THE SECOND WAVE

LOBOTOMY and psychosurgery are upon us again!

In Philadelphia a black man dies of an overdose of heroin, and a reporter notices peculiar scars on his head. A portion of his brain has been burned out in an experimental attempt to cure his addiction. The neurosurgeon is located by the reporter and admits that his monkey experiments were inconclusive before trying his operation on human addicts.

In Louisville a woman is blinded by a prefrontal lobotomy. Testimony in a lawsuit against her surgeon indicates that this 30-year-old woman was lobotomized for pain of psychological origin without being given an opportunity in psychotherapy.

In Jackson, Miss., a neurosurgeon uses a mutilating operation on hyperactive children as young as age 5. He describes one child whose brain he coagulated with electrodes half-a-dozen times. The child is now easier to manage on the ward, but intellectually he is deteriorating. This neurosurgeon refuses to answer questions about the race of his young patients and declines to let reporters and legal investigators see them. But someone slips onto the wards and discovers three of the children are black.

In California, the prison system denies plans to operate on “difficult” prisoners until letters are uncovered detailing extensive plans for a psychosurgical program in cooperation with the University Hospitals of California in San Francisco. When it is then discovered that three prisoners have already been subjected to mutilating operations, the prison officials decide to boast publicly about their best case. But a lawyer discloses a prisoner’s whereabouts, and he is found to be physically crippled and emotionally worse off than before the operation.

In Boston a depressed woman is operated on several times with chronically implanted electrodes until she refuses further surgery, tells her surgeon she never wants to see him again, and expresses rage at her psychiatrist as well. She kills herself the first chance she gets, but the case is reported as “gratifying” by her doctors who argue that the woman must have been recovering from her depression, otherwise she would not have had the energy to kill herself.

Meanwhile, more subtle research is in progress. In Boston, patients are skewered through the brain with two large electrodes, each containing as many as 40 smaller electrodes for brain stimulation and brain-wave recording. These electrodes are left in place for up to a full year for remote control experiments before the psychosurgery is performed by heating up one of the wires.

At Tulane, homosexuals are stimulated in their “pleasure centers” while watching stag films—to condition them to heterosexuality. The same psychosurgeon holds the unofficial “record” of 120 electrodes implanted in the same person at one time. X-rays give the impression of a living pin cushion, but the doctor writes that his work is “therapeutic” rather than experimental and that his electrodes can do no harm.

At the San Francisco Children’s Hospital, ultrasonic radiation (the stuff that knocks the calcium off your teeth) is sprayed into the frontal lobes of patients, including one 13-year-old girl. Not surprisingly, this inventive neurosurgeon is an ex-dentist.

Nob do psychosurgeons limit themselves to clinical aspirations. A group of Boston psychosurgeons writes in the Journal of the American Medical Association that ghetto riots cannot be caused by political factors alone and that violent rioters may suffer from brain disease. The Justice Department rewards them with a grant to develop “screening methods” to find the violent prone among us and to develop psychosurgical means for their control.

Even Congress gets into the act and awards them $500,000 one year and a million the next.

All this is not the work of a few cranks, but of a large number of respected neurosurgeons and psychiatrists working in several dozen or more medical centers around the country, including Boston, Hartford, New York, Philadelphia, New Orleans, Louisville, San Francisco, Santa Monica, and the National Institutes of Health.*

No one knows how many operations are being done each year in the United States—perhaps 600 to 1,000—but everyone agrees that we are witnessing a worldwide resurgence of lobotomy and psychosurgery.

The surgeons have even formed what’s now called the International Association for Psychiatric Surgery. They meet and speak frequently at conferences. Besides that, many new books and papers are coming out, and even standard psychiatric texts are again describing psychosurgery as a legitimate treatment.

The new targets are not backward state hospital patients, but mostly neurotics—depressed, anxious, obsessive and elderly individuals, the majority women. Having disgraced themselves with the wholesale mutilation of 50,000 state hospital patients through the 1950s, the psychosurgeons, many of them the same men, now turn their weapons upon those patients they can catch on a neurosurgical service of a general hospital.

The variety of operations is enormous. One neurosurgeon places a net of electrodes across the frontal lobes and gradually coagulates the patient over a period of months, depending upon how “good” his behavior is on the ward and at home. Others still use the old-fashioned knife on the frontal lobes.

* Most have been documented in detail in my resource paper published in the Congressional Record of Feb. 24, 1972, pp. E1602-1612, while others have been disclosed in the press and in the courts.
The area of the brain attacked also varies widely, including deeper portions of it (such as the thalamus, hypothalamus, cingulum, and amygdala). But all the operations have two things in common: they mutilate non-diseased tissue, and they blunt the overall emotional and intellectual responsiveness of the mind. They subdue or pacify the individual, regardless of the nature of his symptoms or the cause of his difficulties.

**Scientifically, the work of these men can be quickly dismissed.** In the four decades during which they have published hundreds of papers, they have not produced one controlled study comparing the effects of their therapy to the effects of other therapies, or no therapy at all. In the last decade, they have almost given up reporting detailed case histories and usually rely upon one- and two-word clinical descriptions, such as “depressed” or “obsessive,” followed by a number to indicate the degree of recovery.

Sadly, the only controlled studies we have from the entire onslaught are retrospective. Looking back over the first wave of lobotomies, the results are uniformly dismal. The patients still have their psychiatric symptoms, now compounded by lethargy, loss of interest in themselves, and intellectual deterioration—the natural outcome of mutilating the higher centers of the brain.

We can expect the same results, though less severe, perhaps, from the newer, more limited operations. Writing about more conservative forms of lobotomy in 1959, Walter Freeman, the Dean of Lobotomy, describes the patient’s “loss of self.” After a successful lobotomy, he says, “What the investigator misses the most in the more highly intelligent individuals is the ability to introspect, to speculate, to philosophize, especially in regard to the self. Maybe it was the abnormal development of these intellectual-emotional exercises that got the patients into trouble.”

The lobotomies described by Freeman are still being done throughout the country and are the object of at least one current lawsuit. But even the most conservative lobotomies are known as “blunting” operations. Arthur Winter states that his patients become “more placid—sometimes passive.” William Scoville, who has replaced the deceased Walter Freeman as the nation’s spokesman for lobotomy and psychosurgery, has described even the most refined of the recent operations as a “partial” lobotomy, even though they destroy tissue below the frontal lobes.

With the advent of the current public controversy, some of these men have tried to retract, or even deny, their previously published remarks. But these reports are too consistent to be so easily censored.

In the most recently published pro-psychosurgery book, Ruth Anderson gives the most detailed description now available of the effects of one of the most refined operations (amygdalotomy). Although this operation avoids damaging the higher centers of the frontal lobes, she still finds that the effects are similar to those of a lobotomy.

She observes, “Typically the patient tends to become more inert, shows less zest and intensity of emotions. His spontaneous activity tends to be reduced, and he becomes less capable of creative productivity.” She also finds that his ability to learn is sharply reduced.

On a recent panel with me, Sano, another of the world’s most experienced psychosurgeons, described his operation (hypothalamotomy) as “sedative neurosurgery.” This is his “best” case, a young child: Emotional and personality changes: the patient became markedly calm, passive and tractable, showing decreased spontaneity. Similarly, Balasubramaniam speaks of his psychosurgery (amygdalotomy) as “sedative neurosurgery...where a patient is made quiet and manageable by an operation.” His most “remarkable” case, again a child, became quiet, bashful and was a model of good behavior.

Psychosurgeons most often rationalize their work as an effort to reduce the individual’s “anxiety” or “tension,” without mentioning that this merely reflects an overall loss of vitality. Their second most popular rationale, that so-called mental illness is biological, is unproven. But even if it were true, it makes no sense as a justification for brain mutilation. If minimal brain dysfunction (so minimal it cannot yet be detected) can produce severe disabling symptoms, then why would increased brain dysfunction from surgery improve upon anything?

The occasional contention that psychosurgery treats specific diseases with specific operations is not even supported by most experienced psychosurgeons. Scoville has recently written that each of the operations produces the same “blunting” function and that one operation will eventually be settled upon for all forms of psychiatric disorder. Meanwhile, each psychosurgeon has his own favorite operation, and he uses it on every case that comes along.

Had there been any doubt about the non-specific leveling effects of these operations, the animal research literature should have dispelled them. In nearly all animals, the operations produce the same result, regardless of the presence or absence of disease. The animals become more tame, more tractable, more helpless, and less able to learn and to adapt to their natural surroundings. They become much easier to manage in cages but useless for anything else.

The most serious questions about psychosurgery are ethical and political rather than scientific. Do we dare treat man in so cynical a manner, reducing his humanity to solve his problems? Do we wish to make life more tolerable for a woman and for those around her by taking some of her life away? Do we wish to invade the provinces of “self,” treating the person by reducing his capacity to be a person. Do we wish
to produce living abortions—or more accurately, victims of partial euthanasia? Euthanasia, controversial enough in those dying of dreadful diseases, becomes a menace when performed on psychiatric patients.

Psychosurgeons and their supporters are fond of saying that the brain, like the lungs and kidneys, can function adequately with a large part removed. But when a man’s respiratory potential is reduced or when his excretory functions are limited by surgery, the man himself—the person whom we know and who knows himself—remains the same. When the capacity of the brain is reduced by a psychosurgeon, so too is the capacity of the mind. The man is changed, reduced, made into something less than he was.

It is one thing for a man to have “shallow breathing,” another to have a “shallow mind.” Thus, all destructive changes in the mind, unlike the body, become qualitative as well as quantitative. Even if the loss is only partial, we are still dealing with a change in the essence of the person.

This loss of “humanity” in the mutilated individual can be known at from many sides. Whole books, entire novels only manage to touch upon the subject. Another way to approach the issue is this: “Is man a machine, or is he a creature with a creative will?”

If life is to have any moral meaning, man must be treated as if he has free will. The problems of life can then often be examined and understood as reflecting the anxiety generated by free will, the agony of choice, the despair of failure to choose and to act. What is man without this capacity? When we partially destroy the individual’s brain, we bring him and those around him some measure of peace, but at the price of his irrevocable and inescapable enslavement to a permanently defective mind.

It is time to rid ourselves of the notion that lobotomy and psycho-
surgery are “medical treatments.” That something is done by a surgeon in an operating room does not make it “medical.” Like the amputation of the clitoris or the testes in cases of sexual deviance, psychosurgical operations are best compared to the still more ancient practices of cutting off a limb or poking out the eyes of accused criminals. That doctors do the mutilating should not distract us from the function it serves—impairment of the individual to control his behavior.

Nor is voluntary consent a sufficient protection from such atrocities. Witches volunteered for burning; some slaves willingly accepted their masters. Miserable, suffering, humiliated human beings will often submit themselves to the most cruel treatment. They will seek it out, as some individuals will maim themselves or commit suicide.

We can recognize the individual’s right to harm or kill himself, but we can never permit someone else to harm him or to help him toward his self-maiming or suicide. Thus, while suicide itself is considered a right by libertarians, murder is never sanctioned. Psychosurgery is a partial murder, and no one should confuse the issue with a “personal right to treatment.”

From a practical standpoint, the issue of voluntary consent becomes particularly hypocritical when applied to prisoners and mental patients. Due to their circumstances, they are easily subjected to intimidation.

Similarly, the consent form in the psychosurgical unit of the California prison explicitly stated that the prisoner would be released from solitary confinement in return for his “consent” to treatment. Given the powerlessness and the vulnerability of mental patients and prisoners, it is folly to see any protection in voluntary consent.

The physician who chooses to command the spiritual life and death of an individual takes a terrible moral responsibility upon himself. The result at best is the hardening of the physician to moral issues. Thus, the latest texts on lobotomy and psychosurgery make no mention of any moral issues. They seem not to exist for the surgeons!

The exercise of this power brings very practical consequences, many of which are already apparent in the treatment of psychiatric patients. Because we can resort to involuntary hospitalization, stupifying and paralyzing drugs and electroshock, we too often overlook the real human needs for love, kindness, understanding, and courage. We may also fail to grasp the real life problems confronting the patient.

The political issues are ultimately the most important, for what is now a threat to individuals may eventually become a threat to the nation. As technology more and more becomes “the cure” for personal and political problems, we will increasingly lose track of ourselves as individuals.

Minorities will, of course, be the first to suffer. It is no surprise that poor people, the elderly, and women were the primary victims of the first wave of lobotomy in the state hospitals. It is no surprise, either, that ghetto rioters were the first concern of the Boston psychosurgeons, that black prisoners and children are among the first victims as psychosurgeons move into prisons and children’s institutions, and that women and older people again dominate the statistics in the new wave of psychiatric surgery.

The first wave of lobotomy appalled many professionals and much of the public, but it slipped by without encountering any significant resistance. While they grumbled to themselves, the professionals did nothing to stop their colleagues; and the public, while somewhat dismayed, lacked initiative and information. It is time to take action—through professional and public societies, through the courts, through hospitals and government institutions, and through state and federal legislation—to abolish lobotomy and psychosurgery.