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Legitimating Damage and Control: The Ethicality of Electroshock Research

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Abstract

This article probes the ethicality of standard electroconvulsive therapy (ECT) research, examining the politics of the questions asked, the criteria used, and the treatment of participants. In the process it walks the reader through a concrete case. Particularly focal is research connected with effectiveness and/or damage. A pivotal conclusion reached is that all research which in any way promotes an electroshock agenda (the vast majority of ECT research conducted) is unethical, for it is in the service of violence and control. This includes research whose stated goal is improving ECT. The author demonstrates, correspondingly, that the bulk of the research is an institutional product in which the criteria used originate solely with the professionals, seriously clash with the knowledge of participants, and indeed, it is part and parcel of a discourse about efficacy and safety which is at odds with both lived experience and science. Examined in particular detail is recruitment material such as advertisements and information sheets which functions to systematically mislead, prey upon, and otherwise harm prospective participants. While affirming the ethicality of much of the critical research, the article ends by introducing the possibility of knowledge insurrection.

Keywords: electroshock, ethics, effectiveness, brain damage, research trials

In the early 1980s a very curious meeting took place between people from very different locations and with demonstrably conflicting agendas. On one side was a psychiatrist who was a leading electroconvulsive (ECT) researcher and promoter. On the other (and I was one) were representatives of Ontario Coalition to Stop Electroshock (OCSE)—a large abolitionist coalition composed of ECT survivors and their allies. At this meeting, the psychiatrist put forward the following proposition—that using his research money, he and OCSE team up and conduct an extensive empirical study to find out "once and for all" whether or not ECT was "safe and effective." We were even assured that all relevant safeguards would be in place so that there would be no chance of the research being manipulated or poorly conducted. As dutiful members of the coalition, at the next OCSE meeting we presented this curious proposal to the membership. Now to be clear, no one had any doubt that ECT was both ineffective and profoundly harmful. What is also significant, only a few of the activists were familiar with the ins and outs of research as a practice. Nonetheless to a person, everyone was clear that we were in essence being invited to engage in something unethical. "How could we be party to shocking people?" asked D in dismay. "Of course, no matter what, the data gleaned would end up saying what the shock docs want it to say," stated W. "Why in the world would we seek to find out what we already know?" exclaimed a third. I leave you with this incident as a touchstone in the investigation before us.

The topic of this article is the ethicality of standard everyday ECT research. I begin by discussing first the nature of ECT, then the ethicality of ECT as a "practice," for one cannot truly understand the tangle of issues surrounding ECT research ethics in the absence of this. The article proceeds to probe the ethics involved in mainstream ECT research, looking at both the role that research plays in ECT discourse and the more focal question of the treatment of participants. A highlight of the chapter—what makes many of these issues come alive—is a walk through the beginnings of a concrete case—recruitment for a very particular ECT trial which caused a stir in the survivor community. Questions asked with respect to the case are: Why were survivors around the world so upset about the advertisement for participants (for upset they surely were)? And what is wrong with what is happening here? More generally, the questions posed in the article are: Why is research being conducted on ECT? Who determines what is asked? Who decides what serves as indicators of "improvement"? Why are professionals still asking about effectiveness? Whose interest is being served? How are we to understand the "power/knowledge" thereby created? How are gender and age implicated? Are there any circumstances in which ECT research is ethical? And if so, what and why? How do recruitment practices exacerbate the problems already inherent in the constitution of ECT trials? If ECT involving human subjects is unethical by its very nature, do standard ECT research practices introduce additional layers of unethicality, and if so how and why? And finally, what might ethical research with respect to ECT look like?

ECT as Practice: The "Facticity," the History

While all treatment is embedded in knowledge, which in turn, to varying degrees, is a product of and is legitimated by power relations—hence Foucault's (1980) term "power/knowledge"—this reality is particularly poignant when it comes to ECT. ECT is a "treatment" (read power/knowledge practice) that originated in fascist Italy in the late 1930s. Its very origin, that is, speaks to the issue of power and control. It was inspired by the sight of hogs en route to the slaughter being stunned and thereby rendered controllable via the use of cattle prods. The fact that its very first recipient was a homeless man is also suggestive (for details, see Frank, 1978).

ECT consists of delivering sufficient electricity to the brain to produce a grand mal seizure. It is delivered in a series, generally with two "treatments" delivered weekly in Canada and the United States and three in the United Kingdom. Terms typically used to refer to current ECT are "new," "improved" and "modified" (for example, see Abrams, 2002). While the terms "new," "improved" and "modified ECT" are so standard as to be common parlance, and while they appear to suggest that profound modifications were made to ECT recently, in point of fact, the major modifications were made in the early 50s (what is significant here, calling it "new" and "modified" serves to create the misimpression that the myriad of voices which rise up against shock are irrelevant for they are complaining about a prior method). These modifications include the use of muscle relaxants so that people will not break bones from the seizure, the use of different kinds of current, the application of oxygen during the delivery of the current, and the use of unilateral shock[1] (for details on the above, see both ECT proponents such as Fink, 2009, and Shorter and Healy, 2007; and ECT critics such as Breggin, 1991, Frank, 1978, and Burstow, 2006).

It is clear that from the start, damage was intended and controlling "the patient" via damage was the goal. In this regard, along with lobotomy, ECT was initially hailed as one of what was termed "brain damaging therapeutics" (see Freeman, 1940). Correspondingly, in explicating ECT, leading shock advocates transparently used as indicators of success post-shock behaviour that has all the signs of being a product of brain injury. By way of example, Fink, Cahn, and Green (1958) wrote,

> When a depressed patient, who has been withdrawn, crying, and has expressed suicidal thoughts, no longer is seclusive and is jovial, friendly and euphoric, denies his problems and sees his previous thoughts of suicide as "silly," a rating of "much improved" is made. (p. 113)

That the person is intentionally being controlled through damage is painfully evident. Indeed, what is involved here is curing the person of their misery (and hence in addition, the problems that they may pose for others) by "curing" them of the ability to think and to understand. What is more explicit still, witness this statement by early ECT pioneer Abraham Myerson (cited in Ebaugh, 1942, p. 37):

> These people have … more intelligence than they can handle, and the reduction of intelligence is an important factor in the curative process. I say this without cynicism. The fact is that some of the very best cures that one gets are in those individuals whom one reduces almost to amentia.

A note in passing, I am aware of the tensions between parts of the disability movement and the critical and anti-psychiatry movement over the use of the term "brain damage" here (for a hard-hitting critique of such usage, see Withers, 2014), and I would like to reaffirm here that people thereby impaired are every bit as valuable as everyone else, moreover, that all disability is to varying degrees a social construct. That said, the point is that harm and brain damage as materially and traditionally understood happened, was intentional, and it was blatantly in the service of control. This type of harm indeed is ECT's raison d'être, as it were, the way in which it "works." What has survived of this legacy is the very same control, the same "diminishment" of self, reconfigured as success. Indeed, as Breggin so astutely put it, there is a one-to-one correlation between the effectiveness (that is, what is deemed as effective) and the damage done. The only difference is that brain damage stopped being acceptable—hence the ECT discourse shifted to one of damage denial

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[1] Unilateral ECT involves the placement of both electrodes on the non-dominant hemisphere; whereas in bilateral, one electrode is placed on each hemisphere. Despite the credibility gained by the use of the term "modified," as if the old and problematic has been replaced by the new and benign, significantly, bilateral shock has not been superceded. Both forms continue to be used, hence the inclusion of bilateral in the extensive study by Sackeim et al. (2007).

(in this regard, contrast Fink, 1957, with Fink, 2009). In short, the new agenda (read research agenda) was to "find" that there was no brain damage, while constructing the very behavior which is the product of damage (as traditionally understood) as proof of "effectiveness." The inherent contradiction here is: to validate shock and validate the industry (the purpose of the research), research must continually prove that ECT is something other than it is.

A further ethical problem enters in as we look at who is given shock and why. As explicated and documented by Burstow (2006), almost from the beginning two to three times as many women as men have been electroshocked. The standard explanation is that this is because women are more often depressed, and ECT is recommended for depression. However, as the Electro-convulsive Therapy Review Committee (1985) concluded, women are given shock two to three times as often as men irrespective of diagnoses. What further deepens our understanding of the control of women that is involved, often the reasons are blatantly sexist. Witness, in this regard, the following conversation which took place between survivor Wendy Funk's husband and her doctor as prelude, as it were, to her receiving shock:

> "Can't you tell her to . . . spend more time at home?" Dr. King asked.
>
> "I try but she doesn't listen to me," Dan joked.
>
> "So you can't control your wife's behaviour?" Dr. King asked.
>
> (Funk, 1998, p. 15)

Correspondingly, as Burstow (2006), Warren (1988), and decades of survivor testimony have shown, as a result of this brain-damaging treatment and this gender bias, women's lives are at once diminished and made significantly harder. Here, by way of example, is a typical statement by a woman shock survivor:

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

All this being the case, to return to the Myerson quotation, it is clear who is being viewed as having "more intelligence than they can handle." Correspondingly, given these attitudes and this way of proceeding, electroshock has understandably been labelled a form of violence against women (Burstow, 2006).

It is often assumed that people of colour similarly are overwhelmingly in jeopardy of ECT. While statistics relevant to such a determination are but seldom kept, as counter-intuitive as this may seem, in point of fact, a far higher percentage of white people are subjected to electroshock. In this regard, the Texas statistics are typical. In 2007–2008, 1,423 white people were subjected to ECT as contrasted with 100 Blacks, 183 Latinos, 40 Asians, and 14 designated as "other" (Weitz, 2009). By the same token, testimony suggests, it is the middle class, not the poor, who are disproportionately electroshocked (Burstow, 2006). As such, ECT is correctly theorized as principally an attack on white middle class women.

It is beyond the scope of this article to fully make sense of what must seem anomalous here, for without question poor people and people of colour are disproportionately subjected to psychiatry (Ben-Moshe, Chapman, & Carey, 2014). However, one way of understanding this seeming anomaly is to take in the very specific historic trajectories that have figured in the management of people deemed mentally disturbed; and in this regard, ECT may be seen as roughly in the tradition of the rest cure—a 19th-century psychiatric imposition overwhelmingly inflicted on white middle and upper class women (Burstow, 2015). All of which serves as a cautionary note that history is very particular and that additive approaches to understanding oppression, whether simple or even of an intersectional nature, can at times be an obstacle to understanding. That said, while the figures are not as dramatic as with gender, there is one other subordinated location that likewise puts one in extra jeopardy of ECT—being a senior. To cite a statistic in this regard, in Texas in 2007–2008, 40 people 60 years of age were given ECT as contrasted with 13 people 20 years of age (Weitz, 2009). Given that seniors are also disproportionately drugged, a disregard for the damage done seniors can clearly be hypothesized here.

That said, the major research points made to date are that the bulk of ECT research is in the service of the ECT industry and, moreover, generates knowledge lacking in integrity. This notwithstanding, there is also a pocket of both mainstream and critical research that is conducted with comparative integrity. And while some of this research, too, is ethically problematic, conclusions can nonetheless be drawn from it.

What Does the Best Research Establish? And What Are the Implications?

Not surprisingly, given the forgoing, the most well-conducted research establishes that ECT indeed damages the brain and extensively impairs memory and other cognitive functioning (see, for example, Weinberger et al., 1979). This research, I would add, meshes with and indeed confirms what survivors have testified for years (see, for example, Coalition Against Psychiatric Assault, 2005), with the impairment to varying degrees permanent. Of particular significance is Sackeim et al. (2007)—the largest study in shock history. A longitudinal study (in itself a rarity), it involved 7 different community cites, 347 shock recipients, and it included 6-month follow-up. The importance of Sackeim et al.'s work cannot be overstated, for it establishes—to a point way beyond what is needed to establish statistic significance—that irrespective of the type of ECT used, ECT always causes brain damage, always impairs thinking, always results in memory loss (memory of autobiographical details in particular), that women and elderly (the main recipients of ECT) incur the most extensive damage, and minimally, 6 months later, that this damage persists. A formidable finding, I would add, which becomes more formidable still if read in the context of a clarification by Breggin, (2007, p. 83), who wrote, "If traumatic damage has persisted for six months, it is likely to remain stable or even grow worse." Now if we take seriously what this study establishes, ECT of any kind should be ruled unethical. Nor do we have a need for further study. Tellingly, however, while the Sackeim et al. study is what we normally think of as definitive, most psychiatrists and most researchers never so much as mention the study, in short so conduct themselves as to "disappear" it from the discourse (see in this regard Fink, 2009; Enns & Reiss, 2015). Why? Because discovery, as we traditionally understand it, is not the purpose of ECT research as standardly conducted.

Just as damage is confirmed by the better research, effectiveness is called into doubt. Of particular significance, Ross (2006) and others have established that despite the fact that ECT is deemed effective in "the treatment of depression," even with the use of dubious indicators of effectiveness (more on this issue below), it does not outperform placebo after the first 4 weeks. In other words, people (read women) are being impaired and brain-damaged for nothing.

The implication is that the administration of ECT is unethical, that it damages people—women and seniors in particular—and the practice should be discontinued. Now if we applied this implication to its use in research, presumably, a parallel conclusion would be reached. That noted, the bulk of ECT research seems ready-made for a Foucauldian critique—that is, it is not about discovery grounded in ethical practice or indeed any kind of discovery, but about control, power-over and validation. Such then is the backdrop and my opening reflection. Time to home in more closely on the research per se.

The Bulk of ECT Research: Its Nature, Its Ethicality

You would think that there would no longer be a need (if ever there was such a need) to do research into ECT's effectiveness, given Ross's (2006) finding. Nor need anyone investigate the existence of brain damage or memory loss, given the unequivocal findings of Sackeim et al. (2007). After all, we now have answers that by conventional standards are nothing short of definitive. And yet the research continues. Who decides that ECT should continue to be researched—this despite the fact that we now have credible answers about both safety and efficacy even by conventional standards? And who benefits from the research? While there are notable exceptions to be sure, overwhelmingly, those with a vested interest in ECT continuing and, more to the point, those whose interest lies in constructing ECT as safe and effective (the shock industry, the ECT research industry itself), for this in essence is what the research does. It consists of studies typically lacking explicit criteria, and which conclude that ECT is benign and/or effective, thereby generating the "knowledge" that constructs it so.

So is such research ethical? Demonstrably not. It is in essence a power play used to establish a narrative that clashes with experience and that at once obscures and legitimates the damaging of human beings. The larger dynamics of the process being alluded to here plays out as follows: Poorly conducted studies of very little duration are amply funded and conducted. The research takes place over a few weeks and generally establishes a minor degree of effectiveness for that period only.

Correspondingly, what is largely avoided are longitudinal studies, for in these we see the hidden reality of ECT; not simply that there are damaging effects but that these damaging effects continue. Doctors consult such trivializing studies (available in the Cochrane library). These practices in turn at once legitimate the unethical ECT practices and validate the ECT providers. What adds insult to injury, even by conventional measures, this research is woefully substandard. Consider in this regard Read and Bentall's (2010) demystification of all four effectiveness studies positively referenced in Shorter and Healy (2007)—research, that is, being upheld up by the industry as stellar "proof" of effectiveness:

> Three of them … had no control group, vague or nonexistent definitions of "recovery," and the people assessing the recovery were either the hospital staff or not identified … In the fourth … there was no definition of "improved" and no mention of who decided who was improved. (pp. 334–336).

The seriousness of what is involved here is drawn home by survivor testimony. The point is, as leading radical research theorists such as Schostak and Schostak (2008) have so poignantly reminded us, research is never innocent. And use of the standpoint of the professional (e.g., the nurse who ticks a box indicating that the patient has improved) is highly problematic, for it is the standpoint of someone who equates control with improvement. Indeed, not only is there a disconnect between the goals of survivors and those of the professionals, there is a huge and equally profound disconnect between the "criteria" used by professionals to establish "improvement" (e.g., the patient is no longer complaining) and the criteria by which the survivor judges (e.g., I can't remember details of my life). That disconnect is most visible in Van Daalen-Smith's research into ECT. Significantly, Van Daalen-Smith (2011) interviewed both women who had just received ECT and their professional caregivers. In all cases, the caregivers saw "improvement"; in not a single case did the survivor. That noted, I leave you with these words of shock survivor Wendy Funk, who rejigs the concept of "effective" as she critiques professional "knowledge/discourse" in a way that only a survivor can:

> When you hear that ECT is new, improved and safe, it's an obvious lie. When you hear that they don't know exactly how ECT works, it's a lie. But when you hear that it is effective, well, it's true. It is very effective in causing closed head injury/memory loss, which inevitably alters lives. (Inquiry into Psychiatry, 2005, Electroshock, tape 1)

To date, I have emphasized effectiveness and safety studies that involve the application of shock, for these form the bulk of the conventional ECT research conducted. There is one other common type of mainstream ECT research that bears mention, for it seems on the surface acceptable—studies to try to discover the mechanism involved in what are conventionally considered the worst physical effects of ECT—the overheating of the brain during the procedure, for example—this in the interest of some day being able to alleviate them. Let me suggest that to varying degrees, this research is likewise problematic. While obviously, harming people less is preferable to harming them more, such research must been seen in the context of the larger institutional discourse. Besides that ECT will always harm people—damage, you will recall is its modus operandi— such research functions to reinforce the importance of ECT. To put this another way, it constructs ECT as a treatment to be preserved—something, as it were, with just minor problems attending it that diligent practitioners are working on. As such, it becomes yet another strand in the "new and improved" narrative—all of which serves the industry at the expense of the population that it allegedly serves.

That said, thus far we have examined ECT research largely in reference to the institution and its discourse, and we have found conventional ECT research morally wanting. What goes along with this, we have concluded that all research that directly or indirectly serves to promote ECT (the vast majority of ECT research) is, by the very fact of doing so, unethical. Zeroing in on the issue of participants adds a whole new layer to the analysis.

Participants

Most research on ECT involves participants; and in most cases, some or all of the participants are subjected to ECT. As subjecting anyone to electroshock is unethical given the injury that has already been established, this research is de facto unethical. Ethics is further compromised if insufficient information is given, if the information provided is false or misleading, and if vulnerable people are being preyed upon. My review of the trial literature reveals, and works such as Andre (2009) have suggested, that such is routinely the case. How is this duplicity and preying accomplished? Standard ways that have surfaced in my investigations include trivializing, rendering invisible, or downright denying the damage done by the process; decentring ECT so that it appears to be a minor part of the process; writing about ECT in way that suggests that it is safe and effective; and specifically targeting people who would see themselves as in trouble. Indeed, people are not even being told that the treatment is controversial. In addition, vulnerable people are specifically being targeted and given reason to believe that they will benefit from "the treatment" moreover that others will benefit from the "knowledge" thereby generated. What is compromised in all of this is the safety of participants, respect for people's vulnerability, and the right to know exactly what it is that one is consenting to—both what it means for oneself and what it means for others. In unpacking the ethicality so that the complexities of what is confronting us can be more fully appreciated, the next section walks through a concrete case of recruitment.

A Case Study

In mid-2012 recruitment began on a Centre for Addiction and Mental Health (CAMH) study on ECT. The purpose of the study was to learn more about the overheating and inflammation of the brain during regular administration of ECT, so that eventually something might be found to stop the overheating (a relatively new avenue of research, as already noted, so geared as to contribute to the "new and improved" narrative). What the participant would be subjected to was ECT, along with magnetic resonance imaging (MRI) and positron emission tomography (PET) scans both before and after the treatment. While some changes were eventually made in the protocol in response to an official complaint, initially the principal target of the recruitment was the general public, with the prospective participants given strong reason to believe that they would benefit. Relevant outreach and other participant material included: an advertisement on Craigslist, the Inflammation and Electroconvulsive Therapy Study Information and Consent Form, and the ECT Study Brochure (n.d.).[2] Read through the documents and it becomes progressively clear that what is involved here is preying on vulnerable human beings, trivializing the operation to which they are "consenting," and insinuating that ECT will benefit them. Examining the documents one by one is a good place to start, beginning with the Craigslist advertisement, for it is with its sudden appearance on Craigslist that shock survivors throughout the world took alarm. Indeed, I personally came across the advertisement precisely because survivors were upset and wrote to me asking if I could find a way to stop what was happening (personal communication, August 10–August 18, 2014).

The Craigslist advertisement in question was posted under the category "Etcetera Jobs"—a reality which itself alarmed people. The title was "Do You Suffer from Depression that Has not Responded to Medication?" It proceeded to invite people to take part in a study on ECT. There was no mention of adverse effects arising from the ECT. Correspondingly, the crux of the advertisement is the following passage:

> *Did you know:*
>
> - *50–80% of people achieve remission after ECT*
> - *ECT works by telling the brain to create new cells*
> - *Treatment is given while you are asleep (general anaesthetic) for 5–10 minutes*
> - *Half of the people who receive ECT are not staying in hospital.*

Toward the bottom of the advertisement was contact information, assurances of confidentiality, and the words "compensation provided."

What is evident throughout this advertisement is that vulnerable people were being preyed upon, with the problem compounded by misleading information, a trivializing of the procedure, lack of information, and innuendo. By way of example, the very placement of the advertisement under "Etcetera Jobs" signalled that the receiving of ECT is something innocuous, much like accepting any other part-time job (as opposed to something that could endanger one). In what job that we know of is the person strapped down, is the brain convulsed, and is the worker deprived of their ability to navigate life? Other examples of trivialization include: telling potential participants that it is a 5–10 minute procedure (the impression is thereby created that this is something very minor), and leveraging people's identification of

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[2] For all of these documents, see http://coalitionagainstpsychiatricassault.files.wordpress.com/2014/03/camh-study-material.pdf

"outpatient treatment" as minor by providing statistics on the percentage of people who receive ECT without being "in hospital."

The misleading nature of the advertisement reaches a new height with the words "ECT works by telling the brain to create new cells." Besides that this is infantilizing (does the explanation offered here not sound like the sort commonly given to small children?), what is involved here more seriously is a now standard albeit relatively new duplicitous claim about ECT—that ECT is benign in that gives birth to new brain cells. Is this claim totally false? Not all of it. An explanation: While the killing of cells is standard in ECT, it is indeed the case that some new cells are generated (called "neurogenesis"). This is currently so constructed by the industry as to look like a good thing, to use the words of the advertisement, how ECT "works." Besides, however, that the new cells are abnormal (as contrasted with the perfectly normal cells that have been destroyed), as clearly demonstrated by researchers such as Zarubenko, Yakovlev, Stepanichev, and Gulyaeva (2005), the very fact of the neurogenesis constitutes additional proof of ECT-engendered brain damage, for damage is precisely what leads to neurogenesis. By this sleight of hand, what is actually the product of brain-damage and proof thereof, is constructed as a good outcome and indeed the therapeutic mechanism.

What compounds the problem, who was being sought out, who the advertisement is demonstrably aimed at, is precisely people who might be willing to try anything—people desperate, people for whom nothing appears to work. They see the duplicitous remission statistics—and are prompted to think, if this works for others, why not me? A second dimension of vulnerability being leveraged ties in with poverty and the monetary inducement involved. Note the word "compensation" at the end of the advertisement. Read this word in the context of the placement of the advertisement under "Etcetera Jobs," and a clear picture emerges. The point is, the people being targeted are not only depressed, they are likely so depressed that they cannot easily make ends meet, may not have held down a full-time job in years. They go onto Craigslist hoping to pick up some part-time work. For what appears to be but 10 minutes of their time, seemingly, they can at least temporarily alleviate their financial distress.

The second piece of recruitment literature (the brochure) was overtly aimed at people who are already slated for or are currently receiving ECT "for the first time," though it was also provided to the general public. Of course, the fact that people currently undergoing ECT are being asked to give consent itself presents a problem. In the state of depression and confusion, coupled with the desperate desire to seem co-operative so common to those in this situation, can people truly be said to give consent?

That noted, the brochure likewise addressed people depressed, provided the same statistics on remission rate, and made the identical claim that ECT "works by telling the brain to create new brain cells," all this under the misleading title "ECT Works Very Well." It is with this document additionally that the psychological inducement to contribute to the creation of beneficial knowledge is most clear. Besides that the research is called "cutting edge," what was suggested in the brochure is that the knowledge gleaned through this research can make this good procedure even “better.”

The final document was the study information and consent form itself. Herein considerably more information is provided. Potential participants are told the order of what is to occur. And all the procedures involved are spelled out. Correspondingly, certain risks are specified, including the risk of memory loss. Significantly, however, the risks of ECT are greatly minimized: first by positioning them last—that is *after* the risks posed by the each imaging devices (thereby making ECT look even less dangerous than having an MRI); secondly, by leaving out such details as brain damage; moreover, by the inclusion of such statements as, “The ability to acquire new memories recovers completely usually a few months after the treatment.” It is as if the studies which establish otherwise never existed.

It is with this final document that the details of the compensation per se were spelt out. The entire section was bolded so no one could miss it. Under the title “Reimbursement” prospective participants were informed, “You will be paid a total of $645 in recognition of your time involved in the whole study.” Not only is this problematic by anti-oppression practices standards, it would appear to be incompatible even with highly conventional codes of ethics as articulated by national bodies, for they explicitly specify that recompense cannot be such that participants are induced to do what they would otherwise not (see, for example, Panel on Research Ethics, 2010). The point is that who is being reached out to are vulnerable souls who are badly depressed, perhaps so depressed that they can barely drag them out of bed. I would remind readers in this regard how little people are paid on social assistance—the plight of many a psychiatric survivor—and you can readily see that what is being offered constitutes not a small, but an appreciable inducement.

What happening here? By withholding necessary information, providing misleading information, targeting down-on-their-luck and indeed poor populations, creating the impression that what is involved in minor, and offering participants substantial inducement, researchers were creating a situation in which expectably, some people will agree to what they normally would not—in this case, agree to a brain-damaging procedure. Indeed, document after document was so tweaked as to have this effect. Of these none is so obvious as the Craigslist advertisement.

For purposes of disclosure, I would add that a sufficient number of viewers flagged the Craigslist advertisement as abusive that the advertisement was dropped from the Craigslist system. Additionally, as a result of a formal complaint that was lodged with the employer, it was decided that there would be an investigation into the study and that pending the investigation, participants secured through outside recruitment would not be used. Moreover, outside recruitment, for the time being anyway, would stop. While this may seem reassuring, any reassurance must be tempered with these facts: 1) only this study was affected; otherwise ECT trials continued as usual; 2) internal participants for this study itself continued to be recruited with use of the same problematic information; and 3) the panel of “experts” subsequently convened to investigate the complaint, in essence, decided that nothing wrong had happened (C. Zahn, personal communication, 24 August 2012).[3] The point here is, insofar as what was conveyed to me accurately depicts what the panel concluded—and I have no way of verifying this, for in typical institutional fashion, the report has been ruled confidential—the research practices as designed were not outside of what the profession deems to be acceptable practice. What follows, as frightening as this may seem, insofar as this is the case, what we have been analyzing here is not an extreme case (which would have been telling regardless, for extreme cases write large the problems inherent in more normative research). Indeed, what is far more worrisome, with the exception of depicting ECT as a reasonable line of work (which made the manipulation involved more obvious—hence the outcry), it is far closer to a "typical case." And I accordingly present it as such.

Summation, Implications, Reflections

This inquiry began by probing some salient truths about ECT, exposing false claims, and co-investigating and theorizing the purposes of such claims. On the basis of what was uncovered, the article proceeded to explore the ethicality of standard ECT research trials, and has demonstrated that profound unethicality typifies ECT research. What has been shown, to reiterate, is that the very choice of standard ECT research questions and the knowledge gleaned are inseparable from the desire to exert professional control over a vulnerable population. What goes along with this, "knowledge" both drawn on and re-created by the researchers constructs as benign what is actually injurious. In the process of engaging in such studies, correspondingly, participants are misled and exposed not simply to minor but substantial and ongoing harm. The article culminated in the investigation of a concrete case that amply demonstrates that conventional research practices with respect to ECT are not even ethically acceptable by most people's standards—never mind the far higher standards advocated by those of us committed to anti-oppression practices. The question of course arises—and I would comment briefly on this in ending: What would constitute "ethical ECT research"?

To begin with—and this hardly suffices—it would be research that does not physically harm the participants and in no way misleads them. Albeit obviously a variety of different methodologies are possible, some methodologies more readily lend themselves to decent treatment and empowerment than others and so deserve attention. Examples of approaches to research that would stand a better chance of culminating in ethical ECT research would be ones involving critical discourse analysis, narrative analysis, or participatory research. Secondary research that exposes the harm done by ECT is likewise apt, and indeed, this is a tack taken by many of the critics of ECT who conduct research—Breggin generally (e.g., 1991, 2007), and Ross (2006), for example. Whatever it be, using criteria generated by psychiatric "experts" will never lead to ethicality. More generally, for research in this area to be ethical, it must be driven not by the interests of the industry but the

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[3] For this and other correspondence related to the complaint, see http://coalitionagainstpsychiatricassault.files.wordpress.com/2014/07/burstow-institutional-correspondence.pdf

desire and knowledge of the people who have been subjected to it (e.g., case studies that probe the lived experience of the memory impairment, thematic analysis of testimony given by survivors who have chosen to testify about the procedure or about their post-ECT lives; for an excellent example of the latter, see Froede & Baldwin, 1999). Moreover, the standpoint (read: achieved standpoint) of the oppressed group needs to be maintained at all times.[4] Of special importance here are the standpoints of women and seniors, given that they are the primary target. That said, a particularly salient direction to consider—and one befitting anti-oppression researchers—is research specifically designed to help surface and legitimate the subjugated knowledge of the ECT survivor—and something good critical research still falls short of—optimally, to the point of knowledge insurrection (for a general discussion of knowledge insurrection, see Foucault, 1972, 1980). Minimally, as with any other areas, it is critical to turn to the oppressed themselves for direction, moreover, wherever feasible, to yield to that direction.

In ending, I would return to the situation with which this article began—the curious proposition facing the activist organization Ontario Coalition to Stop Electroshock decades ago. Survivors formed a critical mass in this organization; and the proposition put to OCSE was that we team up with a leading shock promoter to co-conduct an extensive empirical study that would show “once and for all,” whether or not ECT was effective, also whether or not it was safe. All necessary safeguards, we were assured, would be put into place and “best research practices” would be followed. The psychiatrist-researcher who extended the invitation even promised to incorporate any measure that we thought wise. And so, what happened? Within minutes of beginning their deliberation, everyone to a person rejected the proposition.

What survivors and their allies knew, whether by bitter experience or by tapping into their better instincts as human beings, is that it is not all right to conduct research that in any way involves individuals being subjected to damage. By the same token, they knew that you do not team up and do research with people whose interests run counter to those of the vulnerable and the oppressed—a principle, I would add, that has broad implications for those of us in the social services. And finally, you do not do research to discover answers when the answers are already known—for besides that this is unnecessary, by its very nature, it suppresses discounted knowledge; it validates the industry; and it inevitably results in institutional capture (translation: falling into the discourse of the ruling regime; see Smith, 2005).

As one of the survivor OCSE members put it—and I cede to her the final word in this article, “C’mon people, nothing good can come of that.”

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[4] Achieved standpoint is the special vision afforded by assuming the position of the oppressed, whether it be women, the proletariat, or psychiatric survivors, then in essence “researching up.” For a helpful discussion of this type of standpoint theory as well as slightly different renditions of it, see, for example, Hartsock (2004) and Smith (2005).

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