

EXHIBIT 2

EXPERT REPORT BY JOHN READ, M.A., Ph.D. April 20, 2021

1. **Qualifications:** I have been a Professor of Clinical Psychology at the University of East London, England, since April 2016. I previously held the same position at the University of Liverpool, England; Auckland University, New Zealand; and Swinburne University of Technology, Melbourne, Australia. At the Universities of Liverpool and Auckland I was also Director of the Postgraduate Training Programmes in Clinical Psychology.
2. I graduated from the University of Wales with an honours degree in Psychology, before attaining my M.A and Ph.D in Clinical Psychology at the University of Cincinnati.
3. Prior to returning to work in academia I worked for thirteen years as a Clinical Psychologist and manager of mental health services, in the United States, England, and New Zealand, predominantly with patients at the extreme end of the spectrum of psychiatric disturbance, e.g., those experiencing psychosis or severe depression and suicidality.
4. I have over 200 research publications (Google Scholar 4.12.2021), which have been cited over 17,000 times. I have published over 50 book chapters and have edited or authored five books. I have given over 60 invited plenary/keynote addresses at psychiatric conferences in 17 countries. A list of my publications authored in the previous 10 years is attached hereto as Appendix A.
5. Since 2009 I have been the Editor of the international, peer-reviewed, scientific journal 'Psychosis: Psychological, Social and Integrative Approaches'. I am also currently the Chairperson of the International Institute for Psychiatric Drug Withdrawal.
6. In 2010 I received the New Zealand Psychological Society's Hunter Award (awarded only every three years) for 'excellence in scholarship, research and professional achievement.'
7. Since 2010, I have published four reviews of the research literature on the efficacy and safety¹⁻³ and mechanisms of action,⁴ of electroconvulsive therapy [ECT] (sometimes referred to as 'electroshock therapy' or 'shock therapy') in peer-reviewed journals. The most recent of these was a 40-page review in 2019,³ with Professor Irving Kirsch, Associate Director of Placebo Studies at Harvard Medical School.
8. I am also the lead researcher on two independent audits of the administration and monitoring of ECT in England's National Health Service.^{5,6}
9. In 2021 I wrote, by invitation, a summary of the ECT research literature for Psychiatric Times, a medical trade publication distributed monthly to approximately 50,000 psychiatrists, primarily in the United States.⁷ I have also published several summaries of the ECT research for the popular media, including Psychology Today and Aeon.
10. In the early 1970s I repeatedly witnessed ECT first-hand as a psychiatric nursing aide at a Bronx psychiatric hospital. I was assigned the role of sitting with people as they recovered

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consciousness and orientation during the postictal state, which can last from a few minutes to several hours following a seizure.

11. I have not previously testified as an expert witness. I am being compensated \$600 per hour for study and testimony in this case.
12. **Description and History of Electroconvulsive Therapy:** ECT is primarily, but not exclusively, used on depressed patients. It involves passing sufficient electricity through the human brain to intentionally cause a seizure. This usually requires between 70 and 120 volts, resulting in about 800 milliamperes of direct current passing through the brain, either across both temporal lobes (bilateral ECT) or, so as to minimise memory loss, across just one temporal lobe (unilateral ECT).
13. The typical course of treatment is between eight and twelve electroshocks, administered at a rate of two or three per week. The amount of electricity required to cause the seizure tends to increase during this process, because each electroshock can increase the seizure threshold of the patient, as the brain seeks to protect itself from additional seizures.
14. Sometimes more than one shock is given before the seizure is elicited. Unless a seizure occurs the treatment is deemed not to have been successfully administered.
15. The procedure now takes place under general anesthesia, with muscle relaxants, to avoid the spinal and other fractures that resulted from the original 'unmodified' form of ECT in the 1940s and 1950s.
16. The intentional causation of seizures was originally based on the belief, in the 1930s, that people with epilepsy do not have schizophrenia (the original target diagnosis for ECT) and vice versa. Therefore, it was thought, the cure for schizophrenia is to cause epileptic seizures. Various approaches to accomplishing this, including insulin overdose, were experimented with before Italian psychiatrist Dr Ugo Cerletti noticed hogs at a slaughterhouse being electrocuted via metallic tongs, to stun them before being killed. After the first administration of ECT, in 1938, the patient begged 'Not another one, it's deadly.'⁸
17. **Memory Loss and Brain Damage:** In the 1940s and 1950s autopsies consistently provided evidence of brain damage, including necrosis (cell death). A review in the esteemed British medical journal, the *Lancet*, concluded that 'all parts of the brain are vulnerable.'⁹ A subsequent review, of the first 20 years of autopsies, concluded: 'damage to the brain, sometimes reversible but often irreversible, occurred in the course of electric shock treatments.'¹⁰
18. It was originally argued that ECT worked because it causes brain damage. In 1941, Dr Walter Freeman, who introduced ECT to the United States, wrote, in a paper entitled *Brain Damaging Therapeutics*: 'The greater the damage, the more likely the remission of psychotic symptoms. . . . Maybe it will be shown that a mentally ill patient can think more clearly and more constructively with less brain in actual operation.'¹¹ Another US psychiatrist explained: 'There have to be organic changes or organic disturbances in the physiology of the brain for the cure to take place. I think the disturbance in memory is probably an integral part of the

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recovery process. I think that it may be true that these people have for the time being at any rate more intelligence than they can handle and that the reduction in intelligence is an important factor in the curative process. . . . Some of the very best cures that one gets are in those individuals whom one reduces almost to amentia.’¹²

19. In 1974, Professor Karl Pribram, head of Stanford University’s Neuropsychology Institute, wrote: ‘I’d rather have a small lobotomy than a series of electroconvulsive shock. . . . I just know what the brain looks like after a series of shock – and it’s not very pleasant to look at.’¹³
20. Today, it is accepted by all concerned, that some degree of memory loss occurs for almost all patients, and that some patients recover that memory loss within a few weeks.
21. A 2004 New Zealand Government report concluded that ‘ECT may permanently affect memory’ and bemoaned the ‘slowness in acceptance by some professional groups that such outcomes are real and significant in people’s lives.’¹⁴ A U.S. psychiatry textbook states that ‘All patients should be informed that permanent memory loss may occur.’¹⁵ The American Psychiatric Association has acknowledged that ‘evidence has shown that ECT can result in persistent or permanent memory loss.’¹⁶ Somatics, a manufacturer of ECT machines includes ‘permanent memory loss’ in its list of adverse effects.¹⁷
22. There is not a consensus, however, on how many patients recover the memory loss over time and how many go on to suffer persistent or permanent memory loss.
23. A 2003 review of studies of self-reported memory loss, at least six months post-ECT, found a range of patients reporting memory loss from 51% to 79%, with an average of 70%.¹⁸ The same review found that the range for ‘persistent or permanent memory loss’ was 29–55%; with an average of 38%.
24. The memory loss caused by ECT can be categorised into two broad types. Anterograde amnesia is difficulty retaining new information. Retrograde amnesia is the loss of memories of past events, known as ‘autobiographical memories.’ There is a consensus that ECT can damage both types of memory loss to some extent. There is less agreement about the severity and duration of the two types of cognitive damage.
25. **Anterograde amnesia:** Almost everyone receiving ECT suffers anterograde amnesia, the inability to retain new information. An American Psychiatric Association report notes that as a result ‘returning to work, making important financial or personal decisions, or driving may need to be restricted.’¹⁶
26. For many the ability to retain new information returns over a period of a few weeks. For an undetermined number of patients this anterograde amnesia has been identified several years after ECT.^{19,20}
27. A 2019 review reported that ‘Recent meta-analyses suggest the most prominent deficits are on measures of attentional/executive control (i.e., tests measuring cognitive flexibility, inhibitory control, and processing speed) and auditory verbal learning/recall (i.e.,

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unstructured list learning), a memory task that is also strongly correlated with executive functioning.²¹

28. **Retrograde amnesia:** Three facts are generally accepted: (a) retrograde amnesia occurs to some extent in almost all ECT recipients; (b) memory of events closest to the treatment are most affected; and (c) some improvement occurs over time for some patients.^{16,22}
29. The APA report¹⁶ acknowledges: ‘In some patients the recovery from retrograde amnesia will be incomplete, and evidence has shown that ECT can result in persistent or permanent memory loss.’ A subsequent review of the research confirmed that ‘ECT can cause persistent or permanent memory loss, especially autobiographical memory.’²²
30. The first large-scale prospective study of cognitive outcomes, in 2007,²³ found that six months after ECT, autobiographical memory was significantly worse ($p < .0001$) than pre-ECT levels. Furthermore, 12.4% were deemed to have suffered ‘marked and persistent retrograde amnesia.’
31. In an earlier study, in which ECT recipients performed worse than non-recipients on ability to recall 1960s celebrities and childhood memories, the average time since ECT was 8.4 years.²⁰
32. **Bilateral vs Unilateral ECT:** There is a clear consensus that Bilateral ECT (where the electrodes are placed on opposite sides of the head) causes more cognitive impairment, including memory loss, than Unilateral ECT (where the electrodes are placed at the front and back of the non-dominant temporal lobe). Unilateral ECT was introduced explicitly as an attempt to reduce the damage caused by the original, bilateral, electrode positioning.
33. The large prospective study in 2007²³ found that six months after Bilateral ECT patients showed significantly more autographical memory/retrograde amnesia impairment than those receiving Unilateral ECT. The Bilateral patients suffered 2.8 times more impairment than a healthy control group over the same time period. The degree of impairment in the Bilateral group was significantly related to the number of electroshocks administered.
34. Subsequent studies of Unilateral vs Bilateral ECT have confirmed the 2007 study. For example, a recent Irish study found, at both 3 and 6 month follow ups, that the recall of autobiographical memories was significantly worse in the Bilateral group than in the Unilateral group. There had been no difference before ECT.²⁴
35. **Gender and memory impairment:** Women suffer more ECT-induced memory loss than men. In the 2007 prospective study women were 2.5 times more likely than men to be categorised as ‘marked and persistent retrograde amnesia’ (16% vs 6%).²³ A recent analysis of 1212 medical records of ECT patients in Sweden found that 31% of women were assessed to have memory loss, compared to 18% of men.²⁵
36. **Memory impairment and depression:** Some ECT proponents suggest that memory problems after ECT are caused by depression not the ECT. Numerous studies in the 1980s and early 1990s demonstrated this hypothesis to be incorrect.²⁶ A Magnetic Resonance

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Imaging (MRI) study found that the number of ECTs administered correlated with reduced grey matter density, after controlling for level of depression.²⁷ A subsequent review of the relevant research found ‘no evidence of a correlation between impaired memory/cognition after ECT and impaired mood, much less a causal relationship’.²⁸

37. Besides the empirical evidence, there are two logical complications. The purpose of ECT is to alleviate depression, so post-ECT cognitive dysfunction could only be caused by depression in those patients for whom the ECT did not work. One research group¹⁸ identified five previous studies showing no significant relationship between anterograde or retrograde amnesia and clinical change after ECT. Their own study found that retrograde amnesia was related to the ECT and not to mood state before or after ECT. Another study found no correlation between post-ECT changes in depression and changes in any of 12 cognitive measures.²⁹
38. The second logical problem is that if there is a relationship between mood and post-ECT memory loss, causality could be in either relationship. Anecdotal evidence suggests that the effects of ECT on one’s memory can be depressing. Just before killing himself, shortly after ECT, Ernest Hemingway asked: ‘What is the sense of ruining my head and erasing my memory, which is my capital, and putting me out of business? It was a brilliant cure, but we lost the patient.’³⁰
39. **Does the memory loss constitute brain damage?** There is no consensus amongst ECT researchers on whether the well documented anterograde and retrograde amnesia memory induced by ECT should be thought of as ‘brain damage.’ On the one hand it can be argued that ‘marked,’ ‘persistent’ and ‘permanent’ damage to the cognitive functioning of the brain is, by definition, damage to the brain. Others highlight the fact that not all brain scan or imaging studies show clear signs of damage.
40. Early autopsies,^{9,10,13} and early theories about how ECT worked,^{11,12} were clear that ECT causes significant brain damage, and named it as such. While some claim that early studies are not relevant because today’s ECT is so different, a constant fact, from 1938 to today, is that sufficient electricity has been administered to the brain to cause a seizure.
41. While scanning and imaging studies have produced inconsistent results, some computerised tomography (CT) scans have found frontal lobe atrophy following ECT.^{31,32} An MRI study found that the number of ECTs administered correlates with reduced grey matter density.²⁷ Marked deactivation in several cortical regions have also been found.³³
42. My own review of more than 100 imaging studies (with Dr Roar Fosse of the University of Oslo)⁴ concluded that ‘the temporarily improved scores on depression instruments following ECT reflect the combination of frontal and temporal lobe functional impairments and activation of the hypothalamic–pituitary–adrenal axis (HPA axis) and the mesocorticolimbic dopamine system. These effects as well as other detailed changes observed in structures such as the hippocampus appear consistent with those typically seen after severe stress-exposure and/or brain trauma.’

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43. Beyond the potential brain damaging effects of the electricity, an editorial of the American Journal of Neuroradiology concluded that ‘A number of experimental animal and clinical imaging studies support the idea that seizures by themselves cause brain damage.’
44. ECT can cause repetitive intracranial mild traumatic brain injury which is not easily captured on standard brain scans. The neuropathology of repetitive high field strength electricity on brain tissue involves compounding microstructural damages only visible under microscope with proper staining technique. Cellular, microvascular, neuronal, voltage-gated ion channel damage is invisible on standard brain scans.³⁴⁻³⁷
45. Bennet Omalu, MPH, a neuropathologist who identified chronic traumatic encephalopathy in National Football League players, stated that, where they exist, functional injuries resulting from ECT must be considered as both repetitive brain injury and repetitive electrical trauma.³⁷
46. Although it is generally agreed that the electricity has a causal role in the brain damage, an Editorial of the American Journal of Neuroradiology notes that ‘A number of experimental animal and clinical studies imaging studies confirm the idea that seizures by themselves cause brain damage.’³⁸
47. The ECT manufacturer, Somatics, now includes ‘permanent brain damage’ in its list of risks from ECT.¹⁷
48. **Psychological impact:** Non biological adverse effects of ECT are rarely studied. In one study, of 20 people who found ECT upsetting, interviews revealed ‘fear, shame and humiliation, worthlessness and helplessness, and a sense of having been abused and assaulted.’³⁹ The UK’s official national guidelines acknowledge that some people report ‘feelings of terror, shame and distress, and found it positively harmful and an abusive invasion of personal autonomy, especially when it was administered without their consent’.⁴⁰
49. **Mortality:** The idea that the mortality rate from ECT is “1 per 10,000 patients or 1 per 80,000 treatments” has been promulgated, without supporting evidence, by the American Psychiatric Association¹⁶ and the FDA.⁴¹ A recent study reported 2.1 per 100,000 treatments but this was based on medical records, i.e. relied on staff recording that they had caused a death.⁴²
50. Numerous studies have found mortality rates many times greater than these claims. Of 8,148 ECT recipients in Texas, seven died within 48 hours.⁴³ Excluding the two deaths considered ‘unlikely to have been related to ECT’ this is one per 1,630. Eight more died within 2 weeks, of ‘cardiac event,’ a common ECT-related cause of death. If these are included the rate becomes one per 627.
51. When researchers wanted to interview 183 people, 1 year after ECT, it was reported that two (one in 91.5) had died during the ECT.⁴⁴ A study by the Royal College of Psychiatry in the UK found that four out of 2,594 ECT patients had died within 72 hours.⁴⁵ It could not be determined whether the one death (4 days post-ECT) among 75 French ECT recipients was

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- ECT-related. This study found a ‘potentially life-threatening complication’ in 16% of patients.⁴⁶
52. A 2019 review of 82 studies found that about one in 50 people suffer ‘major adverse cardiac events’ after electroconvulsive therapy.⁴⁷
 53. The oft repeated claim that ECT causes no more deaths than other interventions involving general anaesthesia ignores the fact that ECT patients are subjected to an average of ten such procedures.
 54. **Is ECT effective?** There is no consensus about whether ECT is effective for depression, its target diagnostic category. The conclusions reached are largely dependent on what methods researchers use to determine effectiveness.
 55. If one uses the normal scientific requirement of evidence-based medicine, randomised double-blind, placebo-controlled studies, ECT has clearly not been demonstrated to be effective.³ (Placebo in this case involves administering the general anaesthetic but withholding the electric shock and, therefore, the convulsion).
 56. There have only ever been 11 such studies for ECT regarding its main diagnostic target, depression.^{1,3} All were pre-1986. Only four described their processes of randomization and testing the blinding. None convincingly demonstrated they were double-blind. Five reported only some of their findings, and buried other findings. Only four reported any ratings by patients. None assessed Quality of Life. The studies were very small, involving an average of just 37 people (across both groups, ECT and placebo).
 57. Four of these 11 flawed pre-1986 studies found ECT significantly superior to placebo SECT (“S” stands for “sham”) at the end of treatment (for a minority of subjects). Five found no significant difference. Two found mixed results, including one where the psychiatrists reported a difference but patients and nurses did not.⁴⁸
 58. No study has ever found any benefit of ECT compared to placebo beyond the end of treatment.¹⁻³
 59. Some ECT proponents continue to claim, despite all these failings, that these early studies constitute evidence that ECT works.^{49,50} Others acknowledge the failings of the pre-1986 studies, but go on to argue that more recent studies, without placebo control groups, such as comparing unilateral and bilateral ECT, are sufficient.⁵⁰ My review² of these non-placebo studies revealed that none ‘produced robust evidence that ECT is effective for depression, primarily because at least 60% maintained ECT participants on medication, 89% produced no meaningful follow-up data beyond the end of treatment, and none investigated whether ECT prevents suicide.’
 60. Others argue that it must work because it has been used for such a long time.⁴⁶ History is littered with ‘treatments’ that were used for decades before being recognised as ineffective, harmful, or both. Lobotomy is just one example.

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61. Some seek to justify the absence of any randomised placebo controlled studies for 35 years by arguing that it would be unethical to treat very ill patients with a placebo.⁵⁰ This is tantamount to arguing that we must not research whether or not X works because it is wrong to withhold X from patients, because we know X works. This positions the ECT proponents making this argument beyond the parameters of science and modern evidence-based medicine.
62. There is also no meaningful evidence that ECT is effective for people diagnosed with ‘schizophrenia.’ A recent commentary on Cochrane reviews (widely regarded as the most objective and comprehensive reviews) reported that ‘What is common in all versions of these Cochrane reviews is that in spite of seven decades of clinical use of ECT for people with schizophrenia, there still is a lack of strong and adequate evidence regarding its effectiveness.’⁵¹
63. **ECT and suicide prevention:** No studies support the hypothesis that ECT prevents suicide. In a recent study 14,810 ECT patients were 16 times more likely to attempt suicide, within 12 months of treatment, than 58,369 non-ECT patients. After controlling for confounding variables the ECT patients remained 1.3 times more likely to kill themselves than the non-ECT patients (not a statistically significant difference).⁵²
64. **Mechanism of action:** Some ECT researchers acknowledge that the mechanism by which ECT produces a temporary lift in mood for some patients remains unknown. Early theories included the supposed incompatibility of mental illness and epilepsy, and the notion that brain damage was beneficial via the reduction of intelligence or erasure of distressing memories.^{11,12}
65. This approach of construing brain damage as a therapeutic tool was recently resurrected by Scottish researchers when their study found that ECT reduces the ‘functional connectivity’ of the brain. The researchers proposed that this was a good outcome because ECT is correcting a supposed ‘hyperconnectivity’ in depressed people.⁵³ The Head of ECT at Massachusetts General Hospital⁵⁰ argues, however, that ECT increases connectivity, which, according to the Scottish group, would increase depression.
66. There are two hypotheses about how ECT temporarily lifts mood for some people, which have empirical support. There is strong evidence in support of the placebo hypothesis, i.e. that most or all of the short-term benefits (there are no long-term benefits) result from the hope and expectations instilled in patients by the genuinely held hopes and expectations of the doctors and nurses, and by the additional attention and care that accompanies ten major medical interventions. Some ECT patients are severely depressed and desperate to try, and to believe in, anything.
67. All but one of the 11 placebo-controlled studies that have been conducted to date have found that sham-ECT (general anesthesia only) improved the patients’ mood to some extent.^{1,3} One reviewer concluded: ‘Rigorously defined endogenously depressed patients did exceptionally well with sham ECT, just as well as with real ECT.’⁵⁴

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68. Several of the psychiatrists conducting the 11 placebo-controlled studies commented on this issue. For example: ‘Effectiveness is due in large part to the attendant procedures associated with, the administration of an anaesthetic and the mystique associated with an unusual form of treatment’⁵⁵ and ‘The results confirm that many depressive illnesses although severe may have a favourable outcome with intensive nursing and medical care even if physical treatments are not given.’⁴⁸
69. The other evidence-based hypothesis about how ECT works (in the short-term, for a minority) is a variation on the theme of brain damage being beneficial. Many studies by ECT proponents identify multiple brain abnormalities following ECT, such as temporary enlargement of the hippocampus, but seek to characterise these abnormal changes as somehow beneficial.^{49,50} As previously noted, my review of more than 100 of these imaging studies⁴ concluded that ‘the temporarily improved scores on depression instruments following ECT reflect the combination of frontal and temporal lobe functional impairments and activation of the HPA axis and the mesocorticolimbic dopamine system. These effects as well as other detailed changes observed in structures such as the hippocampus appear consistent with those typically seen after severe stress-exposure and/or brain trauma.’
70. So the temporary lift in mood for some people following ECT may best be explained by an interaction of positive expectations and the type of brain abnormalities and mild euphoria that often accompanies brain trauma.
71. **Monitoring and Regulation:** Despite their repeated requests, FDA openly acknowledges never receiving premarket PMA studies assessing safety or Product Development Protocols to establish ECT’s safe dosing limits.⁵⁶
72. Eighty years of funded ECT research has produced no safety testing using modern clinical parameters, dosing limits or universal administration technique protocols to reduce known risks and create replicable results.⁵⁷
73. There is no national body monitoring or regulating the administration of ECT in the USA.
74. There is no official path to training psychiatrists in ECT, and no board certification.⁵⁸
75. **Current usage of ECT:** A review of 70 studies found ‘large variation between continents, countries and regions in utilization, rates and clinical practice’.⁵⁹ For instance, a recent audit found a 47-fold difference in usage between the highest and lowest using regions of England.⁶ This is thought to reflect the unusually high variation in personal opinions about ECT held by psychiatrists.⁴⁵ It was recently estimated that ‘fewer than 1000 psychiatrists’ practice ECT in the US, out of a national total of 49,000.⁵⁸
76. ECT use in England has declined from about 50,000 people a year in the 1970s to about 2,500 today.⁶ Nobody knows how many Americans receive ECT each year, or how many are given it without their consent. Nobody knows how many treatments Americans receive in a course of ECT, despite Somatics⁴⁹ and researchers²³ reporting that this is a predictor of cognitive damage.

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77. **Summary:** Based on my reviews of the scientific literature pertaining to the safety and efficacy of electroconvulsive therapy,¹⁻⁴ updated for the purposes of this testimony, it is my opinion, as to a reasonable degree of scientific certainty, that:
78. There is little evidence that ECT is more effective than placebo in the short-term, and none at all in the long-term.
79. ECT does not prevent suicide.
80. ECT causes persistent/permanent memory loss and brain damage in a substantial proportion of recipients, somewhere in the range of 12% to 55%.
81. This damage takes the form of both anterograde and retrograde amnesia.
82. The number of electroshocks received is predictive of the degree of damage done by ECT.
83. Women are more likely to suffer memory loss and brain damage as a consequence of ECT.
84. The New Zealand Ministry of Health was correct to bemoan the ‘slowness in acceptance by some professional groups that such outcomes are real and significant in people’s lives.’¹⁴ This matches my own experience of many ECT researchers and clinicians.
85. This ‘lack of acceptance’ of the damage done by ECT is a serious barrier to thousands of Americans, and thousands more internationally, receiving acknowledgement of what has happened to them and rehabilitation and compensation for that damage.



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References

1. Read, J. & Bentall, R. (2010). The effectiveness of electroconvulsive therapy: A literature review. *Epidemiology and Psychiatric Sciences*, 19, 333–7.
2. Read, J. & Arnold, C. (2017). Is electroconvulsive therapy for depression more effective than placebo? A systematic review of studies since 2009. *Ethical Human Psychology and Psychiatry*, 19, 5-23.
3. Read, J. et al. (2019). Electroconvulsive therapy for depression: A review of the quality of ECT versus sham ECT trials and meta-analyses. *Ethical Human Psychology and Psychiatry*, 21, 64-100.

Dean of School: Dr Aneta D. Tunariu, BSc (Hons), PhD, CPsychol, AFBPsS

4. Fosse, R. & Read, J. (2013). Electroconvulsive treatment: Hypotheses about mechanisms of action. *Frontiers in Psychiatry*, 4, 94-103.
5. Read, J. et al. (2018). An audit of ECT in England 2011-2015: Usage, demographics, and adherence to guidelines and legislation. *Psychology and Psychotherapy: Theory, Research and Practice*, 91, 263-77.
6. Read, J. et al. (2021). A second independent audit of ECT in England: Usage, demographics, consent, and adherence to guidelines and legislation in 2019. *Psychology and Psychotherapy: Theory, Research and Practice*, doi: 10.1111/papt.12335, published online 17.3.2021
7. Read, J. et al. ECT: dangerous on either side of the pond. *Psychiatric Times*, April 5, 2021, 38, 4-7.
8. Impastato, D. (1960). The story of the first ECT. *American Journal of Psychiatry* 116, 1113-4.
9. Alpers, B. (1946). The brain changes associated with electrical shock treatment: A critical review. *Lancet* 66, 363-9.
10. Allen, I. (1959). Cerebral lesions from ECT. *New Zealand Medical Journal* 58: 369-77.
11. Freeman, W. (1941). Brain-damaging therapeutics. *Diseases of the Nervous System*, 2, 83.
12. Myerson, A. (1942). Fatalities following ECT. *Transactions of the American Neurological Association* 68, 39.
13. Pribram, K. (1974). Lobotomy to physics to Freud. *American Psychological Association Monitor*, 5, 9-10.
14. Ministry of Health (2004). *Use of ECT in New Zealand*. Wellington, New Zealand: Ministry of Health.
15. Black, D. & Andreasen, N. (2011). *Introductory Textbook of Psychiatry*. Arlington, VA: American Psychiatric Publishing.
16. American Psychiatric Association. (2001). *The Practice of ECT: A Task Force Report (2nd edn)*. Washington, DC: American Psychiatric Association.
17. Somatics. (2018). *Regulatory update to Thymatron system IV instruction manual*. http://www.thymatron.com/downloads/System_IV_Regulatory_Update.pdf.
18. Rose D. et al. (2003). Patients' perspectives on ECT. *British Medical Journal*, 326, 1363-6
19. Goldman, H. et al. (1972). Long-term effects of ECT upon memory and perceptual motor performance. *Journal of Clinical Psychology*, 28, 32-4.
20. Freeman, C. et al. (1980). ECT: Patients who complain. *British Journal of Psychiatry*, 137, 17-25.
21. Mosti, C. & Brook, M. (2019). The cognitive effects of Electroconvulsive Therapy: a critical review. *Psychiatric Annals*, 49, 152-6.
22. Singhai, A. (2011). ECT and its place in the management of depression. *Progress in Neurology and Psychiatry*, 15: 1-26.
23. Sackeim H. et al. (2007). The cognitive effects of ECT in community settings. *Neuropsychopharmacology*, 32, 244-54.
24. Semkovska, M. et al. (2016). Bitemporal versus high dose unilateral twice-weekly ECT for depression. *American Journal of Psychiatry*, 173, 408-17.
25. Brus, O. et al. (2017). Subjective memory immediately following electroconvulsive therapy. *J ECT* 2017, 33, 96-103.
26. McElhiney, M. et al. (1995). Autobiographical memory and mood: Effects of ECT. *Neuropsychology*, 9, 101-17.
27. Shah, P. et al. (2002). Chronic, treatment-resistant depression and right fronto-spatial atrophy. *British Journal of Psychiatry*, 180, 434-40.

Dean of School: Dr Aneta D. Tunariu, BSc (Hons), PhD, CPsychol, AFBPsS

28. Robertson, H. & Pryor, R. (2006). Memory and cognitive effects of ECT. *Advances in Psychiatric Treatment*, 12, 228-38.
29. Neylan, T. et al. (2001). Cortisol levels predict cognitive impairment induced by ECT. *Biological Psychiatry*, 50, 331-6.
30. Hotchner, A. (1967). *Papa Hemingway*, p.308. New York: Bantam.
31. Calloway, S. et al. (1981). ECT and cerebral atrophy. *Acta Psychiatrica Scandinavica*, 64, 442-5.
32. Carney, S. et al. (2003). Efficacy and safety of ECT in depressive disorders. *Lancet*, 361, 799-808.
33. Schmidt, E. et al. (2008). Changes in brain metabolism after ECT. *Journal of Affective Disorders*, 106, 203-8.
34. Friedberg J. (1981). Neuropathologic effects of ECT. *American Journal of Psychiatry*, 138, 1129.
35. Chen W. et al. (2006) Supramembrane potential-induced electroconformational changes in sodium channel proteins: a potential mechanism involved in electric injury. *Burns*, 32, 52-9.
36. Jafari, H. et al. (2001). Motor neuron disease after electric injury. *Journal of Neurology, Neurosurgery and Psychiatry*, 71, 265-7.
37. Omalu, B. et al. (2021). *Traumatic brain injury advisory board meeting minutes*. California Department of Rehabilitation. August 26, 2019. Accessed February 12, 2021. <https://www.dor.ca.gov/Content/DorIncludes/documents/TBI/TBI Full Committee Meeting Minutes 8-26-19.docx>
38. Bronen, R. (2020). The status of status: Seizures are bad for your brain's health. *American Journal of Neuroradiology*, 21, 1782-3.
39. Johnstone, L. (1999). Adverse psychological effects of ECT. *Journal of Mental Health*, 8, 69-85.
40. NICE (2003). *Guidance on the Use of ECT*. London: National Institute for Health and Care Excellence.
41. Food and Drug Administration. (2011). *FDA executive summary for January 27-28 meeting of the neurological devices panel to discuss the classification of ECT*. Washington, DC: FDA.
42. Tørring, N. et al., (2017). The mortality rate of electroconvulsive therapy: A systematic review and pooled analysis. *Acta Psychiatrica Scandinavica*, 135, 388-97.
43. Shiwach, R. et al. (2001). An analysis of reported deaths following electroconvulsive therapy in Texas, 1993-1998. *Psychiatric Services*, 52, 1095-7.
44. Freeman, C. & Kendell, R. (1980). E.C.T, patients' experiences and attitudes. *British Journal of Psychiatry*, 137, 8-16.
45. Pippard, J. & Ellam, L. (1981). *ECT in Great Britain*. London, England: Gaskell.
46. Tecoult, E. & Nathan, N. (2001). Morbidity in ECT. *European Journal of Anaesthesiology*, 18, 511-8.
47. Duma, A. et al. (2019). Major adverse cardiac events and mortality associated with electroconvulsive therapy: a systematic review and meta-analysis. *Anesthesiology*, 130, 83-91.
48. Johnstone, E. et al. (1980). The Northwick Park ECT trial. *Lancet* ii: 1317-20.
49. Somatics (2018). *Efficacy and Safety of the Thymatron System IV ECT Device, a Comprehensive Review*. 12/26/18. http://www.thymatron.com/downloads/THYMATRON_REVIEW.pdf
50. Henry M. (2021). ECT: An effective and safe treatment. *Psychiatric Times*, 38, 4-7.

Dean of School: Dr Aneta D. Tunariu, BSc (Hons), PhD, CPsychol, AFBPsS

51. Shokraneh, F. et al. (2019). Electroconvulsive Therapy for people with schizophrenia: Updating a Cochrane systematic review for two decades. *British Medical Journal*, 26 February 2019. <https://www.bmj.com/content/364/bmj.k5233/rr-8> doi:
52. Peltzman, T. et al. (2020). Effects of Electroconvulsive Therapy on short-term suicide mortality in a risk-matched patient population. *Journal of ECT*, 36, 187-91.
53. Perrin, J. et al. (2012). Electroconvulsive therapy reduces frontal cortical connectivity in severe depressive disorder. PNAS. doi:10.1073/pnas.1117206109
54. Rasmussen K. (2009). Sham ECT studies in depressive illness. *Journal of ECT*, 25, 54-9.
55. Lambourn, J. & Gill, D. (1978). A controlled comparison of simulated and real ECT. *British Journal of Psychiatry*, 133, 514-9.
56. US Food and Drug Administration. *Neurological Devices; Reclassification of Electroconvulsive Therapy Devices; Effective Date of Requirement for Premarket Approval for Electroconvulsive Therapy Devices for Certain Specified Intended Uses*. US Department of Health and Human Services: Food and Drug Administration; 2019:66103-66124. <https://www.regulations.gov/contentStreamer?documentId=FDA-2014-N-1210-3431&contentType=pdf>
57. US Food and Drug Administration. *Reclassification of Electroconvulsive Therapy Devices; Effective Date of Requirement for Premarket Approval for Electroconvulsive Therapy Devices for Certain Specified Intended Uses*. Published online December 26, 2018. <https://www.federalregister.gov/d/2018-27809/p-181>
58. Kellner, C. (2019). The FDA on ECT: Supporting a vital treatment. *Psychiatric Times*, 36, 20-7.
59. Leiknes, K. et al. (2012). Contemporary use and practice of electroconvulsive therapy worldwide. *Brain and Behaviour*, 2, 283-344.

APPENDIX A

CURRENT POST

April 2016 – Professor of Clinical Psychology, University of East London, London, UK

PREVIOUS APPOINTMENTS

1973-1974 Psychiatric Nursing Assistant, Montefiore Psychiatric Hospital, New York
1974-1976 Manager, Psychiatric Day Centre, Wandsworth Social Services, London
1982-1984 Clinical Psychologist, Private Practice, Cincinnati, USA
1983-1984 Clinical Psychologist, University of Cincinnati Counselling Services, USA
1984-1985 Clinical Psychologist, Community Care Team, Derbyshire Health Authority, UK
1985-1987 Manager, Psychiatric Rehabilitation Unit, Ealing Social Services, London
1987-1992 Director, North London branch of the National Association of Mental Health
(providing therapy, day care and supported housing for approx. 300 psychiatric patients)
1992-1993 Clinical Psychologist, Enfield Health Authority, London, UK
1993-1994 Clinical Psychologist, Psychiatric Inpatient Unit, Auckland Hospital, New Zealand
1994-2013 Psychology Department, The University of Auckland (Senior Lecturer,
Associate Professor, Professor; Director, Doctorate of Clinical Psychology programme
2013-2015 Professor of Clinical Psychology;
Director, Doctorate of Clinical Psychology programme, University of Liverpool
2015-2016 Professor of Clinical Psychology, Swinburne University of Technology, Melbourne

EDUCATIONAL QUALIFICATIONS

1973 Cardiff University, B.A. (hons), Psychology
1978 University of Cincinnati, M.A., Clinical Psychology
1983 University of Cincinnati, Ph.D., Clinical Psychology
2017 UK Higher Education Academy (HEA) Fellowship

Recipient of the New Zealand Psychological Society *Hunter Award* (2010)

Awarded (every three years) for 'excellence in scholarship, research and professional achievement'

CURRENT POSITIONS

2009 - Editor, *Psychosis: Psychological, Social and Integrative Approaches* (peer-reviewed journal)
2018 - Chair, *International Institute for Psychiatric Drug Withdrawal*
2018 - Board Member, *Hearing Voices Network – England*
2019 - Member, *Council for Evidence-Based Psychiatry*
2019 - Director, *Mental Health & Social Change Research Group*, University of East London
2020 - Advisor, *NHS England Withdrawal from Prescribed Medicines Review*

PROFESSOR JOHN READ'S PUBLICATIONS SINCE 2010:

Research Articles

DAVIES, E., READ, J., SHEVLIN, M. (2021). Childhood adversities among students at an English University: A latent class analysis. *Journal of Trauma and Dissociation*, in press

HARROP, C., READ, J., GEEKIE, J., RENTON, J. (2021). How accurate are ECT patient information leaflets provided by mental health services in England and the Royal College of Psychiatrists? An independent audit. *Ethical Human Psychology and Psychiatry*, in press

READ, J., HARROP, C., GEEKIE, J., RENTON, CUNLIFFE, S. (2021). A second independent audit of ECT in England: Usage, demographics, consent, and adherence to guidelines and legislation in 2019. *Psychology and Psychotherapy: Theory, Research and Practice*. doi: 10.1111/papt.12335

READ, J., GIBSON, K., CARTWRIGHT, C. (2021). Are antidepressants overprescribed? Patients' experiences of the prescribing process. *Ethical Human Psychology and Psychiatry*. doi:org10.1891/EHPP-D-20-00006

JONES, A., READ, J., WOOD, L. (2021). A retrospective case study of the thematic content of psychotic experiences in a first episode psychosis population. *Journal of Mental Health*. doi:10.1080/09638237.2020.1755024

WHITE, E., READ, J., JULO, S. (2021). The role of Facebook Groups in the management, and raising of awareness, of antidepressant withdrawal: Is social media filling the void left by health services? *Therapeutic Advances in Psychopharmacology*. doi: 10.1177/2045125320981174

READ, J., RENTON, J., GEEKIE, J., HARROP, C., DOWRICK, C. (2020). A Survey of UK General Practitioners about depression, antidepressants and withdrawal: Implementing the 2019 Public Health England Report. *Therapeutic Advances in Psychopharmacology*, 10, 1-14.

READ, J. (2020). How common and severe are six withdrawal effects from, and addiction to, antidepressants? The experiences of a large international sample of patients. *Addictive Behaviors*, 102, 106157.

READ, J., HARPER, D. (2020). The Power Threat Meaning Framework: Addressing adversity, challenging prejudice and stigma and transforming services. *Journal of Constructivist Psychology*, doi.org/10.1080/10720537.2020.1773356.

READ, J., SACIA, A. (2020). Using open questions to understand 650 people's experiences with antipsychotic drugs. *Schizophrenia Bulletin*, 46, 896-904.

MAGLIANO, L., RUGGIERO, G., READ, J., MANCUSO, A., SCHIAVONE, A., SEPE, A. (2020). The views of non-psychiatric medical specialists about people with schizophrenia and depression. *Community Mental Health Journal*, 56, 744–752.

READ, J., GRIGORIU, M., GEE, A., DIGGLE, J., BUTLER, H. (2020). The positive and negative experiences of 342 antidepressant users. *Community Mental Health Journal*, 56, 744–752.

READ, J. (2020). Bad things happen and can drive you crazy: The causal beliefs of 701 people taking antipsychotics. *Psychiatry Research*. <https://doi.org/10.1016/j.psychres.2020.112754>

READ, J., KIRSCH, I., McGRATH, L. (2019). Electroconvulsive Therapy for depression: A Review of the quality of ECT vs sham ECT trials and meta-analyses. *Ethical Human Psychiatry and Psychology*, 21, 64-103.

LOTZIN, A., BUTH, S., SEHNER, S., HILLER, P., MARTENS, M., READ, J., HÄRTER, M., COWLISHAW, S., SCHÄFER, I. (2019). Learning How to Ask - Does a one-day training increase trauma inquiry in routine substance use disorder practice? Results of a cluster-randomized controlled trial. *Journal of Substance Abuse Treatment*, 107, 8-16.

- HENGARTNER, M., DAVIES, J., READ, J. (2019). Antidepressant withdrawal – the tide is turning. *Epidemiology and Psychiatric Sciences*. doi.org/10.1017/S2045796019000465
- MAGLIANO, L., CITARELLI, G., READ, J. (2019). The beliefs of non-psychiatric doctors about the causes, treatments and prognosis of schizophrenia. *Psychology and Psychotherapy: Theory, Research and Practice*. In Press.
- HENGARTNER, M., READ, J., MONCRIEFF, M. (2019). Comment on Firth et al. *Lancet Psychiatry*, 6, 890.
- WILLS, C. CARTWRIGHT, C., GIBSON, K, READ, J. (2019). Young women's selfhood on antidepressants: 'Not fully myself'. *Qualitative Health Research*, doi.org/10.1177/1049732319877175
- HENGARTNER, M., DAVIES, J., READ, J. (2019). How long does antidepressant withdrawal typically last? A comment on Jha et al. (Correspondence) *American Journal of Psychiatry*. In press.
- READ, J. (2019). Making sense of, and responding sensibly to, psychosis. *Journal of Humanistic Psychology*, 59, 672-680.
- ALLSOPP, K., READ, J., CORCORAN, R., KINDERMAN, P. (2019). Heterogeneity in psychiatric diagnostic classification. *Psychiatry Research*, 279, 15-22. <https://doi.org/10.1016/j.psychres.2019.07.005>
- READ, J., WILLIAMS, J. (2019). Positive and negative effects of antipsychotic medication: an international online survey of 832 recipients. *Current Drug Safety*, 14, 173-181.
- DAVIES, J., READ, J., HENGARTNER, M., COSCI, F., FAVA, G., GUY, A. (2019). Clinical guidelines on antidepressant withdrawal urgently need updating (Correspondence). *British Medical Journal*. BMJ 2019;365:l2238 doi: 10.1136/bmj.l2238.
- READ, J., CUNLIFFE, S., JAUHAR, S., McLOUGHLIN, D. (2019). Should we stop using electroconvulsive therapy? *British Medical Journal*, 364:k5233. doi: 10.1136/bmj.k5233
- READ, J., GEE, A., DIGGLE, J., BUTLER, H. (2019). Staying on, and coming off, antidepressants: The experiences of 752 UK adults. *Addictive Behaviors*, 88, 82-85.
- LOTZIN, A., BUTH, S., SEHNER, S., HILLER, P., PAWLS, S., METZNER, F., READ, J., HARTER, M., SCHAFFER, I. (2019). Reducing barriers to trauma inquiry in substance use disorder treatment – A cluster-randomized controlled trial. *Substance Abuse Treatment, Prevention, and Policy*, 14:23 <https://doi.org/10.1186/s13011-019-0211-8>
- COYLE, L., HANNA, D., DYER, K., READ, J., CURRAN, D., SHANNON, C. (2019). Does trauma-related training have a relationship with, or impact on, mental health professionals' frequency of asking about, or detection of, trauma history? A systematic literature review. *Psychological Trauma: Theory, Research, Practice, and Policy*, 11, 802-809.
- CARTER, L., READ, J., PYLE, M., MORRISON, A. (2019). Are causal beliefs associated with stigma? A test of the impact of biogenetic vs psychosocial explanations on stigma and internalised stigma in people experiencing psychosis. *Stigma and Health*, 4, 170-178.
- DAVIES, J., READ, J. (2019). A systematic review into the incidence, severity and duration of antidepressant withdrawal effects: Are guidelines evidence-based? *Addictive Behaviours*, 97, 111-121.
- HARROP, C., READ, J., GEEKIE, J., RENTON, J. (2018). An independent audit of drug company influence within National Health Service mental health Trusts in England. *Ethical Human Psychology and Psychiatry*, 20(3), 156-163.
- LARSEN-BARR, M., SEYMOUR, F., READ, J., GIBSON, K. (2018). Attempting to discontinue antipsychotic medication: Withdrawal methods, relapse and success. *Psychiatry Research*, 270, 365-374.

- READ, J., WILLIAMS, J. (2018). Adverse effects of antidepressants reported by a large international cohort: Emotional blunting, suicidality, and withdrawal effects. *Current Drug Safety*, 13, 176-1863.
- TIMIMI, S., MONCRIEFF, J., GOTZSCHE, P., DAVIES, J., KINDERMAN, P., BYNG, R., MONTAGU, L., READ, J. (2018). Network meta-analysis of antidepressants. (Correspondence). *Lancet*, 392, 1011-1012.
- READ, J., HARPER, D., TUCKER, I., KENNEDY, A. (2018). How do mental health services respond when child abuse or neglect become known? A literature review. *International Journal of Mental Health Nursing*, 27, 1606-1617.
- KINDERMAN, P., DAVIES, J., MOORE, J., GUY, A., READ, J., TIMIMI, S., DOUBLE, D. (2018). Purpose, humility, civility and science. (Correspondence) *Lancet Psychiatry*, 5, 964-965.
- READ, J., CARTWRIGHT, C., GIBSON, K. (2018). How many of 1,829 antidepressant users report withdrawal symptoms or addiction? *International Journal of Mental Health Nursing*, 27, 1805-1815.
- LARSEN-BARR, M., SEYMOUR, F., READ, J., GIBSON, K. (2018). Attempting to stop antipsychotic medication: Success, supports and efforts to cope. *Social Psychiatry and Psychiatric Epidemiology*, 53, 745-756.
- LONGDEN, E., READ, J., DILLON, J. (2018). Assessing the impact and effectiveness of Hearing Voices Network self-help groups. *Community Mental Health Journal*, 54, 184-188.
- READ, J., HARPER, D., TUCKER, I., KENNEDY, A. (2018). Do mental health services identify child abuse and neglect? A systematic review. *International Journal of Mental Health Nursing*, 27, 7-19.
- TAITIMU, M., READ, J., MCINTOSH, T. (2018). How Māori understand what Western psychiatry calls 'schizophrenia'. *Transcultural Psychiatry*, 55, 153-177.
- READ, J. (2018). Gibt es 'Schizophrenie'? Reliabilität und Validität. *Psychotherapie-Wissenschaft*, 8, 75-83. doi: 10.30820/8242.14
- READ, J., HARROP, C., GEEKIE, J., RENTON, J. (2018). An audit of ECT in England 2011-2015: Usage, demographics, and adherence to guidelines and legislation. *Psychology and Psychotherapy: Theory, Research and Practice*, 91, 263-277.
- CARTWRIGHT, C., GIBSON, K., READ, J. (2018). Personal agency in women's recovery from depression: The impact of antidepressants and women's personal efforts. *Clinical Psychologist*, 22, 72-82.
- CARTER, L., READ, J., PYLE, M., MORRISON, A. (2018). 'I believe I know better even than the psychiatrists what caused it': Exploring the development of causal beliefs in people experiencing psychosis. *Community Mental Health Journal*. doi.org/10.1007/s10597-017-0219-3
- CARTER, L., MORRISON, A., PYLE, M., READ, J. (2018). Causal beliefs in people experiencing psychosis: relationship to the treatment accessed and the perceived helpfulness of treatment. *Psychology and Psychotherapy: Theory, Research and Practice*, 91, 332-344
- GIBSON, K., CARTWRIGHT, C., READ, J. (2018). Conflict in men's experiences with antidepressants. *American Journal of Men's Health*, 12, 104-116.
- LOTZIN, A., BUTH, S., SEHNER, S., HILLER, P., MARTENS, M., PAWLS, S., METZNER, F., READ, J., HARTER, M., SCHAFER, I. (2017). 'Learning how to ask' - Effectiveness of a training for trauma inquiry and response in substance use disorder healthcare professionals. *Psychological Trauma: Theory, Research, Practice and Policy*, 10, 229-238.
- READ, J., ARNOLD, C. (2017). Is electroconvulsive therapy for depression more effective than placebo? A systematic review of studies since 2009. *Ethical Human Psychology and Psychiatry*, 19, 5-23.
- MAGLIANO, L., READ, J., AFFUSO, G. (2017). Predictors of staff attitudes towards schizophrenia treatments. *Psychiatric Services*, 68, 1321.

- READ, J., GEE, A., DIGGLE, J., BUTLER, H. (2017). The interpersonal adverse effects reported by 1,008 users of antidepressants; and the incremental impact of polypharmacy. *Psychiatry Research*, 256, 423-427.
- LONGDEN, E., READ, J. (2017). People with problems, not patients with illnesses: Using psychosocial frameworks to reduce the stigma of psychosis. *Israel Journal of Psychiatry and Related Sciences*, 54, 24-30.
- GEEKIE, J., READ, J., RENTON, J., HARROP, C. (2017). Do English mental health services know whether they followed N.I.C.E. treatment recommendations for depression with patients who killed themselves? *Psychology and Psychotherapy: Theory, Research and Practice*, 90, 797-800.
- HARTDEGAN, M., GIBSON, K., CARTWRIGHT, C., READ, J. (2017). Stressful events and circumstances reported by patients prior to being prescribed antidepressants. *New Zealand Medical Journal*, 130, 45-53.
- MAGLIANO, L., SCHIOPPA, G., COSTANZO, R., PETRILLO, M., READ, J. (2017). The opinions of Italian psychology students about people diagnosed with depression and schizophrenia: A comparative study. *Journal of Psychosocial Rehabilitation and Mental Health* 4, 147-157.
- READ, J., MAYNE, R. (2017). Understanding the effects of childhood adversities: Beyond diagnosis and abuse. *Journal of Child and Adolescent Trauma*, 10, 289-297.
- CARTER, L., MORRISON, A., PYLE, M., READ, J. (2017). Mental health clinicians' beliefs about the causes of psychosis: Differences between professions and relationship to treatment preferences. *International Journal of Social Psychiatry*, 63, 426-432.
- MAGLIANO, L., STRINO, A., PUNZO, R., ACONE, R., AFFUSO, G., READ, J. (2017). Effects of the diagnostic label "schizophrenia", actively used or passively accepted, on general practitioners' views of this disorder. *International Journal of Social Psychiatry*, 63, 224-234.
- MAGLIANO, L., PUNZO, R., STRINO, A., ACONE, R., AFFUSO, G., READ, J. (2017). General Practitioners' beliefs about people diagnosed with schizophrenia and whether they should be differentially treated when in medical hospital. *American Journal of Orthopsychiatry* 87, 559-566.
- SAMPSON, M., READ, J. (2017). Are mental health services getting better at asking about abuse and neglect? *International Journal of Mental Health Nursing*, 26, 95-104.
- CARTER, L., READ, J., PYLE, M., MORRISON, A. (2017). The impact of causal explanations on outcome in people experiencing psychosis: A systematic review. *Clinical Psychology & Psychotherapy*, 24, 332-347.
- DAVIES, E., O'LEARY, E., READ, J. (2017). Child abuse in England and Wales 2003-2013: Newspaper reporting versus reality. *Journalism*, 8, 754-771.
- READ, J., GIBSON, K., CARTWRIGHT, C. (2016). Do GPs and psychiatrists recommend alternatives when prescribing anti-depressants? *Psychiatry Research*, 246, 838-840.
- READ, J., GIBSON, K., CARTWRIGHT, C. (2016). Are older people prescribed antidepressants on the basis of fewer symptoms of depression, and for longer periods of time? A survey of 1,825 New Zealanders. *Australasian Journal of Ageing*, 35, 193-197.
- LONGDEN, E., READ, J., DILLON, J. (2016). Improving community mental health services: The need for a paradigm shift. *Israel Journal of Psychiatry and Related Sciences*, 53, 22-30.
- CARTWRIGHT, C., GIBSON, K., READ, J. (2016). Long term antidepressant use: Patients' perspectives of benefits and adverse effects. *Patient Preference and Adherence*, 10, 1401-1407.
- LONGDEN, E., SAMPSON, M., READ, J. (2016). Childhood adversity and psychosis: Generalised or specific effects? *Epidemiology and Psychiatric Sciences*, 25, 349-359.
- GIBSON, K., CARTWRIGHT, C., READ, J. (2016). 'In my life antidepressants have been....': A

- qualitative analysis of users' diverse experiences of antidepressants. *BMC Psychiatry*, 16, 135.
- READ, J., SAMPSON, M., CRITCHLEY, C. (2016). Are mental health services getting better at responding to abuse, assault and neglect? *Acta Psychiatrica Scandinavica*, 134, 287-294.
- LONGDEN, E., READ, J. (2016). Social adversity in the etiology of psychosis: A review of the evidence. *American Journal of Psychotherapy*, 70, 5-33.
- MAGLIANO, L., RINALDI, A., COSTANZA, R., DE LEO, R., SCHIOPPA, G., PETRILLO, M., READ, J. (2016). Improving future psychologists' attitudes towards people diagnosed with 'schizophrenia': A quasi-randomized controlled trial. *American Journal of Orthopsychiatry*, 86, 253-264.
- READ, J., RUNCIMAN, O., DILLON, J. (2016). In search of an evidence-based role for psychiatry. *Future Science OA*, 2. doi:10.4155/fsoa-2015-0011
- LONGDEN, E., READ, J. (2016). Assessing and reporting the adverse effects of antipsychotic medication: A systematic review of clinical studies, and prospective, retrospective, and cross-sectional research. *Clinical Neuropharmacology*, 39, 29-39.
- MAGLIANO, L., READ, J., RINALDI, A., COSTANZO, R., DE LEO, R., SCHIOPPA, G., PETRILLO, M., ZACCARO, A., CAMPITIELLO, F. (2016). The influence of causal explanations and diagnostic labelling on psychology students' beliefs about treatments, prognosis, dangerousness and unpredictability in schizophrenia. *Community Mental Health Journal* 52, 361-369.
- READ, J., HAMMERSLEY, P., RUDEGEAIR, T. (2015). Por que, cuando y como preguntar sobre el abuso infantil. *Psicopatologia y Salud Mental*, 26, 9-21.
- READ, J., GIBSON, K., CARTWRIGHT, C., SHIELS, C., DOWRICK, C., GABBAY, M. (2015). Understanding the non-pharmacological correlates of self-reported efficacy of antidepressants. *Acta Psychiatrica Scandinavica* 131, 434-445.
- SHEVLIN, M., MURPHY, J., READ, J. (2015). Testing complex hypotheses using secondary data analysis: Is the association between sexual abuse and psychosis moderated by gender in a large prison sample? *Journal of Criminal Psychology*, 5, 92-98.
- READ, J., GIBSON, K., CARTWRIGHT, C., SHIELS, C., MAGLIANO, L. (2015). Beliefs of people taking antidepressants about the causes of their own depression. *Journal of Affective Disorders*, 174, 150-156.
- READ, J. (2015). Saving psychiatry from itself: Will young psychiatrists choose authoritarian power or authoritative respect? *Acta Psychiatrica Scandinavica*, 131, 11-12.
- SEMP, D., READ, J. (2015). Queer conversations: Improving access to, and quality of, mental health services for same-sex attracted clients. *Psychology and Sexuality*, 6, 217-228.
- READ, J., FOSSE, R., MOSKOWITZ, A., PERRY, B. (2014). The traumagenic neurodevelopmental model of psychosis revisited. *Neuropsychiatry*, 4, 65-79.
- MAGLIANO, L., READ, J., SAGLIOCCHI, A., OLIVIERO, N., D'AMBROSIO, A., CAMPITIELLO, F., ZACCARO, A., GUIZZARO, L., PATALANO, M. (2014). Social dangerousness and incurability in 'schizophrenia': results of an educational intervention for medical and psychology students. *Psychiatry Research*, 219, 457-463
- READ, J., CARTWRIGHT, C., GIBSON, K., SHIELS, C., HASLAM, N. (2014). Beliefs of people taking antidepressants about causes of depression and reasons for increased prescribing rates. *Journal of Affective Disorders*, 168, 236-242.
- DAVIES, E., MATHEWS, B., READ, J. (2014). Mandatory reporting? Issues to consider when developing legislation and policy to improve discovery of child abuse. *IALS Student Law Review*, 2, 9-28.

- BENTALL, R., SOUSA, P., VARESE, F., WICKHAM, S., SITKO, K., HAARMANS, M., READ, J. (2014). From adversity to psychosis: Pathways and mechanisms from specific adversities to specific symptoms. *Social Psychiatry and Psychiatric Epidemiology*, 49, 1011-1022.
- READ, J., CARTWRIGHT, C., GIBSON, K. (2014). Adverse emotional and interpersonal effects reported by 1,829 New Zealanders while taking antidepressants. *Psychiatry Research* 216, 67-73.
- GIBSON, L., CARTWRIGHT, C., READ, J. (2014). Patient-centred perspectives on antidepressant use: A narrative review. *International Journal of Mental Health*, 43, 81-99.
- READ, J., DILLON, J., LAMPSHIRE, D. (2014). How much evidence is required for a paradigm shift in mental health? *Acta Psychiatrica Scandinavica*, 129, 477-478.
- VARESE, F., SMEETS, F., DRUKKER, M., LIEVERSE, R., LATASTER, T., VIECHTBAUER, W., READ, J., VAN OS, J., BENTALL, R. (2013). Las adversidades en la infancia incrementan el riesgo de psicosis: metaanálisis de estudios paciente-control, prospectivos y de corte transversal de cohort. *Revista de Psicopatología y Salud Mental del Niño y del Adolescente*, 21, 51-64.
- FOSSE, R., READ, J. (2013). Electroconvulsive treatment: Hypotheses about mechanisms of action. *Frontiers in Psychiatry*, 4, 94-103.
- READ, J., MATI, E. (2013). Erectile dysfunction and the internet: Drug company manipulation of public and professional opinion. *Journal of Sex & Marital Therapy*, 39, 541-555.
- BRABBAN, A., READ, J., MORRISON, A. (2013). Renaming 'Schizophrenia': A step too far or not far enough? *Psychological Medicine*, 43, 1558-1560.
- MAGLIANO, L., READ, J., SAGLIOCCHI, A., PATALANO, M., OLIVIERO, N. (2013). Effect of diagnostic labeling and causal explanations on medical students views about treatments for psychosis and the need to share information with service users. *Psychiatry Research*, 210, 402-407.
- SHEVLIN, M., O'NEILL, T., HOUSTON, J., READ, J., BENTALL, R., MURPHY, J. (2013). Patterns of lifetime female victimization and psychotic experiences: A study based on the UK Adult Psychiatric Morbidity Survey 2007. *Social Psychiatry and Psychiatric Epidemiology*, 48, 15-24.
- MAGLIANO, L., READ, J., SAGLIOCCHI, A., PATALANO, M., D'AMBROSIO, A., OLIVIERO, N. (2013). Differences in views of schizophrenia during medical education: A comparative study of 1st vs. 5th-6th year Italian medical students. *Social Psychiatry and Psychiatric Epidemiology*, 48, 1647-1655.
- KINDERMAN, P., READ, J., MONCRIEFF, J., BENTALL, R. (2013). Drop the language of disorder. *Evidence-Based Mental Health*, 16, 2-3.
- READ, J., CAIN, A. (2013). A literature review and meta-analysis of drug company funded mental health websites. *Acta Psychiatrica Scandinavica*, 128, 422-433.
- SKEHAN, D., LARKIN, W., READ, J. (2012). Childhood adversity and psychosis: A literature review with clinical and societal implications. *Psychoanalysis, Culture & Society*, 17, 373-391.
- MAGLIANO, L., READ, J., PATALANO, M., SAGLIOCCHI, A., OLIVIERO, N., D'AMBROSIO, A., CAMPITIELLO, F., ZACCARO, A., GUIZZARO, L., CERRATO, F. (2012). Contrarrestar el estigma hacia las personas con esquizofrenia en el ámbito sanitario: una experiencia piloto en una muestra de estudiantes italianos de medicina. *Psychology, Society, & Education*, 4, 169-181.
- SCHÄFER, I., FISHER, H., ADERHOLD, V., HUBER, B., HOFFMANN-LANGER, L., GOLKS, D.,

- KAROW, A., ROSS, C., READ, J., HARFST, T. (2012). Dissociative symptoms in patients with schizophrenia: Relationships with childhood trauma and psychotic symptoms. *Comprehensive Psychiatry*, 53, 364-371.
- BARKER-COLLO, S., READ, J., COWIE, S. (2012). Coping strategies in female survivors of childhood sexual abuse from two Canadian and two New Zealand cultural groups. *Journal of Trauma and Dissociation*, 13, 435-447.
- MITCHELL, J., READ, J. (2012). Attention-deficit hyperactivity disorder, drug companies and the internet. *Clinical Child Psychology and Psychiatry*, 17, 121-139.
- READ, J., BENTALL, R. (2012). Negative childhood experiences and mental health: Theoretical, clinical and primary prevention implications. (Invited Editorial). *British Journal of Psychiatry*, 200, 89-91.
- VARESE, F., SMEETS, F., DRUKKER, M., LIEVERSE, R., LATASTER, T., VIECHTBAUER, W., READ, J., VAN OS, J., BENTALL, R. (2012). Childhood adversities increase the risk of psychosis: A meta-analysis of patient-control, prospective- and cross-sectional cohort studies. *Schizophrenia Bulletin*, 38, 661-671.
- WEINMANN, S., ADERHOLD, V., READ, J. (2011). Antipsychotic medication and mortality: A clarification. (Correspondence). *Schizophrenia Research*, 133, 261.
- BARKER-COLLO, S., READ, J. (2011). The role of gender in the relationship between child abuse and psychosis. *New Zealand Journal of Psychology*, 40, 30-40.
- SHEVLIN, M., MURPHY, J., READ, J., MALLETT, J., ADAMSON, G., HOUSTON, J. (2011). Childhood adversity and psychotic hallucinations: A community based study using the National Comorbidity Survey Replication. *Social Psychiatry and Psychiatric Epidemiology*, 46, 1203-1210.
- FOSSE, R., READ, J., BENTALL, R. (2011). Elektrokonvulsiv behandling ved alvorlig depresjon: Ikonflikt med den hippokratiske eden? *Tidsskrift for Norsk Psykologforening* [Norwegian Journal of Psychology] 48, 1160-1171.
- MAGLIANO, L., READ, J., OLIVIERO, N., SAGLIOCCHI, L., PATALANO, M., D'AMBROSIA, A. (2011). The influence of causal explanations and diagnostic labelling on medical students' views of schizophrenia. *Academic Medicine*, 86, 1-8.
- BEAVAN, V., READ, J., CARTWRIGHT, C. (2011). The prevalence of voice-hearing in the general population: A literature review. *Journal of Mental Health*, 20, 282-292.
- CARTWRIGHT, C., READ, J. (2011). Exploratory investigation of Psychologists' responses to a method for considering "objective" countertransference. *New Zealand Journal of Psychology*, 40, 46-54.
- MAGLIANO, L., READ, J., MARASSI, R. Metaphoric and non-metaphoric use of the term "schizophrenia" in Italian newspapers. (2011). *Social Psychiatry and Psychiatric Epidemiology*, 46, 1019-1025.
- READ, J. (2010). Can poverty drive you mad? "Schizophrenia", socio-economic status and the case for primary prevention. *New Zealand Journal of Psychology*, 39, 7-19.
- BEAVAN, V., READ, J. (2010). Hearing voices and listening to what they say: The importance of voice content in understanding and working with distressing voices. *Journal of Nervous & Mental Disease*, 198, 201-205.

READ, J., BENTALL, R. (2010). The effectiveness of electroconvulsive therapy: A literature review. *Epidemiology and Psychiatric Sciences*, 19, 333-347.

KINGDON, D., ASHCROFT, K., BHANDARI, B., GLEESON, S., WARIKOO, N., SYMONS, M., TAYLOR, L., LUCAS, E., MAHENDRA, R., QHOSH, S., MASON, A., BADRAKALIMUTHU, R., HEPWORTH, S., READ, J., MEHTA, R. (2010). Schizophrenia and borderline personality disorder: Similarities and differences in the experience of auditory hallucinations, paranoia and childhood trauma. *Journal of Nervous & Mental Disease*, 198, 399-403.

Books

JOHNSTONE, L., BOYLE, M., CROMBY, J., DILLON, J., HARPER, D., KINDERMAN, P., LONGDEN, E., PILGRIM, D. & READ, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. Leicester: British Psychological Society.

READ, J., DILLON, J. (eds.) (2013). *Models of Madness: Psychological, Social and Biological Approaches to Psychosis*. London: Routledge, 422pp. [2016 Spanish translation. Barcelona: Herder].

GEEKIE, J., RANDAL, P., LAMPSHIRE, D., READ, J. (eds.) (2012). *Experiencing Psychosis: Personal and Professional Perspectives*. London: Routledge. 272pp.

READ, J., SANDERS, P. (2010). *A Straight Talking Introduction to the Causes of Mental Health Problems*. Ross, UK: PCCS Books. 165pp

Book Chapters

15 Chapters in J. Read, J. Dillon (eds.) (2013). *Models of Madness: Psychological, Social and Biological Approaches to Psychosis*. 2nd edition. London: Routledge, 422pp.

READ J, MAGLIANO L. (2019). 'Schizophrenia'. In J. Watson (ed.) *Drop the Disorder: Challenging the Culture of Psychiatric Diagnoses and Exploring Alternatives*. Ross: PCCS Books.

BUCCI, S., VARESE, P., BERRY, K., READ, J. (2019) How attachment theory can develop understanding of and therapy for distressing voices. In K. Berry, S. Bucci, A Danquah (eds.), *Attachment and Psychosis*. London: Routledge.

SCHAFFER, I., ROSS, C., SCOTT, J., SPITZER, C., READ, J. (2019). Childhood trauma in psychotic and dissociative disorders. In A. Moskowitz, I. Schäfer, M. Dorahy (eds.) *Psychosis, Trauma and Dissociation: Emerging Perspectives on Severe Psychopathology*, 2nd edition. London: Wiley-Blackwell.

READ J, DAVIES J, MONTAGU L, SPADA M, FREDERICK B. (2019). What do we know about withdrawal? In A. Guy et al. (eds.) *Guidance for Psychological Therapists: Enabling conversations with clients taking or withdrawing from prescribed psychiatric drugs*; London: All Party Parliamentary Group for Prescribed Drug Dependence.

READ, J., BENTALL, R., FOSSE, R. (2014). Time to abandon the bio-bio-bio model of psychosis: Exploring the epigenetic and psychological mechanisms by which adverse life events lead to psychotic symptoms. In E. Speed et al. (eds.) *De-Medicalizing Misery II: Society, Politics and the Mental Health Industry*. Basingstoke: Palgrave Macmillan, 210-215.

READ, J., BENTALL, R. (2013). Madness. In J. Cromby et al. (eds.) *Psychology, Mental Health and Distress*. Basingstoke: Palgrave Macmillan, 249-282.

LARKIN, W, READ, J. (2012). Trauma and hearing voices: The epidemiological evidence. In M. Romme, S. Escher (eds.) *Psychosis as a Personal Crisis: An Experience-Based Approach*. London: Routledge, 98-109.

READ, J. (2012). The subjective experience of the link between bad things happening and psychosis: Research findings. In J. Geekie et al.(eds.) *Experiencing Psychosis: Personal and Professional Perspectives*. London: Routledge, 127-136.

READ, J., MAGLIANO, L. (2012). The subjective experience and beliefs of relatives of people who experience psychosis. In J. Geekie et al. (eds.) *Experiencing Psychosis: Personal and Professional Perspectives*. London: Routledge, 207-216.

READ, J. (2010). Can attachment theory help explain the relationship between childhood adversity and psychosis? In S. Benamer (ed.) *Telling Stories: Attachment Based Approaches to Psychosis*. London: Karnac Books, 35-49.

Articles in Professional Magazines etc.

READ, J. (2021). Why is electroshock therapy still a mainstay of psychiatry? *Aeon*, Mar 4.
<https://aeon.co/essays/why-is-electroshock-therapy-still-a-mainstay-of-psychiatry>

READ, J. (2021). Report finds monitoring of electroshock treatment unsafe. *Psychology Today*, Mar 15.
<https://www.psychologytoday.com/gb/blog/psychiatry-through-the-looking-glass/202103/report-finds-monitoring-electroshock-treatment>

READ, J. (2021). Online antidepressant withdrawal support groups. *Psychology Today*, Jan 28.
<https://www.psychologytoday.com/gb/blog/psychiatry-through-the-looking-glass/202101/online-antidepressant-withdrawal-support-groups>

READ, J., HANCOCK, S., CUNLIFFE, S. (2021). ECT: dangerous on either side of the pond. *Psychiatric Times*, 38, 4-7.

READ, J. (2020). Can we agree who has schizophrenia? *Psychology Today*, Dec 16.
<https://www.psychologytoday.com/gb/blog/psychiatry-through-the-looking-glass/202012/can-we-agree-who-has-schizophrenia>

READ, J. (2020). 80 years on, do we know if electroconvulsive therapy works? *Psychology Today*, Aug 01.
<https://www.psychologytoday.com/gb/blog/psychiatry-through-the-looking-glass/202008/80-years-do-we-know-if-electroconvulsive-therapy>

READ, J. (2020). Creating a mental illness called schizophrenia: A brief history of an archetypal psychiatric diagnosis. *Psychology Today*, Nov 27. <https://www.psychologytoday.com/gb/blog/psychiatry-through-the-looking-glass/202011/creating-mental-illness-called-schizophrenia>

READ, J. (2020). Withdrawal from antidepressants: A review. *Psychology Today*, Oct 26.
<https://www.psychologytoday.com/gb/blog/psychiatry-through-the-looking-glass/202010/withdrawal-antidepressants-review>

READ, J. (2020). Is Your Antidepressant Effective and Safe? *Psychology Today*, Sep 17.
<https://www.psychologytoday.com/gb/blog/psychiatry-through-the-looking-glass/202009/is-your-antidepressant-effective-and-safe>

READ, J. (2020). Electroshock therapy: From research to action. *Psychology Today*, Aug 24.
<https://www.psychologytoday.com/gb/blog/psychiatry-through-the-looking-glass/202008/electroshock-therapy-research-action>

READ, J., MORRISON, A., WADDINGHAM, R. (2020). Traumas, adversities, and psychosis: Practical implications. *Psychiatric News*, Jul 17.
<https://www.psychiatristimes.com/view/traumas-adversities-and-psychosis-investigating-practical-implications>

READ, J., DAVIES, J. (2019). The international antidepressant withdrawal crisis. *Psychiatric Times*, Jan 11.
<http://www.psychiatristimes.com/couch-crisis/international-antidepressant-withdrawal-crisis-time-act>

JOSEPH, J., CHAUFAN, C., RICHARDSON, K., SHULTZINER, D., FOSSE, R., JAMES, O., LATHAM, J., READ, J. (2015). The twin research debate in American criminology. *Logos*, 15.