



ARTICLE

MEDICAL GENOCIDE

PART NINETEEN

Millions of Americans
have been institutionalized
and drugged against
their will by a rich and
powerful profession
that still seeks legitimacy.

THE POLITICS OF PSYCHIATRY

BY GARY NULL

If you were told that 19 percent of American adults, or nearly 41 million Americans, were mentally ill, would you believe it? You might think it was a bad joke or, if coming from a cynic, a statement on what is going on in the nation today, but it would probably be hard to take such an estimation seriously. Nevertheless, according to statistics released by the National Institute of Mental Health in 1984, this is precisely the situation we face. If true, then mental illness is our No.1 health threat, surpassing cancer, AIDS, and heart disease combined. Economically, if taken at face value, these statistics would threaten to bankrupt a health-care system that is already stretched to its limits. On the other hand, with one out of every five Americans requiring psychiatric care, the mental-health-care profession would receive an unprecedented boon. Psychiatry would be catapulted from a relatively lackluster and obscure position into one of great power and pres-

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tige. The potential for abuse in an area of medicine that is far from scientific should concern us all. This article will examine some of the different diagnostic methods and therapies used in psychiatry, with some of the leading critics of psychiatric abuse sharing their insights into the power, politics, and profits of the treatment of mental illness.

The psychiatric profession in America has long been in quest of scientific legitimacy. Without this recognition, psychiatry would stand little chance of convincing the American public that drugs, electroconvulsive therapy, and lobotomies are really in their best interest. The problem, however, has been that, unlike other areas of medicine, the entire notion of psychiatry is based on subjective analysis. There simply are no scientific criteria for proving mental illness. Psychiatry has sought to resolve this dilemma in two ways. First, psychiatry has set up a "biological model" of mental illness predicated on the theory that mental disorders originate in the body, and hence are a "medical" problem. Second, through the American Psychiatric Association's publication of the *Diagnostic and Statistical Manual of Mental Disorders*, the profession purports to set objective criteria for the diagnosis of mental disorders. For the most part, the ruse has worked remarkably well, to the point where psychiatry today penetrates virtually every aspect of American life from the courtroom to the classroom.

The N.I.M.H.-endorsed study is a good example of how psychiatric mumbo jumbo can be used to justify an ever-expanding role for the profession. The study was designed to give us "the first accurate assessment of the prevalence of specific mental disorders in our population," which, of course, presumes from the outset that an "accurate assessment" can be made. The fact that it is impossible to objectively and scientifically assess anything as amorphous and subjective as mental illness is simply ignored or denied. This is where the DSM comes in. The statistics in the N.I.M.H. survey were based on diagnoses "made in accordance with the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* [the DSM-III], which spells out the criteria used by clinicians to diagnose their own patients." Now in its third revised version, the DSM is a 500-page tome that sets forth and defines all mental disorders recognized by the psychiatric profession. Far from establishing objective diagnostic criteria, the DSM is a compilation of arbitrary and vague categories that are more dependent on the character of the person doing the diagnosing than on that of the patient. So while the N.I.M.H. survey may reflect an "accurate assessment" of mental illness from the A.P.A.'s point of view, it remains to be seen what its observations really mean.

California psychiatrist Lee Coleman is

concerned about the abuses of his profession, and is troubled about its power to control and manipulate people. Says Coleman, "Over the years, millions of Americans have been greatly harmed by forced psychiatric treatment and labels. The immediate effects of shocking and drugging people against their will are serious in and of themselves; the repercussions of labeling someone as mentally ill may be even more damaging. Let me give you an example of a case I am working on. It involves a woman who was upset, depressed, and anxious because her marriage was breaking up. Nevertheless, she was labeled by psychiatrists as a schizophrenic. When I reviewed the medical record, I did not find anything that indicated in any way that she had had a psychotic breakdown.

"Five years later, after being forced into the hospital, she was in a child-custody fight because of her divorce. The label of schizophrenic is hauled out and used

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against her. She not only lost custody of the children, but was prohibited from visiting her children unless she stays on medication. Furthermore, the medications that she is being blackmailed into taking can cause permanent brain damage called tardive dyskinesia."

During the 1940s and fifties, researchers began to observe that certain drugs influenced a person's moods. One drug that was then being studied as a tranquilizer and antihypertensive was found to produce depression in some patients. Other researchers found that certain antihistamines being tested for their role in allergy relief also worked as antidepressants. Around the same time, an Australian physician was reporting that lithium worked as a mood elevator.

These various observations led to a flurry of research into the possibility of developing drugs that acted favorably on certain mental disorders, and opened the door to the biological theory of mental illness. Up until that time, the prevailing theories were those of Freud and Jung, which basically stated that a person's mental state was solely determined by

his or her psychological makeup. Today, however, most psychiatrists are of the opinion that psychological disorders have a dual seat of origin: in the psyche, which is the sum total of a person's conscious and subconscious experiences, and in physiological activity. Psychiatry now employs a wide variety of drugs, designed to counteract the symptoms of most psychiatric conditions.

Especially favored by psychiatrists are minor tranquilizers such as Valium and Librium. According to *The New York Times*, these drugs are "the most widely prescribed drugs in the world." In the early 1970s, use of the minor tranquilizers reached its peak when approximately 90 million prescriptions were filled annually. Later on in the seventies, when prescriptions for tranquilizers were already on the decline, the Department of Commerce estimated that roughly 25 percent of the nation's drug bill (or more than \$2 billion) was spent on these drugs each year.

The widespread use of the minor tranquilizers was undoubtedly due, at least in part, to the massive push from their manufacturers, who initially promoted and sold them as being as safe as aspirin. Yet it soon became apparent that far from being safe, these drugs could have severe side effects, and were very addictive both physically and psychologically. A campaign was launched by consumer and public-interest groups calling for restrictions on the production and prescription of the drugs. In July of 1980, *The New York Times* reported that the F.D.A. would require the manufacturers of "Valium, Librium, and other so-called minor tranquilizers . . . to warn physicians that the drugs are not meant to relieve the stress of 'everyday life.'"

The adverse side effects of certain major tranquilizers, like Thorazine and Stelazine, are potentially even more dangerous. The *Physician's Desk Reference* listing for Thorazine, for instance, describes tardive dyskinesia as a possible side effect of prolonged use of the drug. The disorder is characterized by "rhythmical, involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffiness of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of the extremities. . . . There is no known effective treatment for tardive dyskinesia."

Like the minor tranquilizers, the major tranquilizers were also considered relatively safe when they first appeared on the market. A psychiatry textbook published in 1959, not long after Thorazine was first introduced, read as follows: "Statistics indicate that chlorpromazine [the generic name for Thorazine] is probably the most effective drug in our hands today in the treatment of psychotic patients . . . in quieting manic conditions . . . [and] in cases of schizophrenia. . . . The side effects of chlorpromazine are, in

most instances, not serious."

This apparent ignorance of "serious side effects," even though the drug was still new, is particularly surprising since its potency was well recognized. The same textbook suggested that the new major tranquilizers were capable of producing a "functional lobotomy" (a treatment also in vogue at the time). A question thus arises as to how the statement could be made that these drugs were without serious side effects while, in the same breath, their principal action was equated with an operation designed to destroy healthy brain tissue. Whatever the reason or rationale, one thing is clear—while medical students in the 1950s and sixties were learning that drugs such as Thorazine were effective and relatively safe to use in almost any type of psychiatric condition, clinical evidence was rapidly accumulating to the effect that rather than being safe, these drugs can be quite dangerous. The medical establishment managed to ignore this, or keep it a secret, for some 20 years. But by the mid-1970s, the cat was out of the bag: The 1976 P.D.R. listing for Thorazine and other tranquilizers included warnings, contraindications, and adverse reactions that read a full two pages, and named such conditions as tardive dyskinesia and Parkinson's disease.

Electroconvulsive treatment (E.C.T.) was first introduced in 1935 in Hungary. During the 1950s, it was heralded as "one of the most important events in psychiatry in the last two decades." Even at that time, however, its scientific nature was being questioned. In the same psychiatric textbook that touted its importance, the authors wrote, "A considerable amount of data has been accumulated around the subject of shock therapy; the scientific validity of these data, however, has been questioned in many quarters because the original hypotheses regarding the effects of shock . . . have never been experimentally established."

The original technique of administering E.C.T. involved channeling a pulsating current of electricity through a meshwork of electrodes mounted on a rubber sponge, then attached to the patient's temples. Through what must have been a trial-and-error process, psychiatrists found that while voltages of less than 50 to 70 volts caused pain without producing unconsciousness, currents of 70 to 80 volts could lead to unconsciousness without inducing convulsions.

Originally, E.C.T. was administered without premedication, inducing convulsions so severe that a mouth gag was used to prevent the patient from biting his tongue. The physician was advised to exert strong pressure on the jaw to avoid its dislocation, and to make sure the teeth were protected to "safeguard against pressure on the valuable front teeth." Straps or sheets to tie the patient down afterward were found "useful."

Not surprisingly, a major side effect of E.C.T. was fractures, sometimes to the upper body, but the most frequent of which were vertebral fractures caused by muscular contractions of the back resulting in vertebral compression.

The scandals that began to emerge due to these serious fractures caused a shift in psychiatry, and nowadays premedication (a combination of anesthesia and muscle relaxant) is given to patients to lessen the convulsions—and mildly civilize the image of E.C.T.

Leonard Frank, an activist in the area of mental health reform who was once committed to a psychiatric facility and subjected to E.C.T. against his will, has done extensive research on E.C.T. and explains how it is administered today: "The individual is given an anesthetic which puts them to sleep. This is followed by the administration of a muscle paralyzant, and this paralyzes the individual's muscles, including the respiratory sys-



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tem, so that it is necessary to employ a respiratory device in order to maintain breathing during the treatment. When the person is totally out of it and the body is very, very limp, electrodes are applied to the temple area of the head, and anywhere between 70 and 175 volts of electricity are passed through the brain, causing an epilepticlike seizure, which is somewhat subdued because of the use of the muscle relaxant. The individual, instead of going through one of these very dramatic thrashing, flailing-about convulsions, just experiences outwardly a little bit of tremor in the fingers and toes. However, what is going on inside the brain, of course, is exactly what was going on inside the brain 25 and 30 years ago when they were using electroshock without premedications. If you apply that amount of current to it, you are going to produce the obvious—namely, brain damage.

"The psychiatrists have been denying this effect from the very beginning, despite a large body of evidence to the contrary. They say there is some kind of chemical or metabolic imbalance in the human brain, and by the use of electricity

and convulsions, this imbalance is corrected. But they have never been able to back this claim up scientifically."

In the heyday of E.C.T., the 1950s and sixties, E.C.T. was recommended as especially effective in cases of depression; but what was conveniently omitted from those endorsements was that recovery was more likely than not attributable to memory loss—which, next to fractures, was the second-most frequent side effect of E.C.T. This explanation is confirmed by the admission that while recovery from past episodes may have been high, future episodes of depression could not be prevented. E.C.T. was recommended in view of the suicidal danger in these patients as well as their suffering.

Leonard Frank finds the statistics on E.C.T. troubling. "There are millions of people who have undergone this procedure since it was introduced in the late 1930s," he says. "The best estimate we have for the number of people who are undergoing this procedure currently is about 100,000 to 250,000 every year in the United States alone."

It is not altogether clear why so many psychiatrists cling with such tenacity to a procedure that can be so dangerous and has no proven scientific basis.

The popularity of E.C.T. may be due more to its being a profitable procedure than to any conviction as to its efficacy. While the cost of the E.C.T. itself is not that high, hospitalization and associated services can be very expensive. For depression, about ten E.C.T.'s are usually involved at a rate of \$100 to \$125 per treatment. But it is the adjunct costs that mount up, because 80 to 90 percent of those receiving E.C.T.'s are inpatients in psychiatric facilities, which can cost anywhere from \$500 to \$700 per day. If a person stays in for a series of E.C.T.'s, which might run over a period of 30 days, expenses can easily reach \$20,000, a tidy sum for both the hospitals and their staffs.

E.C.T. provides a good illustration of how medical rhetoric and posturing operate to legitimize a procedure and mask its true nature. But E.C.T. is not the only procedure of this kind that has been adopted and promoted by prominent members of the psychiatric community.

Psychosurgery is defined as a surgical operation on the intact brain for the purpose of relieving mental symptoms. Lobotomy, a specific form of psychosurgery, is an operation that removes, destroys, or otherwise disrupts tissue in the frontal lobes of the brain.

The first experimental lobotomies in this country were performed on chimpanzees. The chimps were taught a complicated routine, and rewarded with food at the end. They were then made to perform the same routine, but this time the food was denied. This resulted in frustration and belligerent behavior. The scientists then removed the chimps' frontal lobes and observed that after the operation, the

monkeys were dazed and calm. The results of this experiment were presented at the Second International Neurological Conference in 1935 (the same year E.C.T. was first introduced) as proof that lobotomy had cured the chimps of their "frustrational [sic] behavior."

That same year, the first lobotomies were performed on humans under the direction of Portuguese neurosurgeon António Egas Moniz. Moniz argued that the fixed ideas and repetitive behavior accompanying certain mental disorders were a result of abnormal cellular connections in the brain. He concluded that in order to cure the patients, these cellular connections had to be destroyed, and set about performing lobotomies on 20 patients. He reported that one-third recovered, one-third improved, and one-third remained unimproved.

Moniz's work was taken up and advanced in this country by Walter Freeman and James Watts. Jenny Miller, an activist in the mental health reform movement who has studied lobotomy and its history extensively, tells of Freeman's first lobotomy case:

"In 1936, Freeman performed his first lobotomy on a 63-year-old woman in George Washington University. She had come to the hospital complaining of nervousness, insomnia, and depression, and added that she could not adjust to growing old. Her husband also told Dr. Freeman that she 'bitched' a lot and was too scrupulous in her housecleaning.

"After her operation, she said she couldn't remember why she was upset. A few days later, she lost her ability to talk. Although she did regain her speech, she died soon after the operation.

"In fact, of the 20 people upon whom Freeman operated, five died within the next few years."

When lobotomy was first introduced, it was performed with an instrument similar to an apple corer. In 1946, a new technique called the "transorbital lobotomy" was introduced. This later became known as the "ice-pick technique," because it was performed with an ice pick-like instrument that was passed through the orbital bone of the eye to destroy the brain tissue. This technique was easy and fast because it did not require opening the skull, and consequently, eliminated the need for surgical training. This became the method of preference, and the number of lobotomies performed in the United States increased from about 100 to 5,000 per year.

All told, between 1936 and 1955, there were approximately 50,000 lobotomies performed in the United States.

In 1949, Moniz won a Nobel Prize for his work, an event that signaled to psychosurgeons around the world that society approved of and valued lobotomy as a therapeutic tool. Walter Freeman was the single most influential person in popularizing lobotomy in the United States. According to Miller, "Freeman traveled all

across the country visiting the back wards of mental hospitals. Sometimes he would do as many as 25 of these 'ice pick' lobotomies in one day. He liked to refer to these trips as 'head-hunting expeditions' and he would call the patients he operated on 'trophies.' "

Perhaps the most amazing thing about Freeman is that he was not some strange aberration, but rather represented the mainstream of psychiatry. He was head of the District of Columbia Medical Society in 1948, and in that same year, was also elected president of the American Board of Psychiatry and Neurology. In a 1959 textbook on psychiatry, Freeman authored the section on psychosurgery, at that time reporting "brilliant results" and recommending lobotomy for such conditions as anxiety, depression, behavior

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disorders, and schizophrenia. Freeman revealed that in many cases, the operation may have been performed more as a matter of convenience for the attending staff: "Depending on the severity of the behavior disorder and its chronicity, the results are quite good, especially from the administrative point of view. Disturbed patients often become friendly, quiet, and cooperative. They retain their basic psychotic dissociations . . . but they no longer react to them so vigorously . . . From the behavioral standpoint, the reduction in spontaneous outbursts, suicidal attempts, refusal of food, and incontinence saves a lot of wear and tear on the hospital."

With the introduction of the psychotropic drugs in the fifties, the lobotomy began to lose its popularity. The public began to realize the full extent of what had been taking place, and that psychiatric institutions across the country were full of people who were rendered almost total vegetables by lobotomies.


Contrary to popular belief, lobotomies are still being performed in the United States. According to Jenny Miller, psychiatrists are usually not very vocal in their support of this treatment because of the adverse publicity. Yet "the *American Journal of Psychiatry* [December 1982] had an article recommending 'modified'

leukotomy as safe and effective in the treatment of obsessional neuroses." (Leukotomy and lobotomy are synonymous terms. Leukotomy is the term used outside the United States.)

This article, entitled "Modified Leukotomy in the Treatment of Intractable Obsessional Neuroses," illustrates that the psychiatric community is not only still using lobotomies, but is actually publicizing this fact in their trade journals. Leonard Frank also notes, "They are not even restricting the use of these operations, which are such major invasive procedures, to people whom they regard as psychotic, but are recommending them for less severe neuroses such as obsessive-compulsive disorders. They report that the effects of these lobotomy operations were favorable—suggesting to other psychiatrists that they also should take advantage of the opportunities of referring their patients to psychosurgeons for this procedure."

It is important that the public see these treatments for what they are, devoid of their slick jargon and scientific rhetoric. These treatments have all been presented to the public as their only alternatives. People are led to believe that if they do not take drugs or undergo electroconvulsive treatment or, as was common in the past, lobotomy, they will become totally insane. All of this is, of course, utter nonsense. In certain closely supervised situations, and when other less toxic alternatives have been explored, drugs may provide some relief to some patients—and in these instances, the benefits of the drugs may outweigh the risks. The cost-benefit analysis is, however, totally lacking as regards both electroconvulsive treatment and lobotomy. Not only has there never existed any scientific proof that these techniques are effective, but even if their efficacy is assumed, the question still arises as to what "effective" really means. Is brain damage that induces memory loss an "effective" treatment for depression? Or is an operation that essentially renders a person a vegetable for life an "effective" treatment for behavioral disorders?

For a long time now, psychiatry has portrayed itself as a legitimate science. Yet any close examination of its practices reveals that most of psychiatry is a house of cards, built upon a series of assumptions and subjective observations.

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