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One Woman's Near Destruction and Reemergence From Psychiatric Assault: The Inspiring Story of Evelyn Scogin

John Breeding[1] and Evelyn Scogin[1]

Abstract

Evelyn Scogin is a 52-year-old woman with a vast range of life experience and accumulated wisdom. She has worked in special education for decades, including many years as a teacher. Evelyn has been on social security disability for about four years, and has not worked for five. Her disability was, like so many of the astounding 1 in 50 of her fellow adult Americans, on psychiatric grounds (Whitaker, 2005), the result of intense iatrogenic damage caused by her treatment at the hands of the mental health system by polypharmacy and electroshock. This article tells a powerful and inspiring story about one woman's near destruction and inspiring reemergence from damage caused by psychiatric polypharmacy and electroshock. Because of her very hard work and good support, Evelyn is now acting powerfully and assertively in the world, liberated from her role as a mental patient, and from all psychiatric drugs and related "treatments."

Keywords

psychiatry, psychiatric drugs, electroshock, mental illness, recovery, drug withdrawal

[1]Fort Clark, Austin, TX, USA

Corresponding Author:
John Breeding, 5306 Fort Clark, Austin, TX 78745, USA
Email: wildcolt@austin.rr.com

Evelyn Scogin is a 52-year-old woman with a vast range of life experiences and accumulated wisdom. She worked in special education for decades, including many years as a teacher. Evelyn has been on social security disability for about 4 years and has not worked for 5 years. Journalist Robert Whitaker (2005) documented a steep increase in the rates of psychiatric disability since 1950, from about 1 in 500 to an astounding 1 in 50 adult Americans in 2000. He concluded that the primary cause of this incredible disability rate was iatrogenic—that is, because of the pervasive use of neuroleptic drugs, which began right in 1950. Evelyn's disability may also be interpreted as the result of intense iatrogenic damage caused by her treatment at the hands of the mental health system.

Evelyn spent the spring and summer of 2009 intensely pursuing work in her field. As the employer need was strong, there were several relevant openings and attendant interviews; although her resume is terrific, she was repeatedly not hired. It is very often exceedingly difficult for people to get hired and reenter the workplace after being on disability.

This particular woman is not about to give up, however. The good news is that Evelyn is now acting powerfully and assertively in the world, liberated from her role as a mental patient and from all psychiatric drugs and related "treatments." That this article exists is a potent example of Evelyn Scogin's decision to speak out; she has read and approved the content and its level of intense self-disclosure. She is currently working on her autobiographical account. What follows is the inspiring, ongoing story of just a little of what this remarkable woman went through to get there.

A Little Background

Evelyn Scogin was born on July 31, 1957, in Fort Worth, Texas. She was the middle of three girls, and she was raised poor. She suffered from hip and leg pain because of an untreated injury from a fall on Halloween at age 13, one legacy of being raised poor. Her parents cared deeply and valued their daughters' education; Evelyn did very well in school, and all the three girls became successful professional women.

Evelyn and her closest sister, Kathy, married brothers in their young adulthood. For Evelyn, this was not only love but also a way to leave a protective home. This marriage lasted 10 years, and on separation, Evelyn moved in with her youngest sister. In fact, she never lived alone until this year. She did, however, begin work at the Denton State School in 1985. Despite being severely head butted on her very first day on the job, Evelyn went back the next day and worked as a frontline staff for 15 years, effectively launching her

career. She obtained her bachelor's degree in special education from Texas Women's University in 1996 at age 40. She learned sign language and moved to Austin, where she began working at a professional level. She taught for Leander Independent School District for 2 years; then she moved to a position at the Texas School for the Deaf, where she worked as a teacher for almost 5 years, often with the most difficult emotionally and behaviorally disturbed children. She was known for her deep caring and reliability.

Evelyn had been working as a special education professional for 20 years when her ordeal began. Her story is a poignant one, downright tragic at times. Her story is unique, as all stories are. In this writer's perspective as a psychologist and an ardent observer and passionate critic of our modern mental health system, I notice elements of psychiatric oppression that are far too common. Before getting into those details, let me tell you how we met.

In the spring of 2006, Kathy Scogin entered the offices of a storage facility in South Austin to inquire about renting space for one of her sons to store his stuff. Kathy is a gregarious woman, and as she chatted up some of the people there, she discovered that the same offices also housed the staff of the Texas chapter of the Citizens Commission on Human Rights (CCHR). CCHR is a nonprofit watchdog group founded by the psychiatrist Thomas Szasz and the Church of Scientology, whose mission is to investigate and expose psychiatric abuse. Kathy told the staff about her sister, Evelyn, who had recently undergone a great deal of electroshock at a local psychiatric facility, Seton Shoal Creek Hospital. As it happens, I had been working closely with allies, including CCHR, on a new project. We had recently formed a new citizens group, the Coalition for the Abolition of Electroshock in Texas (CAEST; 2007), and our first initiative was an effort to stop the practice of electroshock at Seton Shoal Creek. We had been in active dialogue with Seton beginning with a letter on December 8, 2005; as of April 6, 2006, we had received a letter from the Seton Health Network Board of Trustees Chair, Sister Helen Brewer, referring us to medical director, psychiatrist Paul Whitelock. We began a series of direct actions at the hospital on April 24th. (See the CAEST website, www.endofshock.com, for a report of the ongoing dialogue and for direct actions related to Seton Shoal Creek at that time.) A meeting for me to meet Evelyn and Kathy was arranged shortly after Kathy's serendipitous visit to the CCHR offices.

I remember that meeting well. Kathy was earnest and eager, and her bright red hair stood out. Evelyn was quite overweight, had a great deal of trouble walking with a cane, and appeared heavily sedated. She was on large doses of several psychiatric drugs at that time, unhappy and very uncertain of her fate. She did not remember much of the last couple of years. While Kathy was

animated and interested in CAEST, she was very deeply concerned about her sister. They needed help. Evelyn was on full psychiatric disability, and her health was progressively worsening.

The Big Fall

As mentioned above, Evelyn had suffered a childhood fall that left her with chronic pain and discomfort in her hip and leg. Her big fall, however, is the story of her deterioration under psychiatric treatment in Austin. How did Evelyn go from being a competent, productive special education teacher to being unable to think clearly and barely able to walk in less than 2 years?

In the fall of 2003, Evelyn began another year of teaching at the Texas School for the Deaf. But this year she was having a hard time. She had begun to suffer more pain in her body and was diagnosed as being fibromyalgic. She also had surgery on her foot. She does remember being under a lot of stress at work because of tension with her supervisor about policy for handling a certain student who had great difficulty with basic self-care and eating. There was also a difficult family dynamic in that her father was becoming unable to care for himself but refusing to move from his home. In short, there were several significant life stressors Evelyn was feeling. When she told her general practitioner that she was feeling depressed, he did what countless family doctors do today for millions of American citizens—he prescribed a so-called antidepressant, one of those ubiquitous serotonergic drugs—in this case, Paxil.

Psychiatric Drugs

Up until November of 2003, Evelyn Scogin had absolutely no psychiatric history. Now her experience as a mental patient began—medical authority had let her know that her problems were apparently not because of the obvious physical, emotional, familial, and vocational stressors she was simultaneously experiencing. In fact, she was told that she was "mentally ill"—suffering from a depression caused by a regrettable chemical imbalance that could presumably be controlled by the chemical balancer known as Paxil.

Just as Evelyn's role as a psychiatric patient began, so did her experience of inadequate informed consent. Evelyn reports that nobody clarified for her that the idea of chemical imbalance was a theory lacking scientific validation (Lacasse & Leo, 2005) or that the antidepressants are considered by many to actually create rather than cure abnormal brain states (Moncrieff & Cohen, 2006). Evelyn says that she was not told of the full range of dangerous effects caused by Paxil (Breggin, 2001), nor was she informed of the substantial

inefficacy of the serotonergic drugs in treating depression (Kirsch et al., 2008; Turner, Matthews, Linardatos, Tell, & Rosenthal, 2008). In any event, Evelyn was feeling depressed and needy, and like so many, perhaps most, folks, she understandably trusted the doctor.

Evelyn started on Paxil. She got through the year, but things got worse, and on September 28, 2004, Evelyn was admitted at Seton Shoal Creek Hospital as suicidal after an overdose of an antihistamine. According to the medical records (Scogin obtained part of her records from the hospital in early 2007 at a personal cost of $250), she reported being depressed, having trouble sleeping, being irritable, having panic attacks, bouncing checks, and having trouble with the rent because she was buying other things instead. Her blood work indicated a host of significant problems, and the report indicated "a large amount of blood" in her urine. Dr. Shiva Lam became her treating psychiatrist. As a brief but significant aside, in October 2005, Dr. Lam testified in a hearing on forced drugging in Austin (for Seton Shoal Creek Hospital) in which I also testified—on the other side. When queried by the defendant's lawyer, Dr. Lam made a categorical statement that there were no withdrawal effects from any of the drugs—Risperdal, Depakote, and Ambien[1]—he had prescribed for the defendant. This trio of drugs is very similar to some of the ones he had Evelyn on. I refer the interested reader to my write-up of that commitment case (Breeding, 2006); please note that I used a pseudonym in that article; "Dr. Patel" is actually Shiva Lam.

In any case, Dr. Lam diagnosed Evelyn as suffering from major depression on admission and as bipolar disorder, type II, depressed on discharge a week later on October 4. She was admitted with a very poor global assessment of functioning (GAF) of 35, and she was discharged at 55 after she had "achieved maximum benefit from treatment." This assessment is significant as it was repeated verbatim for each of her six inpatient hospitalizations in the period between September 28, 2004, and May 9, 2005. Presumably, the maximum benefit refers to the obvious primary treatment, which may also be characterized as maximum—she entered Seton Shoal Creek taking 25 mg of Paxil. She left a week later on 11 drugs:

1. Zyrtec 5 mg p.o. (by mouth) q.a.m. (in the morning)
2. Nexium 40 mg p.o. q.a.m
3. Neurontin 300 mg p.o. q.h.s. (at bedtime)
4. Lamictal 25 mg p.o. q.h.s.
5. Paxil CR 37.5 mg p.o. q.a.m.
6. Micro-K 20 mEq (milliequivalents) p.o. q.a.m.
7. Novafed 120 mg p.o. q.a.m.

8. Maxzide 1 p.o. q.a.m.
9. Xanax XR 1 mg p.o. q.a.m.
10. Seroquel 100 mg p.o. q.h.s. (every night)
11. Ambien 10 mg p.o. q.h.s. p.r.n. insomnia

Six of these are overtly psychoactive, and two other allergy drugs are known to have psychoactive properties. I do not know about the others, but it would be virtually impossible to calculate all the potential interaction effects. Again, in a related aside, during voir dire in that aforementioned commitment hearing with Dr. Lam, when it was being argued whether the witness may be qualified as an expert for the court, the defense attorney brought up a current finding by the state medical board against Dr. Lam—the charge being the practice of polypharmacy without proper substantiating documentation. I never followed up on the results of that investigation, but this is part of the public record with the Texas Medical Board.

Effects of Paxil include every one of Evelyn's presenting problems—depression, suicidality, insomnia, irritability, and panic attacks. This pattern of sleeplessness, irritability, and panic should be seen as a likely indicator of a dangerous, drug-induced neurological condition known as akathisia, often associated with suicidality. Add to this the presenting facts at her first hospitalization—that she was bouncing checks and having difficulty paying the rent because she was buying other things instead—and this profile becomes one that would fit well in Peter Breggin's new book, *Medication Madness* (2008). Here, he details the research and case after case of the life-damaging effects of involuntary intoxication caused by psychiatric drugs. Rather than seriously address Evelyn's social, economic, and psychological distress; or adequately address her clear, severe physical medical problems; or seriously consider that her troubles may have been exacerbated, if not in some ways directly caused by the Paxil, Dr. Lam and Seton Shoal Creek sent her home after "achieving maximum benefit" in 7 days, on a polypharmic cocktail of 11 different intensely interactive drugs, the majority of which are intensely psychoactive.

Is it any wonder that after a week of an outpatient program, Evelyn was readmitted to the hospital on October 12, after taking 15 ibuprofens in a weak suicide attempt, intensely worried about money and job, feeling "worthless and hopeless?" The record shows that she was still experiencing panic attacks and also "crying spells." This crying had been noted as a sign of too much empathy to be able to benefit from the outpatient group therapy. As a psychologist, I would normally interpret panic attacks as an expression of intense fear and crying spells as emotional healing; I would support and encourage emotional discharge as a healing trend. I also know, however, that the

deranging effects of a drug cocktail as massive as Evelyn's precludes any clarity about what is really going on since separating the drug effects from her true psychic experience would be impossible. Evelyn was discharged on October 18, again having "achieved maximum benefit from treatment," as apparently indicated by a change in her GAF score from 35 at admission to 55 at discharge. She was now on 10 drugs; Paxil was upped to 50 mg and Seroquel was tripled to 300 mg.

For Evelyn, it was back to the outpatient program. A medical consult by Dr. Meyerson on October 31, 2004, described Evelyn as obese and hostile; she apparently responded angrily to his question about when she was diagnosed as diabetic and then told him it was about 6 months ago. She attended as an outpatient until November 4 when she was readmitted, "hearing voices" and having cut her wrist, a reportedly superficial laceration. Five days later Evelyn was discharged after she "achieved maximum benefit," this time progressing from a lower GAF of 25 to the same discharge assessment of 55. Now she was on only 8 drugs as the allergy medications were discontinued. Seroquel went up to 400 mg and 2 mg of Ativan was added, as was a drug for acid reflux, Protonix, which has a side effect of insomnia.

Three weeks later, on November 30, Evelyn was once again admitted as an inpatient, this time for "depressive psychosis-severe." She was severely depressed, suicidal, "hearing whispers" and "seeing shadows," and reportedly cutting herself every day. After another week, she had again "achieved maximum benefit from treatment." She left this time on nine drugs—Lamictal was increased sixfold to 150 mg, 10 mg of Ambien was added, and an additional 25 mg of Seroquel was added to the 400 mg, to be used as many as three times a day as needed for anxiety. The record also showed that her white blood and platelet counts were low, as was her potassium and thyroid function.

Apparently, Evelyn made it through the Christmas holiday; 5 days into the New Year she reentered Seton Shoal Creek on January 5, 2005; this time she stayed for almost 4 weeks. The record shows that Evelyn reported having a lot of problems with her father and that "her depression recently worsened to the point that she overdosed on ibuprofen and cut her left wrist." She also reported auditory hallucinations of "whispers in my ears." Thyroid and potassium were still low.

Electroshock

This time, Evelyn not only stayed longer but Seton Shoal Creek also took its "treatment" to a new level. I have written about psychiatric electroshock, also known as electroconvulsive therapy or ECT (Breeding, 2000), and I most

highly recommend Linda Andre's (2009) exceptional new book, *Doctors of Deception*, as a premier resource on the history and current reality of electroshock. The bottom line is that I and our aforementioned citizens group, the CAEST, see it as follows:

Electroshock always causes brain damage.
Electroshock always causes memory loss.
Electroshock sometimes kills.
Electroshock is never necessary.

Each of these statements is documented on the CAEST website, along with the fact that electroshock is not effective beyond—for some—a very short term lessening of overt symptoms of depression. For Seton, however, as for the institution of psychiatry in general, electroshock is the "treatment of next resort," after all the drugs. I think that it makes things clearer to consider electroshock recipients such as Evelyn, who have already been severely deranged by polypharmic cocktails, as "targeted for destruction," a phrase I first heard in the Reevaluation Counseling Community (www.rc.org). It is certainly true in my experience that it is next to impossible for an electroshock survivor to emerge from the disorienting and disabling effects of ECT in time to file a malpractice or damage lawsuit within the 2-year stature of limitations. At any rate, Evelyn was approached about ECT on January 7 and had a consult with the local electroshock psychiatrist, Nasrul Islam, on that day.

Between 24 and 31 of January, Evelyn received four ECT "treatments"; the record shows that one of the induced seizures lasted 109 seconds. She was discharged on 9 drugs on February 1 as she "appeared to have achieved maximum benefit of treatment." The dose of Lamictal was doubled to 300 mg, and she was switched from Paxil to 150 mg of Zoloft. She was also started on 900 mg of Lithobid, or Lithium.

Psychiatry does not interpret the short-term effect (and inevitable return of symptoms) of electroshock as treatment failure; rather, just as with the need to take "medicine" forever, the belief is that "mental illness" is a biological or genetic defect that cannot be cured or healed, only kept under control. Hence, with depression, there is a need for "maintenance ECT" to keep the disease at bay. At the time of her book (Dukakis & Tye, 2007), Kitty Dukakis had already undergone eight series of ECT between June 2001 and May 2005, or one series every five and a third months on average, with each series apparently consisting of five to seven electroshock sessions. In New York State, the Office of Mental Hygiene attorney Dennis Feld reports that some

people have as many as 300 court-ordered "treatments" as part of their maintenance programs (Feld, July 18, 2007, personal communication).

Evelyn began outpatient ECT the day after discharge, on February 2. By March 1, she had received 13 electroshocks. On March 18, she was reported as "more depressed." On March 25, she received electroshock number 18. The amount of electrical energy used to induce her seizure that day was 161.5 joules. (For her first session, they used 42.1 joules.) Joules is a measure of overall electrical stimulus energy, and 161 joules is a tremendous amount of energy. A watt is defined on Wikipedia as equivalent to 1 joule of energy per second,[2] and Evelyn was shocked with 161.5 joules. This is enough electrical energy to keep a 40 watt bulb burning for 4 seconds, or an 80 watt bulb burning for 2 seconds.

Another way to think about Evelyn's experience is in terms of the flow of electric current. Electroshock researcher Richard Warner (2008) made a few calculations based on the electrical parameter's of Evelyn's 18th shock, available from her medical records. These records show that she received a flow of electrical energy equal to 0.144 amperes (A) (144 millicoulombs per second [mC/s]) for 4 seconds.[3] Although this might seem like a small current, consider the following data from the Princeton University Lab Safety Training Guide (2009). A wire carrying 1 mC/s can be perceived as "live." At 5 mC/s (5 mA), a slight shock is felt. At 6 to 30 mA, the shock becomes painful, and there is a desire to let go of the wire. A current of 50 to 150 mA causes severe pain and muscle contraction causing an inability to let go of the wire.

Estimates of what percentage of the electric current produced by a shock machine actually passes into and through the brain during a shock treatment (much of it is shunted through the scalp) vary from 1% (Swartz, 2009) to more than 35% (Byrne, Farcuharson, & Schofield, 1995). Even if only a very conservative estimate of 4% to 5% of 144 mC entered Evelyn's brain, she was still being subjected to a current flow that could produce pain in someone holding a wire carrying the same current. It is not unreasonable to conclude that having the brain "hold" this wire for 4 seconds might not be such a good idea.

Or think of it in terms of voltage, which may be considered as the amount of electrical pressure used to push the electricity. We are familiar with 6- and 12-volt (V) batteries, or the standard 120-V home outlet. Using the data from Evelyn's 18th electroshock, the calculation is 280 volts! That is considered dangerous high voltage in medicine and in the building trades. The natural electrical activity of the brain is measured in millivolts (mV).

Regardless of the amount of current that enters the brain, it remains that shock treatment produces a grand malseizure and a number of other

physiological effects (blood pressure in the hypertensive range, breakdown of the blood–brain barrier, glutamate excitotoxicity, and other changes in brain chemistry) that are fully capable of damaging the brain and causing cell death, irrespective of the damage that might be caused directly by electrical current (Sterling, 2001). Of greatest concern is the fact that brain damage is cumulative.

Evelyn was readmitted to the hospital on April 11 as suicidal, angry, and experiencing visual hallucinations. The record recounts Evelyn's assertion that she was under pressure from her sister to move out. At this time, she reportedly complained of memory loss, which is the neurologist's sine qua non indicator of brain damage. She was discharged 4 days later on eight drugs, having "achieved maximum benefit of treatment," improving from an admitting GAF of 30 to 55 at discharge. She is now taking 300 mg of Lamictal, 900 mg of Lithium, 600 mg of Seroquel, 150 mg of Zoloft, and 10 mg of Ambien as part of her daily treatment regimen.

The electroshock continued. On May 9, she received electroshock number 25. A series of medical consultations are included in her records, in particular after the electroshocks had progressed. A medical consultation on the 8th electroshock cited many problems, including hypokalemia and hypoglycemia. On June 24, Evelyn received her 31st electroshock, and possibly her last, at least according to the limited records I have seen. As Kathy Scogin reports in a video interview with herself and Evelyn in March of 2007, which may be accessed from the video archives on our website (www.endofshock.com), Kathy had been trying to convince Evelyn to stop the electroshocks when it became apparent that things were only getting worse. Evelyn does not remember this, and besides, she tended to trust and submit to the doctors. Finally, however, Kathy convinced her that she could stop, and after that 31st treatment, Evelyn called Dr. Lam and stopped the shocks. She had managed to get on disability and continued to see Dr. Lam on an outpatient basis.

This last dynamic between Evelyn and Kathy raises the crucial issue of electroshock and informed consent (Breeding, 2000), and Evelyn spoke directly about it when she testified before the Austin City Council on May 15, 2007 (CAEST report, 2007). In that city council hearing, Evelyn challenged earlier assertions by a man defending ECT that informed consent was in place. She pointed out that while she apparently signed consent for each of the 31 electroshocks she received, she was not only heavily drugged at the time but also that she actually remembers none of them. She asked, "Is that consent?" Evelyn does not mince words. She ended with a quote of psychiatrist Thomas Szasz from Leonard Roy Frank's *History of Shock Treatment*:

> The prime purpose of psychiatric treatments—whether utilizing drugs, electricity, surgery, or confinement, especially if imposed on nonconsenting clients—is to authenticate the subject as a "patient," the psychiatrist as a "doctor," and the intervention as a form of "treatment." (Szasz, 1971)

Reemergence

I have very often seen that a significant part of people's reemergence from being devastated mental patients involves reclaiming power by speaking the truth about the forces that hurt them. Groups such as MindFreedom International, the National Association of Rights Protection and Advocacy, the National Empowerment Center, and Prosumers International are active in the dynamic of psychiatric survivors challenging various aspects of psychiatric oppression. As mentioned above, Evelyn Scogin had recorded an Internet video just prior, in late March of 2007, and testified to the Austin City Council on April 4. Just prior to all this, on March 15, 2007, Evelyn was on the stage at the 5th annual Roky Erickson Psychedelic Ice Cream Social Celebrating Electroshock Survivors; she spoke briefly to the music-loving audience as she was honored that day. Evelyn told the deeply moved crowd about how she was not given authentic informed consent when she agreed to be electroshocked. I wrote of the ice cream social (Breeding, 2008); a documentary of the event may be viewed at the CAEST website.

Speaking out was a huge, brave step for Evelyn. On August 2, 2007, just a few months after these springtime events, Evelyn started in private counseling with me. At that time, she was a client with Texas Mental Health and Mental Retardation and was on several psychiatric drugs, including Lithium, Lamictal, Seroquel, Zoloft, and Ambien. We have worked together in counseling since, at times meeting every week, at other times every other week. My general theoretical orientation is humanistic, with a penchant for experiential work that involves emotional release and healing. Evelyn's work in counseling was by necessity very practical in the beginning, as it took a long time to gradually withdraw from all the drugs, address various medical issues, and stabilize her life. She has also demonstrated deep experiential work at times, more so now that she has been off all the drugs and out of crisis for awhile. Her work aligns with the humanistic understanding of choice and self-determination. A little more of this process follows.

In the summer of 2007, Evelyn was very frustrated about the restrictions on her independence. She could not drive, had trouble walking, experienced a very difficult time with short-term memory and directions, and was very often discovering more gaps in her overall memory. And, of course, she had lost her career as a teacher at the Texas School for the Deaf.

Evelyn was facing serious problems with her family as she had moved from her residence of several years with her youngest sister and was now living with Kathy whose son was also living in the small apartment, and was reportedly resentful and hostile about Evelyn's presence. Furthermore, her father was now in a nursing home and progressively weakening. Especially frustrating for Evelyn was the fact that she did not remember many of the events of the past 3 years, in particular the circumstances of having to move from her home and of her father's transition to a nursing home. These profoundly important events were apparently wiped from her memory.

She was having a hard time, and on August 16, a suicide attempt was followed by another brief admission to Seton Shoal Creek. Ironically, the event was a significant step in Evelyn's recovery. Most important, as Evelyn proudly reported to me on August 22, was that she "rejected Dr. Lam four times" in his overtures to continue as her treating physician. This was a huge step in saying "No" to this psychiatrist; there were also other examples of her developing muscles for standing up for herself. A second event involved the subsequent consultation with Dr. Whitelock, the Seton Shoal Creek medical director, who had met with our CAEST steering committee the previous year and reviewed and rejected our appeal for a halt to electroshock at his facility. In this consultation, Whitelock took Evelyn off Lamictal, Seroquel, and Ambien; he replaced them with Geodon, Klonopin, and Zongren. Evelyn said that she was feeling better and more alert on this combination, especially in the mornings. She was continuing to feel more empowered, her appetite for alertness and self-assertion was whetted, and she was chomping at the frustrating bit of restricted autonomy and independence.

From this psychologist's point of view, this last sentence above is way more interesting and rewarding than a treatise on the dynamics of biopsychiatry and psychopharmacology. Terms such as *empowerment*, *alertness*, *assertiveness*, *autonomy*, and *independence* are the lifeblood of humanistic psychology, where purpose, choice, and self-determination are clearly seen as essential to freedom, dignity, growth, and recovery.

Evelyn found a private psychiatrist—a very difficult task for someone on Medicaid—who would listen to her and agreed to support a partial withdrawal from some of the drugs she was taking. As an example of this difficulty, and an irony, Evelyn reports that Dr. Lam does not accept Medicaid patients in his private practice unless they have a secondary insurance to totally cover his full fee. In any event, she gradually weaned, and 14 months after she started, on October 30, 2008, she was off all the psychiatric drugs except Lithium. The psychiatrist drew the line here, and like countless other people, she had to go the rest of the way on her own. Her stated goal had been

to be psychoactive drugfree by the New Year, and on December 30, 2008, she was off all psychiatric drugs and remains so to this day.

I was privileged to support Evelyn in the nitty gritty of counseling as she steered her way through various life challenges, asked brave questions, and made brave statements to friends, family, and professionals. She worked on certain past traumas, including a few sessions on the horror of electroshock, and made her way through intense emotions or fears, shame, and anger. Although memory loss and some degree of learning disability are permanent as a result of brain damage, Evelyn's ability to think and feel has steadily improved. In fits and starts, life got better.

The Role of Physical Medicine

I would be remiss not to emphasize a major aspect of Evelyn's recovery, mentioned in passing in the above narrative summary of her 9-month intensive at Seton Shoal Creek from September 2004 through June 2005. I refer to her physical medical problems, which were both persistent and severe. It is well known, or ought to be, that a variety of physical conditions cause psychiatric symptomatology; the website of Safe Harbor (www.alternativementalhealth.com) makes a great deal of this information available. In our failed negotiations with Seton Shoal Creek to stop electroshock, we had requested and urged them to consider becoming a model program of "psychiatric wellness," offering full screening, assessment, and treatment of physical conditions known to create or exacerbate problems with mood and thought that get diagnosed as mental illness. Two pieces of information available from Safe Harbor that would have probably made a profound difference for Evelyn were that blood sugar problems such as hypoglycemia and diabetes are causative factors in depression and that thyroid problems can cause symptoms that get called bipolar disorders. As noted in the above narrative, Evelyn had multiple medical problems, including blood sugar and thyroid disorders, and these were, of course, only worsened by the drugs and electroshock.

In early September 2007, only a month after we had begun counseling, Evelyn was briefly hospitalized at the nonpsychiatric St. David's for possible heart failure and apparent drug reactions. She was diagnosed with herpes and possibly hepatitis C. On September 12, she found the private psychiatrist who cooperated with her beginning effort to lessen her drug load. Her father died on September 20. She did not have hepatitis, but figuring out what was going on and the handling of her medical problems was an intense aspect of her life in these next 2 years.

On November 22, 2007, Evelyn had a troubling cyst removed. Walking was increasingly painful, and at this time, she was also preparing for upcoming knee replacement. One knee was replaced in December; rehabilitation was hard and painful, but she was doing it. The physical therapy was important. Evelyn also has major dental problems; she had a painful tooth extraction on April 17, 2008. An ongoing frustration was the terrible impossibility of addressing her dental problems as, despite her growing assertiveness and amazing ability to find resources in the community, she could not find a provider to do this through Medicaid. In May, a huge related blow occurred when Medicaid refused to pay for her planned second knee replacement. To this day, she walks with a cane and uses a motorized wheelchair as her transportation to and from bus stops and other needs for extended activity; she powers her wheelchair 1 mile from the neighborhood bus stop to my home office for our counseling sessions.

In that spring of 2008, Evelyn was having frequent throat and respiratory infections, feeling poorly and having difficulty breathing and eating. In early June, she finally found a doctor who took her seriously—there was a serious concern about possible thyroid cancer. This was happening at the same time that she was intensely challenging her apartment complex to install proper handicap access. In October 2008, she finally got a biopsy that said there was no thyroid cancer, but the gland was so severely swollen and disfigured that plans were made to remove it as it was an obvious source of many problems.

Surgery on January 22, 2009, was successful, and after a brief recovery, Evelyn began feeling quite a bit better. Chronic neck pains lessened, and the recurrent throat and respiratory illnesses have abated. Could it be that a proper diagnosis and treatment of her already existing thyroid problems, noted in the Seton Shoal Creek medical records 4 years ago, might have helped really ensure that she had "achieved maximum benefit from treatment" at that hospital? One major effect of a psychiatric "mental illness" diagnosis is that it tends to act as a "stop sign"; the problem is assumed to be explained, and the search for causation is ended—actual underlying causal factors remain undetected.

Returning to Work

Shortly after this last surgery and recovery was when Evelyn actively began her job search. Six months later, the good news was that Evelyn finally got hired at a position with supervisory responsibility at Austin State School, once again employed in her chosen profession. Evelyn's return to work, after 5 years, on the very day I wrote this sentence (September 1, 2009), was an awesome highlight of my professional experience. This exciting

development was intended as the capstone to this article. In my mind, Evelyn would no doubt succeed; true this would be a big challenge—just getting there by maneuvering the streets, sidewalks, and buses of Austin in a wheelchair is daunting. However, I had seen this remarkable woman successfully take on and overcome multiple intense obstacles since we met less than 4 years ago.

Little did I know that 4 days later Evelyn would be fired from the job.

Four days into her new position, during the mandatory training for management of aggressive behavior, Evelyn was asked to be on the receiving end of physical restraints. When she told them that she would happily demonstrate her ability to enforce the procedure, but would not submit herself to restraint, she was fired. The justification was that it was mandatory policy for all to experience what it was like. Evelyn explained that she had years of experience and could do the restraints but that she was not willing to be restrained at this time because that would be retraumatizing for her after what she had been through at Seton Shoal Creek. I heartily empathized and understood; one other shock survivor friend of mine who made a decision to go public and speak out (and who has given her consent to reveal herein this information about herself)—Mimi Greenberg, also honored at the Ice Cream Social—had been unable last year to endure a magnetic resonance imaging scan because she got so terrified when they went to strap her on the gurney. She could not figure it out right away, but when I visited her afterwards at her nursing home, she worked on it and ended up remembering the trauma of being strapped down for electroshock. The supervisors at Austin State School were not interested in Evelyn's reasons and were unwilling to work with her.

Evelyn felt devastated, and I also felt terrible. After a few days and a couple of counseling sessions, Evelyn is still angry but thinking clearly and deciding whether to fight the firing or move on in other directions. She has a number of ideas, including sign language interpretation work and transition specialty work in her field; she is enrolled to take the state sign language interpreter certification exam in March of 2010. Another most excellent development occurred the day I was editing this manuscript (February 25, 2010), when Evelyn came in for a session and excitedly told me that she had just been hired as a special education tutor in one of the Austin schools to begin on March 8!

Evelyn is feeling more and more called on to be an outspoken activist about her experiences; her decision to go public in this article is an example. She also decided that she wanted to let Dr. Lam know about her experience, and she has just completed a letter, sent to him by certified mail, and included as an appendix to this article. The letter is already in the public domain (Scogin, 2010).

The Heroic Client

These 2 years working with Evelyn in counseling have been extremely rewarding; her courage, resilience, and determination have been inspiring, an awesome highlight of my professional experience. Seeing her go back to work was a highlight of observational and vicarious ecstasy; seeing her already bouncing back from the huge disappointment of being summarily fired deepens my respect and admiration. I have been doing this long enough to know, borrowing the title of Barry Duncan and Scott Miller's (2000) book, that Evelyn is "the heroic client." Duncan and Miller conclude after extensive review of psychotherapy outcome research that the client is the single most important factor predicting outcomes in counseling. They call these client qualities, and life circumstances and changes, extratherapeutic factors, outside the counselor's control.

Evelyn most definitely qualifies as heroic, and the primary factors in her reemergence were indeed extratherapeutic. Personal qualities included her resilient spirit, courage, stubbornness, persistence, self-determination, and willingness to take risks. Other extratherapeutic factors included her loyal and supportive sisters (especially Kathy), her spiritual group and beliefs, and the unexpected addition of a litter of kittens to her home shortly after she moved into her own apartment on March 15, 2008—exactly 1 year after being honored at the concert celebrating electroshock survivors!

Evelyn's recovery and reemergence are because of her hard work. Nevertheless, I want to acknowledge myself as an example of the nationwide cadre of so-called mental health professionals—a large percentage holding a presence in the International Committee for the Study of Psychology and Psychiatry—who resist the labeling, drugging, and electroshocking of our brothers and sisters. Many of us work as personal counselors to support growth, transformation, and, in particular, recovery from trauma inflicted by psychiatric oppression. There is a heroic aspect to this work; you have to take a stand against standard practice. Furthermore, it is necessary to negotiate an awkward and risky terrain in support of clients' decisions to reject their diagnoses and especially their "treatments" (drugs, ECT, etc.) considered so necessary by the system that forcible incarceration and drugging of U.S. citizens has become. As attorney Jim Gottstein (2008) details in his comprehensive law review article on the subject, it is "a matter of course."

Psychologists like myself, and other licensed counselors and social workers, require courage and intelligence to support psychiatric drug withdrawal—we are not medical doctors, we cannot prescribe, and we are not legally allowed to give medical advice. We can certainly provide information and we

can encourage, but it is intensely challenging. We are trained to counsel on life challenges, relationships, trauma, and emotional recovery, yet we are faced everyday with clients who have been hurt, often severely, by our colleagues in prior experiences of reaching out for help.

Evelyn Scogin is a profound testament to the human spirit. May this limited report of her inspiring story create a small disturbance in the mental health system that hurt her so badly. May it help us remember that gentle authentic care and support are usually all it takes to help along the natural relentless urge toward wholeness, recovery, and well-being. Changes in attitudes in the workplace would also help.

Appendix

Friday, February 26, 2010

Open letter to Dr. Lam:

When I met you at Seton Shoal Creek Hospital several years ago I was a vulnerable, desperate, confused woman. You and Shoal Creek were my first contact with psychiatry. I expected that you were there to help me overcome the emotional problems that were weighing me down. You were the doctor and I thought you were there to help. Instead of helping me you and all of your pills and electroconvulsive therapy in fact made me ill and very nearly destroyed me. Since leaving your care I have in fact found a real caring therapist who helped me heal myself and figure out a few things into the bargain.

First, I am not now and never was "mentally ill" because there is no biopsychiatric "mental illness" that caused my emotional upset. I did have serious physical medical problems with thyroid and blood sugar functions, which you and Shoal Creek chose to ignore and for which I later received help. Second, I do not need your pills and ECT treatments to "get better." I am a whole individual and there is nothing wrong with my mind. I only needed a place where it was safe for me to explore what issues were causing my emotional distress. Something your pills and treatments would never allow me, or anyone else for that matter, to do. Your brand of "treatment" only serves to shut down any healing and in effect shut-up anything your patients need to say.

I have gotten off of all of your drugs and healed as much as physically possible from the effects of your ECT treatments. I have found my voice again and I will not be silenced. Dr. Lam I am here to tell you and anyone else who will listen how dangerous you and your treatments are. My goal is to

inform as many people as I can of the dangerous effects of all of your forms of help. You once asked me, "Don't you want to get better!" Now I can give you my answer. No!!! I say no because I have nothing to get better from as if I was ill or broken and only by following your orders would I "get better," but never well. As if everything that was happening to me was my fault and I was to blame for it all. I don't need fixing, only caring and understanding, two things you never showed me. A good friend of mine tells me that every time she sees you, you ask about me. In response I say stop. I don't even want that much of your so-called caring treatment.

Sincerely,

Evelyn Scogin
Psychiatric Survivor
Activist for Humanistic Psychiatry

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Notes

1. At a criminal trial, an available transcript would be expected as a matter of course. In the "mental health" court, however, in cases involving abrogation of liberty and/or the right to choose whether to take drugs known to have a wide range of adverse effects, there is often not the same level of legal protections for the "patient"/defendant. There was no transcriptionist present at this hearing on forced drugging. There may or may not be an audio recording on file with the court as there should be a record of some type in case of the exceedingly rare appeal. For this article, consider my assertion about Dr. Lam's testimony to be a personal recollection. It is striking that after having been committed for 90 days, just a few days earlier, as "dangerous to himself and others" because of his severe "mental illness," the defendant was immediately released after this second hearing on the drugging question, which went against the state's desire to forcibly "medicate" their "patient" (Breeding, 2006).
2. More details about the electrical parameters are available from the author.
3. Method of calculation is available from the author.

References

Andre, L. (2009). *Doctors of deception: What they don't want you to know about shock treatment*. New Brunswick, NJ: Rutgers University Press.

Breggin, P. (2001). *The antidepressant fact book*. Cambridge, MA: Perseus Books.

Breggin, P. (2008). *Medication madness*. New York, NY: St. Martin's Press.

Breeding, J. (2000). Electroshock and informed consent. *Journal of Humanistic Psychology, 40,* 65-79.

Breeding, J. (2006). The case of Sohrab Hassan: Assault on liberty in the Texas Mental Health Courts. *Journal of Humanistic Psychology, 46,* 243-254.

Breeding, J. (2008). To see or not to see: Schizophrenia and the possibility of full recovery. *Journal of Humanistic Psychology, 48,* 489-504.

Byrne, P. O., Farcuharson, R. G., & Schofield, I. S., (1995). The pitfalls of dose titration as used in convulsive therapy. *Psychiatric Bulletin, 19,* 207-208.

Coalition for the Abolition of Electroshock in Texas. (2007, May 15). Report on Austin City Council Public Health and Human Services Subcommittee hearing on psychiatric electroshock in Austin. Retrieved from http://www.endofshock.com/5-15-07Report%20on%20Austin%20City%20Council%20Public%20Health%20and%20Human%20Services.pdf

Dukakis, K., & Tye, L. (2007). *Shock*. New York, NY: Penguin.

Duncan, B., & Miller, S. (2000). *The heroic client*. San Francisco, CA: Jossey-Bass.

Gottstein, J. (2008). Involuntary commitment and forced psychiatric drugging in the trial courts: Rights violations as a matter of course. *Alaska Law Review, 25,* 51.

Kirsch, I., Deacon, B. J., Huedo-Medina, T. B., Scoboria, A., Moore, T. J., & Johnson, B. T. (2008). Initial severity and antidepressant benefits: A meta-analysis of data submitted to the Food and Drug Administration. *PLoS Medicine, 5,* e45.

Lacasse, J. R., & Leo, J. (2005). Serotonin and depression: A disconnect between the advertisements and the scientific literature. *PLoS Medicine, 2,* e392. doi:10.1371/journal.pmed.0020392

Moncrieff, J., & Cohen, D. (2006). Do antidepressants cure or create abnormal brain states? *PLoS Med, 3,* e240. doi:10.1371/journal.pmed.0030240

Princeton University Lab Safety Training Guide. (2009). Retrieved from http://web.princeton.edu/sites/ehs/labguide/sec_5.htm

Scogin, E. (2010). *Electroshock therapy 2: ECT psychiatric survivor recovers after leaving psychiatry*. Retrieved from http://www.youtube.com/watch?v=0rdHy_vW2To

Sterling, P. (May 31, 2001). *Written testimony: Hearing on ECT*. New York: New York Assembly Standing Committee on Mental Health, Mental Retardation, and Developmental Disabilities.

Swartz, C. (2009). Electricity and electroconvulsive therapy. In C. Swartz (Ed.), *Electroconvulsive and neuromodulation therapies* (p. 5). New York, NY: Cambridge University Press. Retrieved from http://assets.cambridge.org/97805218/83887/excerpt/9780521883887_excerpt.pdf

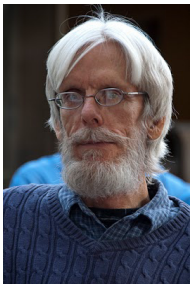
Szasz, T. (1971). From the slaughterhouse to the madhouse. *Psychotherapy: Theory, Research and Practice, 8,* 64-67.

Turner, E. H., Matthews, A. M., Linardatos, E., Tell, R. A., & Rosenthal, R. (2008). Selective publication of antidepressant trials and its influence on apparent efficacy. *New England Journal of Medicine, 358,* 252-260.

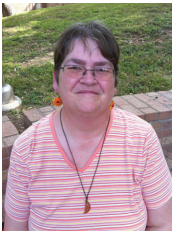
Warner, R. (2008). *Shock treatment: Efficacy, memory loss, and brain damage—Psychiatry's don't look, don't tell policy*. Retrieved from http://www.endofshock.com/Shock%20treatment.pdf

Whitaker, R. (2005). Anatomy of an epidemic: Psychiatric drugs and the astonishing rise of mental illness in America. *Ethical Human Psychology and Psychiatry, 7,* 23-35.

Bios



John Breeding, PhD, is a practicing psychologist in Austin, Texas. He is a founding organizer of the Coalition for the Abolition of Electroshock in Texas (http://www.endofshock.com) and has been active for many years in challenging various aspects of psychiatric oppression. He is the author of four books, including *The Wildest Colts Make the Best Horses* and *The Necessity of Madness*. His website, www.wildestcolts.com, is a great resource on psychology, parenting, human transformation, and issues of psychiatric oppression.



Evelyn Scogin is a certified teacher and has taught young people with special needs for 20 years. Her primary specialty has been in the field of deaf education. She is an active member of the Coalition for the Abolition of Electroshock in Texas and is currently writing a memoir on her experience with psychiatry and her ongoing reemergence.