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LOBOTOMY: THE BRAIN CUTTERS RETURN

The following, by Peter R. Breggin, M.D., a practicing Washington psychiatrist, and Daniel S. Greenberg, SGR publisher, is based on an article by the authors in the March 11 Washington Post.

J. M., a boy of nine with normal intelligence, is described as "hyperactive, aggressive, combative, explosive, destructive, sadistic," by his doctor. To control his behavior and make him more manageable, he is operated upon. Holes are drilled through his skull and electrodes are passed deep into his brain to coagulate both sides of the thalamus, the emotion-regulating center of the brain. Nine months later, the operation is repeated on one side. Now his doctor reports that J. M.'s behavior is "markedly improved," and he is able to return to a "special education school." After another year, his symptoms reappear, and he is subjected to another operation, this time to the fornix, another portion of the emotion-regulating system. His doctor now notes "impaired memory for recent events," a sign of brain damage, and the boy is described as "much more irritable, negativistic, and combative." Consequently, additional destructive lesions are made on the site of the first two operations, the thalamus. Now his doctor can report, "The patient has again become adjusted to his environment and has displayed marked improvement in behavior and memory. But the doctor concludes: "Intellectually, however, the patient is deteriorating."

This report of six destructive lesions in the brain of a child to control his aggressiveness and hyperactivity may strike some as a tasteless satire, inspired perhaps by an over-excited reaction to the film *A Clockwork Orange*, whose sadistic hero undergoes "therapy" designed to eliminate his homicidal and sexual impulses. But it is not satire. The report was published in 1970 in an established medical journal, *Confinia Neurologica*, and the doctor is Orlando J. Andy, professor and Department Director of Neurosurgery at the University of Mississippi School of Medicine, Jackson. The operations that he describes are part of a second wave of psychosurgery—popularly known as lobotomy—that is now gaining momentum in the United States and around the world.

Medically informed laymen and even many physicians commonly say that "it isn't done anymore," reflecting the fact that in the U.S., the procedure became discredited—because of its frequently horrifying results—following some 50,000

operations between 1936 and the mid-1950's, and then was almost wholly supplanted by chemical tranquilizers. But years of experience with tranquilizers have demonstrated their shortcomings, and now, employing new surgical techniques, the psychosurgeons are making a comeback. Comprehensive statistics are lacking, since there is no central registry for surgical procedures. All that is required is a licensed physician, a willing hospital, and a patient, three of whom, according to press reports, were recently provided by the California prison system, which is a pioneer dabbler in
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revamping the brains of selected inmates. Certified criminals, however, are not the only targets of today's psychosurgeons. Increasingly, they are focusing their irreversible procedures on the mildly disturbed, with women predominating among the targets and not a few children included as candidates for the operation.

Nationwide, informed estimates place the total at 400 to 600 patients per year, with the numbers rising. Worldwide, there is also an increase, so much so, in fact, that in 1970, some 100 psychosurgeons gathered in Copenhagen to form the International Society for Psychosurgery.

In the U.S., their work is financed not only by the National Institute of Mental Health (NIMH),

From the Annals of Lobotomy

The bible of lobotomy is a 595-page text, *Psychosurgery*, published in 1942 and re-issued in revised edition in 1950, by two now-retired neurologists, Walter Freeman and James W. Watts. Though essentially a sales pitch for psychosurgery, it is a chatty compendium of cranial carnage, based mainly on the 4000 lobotomies performed by its principal author, Freeman. Among those cited is the 1936 case of a youth of 20, identified only as Rufus, who, in the author's words, "said that he could understand the thoughts of the poets, even the most obscure, whereas other people had no appreciation of them and very little understanding. He would like to write poetry himself—but had not set pencil to paper." The two doctors report that the youth considered himself "something of a mystic," and he harbored the idea "that the trouble with him was in his adrenal glands."

Freeman and Watts write that drug therapy was administered without effect and this was followed by a lobotomy. Following the operation, they report, "Rufus was able to discuss more coherently his present attitude and future prospects, but likelihood of a good occupational adjustment seemed rather remote because of his inertia and because of his resentfulness toward his father's domineering attitude."

The authors conclude: "However, the fantasy life to which he had been so addicted seemed to be smashed and he was no longer interested in poetry or science."

Though he no longer operates, Freeman remains active in the psychosurgery movement. In 1970, he was elected honorary president of the newly established International Society for Psychosurgery, and he recently published a paper advocating psychosurgery for certain young schizophrenics before they become chronically ill.

but also by the Justice Department's Law Enforcement Assistance Administration (LEAA). Among the recipients of the government's support is a Boston psychiatrist, Dr. Frank Ervin, of Massachusetts General Hospital, and co-author, with Dr. Vernon Mark, of *Violence and the Brain*, which proposes development and systematic application of an "early warning test" to detect persons disposed to exceeding "acceptable violence." This is defined by the authors as "the controlled minimum necessary action to prevent personal physical injury or wanton destruction of property. This definition," the authors propose, "would apply equally to police or public authorities as well as to politically activist groups (students, racial, etc.) and all violent acts that did not fit into this category would be 'unacceptable.'" Their perpetrators, the authors propose, would become eligible for violence-inhibiting treatment, including brain surgery.

Mark and Ervin are associated with a newly founded non-profit corporation, the Neuro Research Foundation, of Boston, which holds grants and contracts from NIMH and LEAA totaling at least \$600,000. Included in the funds is a grant of \$108,931 that LEAA awarded to the Foundation's president, Dr. William H. Sweet, to study "the role of neurobiological dysfunction in the violent offender." According to LEAA, "the grantee will determine the incidence of such disorders in a state penitentiary for men; estimate their prevalence in a non-incarcerated population; improve, develop, and test the usefulness of electrophysiological and neurophysiological techniques for the detection of such disorders in routine examinations."

The most frequent criticism of the first wave of lobotomy was that it quieted the patient at the price of turning him into a tractable "vegetable." Typical of this conclusion was a report by a British psychiatrist who wrote in 1965 that "huge cuts in the frontal lobes, as well as relieving some symptoms, often produced mutilations of personality which were at least as socially disabling as the symptoms had been, and very disturbing to contemplate." Doubts about the original-style operations were even being expressed some 20 years earlier by the dean of American lobotomists, Walter Freeman, then chairman of The George Washington University Department of Neurology, who switched his characteristic enthusiasm—following 4000 operations that he performed, though not trained in surgery—to endorsement of the new style of operation. This was based on surgical techniques that permitted more precisely placed, lesser cuts into the brain. Nevertheless, in the mid-1950's, lobotomy went into eclipse, leaving behind some 50,000 victims.

The lobotomists, however, did not disband. Though it was clear that their surgical interventions in the human brain were on a par with firing
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bullets into the hood of a car to remedy a knock—with occasional success—they had experienced enough “success” to arouse the belief that still newer surgical technology could provide the answer. And new technology was not long in coming. As Freeman himself acknowledged in 1964, his original methods were “too damaging to be employed in any but the most chronically and severely disturbed patients.” However, there were the new methods of destroying brain tissue, he reported, among them the injection of liquid butane or “the patient’s own blood,” ultra-sonic beams, electricity to produce tissue-searing heat, implanted electrodes through which current is sent until the surgeon hears “bubbles of steam escaping,” gold needles left in place “for several months while weak currents were passed at intervals,” radioactive seed implantations, beams from a 185-million volt cyclotron, and, of course, traditional cutting, though with finer tools.

One of the most remarkable aspects of psychosurgery, both in the now discredited first wave and

in the current resurgence, is that it takes place in a closed system of evaluation that almost inevitably fulfills the prophecies of the psychosurgeons. To the extent that retrospective studies have been conducted, they are generally by psychosurgeons reviewing their own work or the work of colleagues. Few others are sufficiently interested to bother with the subject, and this is especially true of psychiatrists and psychologists, many of whom consider psychosurgery a surgical barbarism that does not merit interest. The patients are almost invariably either friendless inmates of institutions or burdens on relatives who are at their wits’ end in dealing with “difficult” behavior. In the case of those who have been confined to institutions prior to surgery, the outcome is frequently “improved” behavior, which means that the attendants find them less troublesome. If the patient has been living at home prior to surgery, his newly subdued behavior is similarly regarded as evidence of success. As for the patients, they tell no tales and make few complaints, for as noted in the classic text, *Psychosurgery*, co-authored by Freeman, “None of the patients regains true insight in the full sense of the word, or is really able to appreciate what the operation was for, or its importance.”

The buoyant optimism of today’s psychosurgeons in the face of ghastly evidence which they themselves provide is one of the most bizarre aspects of the new wave. Thus, a text published in 1969 by Lothar B. Kalinowsky, of New York Medical College, and Hanns Hippus, of the Free University of Berlin, states that psychosurgery is unjustifiably held in low repute today because of its earlier failures, and it urges physicians to change their attitudes and employ it more frequently. Kalinowsky and Hippus then go on to cite a study of 300 cases in which the researcher found, “The patients tend intellectually to be more empty, with restricted interests and simpler satisfactions.” They found another researcher reporting “the disappearance of dreams as well as day dreams after lobotomy.” Still another review of lobotomy found that “original artist’s work was impossible even for those who had such abilities before the operation.” It was found, too, that “like all feelings, the religious feeling also becomes somewhat shallower . . .”

The first wave of psychosurgery mutilated some 50,000 victims before the lobotomists themselves were forced to concede the destructiveness of their procedures. Before the new wave proceeds through one more skull, the public, the press, and Congress should demand an immediate halt, to be followed by an independent investigation into the therapeutic claims of psychosurgery.