on their lives, and suggest alternative truths about ECT. In *Madwives* (1987), sociologist Carol Warren writes: “the purpose of this book is to understand the social and historical processes through which certain wives in the 1950s became madwives” (p.3). She found that “ECT was the most significant treatment in the context of gender and family relationships” (p.23). She calls on statistics that show that women have comprised around two-thirds of ECT patients since at least the 1950s (p.129), and that husbands in the 1950s were able to consent for hospitalized wives who could or would not (p.129). She focuses on shock in a chapter titled “Undergoing psychiatric treatment” (p.128). From her analysis of interviews with women conducted in the 1950s, she finds that “what the medical model classifies as a side effect of ECT was for [these] women its intended effect: loss of memory... During the hospital stay, ECT was interpreted in the context of uncertainty and control; on the return home, the focus was on the impact of memory loss and on the restoration of roles and relationships” (p.130).

According to Warren’s interpretation of these women’s words, shock means something very different than the official ECT discourse. She raises the possibility that improvement after shock (the measures of which are rarely discussed) may rely on forgetting depression (p.131). Warren demonstrates that “ECT may function repressively—that is, allow the person to forget disturbing events or persons” (p.135). Warren finds that interviews with the husbands found that some “used their wives’ memory loss to establish their own definitions of past situations in the marriage” (p.140). Further, “Many husbands saw ECT as designed to erase their wives’ troubles, including past ventures toward independence or criticism of the marital relationship” (p.145). It

is possible that the wives forgot about problems with their marriages, or that they accepted their husbands' power over their treatment and submitted.

Dominant images of femininity in current accounts of ECT are not as clear as the role of the 1950s housewife from Warren's work. However, Warren shows that power relationships involved in the choice of ECT as a treatment have an element of gender work that can be analysed.

In literature from Canada, two women use feminist standpoint theory as a starting point for their research into the lived experiences of psychiatric, and specifically ECT, patients. In 1988, Bonnie Burstow collaborated with psychiatric survivor Don Weitz to edit a text of first-hand accounts of psychiatric hospitalization and institutionalization. These included both written works and visual art pieces. Each of the narratives included offers a critical analysis of a personal experience with psychiatry. Together they raise questions about the management of gender, sexuality, and ethnicity within psychiatric institutions.

Burstow more recently has called for the re-framing of shock as a feminist issue (2006 a & b) and a socially condoned form of violence against women. In her work on women and shock, she argues that shock generates terror and degradation (p.382). The context that surrounds the possibility of shock as a potential treatment "mutually constitutes the woman shock recipient as a powerless child who knows that she will not be heard, and the presiding male as all-powerful parent who knows what is best for this child and will enforce it" (p.383). Although Burstow's argument may appear to downplay women's agency, this scenario is consistent with the authorization of psychiatrists to exercise "weak paternalism" and make decisions acting as "responsible parents towards their children" (Otto & Fink 2004, p.26).

An associate of Bustow's has, like me, taken up Burstow's challenge of making ECT a feminist issue. Nurse and Professor of Nursing and Women's Studies Cheryl van Daalen Smith (2011) compares patients' experiences of shock with nurses' experiences of the care of shock patients. She discovers a disconnect; while patients experienced negative effects after ECT, nurses believed the patients had benefited. An extensive list of negative consequences reported by women she interviewed is included in this piece (p.465). While some nurses had reservations about ECT they all reported seeing post-ECT improvements in women patients (p.467), so they believed that it worked without having any knowledge of the women patients' feelings about shock after they left the hospital (p.467).

#### *First-hand accounts: Patients' perspectives*

People who have had negative experiences of shock do not necessarily want it to be completely banned. Simultaneously, reading about first-hand experiences from people whom Fink refers to as examples of positive outcomes reveals more complicated understandings of how shock affected them. How people identify themselves and their experiences is important, but I have found the groups of people I am studying cannot be reduced to three distinct categories of shock survivor, consumer, or expert.

The accounts that I have outlined in my methodologies section each offer a particular truth about shock, either in the form of a narrative or a history. These do not neatly fit into the categories of the satisfied patient or irrational extremist described by experts.

#### **A map of my research**

In chapter two, I present my findings on the commonalities and contradictions within and between various truths about shock therapy. I show how professional accounts can be inconsistent, and identify weak spots in their arguments that may be more susceptible to resistance. I also underline how critical first-hand accounts provide alternative truths to these professional understandings. I pay particular attention to the strategies used by professionals to defend their truths against this resistance, and describe the production of a particular critical subject in professional accounts.

In chapter three, I highlight the commonalities between first-hand accounts that are presented as having very different outcomes after ECT. I show how subjects are constructed in these accounts that are quite different from those produced by professionals in chapter two. I demonstrate how the mental health system offers ways of governing individuals, and how even resistance is constrained by particular ways of being a self-governing individual.

Finally, in chapter four my conclusions offer some areas where further thought and research are necessary and I discuss first-hand narrative accounts as a technique of governance. I also offer some of my reflections on my own thesis work.

### **Limitations**

My choice to study only published accounts of experiences of electroconvulsive therapy means that people who lack the resources to tell their stories publicly are left out of my data. All the featured accounts foreground narratives of educated, professional people. Although I comment on possible problems for people with fewer resources, the people that face these situations themselves are not represented in my data. My data analysis also reflects an almost complete absence of discussion of racialization and ethnicity-related aspects of psychiatric treatment. A



problem that remains and is often obscured in research on the mental health system is the lack of first-hand experiences of people from diverse backgrounds.

## **Chapter 2: The simultaneous construction of truths and subjects**

In this chapter, I demonstrate the interplay between the construction of truths and subjects within and through particular power relationships. I outline and explore aspects of the patterns that emerge in the multiple truths about electroconvulsive therapy found in my data. In order to provide some context, I give a brief overview of the accounts, and discuss how different statuses of the authors and understandings of expertise can affect their authority to tell their truths and be listened to. I then explore common narratives by professionals and patients concerning ECT as a treatment option, and the risks and outcomes of treatment. I also highlight where accounts contradict with common narratives. Because this is an alternative history, I attempt to show how truths are shaped by the context in which they are told, and how they connect to different power relations, particularly gendered relations.

Next, I focus on the different subjects constructed in accounts of shock therapy. This will return to the concept of expert knowledges and their relationship to the construction of subjectivities and identities. Finally, I will explore how one particular understanding of former patients is produced through professional accounts.

I want to stress that truths and subjects are not necessarily distinct; I show how the construction of identities and truths are intricately connected in these accounts of shock therapy, but I use separate sections to try to pay attention to how truths and subjects are discursively constructed throughout these texts.

*A note on the texts*

In my methodologies section, I outlined the accounts that I use as data sources and the method I used to gather the accounts. The professional accounts take the form of a history (Shorter & Healy 2007), textbooks available for “professionals and their patients” (Fink 2009a) that are backed by “fifty years of clinical and research experience” (Fink 1999a), that discuss the ethics of ECT (Ottoson & Fink 2004), and otherwise describe the practice and the relationship between the doctors who administer it and the patients who choose it or otherwise receive it (Fink 1979; 2000; 2007).

Patient-written books all include a first-hand account of being subject to shock therapy. The majority of these can comfortably fit into the memoirs literary genre (Nuland 2004, Funk 1998, Manning 1994, Gotkin & Gotkin, 1992, Endler 1982). Donahue’s (2000) and Rosenberg’s (2002) accounts are shorter articles, but still focus on their personal experiences. Cott (2005) explores his own extensive memory loss by researching memory and interviewing people whom he considers experts on memory loss. Frank’s (1992, 1978) and Andre’s (2009) accounts are different. While they include a brief discussion of their own experiences with the mental health system, they also provide critical alternative histories of the practice. These are two figures that Shorter and Healy associate with the antipsychiatry movement, calling Frank “one of the first psychiatric ‘survivors’” (2007, pp.186-7), and discussing Andre’s role in the Committee for Truth in Psychiatry (p.208). The accounts written by Manning, Nuland, Endler, Rosenberg, and Dukakis are all called on at various times to support professionals’ versions of the truth about shock.

### **Expert knowledges and truths**

People have used the concept of governmentality to explore relationships involving the exercise of expert knowledges (Cruikshank 1996; Rose 2008b). Expert knowledges, unlike subjugated

knowledges, have been discursively authorized and circulate widely throughout the social body. They become tools in relationships of governance. Miller and Rose (2008b) argue that the “language of expertise plays a key role [in networks of governance that align personal goals with strategies of governance], its norms and values seeming compelling because of their claim to a disinterested truth, and the promise they offer of achieving desired results” (p.35). In this chapter, I explore how expert knowledges are constructed, negotiated, and exercised in the relationships between professionals and ECT patients. To do this, I examine strategies used to construct particular truths, points where expert knowledge is accepted and challenged, and how expert knowledge is used in practices of governance as well as resistance. I understand patients’ accounts as another form of (experiential) expertise, and look for how professional accounts work to maintain their own privilege by subjugating these alternative knowledges. Experiential/subjugated knowledges can be a site of resistance against powerful and widely-circulating truths.

Multiple accounts provide us with multiple truths that circulate to a greater and lesser degree in the discursive field. The accounts do not have equal status. The widely accepted form of expertise and established authority of psychiatric professionals have the advantage over knowledge/ expertise that comes from experiences of patients within the mental health system since the dominant understandings of mental illness include an absence of rationality and self-awareness, compared to experts reinforced by scientific /medical discourses. Discourses that are seen as scientifically-valid, natural or common sense circulate more widely and freely. Professionals’ ideas are also more pervasive since journalists, who report to the public about ECT, present professionals’ views more often, treat them as more important, and as facts, in comparison with patients’ “unsubstantiated opinions” (Andre 2009, p.217). They do this by using

techniques like letting doctors speak and giving less space to survivors' voices (Andre 2009, p.216).

After my diagnosis and treatment, I began to do my own research on mental illness and electroconvulsive therapy. I started with literature by mental health professionals because I thought of them as experts, believed them to have my best interests in mind, and they were also the most accessible starting point. Unless individuals have personal experiences with the mental health system and look specifically for narratives from people with similar experiences, it seems to make sense that professionals hold the knowledge and personal experiences are just that—personal. However, I have come to understand the distinctions between the personal and political, and patient and expert as blurred, and a careful investigation of the relationships between multiple truths can emphasize the political nature of personal accounts and power struggles concerning legitimate expertise. At the same time, I began my thesis research with professionals' accounts and initially gathered materials based on their work. Even coming at research from a critical perspective, professionals seem to have the discursive advantage since I immersed myself in their truths first, and relate other accounts to theirs.

### **Professionals' version(s) of the truth**

Throughout the professionals' texts on electroconvulsive therapy, there are patterns that emerge that constitute what appears at first to be a coherent narrative of ECT. This simplified truth of ECT is constructed within professionals' accounts, and infiltrates academic and personal versions, and media and popular culture. However, a closer look at these complicates widely-accepted ideas that are framed by this narrative, which I hope to disturb.

Professionals begin their explanations of ECT by outlining a particular truth from the beginning and re-establishing it by re-stating their claims as factual knowledge and discursively dismissing others'. The main components of this truth are that even though no one knows how ECT works, it has been proven a safe and effective treatment for severe mental illnesses, and that it is only used as a "last resort", but that in many cases it should be used earlier, since "later could be too late" (Shorter & Healy 2007, p.4). Professionals emphasize the speed of response to ECT in comparison to other therapies. Another aspect of this truth is that ECT is needlessly controversial,<sup>5</sup> and professionals attribute the related stereotypes and stigma (Shorter & Healy, pp. 3, 144) to a combination of factors which include comparisons with treatments that are largely condemned within the psychiatric community or by the general public, such as insulin coma therapy and lobotomy; a perceived threat to other psych professionals' treatment choices; negative media portrayals;<sup>6</sup> social movements of the 1960s and 1970s; and extreme former patients. Throughout their accounts, professionals repeat their own claims and defend them by going to great lengths to explain away criticism, usually not by proving their critics wrong through scientific research, but by exerting their power as professionals and undermining the credibility of critics without professional credentials. Importantly, this shows that former patients' discursive resistance to professionals' truths is capable of eliciting a response that has become a central aspect of the professionals' version of the truth of ECT. Former patients' exercise of resistance has succeeded in shaping, to an extent, professionals' truths about ECT.

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<sup>5</sup> Fink has stated that "it is important to avoid characterizing ECT as controversial" (Fink & Kellner 2010) implying that the controversial aspects have been settled and are in the past despite ongoing debates.

<sup>6</sup> It is interesting that the main example of popular media professionals consistently cite is *One Flew Over the Cuckoo's Nest*, where lobotomy is what most visibly damages the patient.

Repeatedly, instead of citing current studies that disprove criticisms about negative effects, professionals position themselves as helping experts who want to use ECT only because it is beneficial for patients, not because it is benefitting them in any way. Fink never acknowledges that he has built his legacy on ECT, and Healy does not mention that he has created an anti-medication niche for himself in psychiatry (Healy 2003). At the beginning of their history of Shock, Shorter and Healy (2007) reassure the reader that the benefits of ECT are so clear, that controversy is completely unnecessary (p.3).

### *Gender neutrality*

The professional accounts I have studied present electroconvulsive therapy as a gender-neutral issue despite the overrepresentation of women being treated. They do this by rarely mentioning the gender differential, and when they do state the rate of women being treated compared to men it is part of a brief discussion on the typical patient (Kellner et al 2005). Usually, this differential is absent or obscured. In professional accounts, women are more often diagnosed with illnesses that respond to shock therapy, so they are more often are treated with it. With no further inquiry into the diagnosis or choice of treatment process, they imply that this is common sense. According to this stance, ECT is used to treat women more often, but that is because women are more susceptible to particular biological illnesses. Professional accounts, like biological-based psychiatry generally, do not consider the possibility that treating women's illnesses in a particular way pathologizes women's bodies and experiences, and helps shape and maintain understandings that legitimize intervention, regulation and monitoring of women (as a group at risk for certain illnesses). In contrast with this "common sense" understanding of why more women are treated with ECT, diagnoses associated with women and femininity, such as

hysteria prior to the 1980s (Fink 1979, p.218) and neurosis since then (Shorter & Healy 2007, p.113), are not to be treated with ECT.

In Fink's new edition (2009a), there is a new subsection devoted to "Psychiatric disorders during pregnancy" (p.82) to replace a shorter subsection in his 1999 edition (1999a, p.23). Supposedly, ECT is safe to use on pregnant women (Fink 2009a, pp.82-3) but Fink's 2009 edition only cites two sources. The first (p.83, note 13) excerpts from a case history from the 1940s that illustrates post-partum ECT treatment (Protheroe, C. 1969) but not ECT during pregnancy as Fink's subsection title suggests.<sup>7</sup> The second appears to be tied to evidence of the safety of ECT, but actually is a note on possible "practical concerns" of administering shock to a pregnant woman (p.83, note 14). Though the use of endnotes makes it appear otherwise, Fink does not actually offer any sources that have studied the effects or outcomes of ECT during pregnancy. While citing a few case studies where children treated with ECT responded to the treatment with a change in their behaviour, Fink says there is an "increasing tolerance for trials with ECT" used on children (Fink 2009a, pp.85-93). Unlike his discussion of treatment of pregnant women, Fink at least admits a lack of research into its use on young people. These examples suggest that he has even more limited interest in the safety of women.

Shorter and Healy (2007) argue that Phyllis Chesler's *Women and Madness* "made ECT sound like some kind of male plot against women" (p. 156), and they blame the feminist movement for criticisms of doctors exercising power over women's bodies as the cause of greater regulations

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<sup>7</sup> Fink cites Protheroe (1969) second-hand from a 2006 book he (Fink) co-wrote with Taylor. Fink conveniently leaves out that the original source goes on to say that the woman from the case history was interviewed in 1962, and that "She could remember little of her stay in hospital during the 7 ½ years prior to being given E.C.T., but much of the few months following" (Protheroe 1969, p.13). Protheroe's research did find ECT to be useful in treating postpartum psychosis in terms of incidence and speed of discharge; however, his work did not look at ECT used during pregnancy, despite Fink's inclusion of Protheroe's work in his subsection on pregnancy.



on professionals' use of ECT (p.192). They are unwilling to further consider the power relations between male doctors and female patients. The quick simplification and dismissal of truth claims made by feminists shows a lack of respect for women's negative experiences of psychiatry, as well as feminist research contributions.

Interestingly, though professionals do not address this, ECT becomes a gender issue in accounts written by both men and women former patients (Dukakis 2006; Endler 1982; Funk 1998; Gotkin & Gotkin 1992; Nuland 2004; Manning 1994). Understandings of masculinity play an important role in men's experience of mental illness, just as expectations about women's roles shape women's experiences. I will return to this in more detail in the next chapter, but for now it is important to acknowledge how professionals' accounts are written in a way that ignores or buries gender relations, while they are a common aspect of first-hand experiences.

Linda Andre's is the only account of all of those I examined that directly addresses the role of gender in ECT treatment, noting the disparity between the majority of male doctors treating patients who are predominately women (p.177). She argues that women with experiences of shock "believe that they are experts on their own experience" (p.177), but doctors do not recognize this form of expertise because "personal experiences (of persons who aren't doctors) is unreliable, suspect; simply, not a valid way of knowing. It is automatically doubted and interrogated, and is guilty until proven innocent. It does not lend authority; to the contrary, it is dismissible as anecdote. Its opposite, science, is the only way of knowing the truth" (Andre pp.177-8). This is reminiscent of Dorothy Smith's (1990) critique of social science research that she argues values "objectified forms of knowledge" (p.61) and excludes women's lived experiences. Andre believes that women are "connected knowers" who recognize different ways

of knowing, compared to men who are “separate knowers” and police knowledge (Andre 2009, p.179). Her inclusion of the gendered dimensions of electroshock is noteworthy. She addresses a problem that often goes ignored, since “in the world of shock... the female point of view is nearly nonexistent” (Andre 2009, p.281).

### **Changes and contradictions throughout the professional narrative**

#### *Should ECT be replaced?*

One change that takes place in Fink’s perspective over time concerns the need to move on from ECT to something better. In his 1979 text, Fink draws on his research, funded by numerous grants since the 1950s, and says that he hopes that research will find a better replacement for ECT (p.238). By 1999, Fink has abandoned the search for an improved procedure. Shorter and Healy are unconvinced that any of the newer methods being developed to replace ECT can provide a more effective treatment for serious mental illness (Shorter & Healy 2007, chapter 11), and present the risks of electroconvulsive therapy as so negligible that an alternative is unnecessary.

#### *Suicide*

Shock is repeatedly presented by professionals as a means to prevent suicide (Shorter & Healy 2007, pp. 4,7; Ottoson and Fink 2004, p.57; Fink 1979, p.22; Fink 1999a, p.33; Fink 2009a, pp.3, 54-5, 56) and as an alternative to medications that can “induce suicide” (Shorter & Healy 2007, p.179). There is criticism that no statistics support the assertion that ECT reduces suicide risk, and that, in fact, studies have shown the opposite (Andre 2009, p.99). Fink (2009a) admits recent findings show that suicide rates post-ECT are actually higher than suicide rates of other

patients in a psychiatric hospital (Fink 2009a, p.34; Munk-Olsen et al. 2007).<sup>8</sup> On the other hand, Shorter and Healy (2007) share the story of a colleague's suicide after he refused ECT, calling his death a "tragedy" that could have possibly been prevented with ECT (p.104).

One aspect of the suicide question that is absent from professional accounts is behaviour or signs they look for to signify a suicide risk (and thus recommendation of shock treatment). This presumed lack of need for discussion of suicide risk factors reinforces an assumption that it is common sense that a psychiatrist would know best who is at risk of suicide, and make treatment decisions accordingly.

#### *The extent of "improvements"*

One of Fink's primary and repeated concerns is to present shock as very different from what it was in the beginning. He has been discussing the modifications to electroshock since at least the late 1970s (Fink 1979, p.1), but he always presents them as new developments. He does this by emphasizing the "fundamental changes" (the addition of anaesthesia, oxygenation, and muscle relaxants) in the preface in both editions of his newer text (Fink 1999a; 2009a), and in the "modern methods" (Ottoson & Fink 2004, p.2) that supposedly have alleviated negative memory effects (Ottoson & Fink 2004, p.11). Although it is unusual for them to depart from Fink's view of ECT, Shorter and Healy (2007) are not completely convinced of the extent of these changes, and suggest that it is the image of the procedure that has changed more than anything else; they write that by the 1950s, "the modification of ECT was complete. Yet in retrospect it is possible to

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<sup>8</sup> Fink adds this statistic at the end of a paragraph describing the low risk of death during ECT: "The mortality rate from natural causes is lower for those treated with ECT than for those who have not [sic]. Suicide rates are higher, however" (Fink 2009a, p.34). There is no more discussion of this contradiction in this text. The confusing phrasing makes it necessary to look to the source he cites, which does find that suicide rates are higher for former ECT patients (Munk-Olsen et al. 2007).

wonder if much of the modification was really necessary or rather if it reflected mainly cosmetic changes rather than therapeutic progress” (p.130). They revisit this position, saying,

It is notable that most of the technological development of ECT basically came to an end in the early 1950s with Holmberg’s introduction of succinylcholine and the anesthesia and oxygenation that were necessary with it. Subsequent changes have been minor, mainly adoption of monitoring the convulsion with an electroencephalograph... All other subsequent innovations have either failed to pan out, such as intensive ECT, or have remained controversial and unproven, such as the assertion that unilateral is superior to the bilateral placement of electrodes.

(p.141).

Despite the subsection “modified convulsions” in his 1979 textbook that says that modifications were in place by 1950 (Fink 1979, p.13), Fink’s more recent texts (1999a; 2009a; Ottoson & Fink 2004) argue that shock therapy continues to be improved without providing evidence to support this claim.

Linda Andre (2009) argues that the image of “new and improved” treatments is a template for the representations of shock in the media set up by the industry as part of a public relations campaign (pp. 132, 216). It functions with the construct of the shock therapy “comeback” used in professional and journalistic accounts of shock (Wells, J. & Zomislic, D. 2012; Smith, D. 2001; Dukakis and Tye 2006, p.8), despite a lack of statistics on the number of patients treated over time. Shorter and Healy indicate that the media began to reverse its negative portrayals of shock in the 1980s (p.246), which is when the idea that shock was making a comeback also appeared (Andre 2009, p. 214). This provides evidence for Andre’s theory that shock advocates are able to safeguard against resistance with a successful public relations campaign.

*“Last resort”*

Another inconsistency in these accounts is that while professionals call shock a “last resort” treatment, in many cases the definition of “last resort” is unclear. Although doctors allegedly test different rounds of medications before resorting to ECT, none of the texts discuss this process in depth. At different times, “last resort” can mean a lack of response to medications, a quick solution to a suicide risk, or an inability to control a patient. Although this last version is presented as a practice from the past, Fink’s work shows more current decisions to use ECT for this reason. In an article where he suggests ECT should be used earlier in the cases of a diagnosis of delirious mania, Fink provides three cases where ECT was administered to one patient on day 11 of hospitalization, and to two patients on their fourth day in hospital. All of these patients had required restraints, and in at least two of the cases, others consented to ECT for them (Fink 1999b, pp.56-7).<sup>9</sup> This raises questions about informed consent, but also about whether “last resort” in a hospital is reached when professionals decide that too many resources are used for patients requiring observation or extra specialized care,<sup>10</sup> or even when they are resisting treatment. In cases where patients report positive experiences of ECT, the “last resort” is when they themselves conclude they have used up all other options, like therapy (Manning), months of medication (Endler), or a combination (Dukakis). At this point, their doctors suggest ECT, and they consider and then eventually choose to have it.

The use of the “last resort” idea reinforces the assumption that mental illness is a biological illness that can only be treated with practices that change our biology: “last resort” often means

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<sup>9</sup> In the third case, it is not stated who consented to ECT.

<sup>10</sup> This raises the question of the importance of the cost-effectiveness of ECT in a neo-liberal context. A related theme of the shock therapy’s “efficiency” (and a lack of explanation of what this means) recurred throughout the data from professionals’ narratives of shock. Considering that the “language of efficiency” connects the goals of politics with the power of expertise (Miller & Rose 2008b, p.43), the role of efficiency in professionals’ accounts of ECT deserves greater attention. However, a detailed exploration is beyond the scope of my present analysis.

medication-resistant. No other treatment options besides drugs or ECT are considered in professional accounts, though patients' accounts feature alternatives like psychotherapy, retreats, and support groups.

### *Memory loss and brain damage*

The relationship between ECT and brain damage is one of the more interesting changes in Fink's body of work over fifty years. Researchers have previously pointed out that Fink's thoughts on brain damage have changed significantly since he began his research, when he equated ECT with brain trauma (Burstow 2006, p.377; Andre 2009, p.49). In 1960, for example, Fink participated in research on "induced altered brain function", saying that shock "provides a unique opportunity for studying the effects of cerebral dysfunction in that more accurate control can be maintained over the degree of induced cerebral dysfunction and its measurement" (Kahn, Pollack, & Fink 1960, p.77). In his 1979 textbook, he states: "Complications of ECT are infrequent and are usually limited to memory impairment and spontaneous seizures. Brain damage is alleged, and death is rare. These complications are seen after head trauma, to which ECT has been compared" (Fink 1979, p.41). Professionals now argue that there has never been any evidence of brain damage (Shorter & Healy, p.104; Fink 2009a, p.118).

Shorter and Healy (2007) briefly revisit the 1960 study, re-positioning Fink by addressing EEG findings after an induced convulsion: "This is a signature for an organic change state: patterns of neural activity have been altered as a result of convulsion. One way to interpret this is that the brain has been traumatized, but this view is not necessarily correct" (p.210). In other words, Fink misspoke, or critics may have misinterpreted his words. They further defend their ideas about

brain damage by arguing that if ECT is banned for brain changes, then drugs and coffee should also be banned (p.212), minimizing the extensive memory loss that some people experience.

The questions of memory loss and brain damage are a complex part of truths about shock therapy and subjects that emerge from ongoing power struggles and contradictions.

Professionals bring up the issue mainly in response to others' criticism. They downplay these risks, and present them as temporary and rare (memory loss), and non-existent (brain damage).

They also explain that memory loss is to be expected, but are concerned that warning patients can cause them to perceive memory loss (Fink 2007, p. 292; Shorter & Healy 2007, p.244) even while openly stating that memory loss is a risk of ECT (Fink 1979, p.41). I will attend to memory loss and brain damage in more detail while considering alternative truths, but it is important to emphasize the inconsistent and contradictory way that professionals talk about these issues.

### **Accounts chosen by professionals to reinforce their version(s) of the truth**

Anecdotes of positive outcomes of convulsive therapies begin most of the chapters of Shorter and Healy's *Shock Therapy* (2007). Mainly, they are written from a psychiatrist's viewpoint instead of the patient's (with the exception of the first-hand account written by "A practicing psychiatrist" in 1965, [p.103]). Most of the stories in Shorter and Healy's text come from the earlier days of the practice, even though this is the time when ECT was supposedly not yet improved. Fink (1999a; 2009a) uses the same tactics (case studies from psychiatrists' perspectives and particular patient/experts voices) to illustrate his version. Professionals do not offer a similar prominent space for stories from critics of the practice; in fact, when they do discuss these former patients, Shorter and Healy include them in a single chapter as actors in

broader social movements for patients' rights, civil and women's rights, and academic resistance to psychiatry and ECT (Shorter & Healy 2007, pp.181-218).

In his earlier text, Fink (1979) does not incorporate first-hand experiences at all. In his later works, he has come to recognize that experiential knowledge can help support his truth claims in the eyes of the public and potential patients. His choices of first-hand accounts form a definite pattern; all are mental health or medical professionals with the exception of Kitty Dukakis. Patient-experts have both experiential and (presumed) scientific expertise, making them valuable people to represent his understanding of the issue. Upon closer inspection of the accounts that these patients have written, their experiences usually do not match Fink's version of the truth as closely as he claims.

### **Alternative truths**

There is no single unified counter-narrative; there are multiple truths about shock therapy. Attempting to understand truths in individual accounts has been complicated, and I must acknowledge the limits of my perspective. That being said, I have immersed myself in these accounts; I have followed patterns, looked for contradictions and similarities that could tell me more about truths and the subjects that shape and are shaped by them, but I do not wish to reduce the intricacies of these truths to my own understanding.

Frank's (1978) and Andre's (2009) books are distinct from those written by other former patients. First, they do not describe the processes that led up to their treatment in depth, because they do not remember that time. Second, they both offer an alternative history to those written by professionals



Linda Andre is the director of the Committee for Truth in Psychiatry (CTIP), formed in 1984 by seventeen women electroshock survivors (and founded by Marilyn Rice [Andre 2007, pp. 157-8]) to resist psychiatric authority and informed consent practices in shock specifically. Andre does not remember her diagnosis or treatment processes: "I have no memory of ever feeling depressed or of my one involuntary encounter with psychiatry. The shock treatment erased five years of my life: four before, one after" (Andre 2009, p.3). She reports a loss of her education, and a drop in IQ score. A neuropsychologist also found that she was suffering from a brain injury (pp.8-9). Andre's account focuses on the history of the "mental patient movement" (p.13), and the strategies used by shock doctors to maintain ECT despite patient resistance. Her version of the truth highlights the theoretical basis of psychiatry, challenging assumptions that psychiatry is sufficiently scientific, and suggests that psychiatric professionals make decisions based on personal gain. She constructs a history of excessive psychiatric power and abuse and frames the understanding of shock as safe and effective as a successful public relations move. Her book can be read as a response to Shorter and Healy's *Shock Therapy* since she confronts and challenges their truth.

Leonard Frank, an involuntary psychiatric patient who in 1962-3 was treated with a combination of ECT and insulin coma therapies believes that convulsive therapies were intended to break his spirit and force a belief system upon him (2002). He calls for shock treatment to be named "electroconvulsive brainwashing" (2002). Frank is the editor of a (1978) book that begins with only a brief personal narrative of his experiences, which resulted in "a total and permanent amnesia for the two-year period preceding the last shock treatment" (1978, p.ix). The book itself is a collection of conflicting professional research and opinions, as well as first-hand accounts of the truth about shock therapy. Frank's book is interesting because he does allow ample space for

ECT advocates' research, while contrasting it with psychiatrists who disagree and patients' accounts. While it is clear that Frank is criticizing shock, he does not ignore the words of those who disagree with him, or even offer his own interpretations of the work explicitly (though as editor, he does choose what to include). Instead, he juxtaposes advocates' knowledge with contrasting findings and experiences, highlighting struggles over shock. In doing so, he does not exercise authority or expertise in the same way as professional advocates do. He simultaneously subverts and reinforces psychiatric authority by condemning some psychiatrists' views through the work of other psychiatric professionals.

Frank exercises resistance through poetry, including "An end to silence" that demands that "these little Auschwitzes be abolished" (1978, p.104), which is included in the 1978 text. He returns to the comparison of mental hospitals to "little Auschwitzes" in a poem he wrote in 1989 (2002, n.p.) that concludes his testimony from a public hearing on ECT. After thirty-five years of research, he has found electroshock to be

a brutal, dehumanizing, memory-destroying, intelligence-lowering, brain-damaging, brainwashing, life-threatening technique. ECT robs people of their memories, their personality and their humanity. It reduces their capacity to lead full, meaningful lives; it crushes their spirits. Put simply, electroshock is a method for putting the brain in order to control and punish people who fall or step out of line, and intimidate others who are on the verge of doing so

(n.p.).

Frank's and Andre's books have necessitated considerable reflection on my part. I wondered whether they compensated for their lack of memory of their own experiences by gathering as many references they agreed with as possible to form a coherent narrative of shock. I also wondered if they, like myself, felt intense pressure to supplement their viewpoints and their expertise by using evidence from professionals, understanding how easy it is to be discredited

when you are a former psychiatric patient critiquing the system.<sup>11</sup> Andre outlines political differences between Marilyn Rice, the founder of CTIP, who “was inclined to work through the proper channels—to ask politely and expect to be heard” (p.114) and Frank, who relied on demonstrations and expressing thoughts in alternative ways, like his poetry. Although Andre calls them “The King and Queen of Shock” she suggests that, “they were united only by their shock experiences and their desire to do something about it” (p.114). This demonstrates how people who are minimally united against a specific power/knowledge configuration exercise different strategies at multiple sites of struggle. Exploring the different techniques of resistance against a powerful set of discourses that constitute psychiatry is the struggle of genealogy (Foucault 1980a, p.84).

The differences between Frank and Rice as explained by Andre also made me consider how gender may affect how survivors express their truths. Frank’s use of poetry and dramatic language, above, may go beyond a dominant understanding of masculinity (as did some of the symptoms that caused his parents to commit him, like becoming a vegetarian and reading Ghandi [Andre, p.113]), but the same tactics used by a woman could be positioned as signs of hysteria, which I will return to later in this chapter.

It is necessary to examine accounts of memory loss when exploring alternative truths of ECT. Loss of memories is an almost universal experience in the first-hand accounts I studied, but likely due to the personal nature of memory, there is no common experience, and they cannot be compared. Rather than attempt to summarize all the experiences of memory loss, I will show how it has become one of the central struggles in the truth about shock, and later, how personal experiences of loss can be used to shape people subject to ECT in a way that maintains an

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<sup>11</sup> In contrast, Shorter & Healy’s history frequently cites “personal communications” as factual.

unequal relationship between psychiatric professionals and patients. Personal narratives concerning memory loss are central to all first-hand accounts of shock therapy, even the positive ones. Different views organize understandings of shock, and they also provide a basis by which people who do not share common views evaluate each others' truths and subjectivities.

*More truths about memory loss and brain damage*

*Memory losses following treatment emerged as a concern thirty years after ECT had been introduced into medicine. It became one of the central battlegrounds in psychiatry, and an important question for us is to consider why this was the case.*

(Shorter & Healy 2007, p.214).

The idea that the debate over memory loss has not always existed is repeated in Shorter and Healy (pp.82, 214, 244), even though they cite studies that show it as a problem contemplated as early as the 1940s (p.111). The question above is brought up near the end of a chapter on the history of patients' rights struggles against unregulated psychiatry and for informed consent practices, which began in the context of civil and women's rights movements. At first, they outline and acknowledge a connection between the social movements of the 1960s and patients' rights reforms in order to explain an enlarged capacity for hurt patients to be able to exercise their resistance. However, critical aspects of the history of mental patients' rights are absent when they treat patients' rights, including criticism of ECT and its effects, as suddenly appearing in the 1960s. They leave out the possibility that maybe patients did complain before, but they were institutionalized, dominated and unheard, or the possibility that few people knew or cared what happened to psychiatrized people. After briefly outlining the rise of antipsychiatry in the 1960s, focusing specifically on the roles of Scientology and individual complainants like Frank and Rice in the rise of informed consent practices, Shorter and Healy shift their focus away

from political struggles onto individual, and eventually internal struggles. They depoliticize patients' criticism by individualizing problems. They suggest that drugs used with ECT may cause memory loss (pp.214-5). Further, they assert that since memory is much more important than it ever was, its loss is perceived as more important than it actually is. Now,

we live in a period where for various reasons memory is seen as the critical human faculty, the thing that makes us human, and it has a centrality it did not have before.... For whatever reason, a premium has been placed on memory; this problematizes difficulties in the realm of memory to a greater extent than might have happened in other areas

(p. 216).

If memory is so important that it makes us human, why would psychiatrists not consider the subjective experience of memory loss to be important enough to be cautious with a treatment that can affect memory, rather than appeal for more widespread use? Whether memory is more important now or not (and how could we know this?),<sup>12</sup> their dismissal of the ties to rights' movements decontextualizes and attempts to depoliticize the voices of resistance of people who experience memory loss by framing the debate as a personal issue that cannot be solved because memory is yet to be understood scientifically (Shorter & Healy 2007, pp. 215-6).<sup>13</sup>

To further reinforce that concerns about memory loss are new and overblown, they rely on expertise outside of psychiatry: "In informed circles, serious memory loss has seldom been

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<sup>12</sup> Shorter and Healy blame a "variety of forces" (p216) for what they deem the new centrality of memory. Instead of citing research to support this claim of a new greater emphasis on memory, they shift attention to other medical procedures, like heart surgery, that are excluded from criticisms of resulting cognitive problems.

<sup>13</sup> At the end of this chapter, Shorter and Healy do acknowledge the absence of former patients from research into shock, saying this is part of a broader pattern in medicine (p.218), but that unlike the pharmaceutical industry, there is no evidence of ECT research suppression (p.218).

considered real” (Shorter & Healy, p.111).<sup>14</sup> Professionals argue that although memory loss is an issue, it is temporary (Shorter & Healy, p.3; Fink 1999a, p.42, 115) or “localized to the treatment period” (Fink 2009a, p.117). They also attempt to attribute loss to “normal” memory loss that happens to everyone (Shorter & Healy, p.111; Fink 2007; Fink 1999a, p.17) or say that it is caused by medications or by the mental illness itself (Shorter & Healy pp.214-5; Ottoson & Fink 2004, p.11; Smith, 2001, p.5).

Professionals emphasize the subjective nature of memory loss, and define it in ways that minimize patients’ experiences or attribute it to a cause other than brain damage. Marilyn Rice resisted this by creating the first patient-written informed consent statement for ECT, which

describes the loss, so different from normal forgetting, because it is the most recent knowledge, not the oldest, that is hardest hit... What varies among patients... is not *whether* permanent memory loss occurs, but the way this memory loss affects their lives and, in turn, how they feel about it: from not minding much to adjusting to disability to being unable to return to their previous way of life

(Andre 2009, p.156).

In 1984, seventeen women electroshock survivors mobilized around the idea of “truthful informed consent to ECT” forming the *Committee for Truth in Psychiatry* (Andre 2009, p.158). Their first act as an organization was to approach the FDA to use Rice’s consent form for ECT. The form “would serve in the future as the basis for [CTIP] membership” (Andre 2009, p.159). The FDA said they were planning to adopt a consent form written by the American Psychiatric Association instead (Andre p.159). The statement offered by survivors discusses a wider range of risks that former patients want potential patients to be aware of; much different from the

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<sup>14</sup> They use one example to illustrate the unbelieving “informed circles”: the legal system did not allow ECT-related memory loss to excuse a defendant from a crime in a 1972 appeals court.

narrow “temporary” loss that professionals call “more annoying than disabling” (Ottoson and Fink, p.72) in the midst of other contradictory statements.

With the exception of Endler (1982, pp.76, 81), all the patients in my sample report some form of memory loss. The extent of the memory loss and the effects of the loss on patients’ lives varies widely, but this near-universal experience is absent from Fink’s repeated assertion that people worry about memory loss because they have heard horror stories from the early years of treatment, before shock was modified (Fink 1999a, p.16; 2009a, p.35). Fink does admit that unmodified ECT was harmful and memory loss was seen as part of the therapy (Fink 1999a, p.93). However, the experiences within the accounts that I studied took place between the years 1962 and the early 2000s, long after modified ECT had been established.

Frank (1978) argues that memory loss is not a “side effect”, as suggested by doctors, but actually the way electroshock works: “In essence, what happens is that the individual is dazed, confused, and disoriented, and therefore cannot remember or appreciate current problems” (p.xiii). Early “amnesia theories” that suggested that shock worked by erasing disturbing memories are consistent with Frank’s claim (Fink 1979, p.165). Early ECT was said to have an advantage over other convulsion-producing therapies like Metrazol because patients had amnesia of the period before and during treatment, and so were willing to submit to more treatments (Shorter & Healy 2007, p.68). Amnesia was also necessary for Ewen Cameron’s “depatterning” experiments, which used intensive electroshock for prolonged periods to treat people with schizophrenia (Cameron, E., Lohrenz, J., & Handcock, K., 1962, 67).<sup>15</sup> A close reading of Nuland’s account, who

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<sup>15</sup> Cameron’s use of ECT is left out of Fink’s accounts, while Shorter and Healy blame Cameron for the forced discontinuation of regressive ECT which they say “was probably a technique that held some kind of a key to improvement in chronic psychotic illness” (Shorter & Healy 2007, p.139). Shorter and Healy leave out the importance of memory loss in Cameron’s work. Cameron argues that his review of others’ work

Fink names to support his version of the truth, actually supports Frank's theory by describing how profound memory loss helped him (Nuland) forget obsessive thoughts (Nuland 2004, p.8).

Fink's two recent textbooks no longer discuss earlier theories of shock, focusing instead on more recent theories involving hormones and neurotransmitters (Fink 1999a, pp.80-4; 2009a, pp.94-102).

Particular narratives of brain damage in relation to memory loss are common. Frank (1978, 2002) and Andre (2009) report brain damage, while Endler (who notes that he did not experience memory loss) states that ECT does not damage the brain (1982, p.77). Dukakis' (2006) take on brain damage is unusual, since she is unconcerned with whether ECT causes brain damage (p. 191). She says she is not a scientist, and does not know what causes her improvement after ECT, but she does not care to understand why (p.191). Her account shows significant evidence of her unwavering trust in her doctor and psychiatric authority generally. She does not claim to be an expert on ECT despite her experience; she leaves the role of expert up to her doctors. Professionals reject the brain damage narrative by saying that claims of brain damage are unfounded (Shorter & Healy, pp.3, 135; Fink 2009a, p.115).

Shorter and Healy (2007) provide an interesting take on the history of the charge of brain damage:

We will show that the charge of brain damage from ECT is an urban myth, one first put forth by the developer of a rival company, Vienna's Manfred Sakel, who tried hard to subvert his competition. We take seriously the assertion that ECT is associated with memory loss, but in the vast majority of patients, memory is restored within weeks after the last treatment, suggesting that no long-term damage to the brain's memory capacities is sustained

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using regressive ECT shows that "the disturbance of memory is the central phenomenon" of intensive ECT to relieve symptoms of schizophrenia (Cameron 1962, p.67).



(p.3).

If they dismiss claims of brain damage, how do they “take seriously” the problem of memory loss? Shorter and Healy offer no alternative for why such a loss would occur, aside from the idea of the power of suggestion (p.244).

### **Producing Subjects**

*For poststructuralist theory the common factor in the analys[es] of social organization, social meanings, power and individual consciousness is language. Language is the place where actual and possible forms of social organization and their likely social and political consequences are defined and contested. Yet it is also the place where our sense of ourselves, our subjectivity, is constructed... Subjectivity is produced in a whole range of discursive practices—economic, social and political—the meanings of which are a constant site of struggle over power. Language is not the expression of unique individuality; it constructs the individual’s subjectivity in ways which are socially specific. Moreover for poststructuralism, subjectivity is neither unified or fixed... [things are] given radically different meanings by various interest groups.*

(Weedon 1987, p.21).

Although from a poststructuralist perspective, subjectivities and identities are constantly being (re)produced, written accounts allow the author to create the appearance of a stable subject. How doctors and patients choose to construct themselves and others in their accounts can tell us about their different ways of knowing the world. Instead of trying to differentiate what is actually “true” or “false” about truths and selves within these accounts, I look at how discursive practices create a true/ false relationship.

Shorter, Healy, and Fink continually reinforce their positions as experts by citing case studies and professional experience, as well as some scientific studies by others. Simultaneously, they position themselves in opposition to those who voice negative experiences, framing these critics as part of the antipsychiatry movement. In Shorter and Healy’s (2007) history, antipsychiatrists

are defined as people who believe that mental illnesses do not exist, and, “from our vantage point in the twenty-first century, this is an argument that the antipsychiatrists seem to have lost” (Shorter & Healy, p.181). This statement has a number of effects. It naturalizes dominant understandings of mental illness, presenting them as common sense. It marks an area where a truth has been established, but also where a defense against resistance, which can undermine that truth, must be reinforced. It draws on and reinforces psychiatric discourse, and re-creates a hierarchy of psychiatric professionals who are just trying to do their jobs (which they say is helping), against a vocal minority who are impeding their ability to do that by attempting to create obstacles like greater regulations. While they acknowledge that people who side with the patients may have good intentions, they maintain that they (as professionals) are the ones who know what is best for patients.

In contrast with these people who tell of ultimately positive outcomes, Shorter and Healy repeatedly use scare quotes around the term psychiatric “survivor” (pp.186, 214, 218, 249) in reference to people like Marilyn Rice and Leonard Frank. They say that a treatment like ECT is easier for opponents to say is something they “survived”, unlike a medication (p.185). This undermines survivors’ identities and ability to know and name themselves. People with positive outcomes often talk of themselves as recovered or recovering, and this identity, as opposed to the survivor identity, is acceptable.

The presumption by professionals that all former ECT patients with bad experiences are antipsychiatry is important, since professionals assume that the antipsychiatry activists have “lost” the struggle over psychiatry (Shorter & Healy, p.181). The unequal power relationship between doctor and patient when it comes to deciding people’s treatment options, and even their identities, also seems to become common sense. However, patients’ resistance to ECT and

the struggle for greater regulation of it demonstrates the use of experiential knowledge/power in a way that can effect real changes. Marilyn Rice's lawsuit against the doctor who administered her ECT was part of a series of struggles against unchecked psychiatric authority,<sup>16</sup> and a larger patients' rights movement that changed the doctor/ patient relationship, exerting pressure for informed consent of medical illnesses and procedures (Shorter & Healy pp.188-200; Kneeland & Warren 2008, pp.72-75). The changes enacted in these relationships demonstrate that resistance from various locations, including from the voices of patients with experiential knowledge, helps to shape the present administration of shock therapy. Professionals who advocate shock therapy can strike back against this resistance using any number of strategies, and I found that one strategy they used was to construct a particular former patient in their accounts.

*Hysteria and the construction of the "still mad" former patient*

*Forms of subjectivity which challenge the power of the dominant discourses at any particular time are carefully policed. Often they are marginalized as mad or criminal...*

(Weedon 1987, p.91).

In professional accounts, the maintenance of a particular truth about ECT depends in large part on the ability of professionals to defend, through discursive acts, their position as holders of knowledge and facts against others who they construct as wrong. In order to construct others as wrong in relation to their own expert knowledge, which is presented as real, objective and scientific, professionals do not just attack former patients' ideas as untrue; they simultaneously construct an image of a "still mad" subject who is unable to know or speak the truth, so that any conflicting perspectives they offer are easily dismissed.

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<sup>16</sup> Marilyn Rice lost her malpractice complaint against her doctor, Nardini (Andre 2009, p.116; Shorter & Healy 2007, p.208).

Showalter has done extensive research into the history of hysteria, and finds that hysteria has been associated with feminists over time (1997, pp.10; 1993, p.289). Patterns have emerged in my data that show a similar occurrence in professionals' description of patients who report negative experiences of memory loss and attempt to tell their stories publicly. Showalter (1997) argues that hysteria has never gone away, but has come back in different forms like chronic fatigue syndrome, Gulf War syndrome, and recovered memories. Most of what she calls the new forms of hysteria still predominantly affect women and draw on and reinforce tropes of feminine irrationality vs. male rationality, as does the construction of the "still mad" patient.

Often, ECT critics and Scientologists are spoken about at the same time, and both are positioned as having extremist views (Shorter & Healy 2007, pp. 184-8; Smith 2001). Shorter and Healy tie Andre and Marilyn Rice (and therefore the Committee for Truth in Psychiatry) with Scientology again by highlighting their relationship with Peter Breggin, an anti-ECT activist in his own right (1991, 2008) and identifying him as a "former student of Thomas Szasz" (Shorter & Healy 2007, p. 208). Szasz cofounded the Citizens Commission on Human Rights with the church of Scientology (Shorter & Healy 2007, p.184). Andre (2009) resists how CTIP is equated with Scientologists, given the dominant view of Scientology as an irrational religion: "It doesn't matter that the claims are false; just by being made, they cast doubt on whether we are what we say we are" (p.158). What does matter is how and by whom the claims are made. Prominent psychiatric professionals exercising power through discourse are more likely to have their truths widely accepted and circulated than people exercising resistance to them. Andre in particular focuses on how when the accepted truth is that ECT is safe, "all opposition to it is irrational" (Andre 2007, p.229).

A narrative that emerged from accounts written by professionals was one that positioned former patients (mostly women like Andre and Rice) who spoke back about their experience as people who remained ill and in need of further intervention and psychiatric treatment (Fink 2007), despite their resistance to further professional interventions. Andre herself has analysed a journalistic description of her (Smith 2001 in Andre 2009, p.229), and demonstrates that Fink framed her as “dangerously crazy” and “disruptive as well as dangerous” (Andre, p.229).

Another common pattern was that ECT is not suited for “neurotic” patients, who “by nature of their disorder, are prone to seeing a temporary memory impairment as a permanent and devastating loss” (Shorter & Healy 2007, p.113). Looking back further, I found that in Fink’s 1979 text, he also excludes patients with the diagnosis of hysteria from being suited for ECT (Fink, 1979, p.218). Neither hysteria nor neuroses are official psychiatric diagnostic categories anymore, but both terms refer to complaints that are unexplained by physical causes that have not been classified as other mental illnesses. This conveniently opens the door to re-frame patients who do report memory loss after shock as suffering from a disorder that does not respond well to ECT, suggesting that wrong decisions were made during the treatment process. Fink does this when he says that patients who complain show evidence of a somatoform disorder (2007), a category which both of these older diagnoses would fit into.<sup>17</sup> This re-

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<sup>17</sup> The abstract of Fink’s (2007) article, “Complaints of Loss of personal memories after electroconvulsive therapy: Evidence of a somatoform disorder?” says Fink “considers the rare complaints of the loss of personal memories after successful courses of electroconvulsive therapy (ECT), which are best characterized as somatoform disorders, rather than as evidence of brain damage, thus warranting psychological treatment for such disorders” (p.290). Using Anne Donahue and Marilyn Rice as his two examples, Fink compares their complaints of memory loss after “successful” ECT to the 1988 “Camelford incident” where residents of a town became sick after hearing that their water had been contaminated with aluminum (p.291). Investigations found that aluminum levels were not toxic, and the media framed the reaction as hysteria. Fink argues that people from Camelford got sick because they associated physical symptoms with exposure to contaminated water, in the same way ECT patients experience memory loss since it is associated with ECT (p.292). He does not think that memory loss should be treated as a “direct

classification appears gender neutral, while past versions of somatoform disorders (hysteria and neurosis) have been widely associated with women and femininity. Fink's dismissal of women who report problems after ECT looks similar to dismissals of the voices of feminist activists.

Even though he rarely comments on the gendered nature of ECT, Fink offers this statement about the people most likely to speak out after negative experiences with shock:

The demographic features of the complainants are interesting. In the published reports and malpractice actions, the plaintiffs are well-educated women, often nurses, with histories of prolonged depressive illness marked by somatic features and suicidal episodes. ECT was the last resort, reluctantly advised and administered, that resulted in relief of depression, physical complaints, and suicide risk. The loss of personal memories is a new focus of illness that is described in painful terms, making return to work impossible. Remarkably, however, the plaintiffs function extremely well in new roles as critics of psychiatry.

(2007, p.293).<sup>18</sup>

Additionally, Fink uses stereotypes associated with femininity to denigrate Andre's *Doctors of Deception*, reducing it to "emotion-laden accusations and name-calling" (Fink & Kellner 2010).

Fink's construction of the "still mad" patient is very similar to Bankey's (2001) description of the "hysterical body", which "has become emblematic of all the traditionally negative characteristics considered to be feminine: duplicity, theatricality, suggestibility, instability, weakness, passivity and excessive emotionality" (p. 40). Fink suggests that these women exaggerate, are too emotional about the loss of particular memories, and are quick to blame others for personal weaknesses.

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consequence of ECT" (p.293). Instead, he suggests it would be better to view complaints as a psychiatric disorder in need of treatment (p.293).

<sup>18</sup> In this article, Fink uses examples of women only to illustrate the "rare" complainant with a potential somatoform disorder, but still fails to mention the gender differential of those treated with ECT.

In contrast with Fink's framing of women like Rice, Donahue, and Andre, Shorter and Healy (2007) re-frame Leonard Frank's negative experience as the outcome of a misdiagnosis of schizophrenia (p.187). Although Frank resists shock therapy like other former patients grouped together by Fink, he is not categorized as having a continuing mental illness in the same way women who resist are. In fact, Shorter and Healy write "the records and Frank's subsequent life suggested that he had had little more than a spell of injudicious usage of marijuana" (p.187). Fink blames the women's ongoing illness, which resides in them, while the blame for Frank's dissatisfaction with his treatment is placed on external factors—other doctors' mistakes in diagnosing and treating Frank.

Fink calls out CTIP, started by seventeen women, as a "vocal antipsychiatry group that still seeks public attention" (Fink 1999a, p.99). Once this hysterical, irrational group is discursively produced, actions of former patients can be attributed to that identity. Former patients may display emotions in their rejection of this identity in their writing and actions, especially in the face of their self-defined truths and identities being dismissed, which professionals can use to reinforce expert-defined truths about their identities. Professionals only want to discuss the aspects of these people that they can make fit with the hysterical subject.

Professionals do not only go back and re-construct meanings about former patients; they also construct a scenario that problematizes informed consent and frames possible reactions by future shock patients in a particular way.

### *Power of suggestion*

*What could account for the rising frenzy about memory loss in the absence of any evidence of actual long-term impairment? In dealing with a culture that lives on a diet of media-induced sensation, one can never discount the impact of suggestion:*

*people believe that something will happen to them because the notion has been implanted in them by suggestion. One sees this in the epidemic spread of such illness attributions as “chronic fatigue syndrome”. Could “memory loss” be a similar phenomenon? If earnest psychologists suggest that you, as a patient, will lose large tracts of memory, post-ECT you might well be alarmed to discover that you cannot recall, in fact, what happened to you in 1985*

(Shorter & Healy 2007, p.244).

Showalter’s research emphasizes the role that the “power of suggestion” plays in recent forms of hysteria. The power of suggestion has also become a threat to informed consent in professionals’ accounts of shock, as they wonder how they should tell the patients about risks associated with ECT, in case they will choose not to have it (Ottoson & Fink 2004, p.35), but also because they argue that telling patients about the risk of memory loss could become a self-fulfilling prophecy (Fink 2007; Shorter & Healy 2007, p.244).

Contrary to Fink’s assertion that former patients benefit from the antipsychiatry movement, if the hysterical narrative works as well as it appears to, considering these voices are marginalized in popular images of shock therapy, these people are putting themselves in danger. They are easily positioned as sick former (women) patients who are suffering and need further treatment. Applying Ottoson and Fink’s *Ethics in Electroconvulsive Therapy* (2004), these women could be treated involuntarily.

In the next chapter, I discuss the construction of (gendered) active citizens in patients’ first-hand accounts of shock therapy, highlighting how this identity contrasts with the “still mad” identity from professionals’ accounts of critical former patients, and how it connects to broader power relations and practices of governance.



### **Chapter 3: Governing through mental health**

Reading an array of accounts of electroconvulsive therapy has made me recognize the wide range of experiences and multiple truths. At the same time, however, my close and careful study of ECT literature has revealed how professionals reduce these experiences to two main groups: the extreme former “still mad” patients that I described in chapter two, and the former patients whom professionals name as accurate representations of shock. Though professionals allow space for brief excerpts of these more positive experiences in their own (professionals’) accounts (Fink 1999a, p.9; 2009a, p.23; Shorter & Healy 2007, pp.103, 146), they rely more heavily on other psychiatrists’ knowledge, and they do not explore the experiences that they do include in detail, choosing to leave out the negative aspects. Fink (2001) calls these patients’ accounts “more accurate pictures of the impact of ECT than the frenzied rhetoric of the antipsychiatry movement” (p. 6, note 31),<sup>19</sup> but reading the accounts Fink refers to shows that their experiences have many similarities to the more critical former patients who Fink attempts to discredit. For example, Fink and Shorter and Healy use excerpts from Martha Manning to illustrate the ECT procedure (Shorter & Healy 2007, p.218; Fink 1999a, p.9; 2009a, p.23) and stigma around ECT (Shorter & Healy 2007, pp.146-7), calling her treatment successful, but they leave out her criticisms of in-hospital treatment as infantilizing (Manning 1994, p.118), and her characterization of the mental health professions as “benign tyranny”, which is “no less oppressive than malevolent tyranny” (p.134). Fink excerpts Endler (1982), but omits that

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<sup>19</sup> In this particular article, Fink includes accounts by A Practicing Psychiatrist (1965), Endler (1982), Manning (1994) and Donahue (2000). This is interesting because Donahue describes extensive, ongoing problems with memory, which Fink regularly refutes. However, Donahue does not call for an end to ECT, but for more responsibility on the part of the doctors prescribing, and the person choosing shock. She thinks her experience was the result of poor administration practices and a lack of information about side effects and aftercare, not ECT itself.

although Endler called ECT “a miracle” (p.83) for lifting his first depression, he relapsed and did not see improvement the second time he had ECT (pp.105, 154).

Professionals present these patients as being “on their side” in the polarized struggles over whether electroconvulsive therapy is a legitimate treatment option. At the same time, professionals do not create as full of a description of these identities as they do with former patients who disagree with them outright. Rather, the professionals incorporate partial truths into their accounts in order to position these patients as advocates of ECT and rational people who are capable of constructing their own identities. To learn about the identities of these patients, we must look to their accounts, where they construct identities that contrast starkly with that of the “still mad” patient. Also, in contrast with the “still mad” identity thrust upon them in doctors’ accounts, I found that former patients claiming negative experiences work to construct identities similar to people who have had positive experiences, presenting themselves as patients who tried to be informed and engaged in their treatment, and actively struggled to maintain control over their experiences within the mental health system.<sup>20</sup> One main difference between these (constructed) groups is that the more critical patients have problems remembering their former selves, and these texts about their experiences with shock are a means to constructing new ones. I began my research expecting to find a variety of conflicting identities, and while I did encounter very different stories, personalities, and reactions to their experiences with electroshock, I also found evidence of a common goal in first-hand accounts: all of the patients construct themselves as active citizens.

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<sup>20</sup>People are able to have control over their treatment to varying degrees. Frank was an involuntary patient with extensive memory loss, and what he knows about his treatment comes from psychiatric records. Gotkin and Funk report experiences that go back and forth between consensual and coercive treatment, but they describe making conscious decisions that maximized their agency in spite of constraints.

The power relations involved in all of the texts I studied produce particular ways of knowing about shock and shock patients, but they also produce (simultaneously) subjects and agents of governance. Liberalism is bound together by taken-for-granted values like liberty, freedom, and autonomy, and the understanding that liberal citizens have rights and responsibilities in relation to the state (Cruikshank 1999), but governing power also extends beyond the state into our everyday lives, to produce particular subjects of governance (Cruikshank 1999; Foucault 1991a, pp.102-3; Miller & Rose 2008a&b; Rose 2000). An active citizen is one who embodies liberal values, exercises rights, and fulfills responsibilities. As active citizens, we have numerous responsibilities in relation to our mental health. As neoliberal re-structuring has made for increasingly privatized mental health care and more strategies of responsabilization, the need for citizens, with the help of experts, to take responsibility for people and problems that have previously been understood as societal issues-- such as the care of the severely mentally ill--has increased (Rose 2000, p.324). Throughout first-hand accounts of shock, former patients construct themselves as knowledgeable about what they perceive as their illness (or lack of it), responsible for personal failings and reflective about interpersonal situations that contribute to the deterioration of their mental health, and willing to ask for professional help and do the work necessary to get better.

Throughout this chapter I explore how former shock patients construct themselves as active citizens in an attempt to show that the boundaries between the groups of people with positive and negative outcomes blur, in spite of professional attempts to polarize the rational patient with a positive outcome and the “still mad” patient. Themes emerge from the texts I studied which suggest that there are specific responsibilities and expectations of being an active citizen-patient that all of the former patients attempt to embody. These themes include acknowledging

their mental health problems, building a doctor-patient relationship, navigating the problem of choice, and risk management. I also discuss how limitations to freedom and choice within the mental health system become obstacles to active citizenship, and how factors like gender and financial resources can make a difference in exercising power through active citizenship. These power differentials are obscured in professionals' accounts. My focus in this chapter is on patients' accounts, and what themes that are prevalent across stories from multiple perspectives can tell us about power relations and practices of governance.

### **Active citizenship**

Barbara Cruikshank (1999) argues that being a citizen and a subject are not mutually exclusive in liberal governmentality (p.23), explaining that democratic governing power can be both voluntary and coercive (pp.3, 32). Davies and Gannon (2006), drawing from Judith Butler's work on subjection, talk about the "paradoxical simultaneity of submission and mastery" (p.17). Texts written by former psychiatric patients demonstrate how they encounter treatment that is both voluntary and coercive in an attempt to "recover" their former status as functioning active citizens. To do this, they "subject" to expert knowledges and psychiatric authority as well as become masters of their own mental health wellness. People who experience shock as positive find that shock helps them recover their status as a free, and active, liberal citizen. Unfortunately for others, shock therapy impedes these processes. Being subjected to shock involuntarily produces a temporary relationship of domination between patient and doctor where the patient is no longer able to exercise power as an active citizen. In cases where ECT is voluntary but memory loss occurs, recovery of a patient's former status is disrupted, and resistance to this disruption can be a way to reclaim the capacity to exercise power.

Cruikshank (1999) explores strategies for transforming subjects into the active citizens necessary for liberal governmentality (p.25). In the preceding chapter, I discussed how professionals create a specific “still mad” subject that can be discredited and found in need of further governance. Here, I explore how people in the accounts I have studied, including “still mad” former patients, construct themselves and others as active citizens. In doing so, they willingly master and submit to self-governance, which is necessary for liberal democratic governance. This suggests that the mental health system offers a space for practices of governance (Rose 2000, p.323) and strategies for transforming patients into subjects of governance.

Nikolas Rose’s work on governmentality has explored issues like self-governance, responsabilization, and risk prevention in relation to liberalism (Miller & Rose 2008a&b; Rose 2005; 2001; 2000), and how these are connected to psychiatry and mental illness (Rose 2010; 2005) but he tends to leave out an analysis of relations of gender. I demonstrate how expectations about femininity and masculinity shape people’s experiences of mental illness and treatment, and how active citizens are gendered.

*Recognition of symptoms – acknowledgement of illness, getting help, and working towards wellness*

The first responsibility of the active citizen is recognizing that they need professional help for mental health and emotional issues. With the exception of Frank (1979, p.ix) and Andre (2009), who characterizes her treatment as her “one involuntary encounter with psychiatry” (p.3),<sup>21</sup> each of former patients in my sample considered themselves to be voluntary patients in the mental health system. This means they recognized their need for professional help in managing

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<sup>21</sup> Andre had originally been (voluntarily) involved with a type of “proactive psychotherapy” that she says “backfired” (p.2) and began her engagement with the psychiatric system.

their own mental health. Their reflections on how they came to accept this need and seek treatment involve distinct individual, personal experiences, but also reveal striking similarities. Notably, their experiences of symptoms are often connected to their perceived insufficient performances of masculinity and femininity and are connected to dominant understandings about gender and active citizenship. Signs of wellness in their texts are also shaped by these understandings.

For instance, at the beginning of her account, Kitty Dukakis characterizes herself as “involved” mother, daughter and wife; someone who “tr[ies] to help people who have problems” (Dukakis & Tye 2006, p.1) and who stays connected to the world by reading “two newspapers everyday” (p.1), perhaps a necessary activity for a politician’s wife. When she becomes uninterested, sleeps more, and drinks alcohol excessively (p.2), (Kitty refers to herself as an alcoholic and a “drug-addicted mother” [p.76]) it is a sign for her that her mental health is deteriorating. Her symptoms “range from an inability to sleep and a loss of libido to ‘empty nest issues’” (p.45). She links her alcoholism to her “fixation with food” (p.33) that started with her mother’s focus on weight and caused her addiction to diet pills (p.33) after she used them to lose weight for her first wedding (p.34). Fitting into a specific image of the female body, and later the role of mother and wife, became a necessary part of her work as a woman. Instead of criticizing the role that cultural understandings of femininity play in relation to her mental health, Kitty blames her own mother, saying she could never win her approval (p.45), individualizing the cause of women’s negative body image. She takes responsibility for the distress she has endured: “I also know now that while Mother had a profound effect on me, my depression along with my addictions are my responsibility—and the only way I am going to overcome them is by taking charge rather than assigning blame” (p.47). Through her writing, Kitty shows that she understands that her

wellbeing, and everyone's, is an individual responsibility, without acknowledging the expectations of women as carers partially responsible for others' mental health. She later argues that knowing when she needs to have ECT is her means of taking charge of her own life (p.120). It becomes her job to recognize the signs of deterioration of functioning in her multiple roles, and to avoid being unable to fulfill her obligations by having shock therapy.

In her position as a well-known politician's wife, she repeatedly states her concern that her mental illness will affect her husband's political career (p.75) or will embarrass him and her children (pp. 39, 80) or herself (pp.41, 125). In order to perform her duties, she is expected to be composed and present herself in a certain way at all times. Kitty's struggles with her weight, appearance and the expectations about her roles as a good woman, wife and mother that are also influenced by her social status, shape her justifications for engaging with mental health services. Instead of resisting or subverting the roles that cause her stress, she looks for treatments that allow her to work through problems that she sees as obstacles to fulfilling them.

Responsibilization discourse and language of the gendered active citizen is most obvious in Kitty's account. She speaks very specifically about utilizing expertise in order to manage her illness and take control. Roger, her therapist, helped her "recognize my manic spending sprees, slog through worrisome drops in libido, and jump back on the wagon each time I had a drinking binge, which was far too often. Therapy did me a lot of good, but it was not enough" (p.85). Among other physical side effects, medications made sex more difficult, so giving up drugs after ECT "made a huge difference to me and my loving husband" (p.121). Further, she is pleased with how ECT "has given [her] a sense of control, of hope" (p.120). Moreover, "it makes [her] feel like [she is] taking concrete, constructive action, which in itself is positive. I feel in control, hopeful"

(p. 191). She argues that ECT works quickly (pp.120-1), allowing her to get back to work on her self: "ECT unfogs your head enough to face issues more honestly" (p.122). The issues that she discusses working on include smoking, "trying to stop or at least streamline my impulsive shopping and to curb my compulsion for candy and other sweets. I am even addressing what my kids call my sense of entitlement" (p.122). Kitty's "bad habits" (p.122) are associated with femininity, and in her account she attempts to show herself exercising control over these aspects of herself.

In her discussion of her improvements, Kitty includes information about her relationships with others. Often overlooked is that women are largely responsible for the "maintenance of interpersonal and social relationships" (Swenson 2010, p.134). Kitty's daughter describes her as the "glue" of the family (p.76). It is not surprising, then, that what her family thinks of the treatments is important to Kitty. Her father told her husband that after ECT, "[t]he other Kitty is back. The good Kitty" (p.122). Her husband calls ECT "our miracle" (p.123). Her kids were skeptical, but are pleased with how ECT has worked (pp.122-3). Finally, it helps her be a good grandmother (p.125). Since Kitty understands her mental illness as detrimental to her multiple roles of wife, daughter and mother (p.2), her family's reinforcement that ECT works validates her treatment choice.

Kitty acknowledges that shock costs her memories, including a trip to Paris that she forgets entirely (p.156) and means that she needs extra care after her outpatient treatments (p.160), but "the control that ECT gives me over my disabling depression is worth this relatively minor cost" (p.163). In fact, her memory loss becomes another thing that she is responsible for. Her "memory issues are real but manageable" (p.157), and include forgetting people's names, phone



numbers, how to get places, and commitments she has made “to help people” (p.157). For her, these are manageable obstacles and she is helped and forgiven, but for others in different economic situations, the same obstacles could affect employment and other aspects of life, making them insurmountable.

Kitty contends that she believes people who say they have had long-term memory loss (p.156), but since it did not happen to her, she offers her story as an alternative to ECT critics. She notes that critics “have strong opinions and voice them everywhere” (p.192) but even so she states that she does not care about her memory loss, or even about the idea of brain damage (p.191); she wants people to know that ECT did work for her. While Kitty says she believes critics about memory loss, it does not mean she has a positive opinion of them. She writes that “I fully expect to be attacked” (p.193) for offering her account. Her expectation that she will be attacked suggests that she understands critics the way professionals present them—as emotional extremists. She does not consider that her account of memory loss is similar to some critics’ but that her relative class privilege may make her memory loss more easily manageable.

One side effect of shock that does concern Kitty is her “free-spending ways” (p.125) after shock, which she finds embarrassing and associates with either an ECT-induced mania or her bipolar disorder itself (p.125). Earlier in her account, Kitty reflects that one of the main traits that distinguishes her from her husband is his frugality compared to her more extravagant tastes in food, clothes and transportation (p.73). This raises the question of boundaries of proper femininity for women with a higher income level. Delhaye (2006) argues how “consumption culture” has historically “contributed to the individualization of the female identity” (p.88), or made it possible for women (with the financial means) to become individuals with freedom to

act and choose even when they did not have the same opportunities for these freedoms as men. Constructing women as autonomous consumers has been a part of processes of individualization that make the self-governing, gendered individual possible (Delhaye 2006, p.102). Kitty's perception that she overspends—but that this may be tied to her mental illness or treatment—allows her the opportunity to recognize her symptoms, take responsibility and exercise self-control. She is working on “staying away from stores, at least in the aftermath of my treatment” (Dukakis & Tye 2006, p.125).

Martha Manning (1994) struggles with the expectations she faces as a professional, upper-middle class woman. She begins her account by describing

a woman who has it all together. She processes things completely the first time they cross her desk. She is up-to-date with bills, pap smears, and teeth cleanings. She knows that her children's drawers are filled with clean, folded clothes. She knows what her family will be having for dinner three days in advance. She is complete

(p.3).

She expands on this:

I want to be domestic. I want to be one of those women who, after working long days, come home and fix nutritious, interesting meals for their families. I want to have bathrooms that are clean enough so that when people drop by unexpectedly, I don't have to worry that they might have to pee... I want to make a pie crust that doesn't stick to the counter. But I just don't seem able to pull it off. And things are getting worse.

(p.6).

These excerpts show that Martha's desire to fulfill the conflicting and heavy labour demands involved in women's active citizenship are tied to her experiences of mental illness. These demands include her employment as a clinical psychologist, volunteer work as a Sunday school teacher, work on her appearance, domestic and caring labour, as well as maintaining familial

and social relationships. She also sees herself as responsible for others' viewing her as successfully mastering these demands. She expresses anxieties about what others think about her appearance, her weight, age, the messiness of her house, as well as her ability to parent.

Throughout the book, Martha demonstrates a fixation on her own appearance (pp.12,15,29,30) and she polices how other women do gender by offering critical commentary on their appearances (pp.51, 71) and actions. For example, when she sees a woman at a diner singing along to the jukebox, she "give[s] Brian [her husband] permission to shoot me if I ever go that far off the deep end" (p.14). Martha acknowledges that the countless responsibilities expected of her as a woman are overwhelming, but instead of giving up attempting to fulfill them, or trying to change them, she takes responsibility for improving herself through mental health treatment so she can function in her multiple roles. By doing so, she reinforces that difficulties meeting expectations of femininity are problems for individual women to work on rather than problems with dominant understandings of femininity. Women are expected to change their attitudes and improve themselves and not subvert these expectations.

Shock, coupled with her class privilege, allows Martha an excuse to take a month off of work to recover (p.113). Unfortunately for Martha and women in similar situations, a mental health crisis is sometimes the only break available from women's work. Women without similar class privilege do not have the same opportunities for a lengthy break from this work, and may be pressured to choose from a more limited range of therapeutic options. Professionals' insistence on the speed and efficiency of shock therapy could make this appear to be the most suitable option, especially for those without access to private mental health care, even though first-hand

accounts of ECT show that resources stemming from class privilege make the side effects of ECT easier to navigate.

Understandings of masculinity influence when the men in these texts seek professional help. For Sherwin Nuland (2004), fears about his masculinity surfaced when he was a young teen and began obsessing over his too-high sex drive and fears he would turn into a “sex fiend” or a rapist (Nuland 2004, p.128). Later, after becoming aware of homosexuality, he began questioning his sexuality “despite feeling no attraction towards men” (p.131), and thinking of himself “as a coward and a fairy” (p.132). Sherwin worried about his lack of ability to fight other young men (p.132). He explains: “The obsessive preoccupation with all of this led rapidly to a kind of constant introverted sadness... [A]ll I could think about was the specter of cowardice and homosexuality” (p.134). He first went to see a psychiatrist years before his ECT, saying he was “obsessed with the entire spectrum of maleness and power” (p.132), in order to deal with “my fears of homosexuality or unmanliness” (p.134).

These crises of masculinity recurred throughout Sherwin’s life, and when they surfaced, to him it meant that he needed help. In the second occurrence of this, he believed his unmanliness meant that he was not worthy of becoming a doctor (p.173). Hospitalization years later resulted from different obsessions and irrational thinking that included “feelings of worthlessness and physical and sexual inadequacy” (p. 4). It eventually ended after twenty rounds of ECT, and he describes his improvement process as being linked to memory loss and how this allowed him to become determined to work on himself:

In the beginning only a bit but after a while more palpably, the depression began to lighten and the obsessions became less insistent. As inexplicable as it seems, I sometimes forgot to think about them entirely... The act of will that had seemed impossible of fulfillment now came within reach, and finally in a single surge of

determination, I made it happen.... It was as though the electroshock had burned away a tightly coiled network intertwined in my brain, constricting free will. And it had also incinerated so much of my recent memory that most of the relatively new reminders to think dangerous thoughts went with it

(pp.7-8).

Sherwin's account of memory loss is more like accounts of critics of shock and older theories about why shock works (through memory loss) than more recent professional accounts, but this is not mentioned when his story is used as a positive example. Sherwin himself, however, describes how shock (and his individual will and determination) allowed him to come to a place where he could begin to improve himself. Sherwin's experience is unique in that one of his doctors prescribed shock as an alternative to proposed lobotomy that other professionals had recommended (p.4).

Similarly, one of the first signs of Norman Endler's illness was when "my sex drive failed me—for the first time since puberty" (1982, p.5). He took the return of his sex drive after ECT as a sign of his improvement (p.83).

Norman reports a post-ECT "hypomania", which he calls a "subdued" form of mania, where there is "no loss of touch with reality" (p.13). His hypomania includes feeling really good (p.83), talking too much, and a sex life that was "better than ever before" (p.84). After ECT, he "was aggressive, talked incessantly, and interrupted others... I was having a good time, I was narcissistically preoccupied with myself" (p. 86). There is a parallel between Norman's hypermasculine hypomania and Kitty's post-ECT mania-induced shopping that can be interpreted as hyperfeminine. Interestingly, the professional accounts I read do not suggest the possibility of hypomania or mania as a side effect of ECT (though Kitty's doctor did warn her about that it was a possible effect [p.125]). Perhaps this is at least in part due to the

understanding that depression, “culturally constructed as a female malady” (Swenson 2010, p.134) is associated with lethargy and a lack of productivity (Ibid) that must be treated, whereas a lack of productivity is not considered a symptom of mania.

Sherwin’s and Norman’s stories show that like women, men also engage with mental health professionals to deal with what they see as faltering gender (and sexual) performances. Again, problems with dominant understandings of how to “do” gender and sexuality are reduced to individual problems managed through work on the self, including changes in attitudes towards the performance of gendered expectations.

Words that the authors associated with their illness were often gendered. Norman and Sherwin repeatedly reflect on whether others will see them as “competent”, and they worry about their sexual and professional “inadequacy”. In contrast, “embarrassment” recurs throughout Martha’s and Kitty’s accounts. These women’s feelings of embarrassment stem from their anxieties concerning whether they are able to do what is expected of them. In other words, they are embarrassed by what they see as their incompetence performing women’s work.

#### *Building relationships with mental health professionals*

Building a relationship of trust with a doctor does not appear at first to have anything to do with active citizenship, but it is part of the active citizen-patient’s work to build and negotiate this relationship. I found that in first-hand accounts of ECT, relationships with doctors that were described in positive terms correlated with more positive outcomes post-ECT. Engagement with expertise and submission to the authority of a trusted doctor are aspects of self-governance here. Health, and mental health, professionals give us advice and prescribe medications that we are expected to comply with. A psychiatric patient who is non-compliant may be considered a

threat, or a risk that must be managed through medications and other psychiatric interventions like involuntary treatment, and even the legal system (Rose 2005). Therefore, a patient with a trust relationship with their doctor who willingly complies is known as responsibly self-governing, and needing less outside intervention (in other words, a more successful active citizen).

According to Kitty Dukakis and Anne Donahue, it is part of the patient's responsibility to find a doctor they trust to administer ECT. These authors do not consider that having a choice among multiple doctors is not realistic for all people. Regardless of their range of options when it comes to acquiring a relationship with a mental health professional, a patient's experience of shock and its consequences may be affected by this relationship.

Fink (1979) has long acknowledged that "trust between doctor and patient is integral to the optimal application of consent procedures" (p.219), and it is clear that the necessity of a doctor-patient relationship also governs psychiatrists' actions. Doctors must expect and encourage patients to be active in their treatment, and they employ strategies to gain and maintain their patients' trust. A theme that emerged from accounts identified as positive shows that doctors work to maintain patients' trust through status recognition.

Even though she is resistant to medication at first because of her training as a psychologist, Martha takes an old therapist's advice and sees a psychopharmacologist, Dr. Bigelow. Her relationship with him helps her to continue to view herself as an active citizen, and she characterizes this to be as important to her health as the pills he gives her. Martha describes how he reinforces her view of herself as active and professional during her meetings with him:

When this fellow professional who knows every lousy detail about me shifts for a few minutes to treating me like a respected colleague rather than a depressed patient, he forces me to make that shift as well. He challenges me, in those brief interactions, to acknowledge those aspects of myself that continue to function, despite this nightmare.

(Manning 1994, p.74).

Norman (1982) shares Martha's need for status recognition, and his psychiatrist, Dr. Persad, respects this. What Norman remembers about their first meeting is that

[Dr. Persad] treated me with sympathy, dignity, and respect—as if I counted, as if I were important even though I didn't feel important. I was pleased that he called me doctor... I felt that I was being treated as an equal by Dr. Persad rather than in a one-down position. This boosted my self-esteem and self-respect"

(p.24).

Dr. Persad's recognition of Norman's professional status as worthy of respect despite the fact that he was seeking psychiatric treatment laid the foundation for a strong relationship, one where Norman "trusted him completely. Trust between a therapist and patient is one of the basic ingredients of an effective therapeutic relationship. It is also a two-way street" (p.25).

Recognition of professional status acknowledges and appreciates that patients' identities are made up of more than a psychiatric diagnosis, and that other aspects of their identities should be respected and maintained throughout the treatment process. This recognition helps establish trust. An effect of this aspect of the doctor/patient relationship is that such an acknowledgment suggests the doctor will not advise treatment options that will negatively impact this status. Patients lacking a professional status or class privilege may not receive the same kind of recognition of aspects of their identity unrelated to their illness, which could affect the development of an understanding of mutual respect and trust.



Professional status was not the only type of status that mattered to these patients. Martha (1994) realizes that her therapists can help her when they recognize her as a strong, determined woman who is suffering from a biological illness (p.70). Only after her doctor helps her understand that her illness is out of her control is Martha able to diagnose herself as being in the midst of a “major depressive episode” (p.72). Here she relinquishes control about the way she is feeling but takes control in relation to her diagnosis. Acceptance of her mental illness means she can now work towards getting better with the help of trusted professionals.

Two different therapists that Martha works with understand her need for recognition of her strength. The first tells her that she “ha[s] a high tolerance for pain and a lot of determination” (p.58). As her next therapist, Kay, suggests ECT might be an option, Kay explains “If it was just a matter of personal strength and determination, you’d be fine. But it’s not. You have to think of this as a serious illness. One that is potentially life-threatening” (p.102). By including these characterizations of her by doctors in her account, Martha simultaneously shows how important it is for her to be seen as determined and hard-working, and reinforces herself as an active citizen by using experts’ authority to support this view of herself. In both cases, the mental health professionals working with Martha reinforce her sense of being a strong person who is able to work through pain, important for a woman navigating multiple personal and professional roles. Because it is essential to her that she perform these roles despite her experiences of her despair, her doctors’ acknowledgement of her successful performance of active citizenship allows Martha to trust their recommendations. This contrasts with professionals’ depiction of critical former patients as unable to know and control their own identities.

Martha's visit to a different doctor when she is experiencing side effects from her pills illustrates how her privileged position allows her to reject professionals when they do not successfully recognize her status as an active citizen and ability to define her self. This doctor tells her that her side effects are likely hysterical symptoms (p.63). Martha is embarrassed and is supported by her therapist, who tells her that the doctor is an "idiot" (p.64), thereby validating Martha's understanding of her symptoms and solidifying their trust relationship while demonstrating the inconsistencies and variations on the construction of the hysterical woman between expert discourses. Martha shows that she can critically evaluate her doctors and be in charge of her treatment when she cancels further appointments with the doctor who labelled her hysterical after the conversation with her therapist.

Kitty reports one of the strongest connections with her ECT doctor, referring to him by his first name, Charlie, and calling him a "very gentle soul" (Dukakis & Tye 2006, p.4). Charlie called her the "perfect patient for ECT", and informed her "that it had an 80 percent success rate, but also would probably cause memory loss. We loved those odds, and liked his honesty about possible side effects" (p.5)<sup>22</sup>. Dukakis had been introduced to the idea of ECT five years before she chose to have it (p.2). She also worked closely with Roger, a talk therapist, for years prior to ECT (p.85). In comparison with most other patients' relationship with their doctors, Kitty had more time to develop a rapport with the doctors involved in her mental health care before she had ECT because she had the financial resources and the time to work with doctors longer-term and try a wide variety of treatments.

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<sup>22</sup> On multiple occasions, Kitty characterized her illness as something that both she and her husband were suffering from. Her choice of treatments and her reactions to them were in agreement with what her husband also felt was right for her, suggesting that she chose treatments based on what she felt was best for her husband.

Kitty says she does not know or care how ECT works (p.190). Her trust in her doctor is enough.

Her view on brain damage is unique:

I don't feel like my brain is damaged. I'm also not sure what damage means. I presume electroconvulsion is changing something in my head. If someone wants to label that damage, so be it. I prefer to trust Charlie and my other doctors, who say there's no evidence of long-term harm and compelling evidence that sending electricity into the brain does something to straighten out its circuitry.

(p. 191)

This statement demonstrates how a high level of trust in expertise can nullify competing truths about ECT. Kitty writes that she does not care how ECT works, but her husband, who is a "problem solver and lateral thinker. He likes clear-cut, measurable answers" (p.190) theorizes that it "works the same as alcohol, jolting me out of my blues" (p.191). Kitty leaves the theorizing to her husband and experts, saying that "we" (her and other people "who have sunk as deep as I had" [p.190]), are not bothered by why it works, just know that it does. These statements reinforce divides between appreciative patients and ECT critics, uphold the traditional constructed dichotomy of irrational, emotional femininity vs. rational masculinity, and reconstruct the image of a passive female patient submitting to the authority of active male experts. This illustrates the complications involved in practicing active citizenship for women patients. Kitty's understanding of active citizenship does not include building her own knowledge about shock, but about her ability to function in her multiple roles through the acceptance of experts' guidance.

Wendy Funk writes that she originally went to the doctor for a sore throat, and felt disrespected (Funk 1998, p.13) when Dr. King questioned her about her relationship with her husband (p.14) and whether she was working too hard at her job as a social worker (p.15). He did not appreciate

her professional status and suggested that she “slow down and spend more time at home” (p.15). Wendy calls Dr. King a “wannabe therapist” (p.15) who was concerned that her husband could not control her and that she did not spend enough time doing traditional women’s work (p.15). Dr. King prescribed her antidepressants instead of antibiotics (p.16), thinking that her physical symptoms would be relieved (p.17). The assumption that her physical symptoms were based on emotional imbalance is a sign that her doctor thought she was hysterical. Wendy reports Dr. King comforting her through inappropriate physical touch (pp.33, 39, 49).

Though originally Wendy did not agree with Dr. King’s diagnosis, a few days later she was convinced she was depressed and returned to Dr. King (p.19), who coerced her into being admitted into the psychiatric ward under in order to get better (pp.20-1). Despite her original tentative acceptance of in-hospital treatment, Wendy became increasingly distrustful of Dr. King. At first, she threatened him with legal action for his “lack of competency—having me locked up on a psych ward for a sore throat” (p.28), but then she realized that in order to be released “I would have to rethink my attitude” (p.28). She recognized the power imbalance; according to Wendy, under Dr. King’s care, she was trapped like she was in her first marriage, where her husband had abused her (p.29).

Wendy learned how to “suck up to the captor” (p.33) and comply with the rules of the hospital (p.39) to avoid more intensive institutionalization that she was threatened with (p.29). However, this meant she relinquished her control over most of her treatment decisions, and her consent to have ECT was acquired under circumstances different from those of Kitty, Martha, or Norman, who had an opportunity to try many different treatment options, and consider ECT extensively, before choosing shock. Wendy’s lack of trust in her doctor made it impossible for her to work

with him to better herself, and she instead focused on procuring small freedoms like the occasional visit home. She struggled to accept her diagnosis, and then was not able to successfully build a relationship with her doctor. The effects of these unfulfilled duties included reduced decision-making, and coercive and involuntary treatment. Even though her doctor's actions were unacceptable to her, his presumed expertise allowed him to exercise power through treatment to transform Wendy into a governable patient with little room for resistance. Wendy's account shows how the unregulated exercise of psychiatric power without trust contributes to a negative outcome. However, a gendered active citizen is still produced as Wendy described how psychiatry "cleared my brain of its contents, and then programmed it with the desired messages. In my case, it meant teaching me how to be a proper woman. One who was a good wife" (p.151). Her resistance is channelled into her book, which individualizes problems with power dynamics that constitute the mental health system by making it appear that her doctor specifically was the problem.

Janet Gotkin (1992), like Wendy, learned how to be a "model patient" (p.120) in order to get discharged from her numerous hospitalizations, but her relationship with her doctor was very different from Wendy's. Janet became dependent on Dr. Sternfeld, working with him on her illness multiple times a week and calling him the only person she trusted (p.132). To Janet, "he offered himself as Savior, Rock, Father, and Friend" (p.123), and the greatest threat for Janet was that he would stop treating her (pp.166, 175). This meant consenting to treatment that she did not think would help, knowing that voluntary treatment could become involuntary if she resisted (p.143). Janet writes about her distress stemming from her parents' too-high expectations (pp.27-8), and her struggle to be a good daughter and a "good Ellis girl" (p.60) at college. This need to please infiltrates her relationship with her doctor, suggesting that power

differentials linked with gender, age, and an association of proper femininity with submission, intersect to illustrate the potential complexities of the negotiation of trust in the doctor-patient relationship. Even though their relationships with their primary mental health professionals are very different, Wendy and Janet both write about how these relationships reduced their freedom to choose treatment, and found that actively learning how to become a particular subject of their doctor's orders maximized their agency in constrained situations.

Janet and Wendy both discuss how their doctor physically comforted them in ways they considered inappropriate, illustrating how doctors have the ability to take advantage of their female patients (no accounts from men spoke of being physically touched by mental health professionals). On the surface, these stories offer examples of bad doctors who need to be managed, but power differentials on an individual level connect to broader gender relations.

#### *Choice and informed consent*

An active citizen-patient who has accepted their illness, learned about their symptoms and built a relationship with their doctor is in a position to make choices about their treatment options and manage the negative effects of their treatment.

Former patients who write about the previously outlined obligations of recognition, acceptance and work on their illness and building a relationship with their primary mental health professional as partially or unfulfilled experienced more hospitalizations and inpatient ECT. They also were less likely to have the ability to make decisions about their treatment, and reported more negative outcomes. Deficiencies in active citizenship are associated with more interventions, reported coercion and limited freedom. People identified as severely mentally ill are treated as if they have not activated their rights properly. Insufficient fulfillment of an

individual's citizenship duties can result in further limits on their capacity to be in control of choices concerning their treatment, and in the case of hospital patients, about their daily lives, which are structured by routines and infantilizing group therapy (Manning 1994, pp.115-20). Martha (1994) expresses her frustration with a mental health system that she interprets as punishment for personal failures:

The concept of privileges on inpatient units has always irked me. Adults come onto a unit with a number of 'rights,' some of which must be curtailed for their own protection. However, I have often seen rights turned into privileges and conferred on people for compliance, rather than health. In the space of one hour, the right to set out walking whenever I please has become a privilege, something that must be bestowed upon me. How do I earn it? By behaving myself, spilling my guts, providing a shining example?

(p.115).

The hospital is a place where "freedom is a privilege" (Gotkin & Gotkin 1992, p.91). People must prove some level of taking responsibility for their wellness—complying with experts when they make treatment choices—in order to gain freedoms that we take for granted as active citizens who fulfill our obligations. If they (we) are unable or unwilling to comply, their (our) choices can be limited.

Most of the authors of these accounts never consider how different levels of resources may restrict the extent to which people can embody active citizenship in relation to their mental health treatment, and how this may influence a professional's choice to administer, or a patient's choice (or lack of choice) to receive shock. Norman is the only person who discusses how different economic situations may affect treatment. He acknowledges that income disparities shape treatment choices, saying "the lower class and middle class person cannot afford a long-term illness. I was able to enjoy the 'luxury' of being ill the whole summer of 1977 and did not suffer financially" (Endler 1982, p.150). He writes:

The lower and lower middle class person is strongly motivated to find the treatment that will work most rapidly and effectively and that will get him or her back to work as quickly as possible. The lower class person would be more likely to accept an inpatient course of ECT treatment, whereas most middle class and upper middle class persons would prefer ECT on an outpatient basis. The upper classes, especially the intellectuals, would also be more concerned about mental 'impairment'

(p.150)<sup>23</sup>.

Kitty has opportunities to try out different types of therapies, treatment centres and medications for addiction and mental illness (these are outlined in Dukakis & Tye chapter 5). Martha (1994) is also able to go on retreats for her anxiety (p.48), and work on her problems in therapy prior to choosing ECT (p.57).<sup>24</sup> Many average patients do not have the time or resources to exhaust numerous options before resorting to ECT, and insurers are more likely to cover the cost of ECT than psychotherapy (Cott 2005, p.6). Further, insurance companies may cover inpatient shock but not outpatient, reducing treatment choices for people depending on insurance plans (Manning 1994, p.110). People accessing publicly-funded treatments are likely to have their choices about where and when to get shock further reduced. As I have mentioned before, a "last resort" treatment means different things to people, and this meaning, along with the meaning of "choice" in relation to mental health treatment, is shaped by gender and class relations. Kitty and Martha both worked with numerous mental health professionals, understood shock as the last resort, and had doctors willing to work with them on other options previously. Linda Andre, Jonathan Cott, and Wendy, on the other hand, were hospitalized quickly and the exploration of alternatives was cut short.

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<sup>23</sup> Norman offers that a Dr. Leonard Cammer (a psychiatrist) found that lower- and lower middle class people seem to recover more quickly from depression than upper class people, but he does not explain further where his information about greater acceptance of ECT/ less concern for "mental impairment" in the "lower class" comes from.

<sup>24</sup> Despite resistance to the idea of having her ECT on an inpatient basis, after much reflection Martha did choose that option because her insurance only covered inpatient treatment and the out-of-pocket cost "staggered us" (p.111).



Kitty, Norman and Leon Rosenberg all chose to get outpatient ECT.<sup>25</sup> This meant they needed extra home support that is not available to all patients (both Leon [2005, p.5] and Norman [1982, p.37] credit their wives with taking care of them when they felt they were acting like babies during their illnesses [Rosenberg p.1,Endler p. 46]). Women patients do not report the same intensity of care. Janet, Wendy, and Martha discuss the support they received from their husbands, but stressed the financial or emotional toll their husbands faced. Their husbands' care work was also supplemented with in-hospital treatment. Professionals require that there is someone to provide care for patients who have shock therapy on an outpatient basis (Fink 1999a, p.14; 2009a, p.33). Throughout the accounts, there is an emphasis on the necessity of support from family and friends, an effect of the privatization and responsabilization of mental health care, but no mention that women are usually the ones who do this type of care work. This gendered division of labour suggests that class privilege is especially necessary for women (who are the majority of shock recipients) to have a wide array of treatment options that includes outpatient ECT.

Norman (1982) and Kitty (2006) have the ability to travel in order to "get away" (Dukakis p.86), which helps them manage their own symptoms. This is a luxury not available to most of the population. The absence of accounts written by people who only have access to publicly-financed mental health services suggests that only people who can afford to take care of their mental health needs privately are able to speak authoritatively on their experiences of these aspects of the mental health system.

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<sup>25</sup> Rosenberg was discharged after his second ECT and continued to undergo treatments on an outpatient basis.

People who had outpatient ECT (Kitty, Norman, and Leon) had more financial resources and a wide variety of care options, and did tend to be more positive about ECT. They also reported having unilateral treatment, as did Martha. Unilateral ECT was developed in response to concerns about memory loss, and in the beginning it was used to intentionally spare what were considered more “valuable” minds. A 1958 study recommended unilateral ECT for “patients of very superior intelligence and especially those who have to earn their livelihood with retained knowledge” (Lancaster in Shorter & Healy 2007, p.121). Despite research that states the contrary, Fink continues to call unilateral ECT less effective and slower than bilateral. In the accounts I studied, professional people with financial resources and the ability to take time to recover after ECT were given unilateral. Record-keeping on the demographics of those who get unilateral and bilateral and transparency concerning how this choice is made by doctors and patients could provide more information about whether class privilege, gender and ethnicity affects the choice of type of ECT given, and how particular methods of administering shock may influence patients’ outcomes.

Informed consent governs professionals’ practices and how they write their accounts. The concept has become more important since Fink’s 1979 text. Then, the need for patients’ consent to have shock was new, following the 1977 decision in the malpractice case brought against John Nardini by Marilyn Rice. Though Rice lost her case after the defense argued that her memory loss was due to “menopausal insanity” (Andre 2009, p.116) rather than ECT, Rice’s lawsuit, and other legal decisions in the US since the 1960s recognizing patients’ rights (Shorter & Healy 2007, pp.188-95), made consent an issue that doctors had to consider. Individual states passed laws regulating the use of ECT beginning in 1967 (Shorter & Healy 2007, p.196). In recent texts,

ECT professionals spend time outlining the need for consent and rationalizing when a patient's consent is not necessary (Otto & Fink 2004).

### *Managing the risks of treatment*

A specific type of risk management that emerges from these accounts concerns managing the risk of side effects or a negative outcome. People with more positive outcomes reported being told of harmful side effects—even when they were presented as rare like long-term memory loss—before agreeing to ECT. Anne Donahue (2000) and Kitty Dukakis (2006) both suggest that extreme negative outcomes are associated with specific doctors, poor administration practices, insufficient informed consent procedures, and a lack of follow-up support. From their perspective, greater regulations and more information for patients are needed to help reduce risks associated with ECT and its subsequent effects (Dukakis & Tye 2006, p.194). However, by developing checklists of questions potential patients need to be aware of when considering shock (Donahue 2007; Dukakis Epilogue) the avoidance of potential risks becomes the assumed responsibility of the patient, even in times of crisis. This individualization of problems associated with ECT can position patients, rather than doctors, as accountable for their own side effects. While doctors are responsible for informing about risks, patients are made responsible for gathering knowledge beyond what we are told. It is our job to be discerning consumers of mental health advice and treatment.

Checklist-type documents from Anne (2007) and Kitty (2006, pp.211-216) outline considerations for potential ECT patients. These lists are compatible with what journalist Larry Tye calls Anne's "middle way" (Dukakis & Tye 2006, p.164), which understands that risks and benefits exist with ECT, and the main concern is that patients be aware of these before making decisions whether

to get it. The lists outline potential shock patients' responsibilities, including knowing when the time is right for shock, finding the right doctor by asking specific questions, and knowing and preparing for possible side effects. It is important that the patient prepare for memory loss, since "There are some very important things [you can do to prepare for memory loss], and unfortunately, most doctors do not suggest them, so the patient needs to take charge" (Donahue 2007, p.8). Also unfortunate is that memory loss is difficult to prepare for when it is impossible to know the extent it can affect life before one experiences it.

There are a number of limitations to these lists. They exclude people who are being treated involuntarily. They assume people have unconstrained decision-making abilities, not acknowledging how gender, class and other power differentials can affect the decision-making process. They may not be practical for people who cannot try out multiple doctors, or who are in the midst of a crisis (and this is the time they are most likely to be presented with the option of ECT). Although the intentions of the authors are to give advice and support to people while they make choices about their treatment, they are also shifting more responsibilities onto potential patients, including greater responsibility for a negative outcome.

#### *How to criticize shock therapy*

If people are dissatisfied with their mental health care, it becomes their responsibility to make changes through actions that are acceptable ways of making change in a liberal democratic system. One acceptable way is exercising power through the legal system, through the development of things like greater administration regulations and informed consent reforms (outlined in Dukakis, Donahue, and Cott). Another is to politicize personal experiences in order to gain support and initiate change through political movement of mobilized citizens. The

expectation is that former patients go through acceptable bodies to produce reforms instead of a complete overthrow of the psychiatric system. Even Andre, who says that shock “must be banned” (Andre 2009, p.286) must go through the proper channels, attending conferences she disagrees with, campaigning to the FDA, and presenting detailed, extensive facts and experiences to support her argument.

Andre’s account suggests that shock made it difficult for her to embody the traits of the active citizen. She argues that ECT-induced brain damage destroyed her capacity for learning and her ability to do her previous work. She talks about her accomplishments prior to shock—her graduate studies and numerous publications (Andre 2009, p.2), and argues that the “erasure” of her memory meant an “overall lowering of cognitive ability” (p.10). After shock, “there is no way I can come anywhere close to what I was able to achieve before” (10). She is angry about things that make her less of a full citizen:

Because I lost my knowledge and skills, I could no longer work. Because I couldn’t work, I became financially and socially marginal. Without work, friends, or identity, I lost my place in the world. Because I have no place in the world, my son has no place

(p.11).

Here, Andre speaks to the limits of her citizenship, which includes being a worker but is also gendered as she considers her role as a mother.

Throughout the rest of her book, Andre’s extensive research and detailed writing contrasts with the “still mad” hysterical identity that Fink has built for her. Her personal experience is the subject of the first chapter, but then she avoids discussing her own emotions in favour of her knowledge about doctors and the nature of their expertise. However, by focusing her energy on discrediting doctors and ECT, she too excludes a discussion about distress that goes beyond a

biomedical understanding. Even as she succeeds in re-constructing herself in opposition to an identity given to her by these doctors, she reinforces a specific way of knowing that includes the necessity of expertise, scientific facts, and ultimately her own responsibility for her own wellbeing. Despite the obstacles that she attributes to electroshock, she manages to construct herself as an active citizen through her account.

When Janet Gotkin (1992) is finally done with hospitals and therapy, the epilogue to the new edition of her book describes her life. She has kids and says she is living a full life and being politically active through her story. She says she has a normal life. Although Janet criticizes the mental health system and attempts to raise awareness, she is able to embody the definition of wellness she previously described: “Well was functioning, going to school, working, getting married, having children, never wanting to die” (p.172). When out of mental health system, she concluded that she was not ill, but that instead she must keep deciding whether to live or die (p.377).

Even as people like Leonard Frank, Linda Andre, Janet Gotkin and Wendy Funk resist the power of psychiatric authorities and take control of the construction of their own identities in the text, they become active citizens responsible for their own, individual wellbeing, and reinforce that this is, ultimately, the individual’s personal responsibility, effectively excluding an analysis of the role external forces play in relation to mental health. Marilyn Rice and the Committee for Truth in Psychiatry, in drafting an informed consent procedure (Andre 2009, p.156) and asking for “truthful informed consent” (p.158), did not threaten power relations both inside and outside psychiatry that guide how we speak and act concerning the causes of distress/ mental illness, and the connections between these understandings and active citizenship. Struggles around

informed consent procedures do not address the problems associated with the individualization and responsabilization of mental health or non-biological factors that contribute to distress, like dominant understandings of gender and work roles. They are so constrained by pre-existing struggles and power differentials that they are unable even to address the idea that people may not subscribe to these understandings.

## **Chapter 4 – Conclusions**

The data I have gathered from my thesis research has initiated a re-shaping of my understandings of the connections between gender, mental health and illness, and governmentality. My thesis has allowed me to demonstrate what I have learned throughout this process. For example, prior to reading the accounts in my sample, I was concerned about the possibility that the gendered aspects of mental health treatment may not be discussed in first-hand accounts of electroshock. Instead, I found overwhelming evidence that gender is connected to personal experiences with the mental health system. I found that professional discourse turns ECT into a gender neutral practice, and (re)constructs a version of psychiatric expertise that is presented as objective and seemingly detached from constructed gender roles. However, patients' accounts reflect and reinforce dominant understandings of masculinity and femininity when they uncritically describe the symptoms of their mental illnesses as attached to gendered expectations, and struggle to fulfill their obligations. Occasionally, patients resist and speak back to these gender expectations through their accounts (Andre 2009, p.178; Funk 1998, p.151; Frank 1978).

As I followed and analysed the themes that emerged from my data, I reached additional conclusions that I will discuss in this chapter.

### **Practical concerns and a need for further critique**

There are a number of practical concerns that come out of my research. Although some patients from my sample challenged the idea that their consent to ECT was actually informed (Andre 2009; Donahue 2000), and some reported being coerced into it at points (Gotkin, J. & Gotkin, P.



1992; Funk 1998) most of the patients voluntarily consented to shock therapy.<sup>26</sup> As a result, and to begin with, more patient-designed research into the informed consent procedures and whether they are sufficient should be conducted. This research should also include long-term follow-up studies that attend to the possibility of lasting negative effects. Patients' perspectives are necessary if patients' interpretations of their outcomes following ECT are to improve.

Another area that is lacking in research into electroconvulsive therapy is record-keeping of who gets it. Though a variety of studies at different points in time have established the reality of a consistent gender imbalance in terms of people treated, there is no clear picture of other demographic characteristics, on the number of people who are treated voluntarily in comparison with involuntary patients, or who gets treated with unilateral and bilateral treatment. Further, research needs to be done on involuntary patients who are treated with electroshock with a focus on reasons for that treatment choice and their outcomes. First-hand accounts of their experiences should be encouraged so we can gain a fuller understanding of the diagnostic and treatment decision-making processes where involuntary patients are concerned.

Though my sample has provided me with diverse understandings of ECT, the stories are told by people with race- and class-based privilege. Even if white, educated people are those most likely to have ECT in private facilities, there are other patients from different backgrounds, treated under different circumstances, who are absent from the literature. The inclusion of their stories may lead to more complex understandings of mental health and illness, privilege, gender

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<sup>26</sup> Leonard Frank was an involuntary patient in a private psychiatric hospital (Frank 1978, ix; Frank 2002, 63). Andre also reports that her treatment was involuntary and that "the mere threat of commitment, repeated over and over, had worked to convince me that I had no choice but to submit to whatever the doctors wanted..." (p.3).

performance and active citizenship. A greater diversity of stories can offer us more truths and knowledges to consider.

It is not my place to say whether or not ECT should be banned. A main concern that arose from my thesis work was the necessity of critiques of the processes involved in the lead-up to treatment with electroconvulsive therapy. How do people come to need shock? This question cannot be answered by a simple reference to a chemical imbalance. Expectations associated with gender, sexuality, work, and understandings of personal identity are all involved in getting people to the point where they (we) require a drastic intervention like shock therapy. Criticisms of and resistance to the practice itself are insufficient when it is clear that many people reach a point when they (we) need such an intervention to keep living in a particular way. Critiques of shock therapy and other aspects of the mental health system should account for possible problems with expectations for our lives that are connected to psychiatric practices and individual treatments and outcomes.

### **Former patients' accounts of shock as bibliotherapy**

Barbara Cruikshank (1999) investigates how the development of the self-esteem movement in the United States has created a problem that liberal governmentalities attempt to solve through the deployment of expertise through technologies of the self. These technologies work on individuals, shaping how we understand our selves and consequently how we act according to these understandings. Expertise is exercised through an interconnected network of institutions, experts, and discourses in order to align personal goals with needs on a societal level, (Cruikshank 1999, p. 90; Miller & Rose 2008b, pp.35, 43) shaping how we activate and practice citizenship and govern our selves. Cruikshank (1996) writes that "self-esteem is a practical and

productive technology available for the production of certain kinds of selves” (p.89). She argues that we engage in bibliotherapy as a technique of self-governance (p.89). In her study, bibliotherapy involves engagement with texts that instruct us in ways to build our self-esteem and offer examples for us to judge our own actions against.

Bibliotherapy is an example of what Cruikshank calls a technology of citizenship. Such technologies are “aimed at making individuals politically active and capable of self-government” (Cruikshank 1999, p.1). These technologies “operate according to a political rationality for governing people in ways that promote their autonomy, self-sufficiency, and political engagement; in the classic phrase of early philanthropists, they are intended to ‘help people help themselves’” (Cruikshank 1999, p.4).

Philip’s (2009) analysis of the effects of particular self-help books that aid the recovery from depression shows how psychological expertise becomes a technology of the self. The books employ techniques that “encourage readers to judge their behavior against distinctively liberal virtues, such as autonomy, rationality and productivity” (Philip, 2009, p.161). Responsibility for treating depression is shifted onto the consumer through the book since it allows them to develop their own psychological expertise. One book includes the *Burns Depression Checklist* – a tool individuals can use to evaluate themselves and check for depression. As a technology of government, this book serves multiple purposes. It is a vehicle for the dispersion of psychological authority. It also establishes the causes of depression as entirely biomedical, the result of “disordered thoughts” (Philip, 2009, p.158) that must be treated in individuals. It excludes the possibility of external events as causes. It helps develop the ideal subject of liberal governance.

The first-hand accounts of ECT in my sample are a form of bibliotherapy. The books written by former patients offer the authors a means of self-improvement through constructing themselves as active citizens who have overcome hardships. The themes of recovery from mental illness or psychiatric treatment and the subsequent advocacy for or against ECT play a similar productive role in that they produce engaged, active citizens. From descriptions of recognition of symptoms, to treatment decision-making processes, through to post-ECT actions, these accounts are a vehicle for psychiatric expertise (mediated through patients' experiences) and offer the reader models for ways of being engaged and active (gendered and classed) patients as well as active citizens and subjects of governance. By the end of each author's account of ECT, regardless of whether they position shock therapy as positive or negative, they have constructed themselves as a self-sufficient, politically active citizen.

Although it may seem that our private decisions only impact our own lives, they also have political consequences. The (re)production of our selves as responsible, rational self-governing subjects in control of our own destinies (Miller & Rose 2008b, p.80) is part of larger processes of neo-liberal strategies of responsabilization and individualization. Bibliotherapy and the self-esteem movement both ask us to "'autonomously' align [our] hopes and aspirations with psychological norms of behavior, such as productivity and rationality" (Philip 2009, p.164). A message from the self-esteem movement is that "personal fulfillment becomes a social obligation" (Cruikshank 1996, p.232). Mental health patients are similarly obligated to recover from mental illness and unsuccessful psychiatric treatment when necessary or risk losing the freedoms tied to active citizenship and being subjected to coercive psychiatric interventions, which remain unspoken in professional accounts of shock therapy.

## **The contradictory nature of a critique of active citizenship**

I struggle with the possibility that I am reinforcing existing power relations through my resistance. For a long time, I have understood my experiences to be connected to something bigger than me, and I have felt a need to prove it. As I have written my thesis, I have become increasingly aware of this, and how I feel that it is necessary that the instability of my identity and my understanding of ECT be seen as legitimate. Like all the accounts I have read, I want to be recognized as an active citizen, who has succeeded in taking control of my own life despite an incapacitating obstacle. I write this to prove I have something valuable to say. I consider the possibility that in doing so, I am reinforcing a particular view of citizenship; that one must prove themselves worthy of compassion, a voice and the space to speak, in my case through a legitimate, acceptable mode of resistance—academia. Another tension present in my own work is that my call for greater diversity of representations of ECT and ways of knowing and being may contribute to the understanding that potential patients should be held responsible for knowing and preparing for the risks of shock therapy.

Reconciling my critique of active citizenship while simultaneously reinforcing my own status as an active citizen and possibly promoting responsabilization will be an ongoing struggle. However, recognition and attention to these tensions allows for further critique. It has forced me to reflect on my work and to understand more fully the need for the ongoing creation of spaces to explore new strategies of resistance.

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