ECHOES OF THE SOUL:
A RHETORICAL HISTORY OF LOBOTOMY

A Dissertation in

English

by

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Abstract

Using critical techniques drawn from rhetorical studies, science studies, and cultural studies, *Echoes of the Soul: A Rhetorical History of Lobotomy* examines one of the most controversial chapters in American medicine by analyzing its rhetorical life in biomedical and popular discourses. Rather than divide these sites of discursive production, this project uses their points of articulation to explore the reciprocal relationship between biomedicine and other forms of culture. *Echoes of the Soul* first argues for the contribution of a rhetorical perspective to the history of medicine, and then presents lobotomy as a compelling case study. Chapter 2 troubles the demarcation between clinical practice and biomedical research by analyzing the arguments for lobotomy’s contribution to neurophysiology in Walter Freeman and James Watts’ *Psychosurgery* (1942). The next two chapters trace lobotomy’s rise and fall in American medicine by positioning this trajectory next to the shifting evaluation of the operation in popular discourse from the mid-1930s to the mid-1950s. Chapter 3 analyzes lobotomy’s articulation with anticommmunist fictions (novels and films, the “brainwashing” panic, and ultraconservative conspiracy theory) in order to argue for a broader contextualization of lobotomy’s displacement by psychopharmacology in the mid-1950s. Chapter 4 examines the rise and fall of lobotomy in the popular press by connecting shifting arguments for its efficacy with a concomitant shift in the gender of case histories used as evidence for its success or failure. The dissertation’s final chapters explore the use of lobotomy as a mnemonic trope in public debates over other forms of psychiatric neurosurgery. Chapter 5 looks at the rhetorical “return” of lobotomy in public campaigns against psychosurgery.
in the early 1970s, and Chapter 6 concludes with an analysis of the use of lobotomy as a rhetorical-historical device in recent press coverage of vagus nerve and deep brain stimulation. Ultimately, *Echoes of the Soul* shows how biomedicine interacts rhetorically with other forms of culture and argues that this interaction shapes biomedical development, the construction of a useable medical past, and the ethical commitments that guide our vision for medicine’s future.
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This dissertation is dedicated to my parents, and to my grandfather, Leonard Johnson.
Pilgrim State’s Rockland’s and Greystone's foetid halls, bickering with the echoes of the soul…

Allen Ginsberg, “Howl”
In 1949, Beulah Jones entered Pilgrim State Psychiatric Center and was diagnosed with dementia praecox, a condition that contemporary psychiatry would diagnose as paranoid schizophrenia. After living at Pilgrim State for four years, Beulah received a prefrontal lobotomy. Recalls daughter Janice Jones-Thomson:

My father said that doctors would operate on her brain and this would take the violence out of her, that she would be docile after that. Well, my recollection was there was no change in her behavior other than she lost her higher intellect. She could not sit down and read anymore. She could barely write. She had no long-term memory, it was like everything was right here in this minute, her attention span was thirty seconds (Jones-Thomson). Beulah spent the next forty years in and out of state institutions and halfway houses. After Beulah died in 1989, her granddaughter, medical librarian Christine Hamilton, made it her mission to discover why her grandmother had received the operation. She wrote a number of letters to Pilgrim State requesting her grandmother’s medical records and eventually discovered that lobotomy had been prescribed for Beulah not to cure or even treat her mental illness, but because she had become a “difficult” patient. Hamilton writes that Pilgrim State was “a factory, a warehouse, a prison, and they had no interest in dealing with a rambunctious patient who was making life difficult.” Outraged at the
treatment her grandmother and other lobotomy patients had received at the hands of their medical caregivers, Hamilton decided to take action. “As a librarian and historian,” she writes, “I know that this tragedy cannot be glossed over. It must be brought to light and examined by society, the same way the Thalidomide tragedy and the Tuskegee study have been exposed” (Hamilton “Learning”).

One of Hamilton’s first actions was to mount a campaign to strip Egas Moniz, the Portuguese neurologist who developed leucotomy (lobotomy), of the Nobel Prize he was awarded for Medicine or Physiology in 1949. In Alfred Nobel’s will, the document that established the parameters of the famous competition, Nobel stipulated that the prize for Medicine or Physiology should honor the discovery in the previous year that “conferred the greatest benefit on mankind” (Lindsten and Ringertz). Moniz’s critics do not challenge his claim to be the first to develop a surgical intervention for mental illness. They charge that what it “conferred on mankind” was not benefit but grievous harm.

Hamilton’s campaign began after she read an essay on the Nobel Foundation’s website that dismissed criticism of Egas Moniz because there were “no effective alternative therapies” for mental illness when it was developed (Jansson). In a letter to Nobel, Hamilton wrote that she and other family members of lobotomy patients found Jansson’s defense of Moniz “extremely hurtful and insulting,” and requested the foundation remove it from the site. In response to Hamilton’s request, a foundation

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1 Hamilton has received mail from Portuguese citizens furious about her campaign to rescind Moniz’s prize. Moniz was the first Portuguese to receive a Nobel, and novelist Jose Saramago was the second. Hamilton comments, “I feel awful about it, because they're taking a very nationalist kind of feeling to it. 'Those rotten Americans again'... I wouldn't want to take away from the rest of his life. But this part has touched my life and I have to speak out about it” (Stewart).
representative stated that although Nobel sympathized with the patients’ families, the essay would remain unedited:

The essay describes the history leading to the establishment of lobotomy as a treatment for psychiatric disease for which, at the time, there was no effective alternative therapy. Treatment changed dramatically when first [electroconvulsive therapy], and somewhat later neuroleptic drugs were introduced. The opinions expressed in the essays are those of the author and not the editorial board. However, the editorial board thinks that the essay in a fair, critical and balanced way recapitulates the history and the period following the gradual abandoning of lobotomy. We therefore are unwilling to remove it from our repertoire of essays (Hamilton “Nobel Responds”).

As for the question of whether Moniz’s prize might be revoked, Nobel’s executive director Michael Sohlman has stated unequivocally that the issue is a “nonstarter” (Johnson “Relatives”). The Nobel foundation clearly has a stake in the historiography of lobotomy. By promoting a history that claims that lobotomy was the only available treatment modality for mental illness, Nobel removes culpability from Egas Moniz and also from the foundation, whose conferral of legitimacy and praise upon the operation likely contributed to its spread.² According to Nobel’s interpretation of the past, physicians who prescribed lobotomy were using the best available means to treat their patients, an action which merits praise, even if today we might find their solution

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² The Nobel committee’s statement implies that ECT was developed well after lobotomy and resulted in a “dramatic” decrease in the operation does not match the historical record—ECT was invented in 1938 (only three years after Moniz’s initial use of leucotomy) and was in regular use throughout the period in which lobotomy was performed on patients.
reprehensible. Families of lobotomy patients also have a stake in the way this story is told: an operation characterized today as one of medicine’s most infamous mistakes irreversibly changed their loved ones and destroyed many of their families. Family members like Christine Hamilton seek a measure of justice in an historical account that forces medical actors to take responsibility for their failures.

In 1960, Howard Dully received a lobotomy at the age of twelve. Like Christine Hamilton, Dully recently began to seek out information about the operation that had damaged his brain. Working with radio producers Dave Isay and Piya Kochar, Dully retrieved his medical records at George Washington University, which holds the archives of his former doctor, Walter Freeman. In November 2005, National Public Radio’s *All Things Considered* broadcast “My Lobotomy,” Isay’s documentary about Howard Dully’s search for the truth about his past. The 22-minute program documented Dully’s journey as he pieced together information from medical records and interviews with his father, medical professionals, family members of other patients, and even Walter Freeman’s children. Narrated with Dully’s rich baritone, the documentary tells the

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3 Dully found the answer in his case file. Shockingly, he read, he had received a lobotomy in large part because he and his stepmother didn’t get along. A later interview with his father confirmed that Howard’s stepmother specifically sought out the operation for Howard:

RD: I think she tried some other doctors who said, “nah ah, there’s nothing wrong here…” ya, ya, ya, “he’s a normal boy”. It was the stepmother problem...

HD: My question would be naturally, why would you let it happen to me if that was the case?

RD: I got manipulated pure and simple. I was sold a bill of goods. She sold me and Freeman sold me. And I didn’t like it (“My Lobotomy”).
history of lobotomy as the history of Howard Dully’s experience with lobotomy. To the best of my knowledge, Dully’s narrative is the first public account of lobotomy from a patient’s point of view. His story vividly puts a human face on one of the darkest episodes in American medical history and introduces a long absent perspective on lobotomy into the historical record.

In their efforts to bring lobotomy back into the public spotlight, Hamilton and Dully both challenge the way that we approach lobotomy’s history. How do we know what we know about lobotomy, one of the most universally reviled operations in the history of medicine? Whose accounts carry authority, and how is that authority conferred? How should we remember lobotomy—its inventors, its practitioners, its patients and their families? What meaning have we taken from lobotomy and what lessons should we learn?

There are two book-length histories that take lobotomy as a primary subject: Elliot Valenstein’s *Great and Desperate Cures* (1986) and Jack Pressman’s *Last Resort: Psychosurgery and the Limits of Medicine* (1999). Both histories weave a tight narrative of the development of lobotomy in American biomedicine. Pressman comes to particularly astute conclusions about lobotomy’s development within the coevolving professions of neurology and psychiatry in the first half of the twentieth century.

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4 Audience response to the broadcast was literally overwhelming: immediately after the story aired, listeners generated such heavy email traffic that NPR’s server crashed for the first time in its history. In response to the wide critical acclaim, Dully later co-authored a written memoir, also entitled *My Lobotomy*, with writer Charles Fleming.

5 Judy Segal writes, “The history of medicine in the West is the history of biomedicine…referred to variously as ‘Western,’ ‘scientific,’ and ‘modern’ medicine” (23-4). See Hunter for an excellent analysis of the epistemological entanglement of science and medicine.
Although historians and physicians alike have characterized the lobotomy era as an aberration in the history of medicine, Pressman argues that by contextualizing the operation within early 20th century neuropsychiatric research and practice, one can see that lobotomy was very much within the biomedical mainstream, a conclusion far more discomfiting than the traditional storyline that places lobotomy at medicine’s margins.

“In the case of those physicians of the past who stand before us today in shame and disgrace, it is all too easy to explain away their actions as the consequence of reckless judgment—no doubt something that right-minded persons (like us) can recognize and avoid when facing similar challenges, now and in the future” (Pressman 17).

In his effort to tell the true medical history of lobotomy, Pressman explicitly excludes certain material from his account:

An argument could even be made that [lobotomy] has become our most visible icon for everything that is dangerous and bad about uncontrolled medical science, about the havoc that can ensue when evil (or perhaps simply misguided) individuals masquerade as competent scientists or doctors. A steady production of popular books, movies, and plays—*One Flew Over the Cuckoo’s Nest*, *Planet of the Apes*, and *Frances*, to name a few—have forcefully explored this point…

While the mad-doctor characterizations make for great polemics and for spine-tingling science fiction, as history they are often just plain wrong (4).

As Pressman points out, lobotomy frequently found its way into popular discourse in the early 20th century—represented not just in novels, films, and plays, but also in newspapers and magazines, political debates, anticommunist conspiracy theories, and
many other discursive terrains located far from “legitimate” scientific and medical discourse.

But why did lobotomy attract so much popular attention, and what was the effect? Why does lobotomy, a discredited medical practice from the mid-twentieth century, continue to appear as shorthand for various ideas like “stupid” or “mind control”? Howard Dully writes that before he began his research, he often wondered if he might have imagined his operation, because he knew he wasn’t a “vegetable,” a point that also made him wonder if what he “knew about lobotomies was true” (My Lobotomy 212). If not drawn from his memory or from medical history, what did Dully know about lobotomies, and where did that information come from? Why is it that when I have described this project to others, I have never been asked what’s a lobotomy?

Unlike medical interventions such as heart surgery or kidney surgery or even other types of neurosurgery, lobotomy irreversibly altered the biological material of the self. The taboo attached to medical tampering with the individual personality made lobotomy a powerful symbol for a host of social and political issues in much the same way that Prozac, today, signifies much more than the brand name for fluoxetine. If, as Pressman suggests, lobotomy is one of the most visible icons of medical failure, then there is a history to that visibility and iconicity too. Lobotomy has a history within biomedicine and clinical practice, to be certain, but it also has a history as a symbol. I contend in this dissertation that these histories are not as separate as they might first appear.
A Rhetorical History of Medicine

In this dissertation, I offer a rhetorical history of medicine that takes lobotomy as an extended case study. The terms “rhetoric,” “history,” and “medicine” first need a little unpacking, as does my proposal to put them back together again as more than just three personal research interests. First, *rhetoric*. In this project, I follow the tradition in rhetorical studies that operates from Kenneth Burke’s definition of rhetoric as “the use of language as a symbolic means of inducing cooperation in beings that by nature respond to symbols” (43). As such, a rhetorical perspective is interested in the power of symbols—words as well as images—as dynamic forces of change within particular historical and cultural contexts. Rhetoric investigates the action of language and seeks to reconstruct the mechanism of its production and, when available, its residual marks or effects.

Second, *rhetorical history*. The relation of rhetoric to history is a contentious one, as rhetoricians and historians alike have accused the rhetorical historian of stepping into territory that does not “belong” to him/her. In an essay in *Doing Rhetorical History*, David Zarefsky asks pointedly, “why should rhetoricians do history, especially when there is also a history department?” (31). Rhetoricians interested in “doing” history respond that the rhetorical historian offers a unique vantage point: “what distinguishes the rhetorical historian is not subject matter but perspective” (Zarefsky 30). A rhetorical perspective enables one to ask “questions that historians would not think to ask,” writes Kathleen Turner (4). Furthermore, Turner argues, “the rhetorical perspective affects not only the questions we ask of history, but also what we consider to be ‘evidence’ and how
we interrogate that evidence” (5). The traditional historian 6 sifts through documents of the past and attempts to construct a historiographical narrative that approaches an accurate account of the past. Even if never fully realizable, the principle of accuracy is an organizing disciplinary standard for most historians. In contrast, for the rhetorical historian, “accuracy is only one rather minor and elusive consideration; the power of… stories and images as symbolic constructions of reality for their publics is precisely the stuff of the rhetorical historian” (Turner 5). This does not mean that rhetorical historians perform sloppy scholarship—it simply means that the rhetorical historian often finds value in stories discarded as inaccurate, untrue, or apocryphal.

I do not believe that rhetorical history should supplant “traditional” history, nor do I believe the story that it tells is a better or more accurate tale. 7 I simply hold, with Kenneth Burke, that a rhetorician is “one voice in a dialogue. Put several such voices together, with each voicing its own special assertion, let them act upon one another in cooperative competition, and you get a dialectic that, properly developed, can lead to the views transcending the limitations of each” (“Rhetoric—Old and New” 203).

Which brings us to the rhetorical history of medicine, the approach I propose with this dissertation. The subfield of the rhetoric of medicine is a relatively new one, illustrated by Judy Z. Segal’s broadly entitled recent book, Health and the Rhetoric of

6 I recognize that the “traditional” historian is a bit of a mythic straw man, much like the “scientist”; to lump all historians into the category of “traditional” history is to commit an unfortunate generalization. There are a number of historians who take innovative methodological approaches to historiography. Micale, Sadowsky, Reverby, Pandora, and Porter are some excellent examples of innovative historians of science and medicine.
In 2005, Segal can wonder about the general intersection of rhetoric and medicine in much the same way Alan Gross could write a book broadly entitled *The Rhetoric of Science* in 1991; each scholar first needed to stake the claim that there might be such a subfield before any specific work could begin. Embarking on a new course of inquiry, rhetorical scholars interested in medicine have found it necessary to take their methodological cues not only from the general field of rhetorical studies and the subfield of rhetoric of science, but also from other related (inter)disciplines.

In his 2003 *Risky Rhetoric*, for example, J. Blake Scott argues for a hybrid approach to the rhetorical study of science and medicine, which “cross-pollinates” rhetorical studies and cultural studies. Although inroads have been made to unite the two fields, Scott claims that rhetoricians of science have been particularly reluctant to embrace cultural studies approaches within their own scholarship, which has focused on policy discourse about science and technology, close textual reading, and analyses more sociological than rhetorical. Scott explains that he started his project about HIV testing by using traditional rhetorical criticism to critique the “argumentative frames, lines, and appeals” involved in HIV testing discourse; however, he writes, “my study of testing demanded more than a traditional rhetorical approach. I needed to track the functions and transformations of testing across various cultural arenas, to account for the ways rhetoric works with extramaterial actors and to focus on testing’s subject-related effects” (4). Seeking to expand the toolkit available to rhetoricians, Scott proposes a rhetorical-cultural approach, which draws from literature in rhetorical studies, cultural studies,

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8 Segal’s chapter on the rhetorical history of medicine will be discussed further in Chapter 2.
9 See Rosteck for a number of essays on the interdisciplinary possibilities of rhetorical and cultural studies.
feminist science studies, and the medical humanities in order to shape inquiry into the symbolic practices of science and medicine.

The rhetorical history of medicine I propose with this dissertation similarly views its subject matter with a perspective developed from many of these fields, which leads me to a rough sketch of some of the questions it will ask and approaches it will take. First, drawing from the rhetorical tradition, I suggest that a rhetorical history of medicine ask how a given text works to construct and to persuade its audience at a situated moment. As Thomas Kuhn famously argues in *The Structure of Scientific Revolutions*, scientific practice changes not because science has found a better fit with nature, but because scientists successfully persuade their colleagues of the soundness of a particular paradigm:

because scientists are reasonable men [sic], one or another argument will ultimately persuade many of them… [I]f the paradigm is destined to win its fight, the number and strength of the persuasive arguments in its favor will increase. More scientists will then be converted, and the exploration of the new paradigm will go on (158-9).

For Kuhn, argument and persuasion serve an essential role in the development of scientific practice and drive its moments of revolution. In a similar vein, rhetorician Leah Ceccarelli has explored the use of rhetoric in the creation of new interdisciplinary fields of scientific inquiry through books that function as “interdisciplinary inspirational” foundational texts. Whether or not these texts succeed, Ceccarelli argues, is largely due to their ability to speak to diverse audiences with a polysemic vocabulary. To study the history of medicine from a rhetorical viewpoint similarly directs one to examine how
particular arguments are made about diseases, treatments and patients, to which audiences, under which circumstances, and, if one is able to support the claim, to what effect.¹⁰

Second, drawing from the literature in science studies and the cultural studies of medicine, a rhetorical history of medicine asks us to reconsider what discourse “counts” as proper to the domain of medicine. The production of scientific or medical knowledge often is characterized as operating within disciplinary constraints that authorize certain actors (biologist, physicist, cardiologist) and discourse (peer-reviewed journal article) and exclude others (science journalism, fiction, film). Like science, which “consists not simply of laboratory practices and their finished products,” medical practice is not confined to the examination room or surgical theater (Taylor 7). Catherine Waldby has offered the term “biomedical imaginary” to describe the “speculative, propositional fabric of medical thought, the generally disavowed dream work performed by biomedical theory and innovation” (Visible Human 136). Drawing on Waldby’s concept, Susan Squier suggests that scholars “investigate the biomedical imaginary when we consider how medical issues are articulated and engaged with across all cultural fields, from medicine to government to popular culture and religion” (15). Squier directs us to look for the biomedical imaginary in sites traditionally excluded from the production of biomedical

¹⁰ This is the approach I take with Chapter 1; one might also investigate how arguments for lobotomy were framed during the reign of psychoanalysis, whose adherents were not sympathetic to most somatic interventions (much less surgical interventions) into the human psyche. In one striking instance, Walter Freeman entitled a later unpublished paper “With an Icepick and Camera in Search of the Superego,” a work in which he attempted to explain the effects of transorbital lobotomy using Freudian language. See also Jonathan Metzl and Jonathan Sadowsky on the tensions between psychoanalysis and biopsychiatry in the mid-century.
knowledge, and also asks that we trouble the process of their division, the work of demarcation that authorizes some discourses to talk about scientific and medical matters and which renders others illegitimate.\textsuperscript{11}

Historian Katherine Pandora has suggested that it is precisely the illegitimacy of “vernacular” engagements with science that make them a rich source of information about the past. Pandora develops her understanding of the vernacular from scholarship in rhetoric, folklore, and linguistics, which use “vernacular” to describe discourse created outside of, or in response to, discourses authorized by dominant institutions.\textsuperscript{12} Although this term suggests a division between two spheres of discursive production (one of learned, initiated “elites,” and one that “does not require special skills”) the vernacular also “refers to the language that each of us regularly speaks and represents the group to which we all belong, no matter what our other specialized memberships might be” (Pandora 492). The vernacular is the space of the everyday world comprised of scientists and nonscientists; a space, Pandora insists, where knowledge is “held in common.” Because they are unauthorized (and often appear as oppositional), vernacular discourses about science and medicine “make possible modes of communication that professional strictures inhibit, permitting, for example, the open acknowledgment of political or metaphysical issues and providing opportunities to engage in speculation at odds with the rhetorical norms of academic science” (492).\textsuperscript{13} For Pandora, the analysis of

\textsuperscript{11}See Taylor, who argues that the process of scientific demarcation is a rhetorical practice.

\textsuperscript{12}For a discussion on the relationship between institutional and vernacular discourse that highlights their intrinsic relation, not separation, see Howard.

\textsuperscript{13}Squier makes a similar argument: “[Fiction], the zone where objective truth is not told, paradoxically becomes the site where one specific truth is best articulated: the workings of the biomedical imaginary, the desires propelling biomedicine…” (17).
vernacular discourse allows us the “fullest possible understanding” of what science or medicine means at a particular place and time (492).\textsuperscript{14}

The vernacular does not just receive knowledge about science and medicine from institutional sources, but creates, disseminates, challenges and gives meaning to that knowledge as well. The vernacular is not passive space of reception, but as Gerard Hauser explains, the vernacular forms a creative space wherein “a public’s members converse through the everyday dialogue of symbolic interactions by which they share and contest attitudes, beliefs, values, and opinions” (qtd. in Pandora 492). The thick line often drawn between “medicine” and “culture” or “public” (or between “expert” and “nonexpert”) does not divide—it connects, and at many points.

To follow Bruno Latour’s famous directive to study science “in action,” writes Squier, “means being ready to investigate the scientific and popular scientific writings of an era, as well as its literary texts; it means understanding that influence can flow back and forth between literature and science, and that literary works (and workers) can influence science, as well as the reverse” (47). In a similar move, Charles Alan Taylor asks that we conceive of science not as an isolated set of practices, but as a kind of

\textsuperscript{14}Vernacular engagements with science and medicine take place in more varied forums than Popular Science, the Scientific American or the Science and Medicine sections of the New York Times. Scholars who study public engagement with science have recently considered the role of everything from postage stamps (Jones) and film (Weingart, Muhl, and Pansegrau), to superhero comics (Locke) as actors in the network of technoscience. And that’s just in Public Understanding of Science, a British journal with methodological leanings more reflective of sociology than cultural studies. The diffuse network of science and medicine neither begins nor ends at the walls of the laboratory or clinic, but should, as Bruno Latour argues, be seen as “all the elements tied to the scientific contents no matter how dirty, unexpected, or foreign they might seem” (174).
ecosystem “spread ever more widely throughout contemporary culture—that of a member of the body politic” (14). In *The Meaning of the Gene*, rhetorician Celeste Condit takes such an ecological rhetorical approach to the history of genetics, tracing the reciprocal relationship between public discourse, scientific conceptions of heredity, and social factors such as “world wars, the arrival of computers [and] changing population demographics” in order to track how meanings of genetics and eugenics have changed throughout the 20th century (13). Unlike other histories of genetics, which have focused on the discourse of scientific elites such as Galton or Wisemann, Condit takes public discourse as her object, which though “rarely orderly, consistent, and philosophically well developed,” has nonetheless had a significant impact on scientific practice and public policy (10). For Condit, Taylor, and Pandora, public discourse about science is an active arena of epistemological production, helping to shape (not just understand) scientific and medical knowledge and practice. Taking its cue from this move to investigate the discursive “traffic” between science and “nonscience,” to use Donna Haraway’s term, a rhetorical history of medicine *approaches the intertextuality of medical and nonmedical discourse not as a one-way flow of information (from medicine to its “outside”), but as reciprocal or ecological relationship.*

Finally, I suggest that a rhetorical history of medicine should not just gaze on the past, but also should *consider the methods by which a medical past is produced and put to use by the present.* Many rhetoricians concerned with historiography have pointed out that the writing of history is a rhetorical act that is “simultaneously narrative and argumentative” (Gronbeck 50). Medical historians also have recognized that the

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15 Haraway writes, “I am not interested in policing the boundaries between nature and culture—quite the opposite, I am edified by the traffic” (*Primate Visions* 377).
traditional shape of historical inquiry often supports a “great doctors” and “great cures” narrative of medical progress, particularly when that history is written by members of the profession (Warner). Yet historians are not the only actors concerned with the rhetorical construction of the past, as many scholars who work in memory studies have argued. As Christine Hamilton illustrates in her challenge to Nobel, how, where and why we remember medicine matters, and this memory poses a far more significant question than whether a particular history gets its facts right or wrong. With regard to collective memory, writes Bruce Gronbeck, “some present need or concern is examined by calling up a past, shaping it into a useful memory that an audience can find relevant to the present” (57). When memory is performed publicly on a commemorative website like Nobel’s, “performed within contexts of power and aspirations,” as Stephen H. Browne writes, the methods by which we remember medicine, the stories we use to construct that memory, and the application of that memory to contemporary medical practice become political matters (466).

**Lobotomy in American Medicine**

Before I begin, it will be helpful to provide a brief general history of the rise of fall of lobotomy in American medicine, as I assume this is a story with which my reader is unfamiliar. Lobotomy is a type of neurosurgery called “psychosurgery,” surgical intervention designed to treat the affective symptoms of psychiatric conditions like depression, obsessive-compulsive disorder, and schizophrenia. Because it is used on

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16 See also Porter, who advocates for a patient’s view of medical history.
otherwise healthy brain tissue, psychosurgery is differentiated from other neurosurgeries, which are used to treat neurological disorders (like epilepsy), pathologies (like tumors) or other trauma to the brain. “Psychosurgery” was coined by 1935 by Egas Moniz, who postulated that ablating (severing) the connecting fibers between the frontal lobes and thalamic regions of the brain would reduce the emotional symptoms of certain psychopathologies. Moniz called his specific procedure “leucotomy,” because it targeted the white connecting fibers (from the Greek, leukos “white” and temnein “to cut”) between the frontal lobes and the thalamus, and developed a special tool called a leucotome with which to perform the ablation of brain tissue.

After Moniz’s initial report of operational success, neurologist Walter Freeman and neurosurgeon James Watts brought the procedure to the United States in 1936 and renamed it “lobotomy.” Though Moniz was awarded the Nobel Prize, it is Walter Freeman who has become synonymous with the procedure. A recent biography of Freeman is entitled “The Lobotomist,” and he widely is referred to in medical and popular literature as the “dean” of lobotomy. The first lobotomies of Freeman and Watts were prefrontal: in these operations, surgeons drilled two burr holes through the front of the skull, inserted a leucotome through the holes, and swung it in arcs between the two hemispheres of the brain in order to sever the white connecting fibers. In the late 1940s, Freeman developed a simpler version of lobotomy based on the work of Italian psychiatrist Amarro Fiamberti, which Freeman called transorbital lobotomy. Instead of

\[17\] I have not been able to find information about the logic behind this name change, and Freeman frequently switched between “leucotomy” and “lobotomy” in drafts of his work. It could be, as I argue in the next chapter, that the focus on the frontal lobes in Freeman Watts’ arguments prompted a change in emphasis from the leukos to the frontal lobes, even though leucotomy and lobotomy both targeted the fibers between the frontal lobes and the thalamic regions of the brain.
local or general anesthesia, Freeman used an electroshock machine to render patients unconscious and then inserted a slender instrument (in the first operations, an actual ice pick) under the eyelid. With the help of a small rubber mallet, Freeman drove the tip of the leucotome through the thin portion of skull behind the eye into the brain, which allowed him to sever the same white fibers that prefrontal lobotomy reached through the top of the skull. Unlike prefrontal lobotomy, the transorbital procedure did not require the services of a surgical team and could be performed in a doctor’s office rather than an operating room, a drastic reduction in cost and effort. Freeman hoped transorbital lobotomy eventually would find common use in the treatment of mental disorders “somewhere between shock therapy and major frontal lobotomy”; the “simple,” “safe,” and “quick” procedure, Freeman believed, was a perfect fit for state hospitals short on doctors, beds, and financial resources (“Transorbital Lobotomy” 261).

James Watts vehemently disagreed with Freeman’s characterization of transorbital lobotomy as a “minor” surgical operation, a difference in opinion that contributed to their professional split in the early 1950s.18 Despite the objections of

18 In a draft for the second edition of the jointly-authored Psychosurgery on the subject of transorbital lobotomy (the published comments are much shorter and less passionate), Watts explains his objections:

Dr. Freeman has expressed the opinion that this is a procedure which can safely be performed by psychiatrists and referred to it as a minor operation. I am inclined to think that any intracranial operation upon the brain is a major procedure and that merely because it does not require any many surgical instruments or very long to complete the operation, does not take it out of the class of a major procedure. While he, himself is one of the best nueroanatomists [sic] and neuropathologists in the country, the majority of psychiatrists in whose hands he would place the operation have little interest and
Watts and many others in the medical community, however, Walter Freeman promoted transorbital lobotomy across the country’s state hospitals, and once performed twelve procedures in a single day, prompting his daughter to nickname him the “Henry Ford of Psychiatry” (Freeman *Autobiography* n.p.). In the mid-1950s, however, professional interest in prefrontal and transorbital lobotomy waned and was virtually abandoned, although Freeman continued to perform lobotomy well into the 1960s. In 1967, California’s Herrick Memorial Hospital stripped Freeman of surgical privileges when one of his patients died from a massive cerebral hemorrhage after her third transorbital lobotomy (El-Hai 293).

Many historical accounts of psychosurgery conclude with the decline of lobotomy in the mid- to late-1950s. In the late 1960s, however, medical interest in psychosurgery was revived with changing theories of neurophysiology and the development of new surgical techniques such as bilateral cingulotomy (severing fibers in the cingulum bundle) and amygdalotomy (severing fibers in the amygdala). These surgeries remain in the contemporary psychiatric armamentarium, in addition to newer psychosurgical techniques such as vagus nerve and deep brain stimulation, procedures in which electrodes are surgically implanted in the brain or surrounding nerves to stimulate neuronal activity.
Chapter Outline

This dissertation intervenes into the history I have detailed above by pausing at different points in its trajectory and considering certain events from a rhetorical point of view. Chapter 2 offers a rhetorical analysis of *Psychosurgery*, Walter Freeman and James Watts’ book-length argument for lobotomy published in 1942 and in a later edition in 1950. While most of Freeman and Watts’ writing on lobotomy argues for its clinical value, I suggest that a study of the book’s rhetorical features reveals a second argument about lobotomy’s *scientific* value directed toward researchers. In this work, lobotomy is presented as “a sort of beneficient vivisection,” a source of knowledge for researchers so that they might study the function of the frontal lobes by observing personality deficits in post-operative lobotomy patients.

The numbers of lobotomies steadily rose throughout the 1930s and 1940s, peaking around 1950 after Moniz’s Nobel Prize. Just a few years later, however, the number of lobotomies in the United States began to rapidly decrease, a phenomenon that is usually attributed to the development of psychotropic drugs like chlorpromazine in the mid-1950s. Chapter 3 seeks to expand the story of lobotomy’s medical decline by exploring a motley set of discourses in which lobotomy became articulated with political anxieties about communism during the Cold War. In addition to works of imaginative fiction like Bernard Wolfe’s *Limbo*, which used lobotomy as a trope for the threat to American individualism, lobotomy also emerged as a suspicious practice in a number of discourses surrounding the “brainwashing” panic of the early 1950s. Closely related to anxieties about brainwashing was an ultra-conservative critique of psychiatry in which
lobotomy was characterized as a nefarious weapon of Communist design. Although clearly works of fiction, these characterizations of lobotomy clearly found purchase in the American imagination as well as the psychiatric profession: I conclude the chapter with moments in medical discourse in which psychiatrists grappled seriously with these attacks on their profession.

In chapter 4, I consider another site of lobotomy’s decline: the evaluative arguments of the popular press. Returning to 1936, the moment when lobotomy first entered the American popular press and following press coverage of the operation to the late 1950s, I chart the shifting claims about the operation’s value by considering the interpretation of patient case histories used as evidence for its efficacy. As arguments began to shift from the praise of lobotomy to its blame, a related series of other shifts took place. I show in this chapter that case histories used as evidence overwhelmingly switched gender from men to women; in addition, the behavioral effects of lobotomy initially used as evidence for its success in women (such as docility and childlike behavior) were redeployed as evidence of its failure in men.

Chapter 5 analyzes the rhetoric of psychiatrist Peter Breggin, who undertook a national campaign to end the practice of psychosurgery in early 1970s America, and contextualizes that campaign within larger social and political concerns about the biological basis of violent behavior. Breggin’s efforts, in concert with other events that pushed biomedical ethics into the public eye, eventually led to federal intervention into psychosurgery, including Senate hearings and a five-year investigation of psychosurgery by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. Although Breggin’s radical critique of the biological
underpinnings of mental illness have caused many in the psychiatric community to write him off, I argue that his efforts in the anti-psychosurgery were clearly successful, his rhetoric found a large and sympathetic audience, and he therefore deserves a significant place in any rhetorical history of psychosurgery.

To conclude this dissertation, Chapter 6 turns to contemporary discussions of deep brain and vagus nerve stimulation in order to explore how the collective memory of lobotomy functions to connect these new therapies to lobotomy’s “dark legacy” in medical and public discourse. I show in this chapter how lobotomy enters these discussions as both a point of differentiation and a point of similarity in order to serve different arguments about psychiatry’s use of surgical interventions as well as the “proper” use of its past.

Although lobotomy is the case I have chosen, I envision many other applications of the approach that I take in this dissertation, particularly in cases of medical phenomena that, like lobotomy, have served as lightning-rod issues of public concern. Put another way, a rhetorical history of medicine would be an ideal method to explore matters of what we might call public bioethics. Euthanasia, for example, would be a topic well suited to a rhetorical history of medicine, as would gene therapy, organ transplantation, and psychopharmacology, to name but a few topics that have become the topics of public controversy and debate. In the spirit of the interdisciplinary literature that has inspired and influenced this project, I hope that a rhetorical perspective on the history of medicine would appeal to a wide audience: rhetorical scholars, scholars within science studies and the medical humanities, and even a few historians who are willing to see where the conversation might take us.
A “Beneficent Vivisection”

Psychosurgery and the Argument for Lobotomy’s Contribution to Neuroscience

These drastic operations with unfortunate sequelae, however discouraging to the physicians in charge, are extremely valuable from the point of view of psychological research. Psychosurgery has performed a sort of beneficent vivisection…

Mary Frances Robinson and Walter Freeman, Psychosurgery and the Self

In 1889, W.W. Keen, one of the most revered surgeons in 19th century America, became embroiled in a national controversy over the use of vivisection in laboratory animals. Keen had written an article in Harper’s in which he extolled the “astonishing” progress made in surgery in the recent years, advancements Keen attributed to the development of antisepsis as well as the increasingly popular practice of “laboratory work and experiments upon animals” (“Surgical Progress” 703). Keen was attacked both publicly and privately for his views by the burgeoning anti-vivisection movement; in response to his critics, he published another article in Harper’s four years later.19 In this article, Keen sought to justify the practice of vivisection by arguing that it offered invaluable insight into human brain function; new knowledge about brain physiology,

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19 For more on the 19th century movement against vivisection, see Harriet Ritvo and Deborah Rudacille.
wrote Keen, was “derived almost wholly from experimentation upon animals” (“Vivisection and Brain Surgery” 128). Vivisection helped researchers map particular regions of the brain with specific functions, a process known as localization. Although some of the new knowledge about localization came as the result of “observing the effects of injuries and diseases in man,” Keen explained that “very, very rarely does disease or injury involve only one of these very limited regions of the brain,” and estimated that “nine-tenths of our knowledge has been derived from exact experiment upon animals” (128). Although Keen continued to receive criticism for his pro-vivisection views, W.W. Keen was later elected president of the American Medical Association, and enjoyed a fruitful academic and clinical career of international renown. Keen’s grandson Walter Jackson Freeman followed his grandfather into medicine; like Keen, Freeman was fascinated by the function of different regions of the brain. Unlike his famous grandfather, however, Walter Freeman became one of the most reviled figures in American medicine—the infamous “dean” of lobotomy.

In this chapter, I analyze Walter Freeman and James Watts’ *Psychosurgery*, published in two editions in 1942 and in a revised edition in 1950. While *Psychosurgery* has not escaped the attention of historians, I suggest that its rhetorical analysis offers a vantage point with which to examine the authors’ comprehensive arguments for lobotomy’s contribution to neuroscience. I begin this chapter with a discussion of the unique rhetorical features of the scholarly scientific book, and explain how these aspects of *Psychosurgery* merit its close examination. Next, to contextualize the primary argument of this chapter, I briefly describe the project of neuroscience to map the structure and functions of the brain, with particular attention to debates over frontal lobe
physiology that preceded lobotomy. Drawing from both editions of the text and archival material, the remainder of the chapter offers a close reading of *Psychosurgery*’s theoretical arguments for normal and pathological frontal lobe function, and the case it made for lobotomy’s contribution to neuroscientific research.

*The Scholarly Scientific Book*

The genre of the research article (RA) has received considerable attention by scholars in the rhetorical studies of scientific communication. Scientific book-length manuscripts, however, have received far less critical attention. The reason for rhetoricians’ preference for the research article is clear enough: articles are regarded by the scientific community as “the canonical form for the communication of original scientific results” (Gross, Harmon, and Reidy 4). In addition, unlike the humanities, where book writing is considered the hallmark of scholarly production, book writing in the sciences and medicine is often denigrated as a “low status activity” practiced by “non-scientists, failed scientists or ex-scientists as part of the general public relations effort of the research enterprise” (Varghee and Abraham 202). Unlike the research article, which is directed toward a narrow audience of disciplinary specialists, the scientific scholarly book (SSB) has a wide audience field: it often speaks across disciplinary lines, and in

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20 One notable exception is Leah Ceccarelli’s *Shaping Science with Rhetoric*, which performs a close reading of three book-length manuscripts. Although Ceccarelli identifies a number of unique features of these texts, which she classifies as an “interdisciplinary inspirational” genre, she does not comment on one feature common to each text: their composition as books, rather than articles.
many cases, it may include nonscientists in its intended audience. If this aspect of the SSB (as “public relations” rather than participation in the hyper-specialized world of “research enterprise”) may devalue the book’s status in the scientific community, it is also the feature that should draw the interest of rhetoricians committed to an ecological model of science, which views its subject as “a complex network of cultural practices rather than simply laboratory practices and the claims issued from them” (Taylor 62).

This is not to say that rhetoricians of science have not discussed scholarly scientific books. However, the unique rhetorical features of the SSB are rarely the topic of analysis; books and articles are usually treated in science studies literature as interchangeable elements of scientific discourse (Gross, Harmon and Reidy 4). In one of the only analyses of the scholarly scientific book qua book, Susheela Varghese and Sunita Abraham argue that SSBs exhibit a number of rhetorical features that merit their separate consideration from the research article. The first notable difference, as I mentioned above, is that the SSB speaks to a wider audience. The second difference, closely related to the first, is that SSBs exhibit a markedly different style of writing. Freed (or at least loosened) from the research article’s narrow audience of specialists, books frequently exhibit stylistic and organizational features at odds with the rigidly prescribed contours of the prototypical research article.

In addition to a wider audience and a non-traditional writing style, Varghese and Abraham argue that scholarly scientific books engage in theoretical speculation and inquiry in order to “draw connections to universal issues of the human condition” and “[link] their research explicitly to broader human concerns”—in other words, if research articles work to specialize, scholarly scientific books work to universalize (202). The
scholarly scientific book provides more than just a snapshot of one particular claim or study; in addition to presenting its research, the SSB also typically argues for its significance. Close attention to the rhetorical features of these books provides a much more comprehensive picture of how scientist-authors position their work within a larger field of inquiry.

_Psychosurgery_

After rejected from MacMillan as too “controversial,” _Psychosurgery: Intelligence, Emotion and Social Behavior Following Prefrontal Lobotomy for Mental Disorders_, was released in 1942 by Charles C. Thomas, a publisher of scientific and medical textbooks and monographs (Watts to Freeman 6 Aug. 1940). Thomas published a second, expanded edition in 1950, with a revised title: _Psychosurgery in the Treatment of Mental Disorders and Intractable Pain_. Each edition sprawls over nearly 600 pages and covers the history of “primitive” psychosurgery, the career of Egas Moniz, historical and contemporary theories of frontal lobe physiology, descriptions of operational technic, richly detailed case histories of patients, and theoretical speculation about psychopathology. Both editions are illustrated lavishly, furnished with diagrams, drawings of surgical tools, pictures of cadaver brains, and dramatic photographs of patients.

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21 The research article rarely argues for the significance of its findings, and if it does, it does so in carefully qualified terms. The classic example is the conclusion to Watson and Crick’s first paper on the structure of DNA, in which they dryly state: “it has not escaped our notice that the specific pairing we have postulated immediately suggests a possible copying mechanism for the genetic material” (738). See Fahnestock for the differences in arguments of significance between writing for scientific and popular audiences.
patients before and after the procedure, which also doubled as visual arguments for the operation’s success.\textsuperscript{22}

Unlike the research article, which takes its specialized audience for granted (Varghese and Abraham 208), \textit{Psychosurgery} clearly identified its appeal to an interdisciplinary audience. Although information about audience is usually found within the text, \textit{Psychosurgery}’s audience is identified on its dust jacket:

> The practicing physician will find out what types of patients can be helped by psychosurgery and how to recognize them. The neurosurgeon will find the technical details of prefrontal lobotomy fully illustrated. The psychologist will find new material for his studies of human behavior.”\textsuperscript{23}

\textit{Psychosurgery} thus claims at least three functions for three different audiences: a diagnostic manual for the clinician, a technical manual for the surgeon, and a compendium of case studies for the research psychologist.

Although \textit{Psychosurgery} clearly indicated scientific and medical professionals as its primary audiences, the dramatic, non-scientific language of the book’s jacket suggests

\begin{itemize}
\item \textsuperscript{22} In the 1950 edition, referring to criticism about their use of the lobotomy on children, Freeman and Watts write, “the change in facial expression that we have recorded in photographs from time to time after operation is the best answer we have to [criticism]… We take comfort from the perceptible brightening of the countenance. The world of hate, fear and frustration is no longer reflected in their eyes” (380).
\item \textsuperscript{23} I was only able to find an original dust jacket on the copies of \textit{Psychosurgery} from the Freeman and Watts archives, although Valenstein reproduces the image in \textit{Great and Desperate Cures} (166). In library copies of \textit{Psychosurgery}, as with most hardcover books, the book jacket usually is removed. This is a shame, as I suspect that this is not the only example in which a book jacket provides considerable material for rhetorical analysis.
\end{itemize}
that the text was directed toward a nontechnical audience as well. Walter Freeman composed the jacket copy himself after rejecting the initial “publisher’s note” suggested by Charles C. Thomas. Thomas’s copy began modestly: “this book establishes a solid foundation for the surgical treatment of mental disorders by an original, operative technic: prefrontal lobotomy, or psychosurgery.” Thomas then praised the “sound analytical basis” of the book, “documented by a careful and detailed report of their investigations, operations, and varied results over a four year period” (Thomas to Freeman, 12 Dec. 1941). After Thomas sent the first version of the jacket copy to Freeman and Watts for their approval, Freeman immediately responded that he “was not altogether satisfied with the suggestion submitted,” and enclosed a considerably longer and more colorful blurb:

This volume inaugurates a new era in the treatment of mental disorders, a surgical era. In it the authors have assembled a wealth of observational material from eighty patients studied over the past five years. Under their skillful literary treatment these patients come to life, speak and act like human beings. Some of them you will see emerge from a distressing mental disorder even while lying upon the operating table… This is a solid factual account, illustrated with many case histories, of new adventures in that exciting field of the brain and the mind.

Here for the first time certain intellectual processes are revealed as running along

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24 One physician, Cornelius C. Wholey, wrote to Freeman with a critique of the nonscientific aspects of the book jacket: “your book seems to be edited with great scientific completeness, with splendid index, references and attractive form, though personally I would prefer a dull finish paper. I am confused by the word ‘literary’ fourth line, first paragraph of cover slip” (CW to WF 26 Jan. 1942).
without emotion, when the connection between the frontal lobe and the thalamus is severed.

The jacket language exhibits its contents as a spectacle, not unlike the “step right up” call of the carnival Barker. A text box at the top trumpets: “Read the last chapter to find out how those treasured frontal lobes, supposed to be man’s most precious possession, can bring him to psychosis and suicide!” Thomas acquiesced to these suggestions—it was Freeman’s version that made it to press.

Freeman’s flair for the dramatic duly caught the attention of the media: although ostensibly directed toward physicians and scientists, Psychosurgery was reviewed by newspapers and magazines across the country. One writer for the New York Times proclaimed, “There is no book like [it]”:

Even if prefrontal lobotomy, as it is called, did not have scores of successes to its credit, this book is bound to be read by every progressive psychiatrist, neurologist and psychologist. Its approach is practical and realistic. “Psychosurgery” is not too technical even for laymen. This department found it more exciting than most novels. And why not? Probing into the brain, breaking up fixed pathways in compelling the thalamus and the prefrontal lobes to find new ones, watching uncontrolled minds slowly return to more normal ways of thinking -- no novelist ever had a more thrilling subject (Kaempffert 7).

The book’s accessible language and exciting subject matter even made a fan out of the teenage daughter of one state hospital superintendent. After reading the book she declared, “this is the most interesting medical book that I have ever seen. Even I can read it and understand what I am reading about” (C.F. Williams to WF 19 Feb. 1942).
Freeman’s sensational description of the book’s contents (“skillful literary treatment”) and bombastic vision of its significance (“a new era,” “for the first time,” “new adventures in that exciting field”) immediately differentiate the book from the dry prose of the research article. In addition to its striking style, *Psychosurgery*’s frequent theoretical speculation suggests a rhetorical function for the book that goes beyond a simple restatement of clinical data. As I will show in the remainder of this chapter, the theoretical arguments about frontal lobe function within *Psychosurgery* and their placements of emphasis in the text suggest a great deal about the book’s function for its audience of researchers. Before I turn to these arguments, it is first necessary to sketch out a brief description of research into frontal lobe function during the early 20th century.

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25 I am wary of speaking too much of the authors’ intention, and don’t presume to know what they did or did not consciously intend to do. On this point, I turn to Leah Ceccarelli, who comments, “the intentional fallacy keeps scholars from drawing conclusions one way or another about what an author consciously and deliberately did in a text. Recognizing this, rhetoricians often use the terms strategy and design without implying conscious intent on the part of authors. Just as an organism might adopt a successful evolutionary strategy without being consciously aware of it, so too might an author adopt a successful rhetorical strategy without being consciously aware of it” (5f).
Mapping the “Silent Lobe”

Nowhere is the pursuit of knowledge more exciting than the correlation of structure and function in those areas of the cerebral cortex traditionally termed ‘silent.’

John Fulton, “Functional Localisation in the Frontal Lobes”

The human body long has been described as a fleshy terrain to discover, explore, chart, and map. As anatomists have struggled to create knowledge about the general human body (as opposed to the singular human bodies that populate the examination tables of clinical medicine), they have described their object as territory to explore, and their pursuit of that territory in terms nothing less than colonial. The ongoing project to map the body is the project to know the body in a way that allows future navigators to follow the lead of those who have come before. As Catherine Walby writes in The Visible Human, “the spatialisation of flesh that takes place in anatomy involves the destruction of this local entity [flesh] in favour of its trace—writing of the body as intelligible, communicable terrain, and hence useful to medicine” (Waldby 89). The “trace” Waldby describes is the body of medical knowledge, which travels the epistemological circuit from anatomist to teacher to textbook to student from year to year. With map in hand, explorers of the body are able to navigate the terra (increasingly)

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26 Jonathan Sawday has described early modern anatomists as “Columbian explorers”: “early discoverers dotted their names, like place-names on a map, over the terrain which they encountered. In their voyages, they expressed the intersection of the body and the world at every point, claiming for the body an affinity with the complex design of the universe. This congruence equated scientific endeavour with the triumphant discoveries of the explorers, cartographers, navigators, and early colonialists” (24).
cognita of the flesh, carefully adding to the cartography of the body in finer and finer detail.

Unlike the maps of geographers, anatomical maps of the body’s structure are closely tied to physiology, or the integrative study of the body’s function. As the study of anatomy’s function, physiology adds what humanists might term a hermeneutic dimension to the territory established by anatomy. A physiologist must not simply describe what a given structure looks like or identify its difference or similarity to other structures; in order to know the body as a holistic unit, the physiologist must be able to interpret these locales. What, for example, does the spleen mean to the immune system; what does the immune system mean to organism as a whole?

Neurophysiology is related intimately to theories of localization, the connection of particular neurological sites with specific functions such as language, memory, motor skills, or sensory input and processing. In some regards, writes one contemporary neuroscientist, the history of neurology can be read as the history of the theory of localization “being applied to the whole and then to increasingly smaller parts” (Finger 3). To stretch the geographic metaphor: the map of the localized brain began by sketching out the continents (cerebrum, cerebellum, brainstem), its topography (gyri, sulci) and major landmarks (thalamus, hippocampus, medulla). It drew boundaries (frontal, temporal, occipital and parietal lobes) and marked paths between areas (corpus collosum, leukos). Eventually, with the interdisciplinary help of geologists (neurochemistry and neurophysics) contemporary neuroscience seeks to mark even the smallest bits of earth—neurons, glia, synapses.
As W.W. Keen suggested at the outset of this chapter, neuroscientists’ first arguments for localization were enabled by their observation of changes in behavior and motor skills in patients who had suffered pathologies identifiable in autopsy (such as strokes or tumors) or who had experienced severe physical trauma to particular parts of the brain—a process we might call negative neurogeography, to build on Elizabeth Wilson’s term. One of the most famous examples of negative neurogeography is undoubtedly the case of Phineas Gage, the American man who survived an 1848 railroading accident that drove a three and a half foot tamping iron into his cheek and out the top of his head, straight through his frontal lobes.

A recent textbook on frontal lobe physiology claims that “contemporary research on the frontal lobes started” with Gage’s accident (Mesulan 8). The significant behavioral changes in Gage led researchers to surmise that the areas in the frontal lobes damaged by the tamping iron were responsible for certain aspects of the human personality. 19th century neurologist John Harlow describes the changes in Gage after his accident:

[He] was fitful, irreverent, indulging at times in the grossest profanity (which was not previously his custom), manifesting but little deference for his fellows, impatient of restraint or advice when it conflicts with his desires, at times pertinaciously obstinate, yet capricious and vacillating, devising many plans of future operations, which are no sooner arranged than they are abandoned in turn for others appearing more feasible. A child in his intellectual capacity and manifestations, he has the animal passions of a strong man. Previous to his injury, although untrained in the schools, he possessed a well-balanced mind, and
was looked upon by those who knew him as a shrewd, smart businessman, very energetic and persistent in executing all his plans of operation. In this regard his mind was radically changed, so decidedly that his friends and acquaintances said he was ‘no longer Gage’ (Harlow 390).

Gage’s injuries have become the stuff of medical legend: his skull and tamping iron remain on display at the Warren Museum at Harvard’s School of Medicine and there is a memorial to Gage at the site of his accident in Cavendish, VT. Though his injuries eventually contributed to his death, the information that Gage’s accident provided to future theorists of cerebral location was invaluable: the lesions in his brain suggested that the brain, the frontal lobes in particular, might regulate personality, sociality, and even morality. However, without an autopsy of Gage’s brain, Harlow had little physical evidence with which to support his theories about the frontal lobes, and his research was largely ignored in his time.27

Another textbook example of frontal lobe negative neurogeography came from 19th century neurologist Pierre Paul Broca, who published the case of a Monsieur Leborgne, who had been hospitalized in a state institution for twenty years and suffered from epilepsy and paralysis on the right side of his body. Unlike Harlow, Broca had both behavioral and observational data in hand after Leborne’s death in 1861. Leborgne had exhibited an unusual form of aphasia that restricted speech to the syllable “tan.” As a result, Leborgne was known throughout Bicêtre hospital as “Tan,” or “Tan-tan” and is

27 According to Damasio et.al, a major “factor likely to have contributed to the indifferent reception accorded Harlow’s work was that the intellectual atmosphere of the time made it somewhat more acceptable that there was a neural basis for processes such as movement or even language rather than for moral reasoning and social behavior” (1103). See also Malcolm Macmillan’s work on the history of the Gage case.
referred to as such in Broca’s papers and in psychology textbooks everywhere. After Leborgne’s autopsy, Broca noted that his brain contained areas of “softness,” especially in the middle of the frontal lobe of the left hemisphere. Broca’s tentative assertion in this first paper was “the belief that, in the present case, the lesion of the frontal lobe was the cause of the loss of speech” (Broca 237). In a paper given later that year, Broca’s cautious claim became a full-fledged argument for the localization of speech. The soft part of Leborgne’s frontal lobe is now called “Broca’s area,” one of the areas of the brain where language has been localized (in addition to Wernicke’s area, discovered, mapped, and named in 1876). Despite these initial forays into frontal lobe localization, the frontal lobes of the brain were still a matter of considerable mystery to neuroscience well into the 20th century to the point that the frontal part of the brain was often called the “silent” lobe. In 1935, however, the silent lobe began to speak.

In 1935, London hosted the Second International Neurological Congress, which drew some of the most highly respected figures in the neurosciences. A full day of the conference was dedicated to panels discussing frontal lobe physiology, including a session that featured Yale neurologist John Fulton and research psychologist Carlyle Jacobsen, who had been conducting psychological experiments on chimpanzees whose frontal lobes had been surgically removed. The scientists reported that while the chimpanzees did not appear to suffer any intellectual deficits as the result of the loss of their lobes, their “experimental anxiety” was lessened by the operation; Jacobsen later wrote that one of the surgically-altered chimpanzees looked as though it had “joined the 'happiness cult of the Elder Micheaux, and had placed its burdens on the Lord!'” (Jacobsen, Wolf, and Jackson 10). Present at Fulton and Jacobsen’s paper was
Portuguese neurologist Egas Moniz who, it is widely reported, asked Fulton during the discussion whether his research might suggest a possible therapeutic application in humans. Fulton’s “startled” and negative response did not sway Moniz, who returned to Portugal and began a series of operations on twenty patients only two months later (Pressman 47).

Unlike the operation performed on Fulton and Jacobsen’s chimpanzees (lobectomy, in which both lobes were removed completely), Moniz’s operation severed the white connecting fibers between the frontal lobes and the thalamus. In the first publication on his procedure, Moniz admitted that his proposal to surgically intervene in mental illness was “audacious.” In part, the audacity of Moniz’s proposal was that it relied almost entirely on idiosyncratic arguments that identified the frontal lobes as the origin of mental illness. Moniz had conducted no animal experiments before beginning his series of twenty operations, and his first published paper cites few of his contemporaries, such as Fulton and Jacobsen, who specialized in frontal lobe research. Moniz writes that he and surgical partner Alemeida Lima began the psychosurgery “experiment” solely “by reasons of theory.” The results of the experimental operations, he declared in hindsight, “appear to prove that we were right” (1111).

Moniz’s theory of the relation between psychopathology and the frontal lobes was thin, to say the least. He suggested first that the frontal lobes were an area where “psychic activity” occurred and proposed that “thoughts and ideas are somehow stored in the nerve-fiber connections between brain cells” (Valenstein 84). Certain mental illnesses emerged, Moniz argued, when ideas became “fixed” in the patient’s brain. These ideas “not only [dominate] their psychic life but also [direct] their actions and can
lead them to suicide or crime. The delusions of these patients constitute all that there is in their life; other things, even those which are chief importance, are obscured in their mentality” (1113). Once ideas become fixed within “certain celluloconnective groups in the brain,” Moniz concluded, “in order to be able to achieve recovery of these patients, we must destroy the celluloconnective arrangements and we think that the principal ones among them are those that are linked within the frontal lobes” (1113). Moniz reported the results of his twenty “experimental operations” briefly, and without commentary:

1. No deaths. The intervention is harmless: when the necessary care is taken.
2. None of the patients became worse after the intervention.
3. From all the cases, we obtained:
   
   Clinical recovery……………………35%
   
   Ameliorations……………………..35%
   
   No result…………………………….30% (1114, italics in original).

In Moniz’s theory, psychopathology develops because “delusional” ideas become locked within the neurological connections in the brain. Future headlines would later claim that lobotomy was able to literally “cut worry out of the brain”; according to Moniz’s conception, this claim wasn’t too far off the mark—if ideas are the source of the trouble, then one needs to take a knife to the ideas. Since leucotomy resulted in “no deaths,” Moniz concluded, the operation was “harmless.”

Although Freeman and Watts took their inspiration for lobotomy’s operational technic from Moniz, they viewed his theory of psychopathology with suspicion. Their great debt to Moniz, however, seems to have tempered their criticism for the odd theory of “fixed ideas” that justified the invention of psychosurgery: “there is no doubt about the
stereotyped thinking and stereotyped activity indulged in by many of the patients,” Freeman and Watts admit, “but whether such ideas and activities are actually in relation with abnormal stabilization of synaptic patterns in the brain is another matter.” To construct a better theory of lobotomy’s effect on psychopathology, they suggested, “it is necessary to study the patient both before and after operation…in order to understand the personality deviations that occur postoperatively in these patients” (1942, 18).

It might seem shocking that Moniz, Freeman, or Watts would perform or advocate for a procedure before they fully understood how it worked. We might expect, for example, that an innovative surgery for heart disease would be based on a solid understanding of heart structure and function. Yet proponents of lobotomy operated first with the conviction that it worked and then, after observing the operation’s effects on particular patients, they reasoned back to why. It bears comment that contemporary biological psychiatry operates in roughly a similar fashion with regard to somatic therapies like psychopharmacology and electroconvulsive therapy. While new treatments now undergo a period of rigorous clinical trials regulated by the FDA (something not required—or available—during the lobotomy era), there is considerable disagreement about how these treatments work, controversy that follows a perennial debate about the biology of the mental illnesses they are designed to treat. Some scholars have even suggested that physical interventions like psychopharmacology work to retroactively shape our theories and definitions of mental illness. David Healy, for example, in a study of the development of antidepressants, describes the contributions of psychopharmacology to psychopathological etiology as a kind of “pharmacological
scalpel,” which negatively carves out the “outlines of a disease” through the observation of behavioral and emotional changes in patients (62).

Freeman and Watts moved one step further than Healy in *Psychosurgery*: by observing the personality changes created by lobotomy, they suggested, one is not only able to construct better theories of psychopathology, but “normal” brain function as well. A careful study of the arrangement, emphasis, and arguments of the text reveals that in addition to its clinical value, *Psychosurgery* argued that lobotomy’s contribution to biomedicine was also the “intimate knowledge” it provided neuroscience with regard to frontal lobe function (1950, 356).

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28 “It is the value of all morbid states,” writes Nietzsche, “that they show us under a magnifying glass certain states that are normal—but not easily visible when normal” (qtd. in Canguilhem 45). Canguilhem’s discussion of the epistemological relationship between pathology and biology in *The Normal and the Pathological* is one of the best discussions of medicine’s use of the negative, and it profoundly influenced the early work of his student Michel Foucault.

29 Writing of *Psychosurgery’s* research value, Cora Louisa Friedline, a research psychologist, wrote to James Watts, “Quite aside from the operative technique, and that part of the book, the history of the literature on the frontal lobes is the best I know of in any text. The style of the writing is excellent. I feel that so often medical books are savage in their verbalizations—but in your book there is genuine literary style as well as scientific fact” (25 Feb. 1942, GWU).
A “Beneficent Vivisection”

The brain has been opened and compelled to give up its secrets, and to yield itself to the successful assaults of the surgeons.

W. W. Keen, “Vivisection and Brain Surgery”

Walter Freeman, who originally began his training as a neuropathologist, had wondered about the mysteries of the frontal lobes for years before he and James Watts began to cut them in living human beings. Like his neurological forefather, Silas Weir Mitchell (the physician responsible for the infamous “rest cure” fictionalized by Charlotte Perkins Gilman in *The Yellow Wallpaper*), Freeman wrote poetry on medical and scientific subjects. Freeman was so proud of one poem, entitled “Psychological Plagues,” that he self-published it in 1933; it was later re-published in the *Medical Annals of the District of Columbia* in 1950 at the height of his career.

“Psychological Plagues” tells the fable of a character called “The Master of Evil,” a Satan-like figure who had observed that his subject Man had acquired “power over all living beings.” To punish Man’s hubris, the Master of Evil “sent upon him the plagues of invisible things,” an infliction that Man promptly countered with his great skills with medicine. Frustrated, the Master of Evil summoned his sons “Hurry,” “Worry,” and “Flurry,” and instructed them to “defeat his advances and turn his prowess into misery.” “Hurry” quickly wore Man out by increasing the pace of his machines, his labor, and

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30 The first story about Freeman in *Time* magazine described the neurologist as a “poetaster in his spare time” (“Southern Doctors” 67).
ultimately, the pace of his life. “Flurry” made Man weak and timid; he raised “his blood pressure when he comes in controversy with his equals / And drain[ed] the water from him when he bows to his superiors.” Pleased with the successful blows of his first two sons, the Master of Evil “called Worry unto him / And Worry was the greatest of his three sons.” Worry could wreak the havoc of his brothers, and more:

I can work upon Man’s imagination,
That same power with which he develops his theories and his machines.
I can cause him to foresee events…
I can cause him to interpret falsely the action of his friends…
I can cause him to fear decisions
And to brood over mischances.
And I can cause him to lose sleep in prospect of the morrow.

When the Master of Evil saw that his sons’ efforts had been effective at curtailing Man’s ambitions through his mind—the very instrument of his accomplishments—he commanded them to labor continuously among “the men of the Machine Age”:

Go ye three upon the Earth
And burn the candle of Man’s life at both ends.
*Spare not his frontal lobes* where foresight
And ambition
And judgment
And self-control
Are centered,
But tire them out by constant work….
Thus shall ye compensate for the lowly esteem in which we are fallen
Since Man gained power over natural forces.
Himself
He has not learned to control (2 emphasis mine).

What the poem lacks in aesthetic merit, it more than makes up for as a prescient description of Freeman’s theories about the connection between the frontal lobes and psychopathology, fully three years before he began to experiment with the new surgery for mental illness.

As the book jacket indicated, although much of *Psychosurgery* might best be described as a technical manual for clinicians and surgeons, a significant portion of the text also furnished “new material” to the psychologist in the form of richly detailed case histories of patients pre- and post-operation. As the method by which this “material” was gathered, lobotomy thus served an experimental, in addition to a therapeutic role. The final paragraph of the 1950 introduction, for example, is directed not to the neurosurgeon or the clinical physician, but to the research psychiatrist:

Prefrontal lobotomy has furnished the psychiatrist with a new tool for the investigation of mental disorders … [The psychiatrist] must determine for himself what contribution the frontal lobes make to normal social existence, and he must further examine his understanding of the functioning of the personality in relation to mental disorders, for it would now seem to be self-evident that without the frontal lobes there could be no functional psychoses (xvii).

In this section, any humbling hedges are removed: “now” it is “self-evident” that the frontal lobes definitively contribute to mental illness—a shot across the bow, perhaps, at psychoanalysts, who had come to dominate the field of psychiatry by 1950 and for whom
Freeman held the greatest contempt. In this final paragraph of the introduction, one of the text’s prime places of emphasis, lobotomy’s value is described not as a “new tool for the treatment of mental disorders,” but as a “new tool for the investigation of mental disorders.”

By “scrutinizing the behavior of the operated individual,” Freeman and Watts argued that they were able to “discern what qualities of imagination are lacking” after lobotomy, qualities they summed up as “foresight” and “insight” (569). Foresight, they define, is the individual’s ability to situate himself in time, “projecting an image of himself onto the screen of the future”—a sense of the connection between past and present action and future consequences. Foresight allows us to “plan ahead, seeking in the mazes of the future to discover that course which will most certainly lead us to achievement of pleasure and avoidance of distress” (1950, 569). Furthermore, the capacity to make goals and to imagine their fruition is the very heart of creativity, “the

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31Freeman wrote volumes of derogatory comments about the field in his personal writing and correspondence. One of the most vivid, however, was a scathing comment Freeman crossed out of a talk he gave to the APA entitled “Psychiatrists who Kill themselves: A Study in Suicide”: [Psychoanalysts] are the most rigid, self-righteous and supercilious of all psychiatrists. They are so sure of their own salvation (outwardly) that they have no patience, only contempt, for those who have not undergone personal analysis. They seal themselves off from other methods of treatment, and pursue their own way little, if at all, influenced by methods developed outside the doctrine. They continue in compulsive fashion to apply analytic procedures in the face of obvious lack of success, and their interpretations either meet with stony resistance on the part of their victims, or succeed only too well in brain-washing their more suggestible patients and reducing them to equally intolerant and rigid individuals who join with others in laudation of their masters, a sort of intellectual and even emotional emasculation (paper draft in GWU).
highest in human achievement” (1950, 256). Freeman and Watts located creative thought as “an intrinsic function of the frontal lobes” by observing that “the spiritual, aesthetic and recreational values of the arts seem to have suffered from permanent and even progressive reduction” in post-lobotomy patients (1950, 256).

In addition to providing the individual with foresight, Freeman and Watts asserted that the frontal lobes also contribute to the capacity for “insight.” In their argument, insight is best thought of as self-awareness or self-consciousness, situating the individual in relation to the environment and to other people, an awareness of one’s membership in a social milieu. “By virtue of this cerebral equipment we are made aware of our duties and obligations to ourselves and to others, of the figure we cut in the eyes of other people and of the quality of the work we do” (1950, 569). Although lobotomy did not appear to affect the basic religious beliefs of patients, the reduction of their insight resulted in the decrease of “deep conviction or enthusiasm” for their religious practice. Freeman and Watts briefly noted, “it is readily perceived that the spiritual life is greatly affected by prefrontal lobotomy” (1950, 242). The foresight and insight functions of the frontal lobes, they write,

longcircuit our actions, make for deliberation and delay, to the end that the decision shall be mature and the results measure up to expectation… Whether we visualize with a certain objective simplicity the streets paved with gold on the one hand, and Satan and Beelzebub on the other, or indulge in more metaphysical

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32 Freeman provides a glib discussion of insight in his Autobiography: “Insight is a terrible weapon, and few know how to use it constructively. When we realize, really get to know what stinkers we are, it takes only a little depression to tip the scales in favor of suicide.”
ruminations upon the probable existence of a soul without a body, we are teasing our prefrontal regions to know the unknowable and ‘screw the inscrutable.’

These regions enable us to select from the variety of incoming impressions those that are particularly related to the problem in hand, and to banish the others. For this reason we are able to contemplate, to philosophize, to speculate, to build air castles and to conquer fiery dragons—and to marry the princess” (1950, 570).

If the frontal lobes were the locus of capacities Freeman and Watts categorized as distinctively human, why would they argue for their destruction? “How is it,” Freeman and Watts ask in the introduction to *Psychosurgery*, “that these frontal lobes, the highest endowment of mankind, can lead him to utter degradation and suicide?” (1950 xxiii).

Freeman and Watts suggested that mental illness was not located in the frontal lobes *themselves*, but emerged as the result of an imbalanced connection to the thalamus, widely regarded as a crucial player in human emotion. To illustrate the difference between the “normal” and “pathological” functioning of this connection, Freeman used an example of his own brush with irrationality:

Every town was supplied liberally with signs reading “Ecole-School” and with every new impression and in between signs, the cadence went singing through the mind: “Ecole—School; Scuola di Somebody; Scuola di Whoozis.” It was not until days after the signs no longer stimulated the sight that the refrain died out. But suppose…the harmless and senseless refrain should be replaced by an implied threat: ‘You’re killing yourself this way!’ (Case 76)… Now, with the implied threat, the emotional component becomes magnified, and the ideational processes carry the individual into a search for the cause of the manifestation and its
meaning in terms of personal safety… The repercussions of this complex upon the individual may be exaggerated far above its intrinsic importance through interaction of the past with the future in the synthetic activities of the prefrontal areas. Thus the ability to abstract from its environment a single idea to and pursue the ramifications of this idea into all its possible implications, may have a destructive effect upon the whole behavioral adaptation of the person” (1950,570).

According to Freeman and Watts, emotions—even strong emotions—are not necessarily a bad thing. “Normal” individuals frequently have thoughts and ideas powered by a strong emotional component. These emotionally charged ideas cause worry and even prolonged rumination on unpleasant subjects, mental states that while disagreeable, are still not pathological. “Which of us,” they asked in another article, “when confronted with a local pain or swelling or eruption, does not cast about for an explanation?” (“Behavior and the Frontal Lobes” 306). It is “normal” to worry about a malady, to feel sad or anxious, or to dwell on past behavior or future outcomes. “It is well for the individual to have a little fear, a little anxiety, a fairly high ambition, a bit of the perfectionist spirit, an abundance of foresight and an awareness of himself both as regards his internal functioning and a regards his functioning as a social unit” (1950, 573). However, the difference between this reaction and the pathologic one resides in the fixation of the ideas….which…[are] in relation to relatively fixed constellations of neuron patterns… [The] fixation of the ideas becomes dependent upon the interaction of
the frontal lobes with the thalamus, the emotional component having the function, as it were, of fixing the idea (1950, 306).

Building on Moniz’s original theory of “fixed ideas,” Freeman and Watts suggested that when ideas with a strong emotional current were repeatedly recalled, they began to etch a pathway in the brain that increased both the frequency of these ideas and their emotional intensity. If this “circuit” was not acted upon by severing the connections between the frontal lobes and the thalamus through lobotomy,

the emotional flow increases to the point where all cortical activities are submerged in the psychotic deluge. At first this is reversible, but as the process continues, the closed circuits, however extensive they are, continue with the reverberation but with more automaticity and less need for power input from the thalamus (1950, 563).

This fixation of ideas, they surmised, eventually leads to mental illnesses “along the lines of somatic preoccupations (hypocondriasis), intellectual preoccupations (obsessive states), or social preoccupations (paranoid reactions), or similar conditions” (1950, 307).

Within this theory, mental illness is not simply a disorder of the emotions, or the result of a pathological structure in the brain, but emerges as a disordered relationship between cognition and emotional force, a conception that is remarkably closer to Freud’s vision of psychic activity in Project for a Scientific Psychology than it is to neurological theories of localization. In her reading of Freud’s Project, Elizabeth Wilson claims that Freud was able to radically disrupt the theories of cerebral localization of his contemporaries by reterritorializing the terms under consideration—namely, location and topography—by “recast[ing]” them “though an irreducible debt to force” (186). Whereas
the primary goal of the neurophysiologist was to decisively map function to place, Freud posited that the primary concern of the neurologist regarding the brain’s functional activity was energy—not ideas, not anatomic structures, but a kind of force. Psychopathology, in this formulation, much like Elizabeth Wilson’s discussion of the Freudian “psychic trace,” is not a single locatable presence, but rather an abnormal force of emotion, an imbalanced economy of energy from the thalamus that is “neither fully present nor absent, neither freely mobile nor totally static,” but “poised undecidably between force and space, between dynamism and location…” (Wilson 186). Such a complex interplay of elements, not all of which are empirically locatable, would seem to suggest a complex treatment for psychopathology. Yet the lobotomy operation in all forms was crude, almost aesthetic, in the simple justification for its use—if there’s a problem with ideas and emotions, and there’s too much emotion attached to certain ideas, then the logical action is to cut off the flow of emotion to ideas.

Although the thalamus was a crucial component of their theory of psychopathology, it receives far less attention in Psychosurgery than the frontal lobes, to which both editions devote no less than five chapters. If the theory of psychopathology that justified lobotomy was not that mental illness was located in the frontal lobes, but was the product of the interaction between the frontal lobes and the thalamic “power source,” one might expect that the thalamus would have received more ink. Yet it is the frontal lobes that take center stage of Psychosurgery. Why?

As the most “mysterious” and “silent” part of the brain, the function of the frontal lobes was an attractive and exciting area of research. By focusing on frontal lobe physiology, Freeman and Watts positioned lobotomy as a valuable contribution to one of
the major neurological mysteries in their day, which also gave them a chance to stake a claim in the ongoing project to map the brain. By observing patients before and after the procedure, and charting what they had lost in the lobotomy operation, Freeman and Watts were able to speculate about the primary functions of the damaged areas—functions, they suggested, that added “foresight” and “insight” to the human personality. Unlike researchers who observed behavioral deficits as the result of trauma and pathology to localize brain function negatively, lobotomy surgeons knew where in the brain the lesions were made, how deep the cuts were, and furthermore, they were able to observe the acute effects particular lesions had on personality changes. According to Freeman and Watts, lobotomy was not just a new psychiatric treatment, but also served as “a new tool for the investigation of mental disorders” as well as a tool with which to investigate normal frontal lobe function—“a sort of beneficient vivisection.”

In 1945, Donald O. Hebb, a prominent psychologist and one of the founders of the field of neuropsychology, published an article entitled “Man’s Frontal Lobes” in The Archives of Neurology and Psychiatry in which he flatly countered the scientific contributions of lobotomy to frontal lobe research. Although he called lobotomy “a landmark in psychiatric therapy,” he directly challenged the claims that Psychosurgery provided “any interpretable evidence concerning what goes on in the normal frontal lobes” (21). Although Freeman and Watts had published a good dozen papers on the subject by this time, Hebb took aim at Psychosurgery, which, as I’ve described, is the most comprehensive argument for its scientific value. Hebb criticized Freeman and Watts’ theories of foresight and insight specifically, writing that they “explain at once too much and too little. The terms are too broad and ill defined to be meaningful, and they
are too likely to lead to an *ad hoc* interpretation of symptoms” (23). In addition, he challenged the methodology leading to their claims:

The evidence on which intellectual and moral defects have been attributed to the surgical removal of frontal lobe material is very poor. It has been obtained from (1) individual cases, in which the complication of the surgical lesion by extensive pathologic processes is at least highly probable, and (2) average scores for a number of cases indiscriminately grouped… Finally, there is no possibility at all of interpreting normal functions on the basis of pathologic cases in which surgical treatment is not attempted (23).

Hebb’s criticisms of *Psychosurgery* clearly made an impression on Freeman and Watts. This particular article is cited no less than three times throughout the revised 1950 edition of *Psychosurgery*. Rather than back away from their theories of frontal lobe function in this edition, however, Freeman and Watts expanded their speculation, especially the concluding chapter that ruminated on the role of the frontal lobes in psychopathology, which increased in the second edition from six to ten pages. In this second edition, after directly quoting Hebb’s comment that lobotomy “has yet to provide any interpretable evidence concerning what goes on in the normal frontal lobes,” Freeman and Watts state, “this was in 1945,” and begin a new paragraph:

We hope to show that something of considerable importance goes on in these frontal lobes. We shall have to get away from the academic concept of the psychologic laboratory, and the psychologist will have to make friends with these patients (they are friendly enough!) and observe them at work and at play, at home with the folks and on display with strangers, when they are enjoying
themselves and when they are facing disagreeable tasks, when they are listening to others and when they are trying to express their own thoughts, to come to any valid conclusions as to why man was ever endowed with frontal lobes in the first place (1950, 20).

Freeman and Watts directly challenged the criticism of the soundness of their science by retorting that the quantitative, carefully controlled laboratory studies advocated by researchers like Hebb were not adequate to form “valid conclusions” about frontal lobe function. Hebb, however, got the last word in the published exchange. In a review of the 1950 edition of Psychosurgery in the Journal of Abnormal and Social Psychology, Hebb wrote that “the book that marked a new era in psychiatric treatment has been extensively rewritten, but without greatly adding to the scientific significance of the first… Though rewriting has improved its coherence, the organization of the book is still poor, and it is far from being a scholarly production” (43).

Jack Pressman brilliantly argues in Last Resort that neurologists and psychiatrists saw their use of lobotomy not as cure, but as a form of “human salvage”: “it was to reclaim—if just partially—souls that otherwise would be forever consigned to the darkness of the nation’s asylums” (206). Lobotomy’s primary clinical goal was to transform “taxeaters into taxpayers,” to use Freeman’s blunt phrase, returning patients from the horrors of the asylum to their homes and a modicum of social usefulness (“Prefrontal Lobotomy” 25). The appalling conditions of psychiatric hospitals in the first half of the 20th century (and the last half, for that matter) drove the argument that anything that could be done to return mentally ill patients to their families was worth
trying. And if those patients could become reasonably productive members of society, then lobotomy should be considered a success—lobotomy, as Freeman was fond of saying, “got them home” (“Lobotomy in Limbo”)  

A close examination of *Psychosurgery* suggests that we might read the term “salvage” in another way, in the sense of the salvage yard. In the salvage yard, discarded material—other people's waste—is put to another use. In this way, lobotomy was not just a process of clinical salvage, but a scientific salvage as well. As Freeman states in the epigraph to this chapter, “these drastic operations with unfortunate sequelae, however discouraging to the physicians in charge, are extremely valuable from the point of view of psychological research.” The grossly understated phrase “unfortunate sequelae” refers to people who have clearly suffered *operational failures*—those patients who had received significant permanent damage or even died as the result of the operation. In this description, the “beneficence” connected to “vivisection” was beneficial not to the patient, but to scientific research.

Pressman comments that Freeman’s “service role [was] that of a private-practice clinician, not an academic researcher” (352). Whether or not Freeman or Watts actually *was* an academic researcher (in the sense of working in a laboratory and performing controlled experiments with a cadre of graduate students) is one question; whether or not Freeman and Watts *rhetorically positioned* themselves as researchers and their work as research is a different question entirely. Leah Ceccarelli argues that a rhetorical

33 Freeman reflected on this point in his autobiography, writing after his career had ended: “when I visit the large state hospitals and see hundreds of idle patients, I am appalled at the waste of manpower and woman power, and long to do something about it. I estimate that 10% of patients could be operated upon each year with substantial benefit. But nobody else sees it that way and it is very doubtful whether I shall ever be given the chance to prove my point.”
perspective has much to offer the history of science: “by closely examining the
microstructures of the texts themselves, and the responses of audiences who read them,
we can come to recognize the different explanations of their function, value, and meaning
as partial truths that…unite to produce a more complete picture of these books and their
influence on the history of science” (177). While Freeman and Watts’ oeuvre of research
articles repeat many of the technical details and case studies of Psychosurgery, they lack
the comprehensive view Psychosurgery provides, particularly with regard to claims about
the operation’s significance. The rhetorical aspects of Psychosurgery, as well as its
critical reception, reveals that the text not only argued for lobotomy’s contribution to
clinical practice, but also made the case for lobotomy’s contribution to the ongoing
project to map the human brain.

It would be grossly inaccurate to claim that Freeman and Watts performed
lobotomy in order to provide “material” for research into the frontal lobes. It is
impossible to read through the volumes of both men’s personal and professional writing
without coming to the conclusion that they genuinely believed they were helping their
patients. My focus on Freeman’s “vivisection” comment is not meant to suggest that he
and Watts were engaged in the kinds of human vivisection practiced by, say, Joseph
Mengele. However, Freeman’s use of the term “vivisection” (even with the “sort of” and
“beneficent” qualifiers) as well as the aspects of Psychosurgery that argued for its value
to research, demand that we acknowledge this aspect of lobotomy’s history, or any
medical intervention for that matter.
3

Communist Zombies

_Imagining Lobotomy during an Age of Anxiety_

We learn less about your profession from *The Psychopathology of Every Day Life* than from *The Snake Pit*; thus have you psychiatrists come into our art.

self-described “member of the public” June Bingham, addressing the American Psychiatric Association in 1950

Throughout the 1930s and 1940, lobotomy increasingly became an accepted treatment in American medicine, reaching its peak in 1949, the same year Egas Moniz was awarded the Nobel Prize (Pressman 10). During the Nobel awards ceremony, neurosurgeon Herbert Olivecrona praised Moniz’s achievement in no uncertain terms: “prefrontal leucotomy must be considered one of the most important discoveries ever made in psychiatric therapy because through its use a great number of suffering people and total invalids have recovered and have been socially rehabilitated” (Olivecrona). Carl Skottsberg, president of the National Academy of Sciences, also praised the work of Moniz during the ceremonial banquet, calling the first Portuguese laureate “a wonderful man, a famous scientist, a writer of historical books, a politician, statesman and diplomat, all in one person.” As for Moniz’s operation, Skottsberg remarked, “today his method is practised everywhere with very good results” (Skottsberg).
Ten years after earning medicine's highest honor, however, lobotomy all but disappeared from American psychiatry. Most academic and informal histories of psychosurgery explain lobotomy’s abandonment as the direct result of the rapid dissemination of anti-psychotic, anti-anxiety, and anti-depressant drugs throughout state hospital systems in the mid-1950s. Jack Pressman writes conclusively, “the era of psychosurgery as a widespread hospital therapy ended with the introduction of the drug chlorpromazine in 1954” (401). J. Sydney Smith explains, “[the] advent of the psychotherapeutic drugs resulted in a reduction in the number of psychosurgical operations” (“Introduction” 1). Neurologist Russell DeJong, describing lobotomy as “an unhappy chapter in the history of the neurologic sciences,” writes that after the “advancements” of psychopharmacology, “physicians soon became disillusioned by the untoward consequences of such psychosurgery… and the technique lost favor almost as rapidly as it had gained it” (101). In 1958, even Walter Freeman admitted that “today [psychosurgery] is in eclipse, overshadowed by the tranquilizers and euphoriants” (“Psychosurgery: Present Indications” 429). There appears to be no doubt that lobotomy began to disappear at precisely the point when chemical treatment for mental illnesses began to ascend.

But under which conditions did medicine shift away from lobotomy and toward psychopharmacology? Or to put it another way, taking a cue from Thomas Kuhn, what was the situation during which psychiatrists and other physicians were persuaded that psychopharmacology was a better treatment for mentally ill patients? Instead of placing this shift within a progress narrative of medical history, which would assume that one biotechnology replaces another because it’s self-evidently more effective, a rhetorical
perspective considers these shifts as rhetorical situations in which a growing number of physicians became persuaded that lobotomy was an inferior choice. Working from the rhetorical principle of *kairos*, or fitness-to-situation, Judy Segal suggests that one way to view a “rhetorically-tilted” medical history is to consider not only the “chronology of events but also a *kairolgy* of them: a study of historical moments as rhetorical opportunities” (23). Drawing from the work of Ian Hacking, Elaine Showalter, and Edward Shorter, who suggest that particular constellations of symptoms emerge as diseases at particular points in time, Segal finds in *kairos* an ecological vision of medicine that may “illuminate the current medico-cultural moment when popular and medical interests converge on certain themes…” and which understands the history of medicine as “a history of shifts that can be understood as responses to changes in situation” (36, 22).

In this chapter and the next, I consider the long “moment” when lobotomy fell from grace within medical practice, a moment that most historians have placed within the mid- to late 1950s. If we were to narrow our gaze to medical discourse, what we would see is an increasing number of articles devoted to psychopharmacology as well as a decreasing number devoted to lobotomy. These figures would tell us *that* that shift had begun to happen, but provide little information about the larger cultural context in which particular physicians began to move away from surgical and toward chemical treatments for mental illness. In this chapter, I sketch at least a part of that context by tracing points at which lobotomy became articulated with powerful anticommunist anxieties that suffused the early years of the Cold War.
There is no question that the texts I analyze in this chapter do not tell the “truth” of lobotomy as it is understood in traditional medical history, even though some of these fictions drape themselves (sometimes outrageously) with the mantle of fact. The characters of this chapter—zombies, robots, aliens, power-mad doctors, and covert Soviet spies—are precisely the representations of lobotomy Jack Pressman excises from historical consideration in *Last Resort* as “just plain wrong” (4). A rhetorical perspective of history, however, asks that we reconsider what counts as source material in our accounting of the past.\(^{34}\) The fictions about lobotomy I analyze in this chapter stray far from the medical reality of lobotomy (or at least how this reality was represented in the medical literature), but in their wandering, these texts provide a fertile source of information about what lobotomy had come to signify in America at the moment at which it began to disappear in medical practice.

I begin with the critique of lobotomy offered in Bernard Wolfe’s 1952 novel *Limbo*, a work of speculative fiction set in the aftermath of World War III. For Wolfe, lobotomy is a biotechnological incarnation of the death drive, a medical manifestation of humanity’s masochistic desire to annihilate itself. Although Wolfe uses lobotomy as metaphor in the novel, he also calls attention to its use in medical practice, framing the novel as a *kairotic* social commentary on the seductive dangers of medical technology in 1950. In the next section, I explore a motley set of texts from the “brainwashing” panic that swept through America in the early 1950s. Although based on the experience of

\[^{34}\] Even stories that get the facts “wrong,” writes oral historian Alessandro Portelli, are of value when constructing an account of the past: “the wrong tales allow us to recognize the interests of the tellers and the dreams and desires beneath them… Errors, inventions, and myths lead us through and beyond facts to their meanings” (qtd. in Reverby 22).
Korean War POWs, the “brainwashing” scare in America was an entirely discursive phenomenon that emerged from the interactions of anxieties about psychiatry with anxieties about communism. Within these anxious stories about the malleable human personality, lobotomy was imagined as a potential tool of political repression. To conclude the chapter, I turn to the anticommunist campaigns of a loosely knit group of ultraconservative political activists who characterized the field of psychiatry as a Trojan horse for the communist infiltration of the United States. In these wildly speculative stories, lobotomy is characterized as a political weapon, proof that the communist plot to take over America was not only a possibility—it was already under way. Although characterized (and dismissed) by many historians as the paranoid ramblings of the “lunatic fringe,” the conspiratorial fictions disseminated by these campaigns found a wide audience, including the psychiatrists they critiqued.\(^{35}\)

**Lobotomy as Self-Annihilation: Bernard Wolfe’s Limbo**

In 1952, Random House published Bernard Wolfe’s *Limbo*, a work of speculative fiction about a lobotomist who escapes to a remote African island during the middle of a nuclear World War III and who returns, years later, to a decimated America run by voluntary amputees. The book long has been out of print, and rarely is regarded as an

\(^{35}\) For a discussion of historians’ treatment of the ultraconservative campaign against mental health, see Nickerson.
object of contemporary literary criticism.  Yet it appears that Limbo it was widely read in its time: Los Angeles Times book critic Harlan Ellison indicates that Random House “made a potload” off the book and suggests that his readers would have been as familiar with Wolfe in 1952 as they would have been with Hemingway or Salinger (Q4). Despite its popular success, as a work of literature, Limbo was panned by critics, who assailed its clunky prose, tiresome puns, and “classroom” tone. One review by William Peden in The New York Times concluded that Limbo “fails as fiction.” Even though Wolfe was an aesthetic disappointment, Peden nonetheless granted that as an “orator,” Wolfe was “worth listening to” (46).

Although the book is set in the future, Wolfe explains in an “author’s note and warning,” Limbo should be read as a piece of satire that focuses on the present moment:

Anybody who “paints a picture” of some coming year is kidding—he’s only fancying up something in the present or past, not blueprinting the future. All such writing is essentially satiric (today-centered), not utopic (tomorrow-centered). This book, then, is a rather bilious rib on 1950—on what 1950 might have been like if it had been allowed to fulfill itself, if it had gone on being 1950, only more and more so, for four more decades… I am writing about the overtone and undertow of now—in the guise of 1990 because it would take decades for a year like 1950 to be milked of its implications (438).

Wolfe thus positions his novel as a piece of kairotic social commentary that seeks to draw out and connect the elements of the present that most endanger the future. While a

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36 The notable exception is Katherine Hayles’ excellent analysis of the novel’s cybernetic themes in How We Became Posthuman, although Hayles spends little time discussing the novel’s use of lobotomy (113-130).
number of these elements deserve critical attention, I will focus on Wolfe’s critique of lobotomy, which is used to frame the novel in its first and final chapters.

*Limbo* follows the adventures of Dr. Martine, a lobotomist drafted into the army during World War III. Panicked by the impending nuclear bombing of his outpost, Martine deserts and pilots a plane to a remote island off of the coast of Africa, where he is integrated into a native population of people called the “Mandunji.” The Mandunji are a people characterized by a peaceful existence, both socially and psychologically. The title of “Mandunji,” the novel explains, means those “whose heads are without devils.” Ubu, Martine’s Mandunji assistant, explains that Mandunji “means, simply *the sane ones, the normal.* Among us it is considered a very good idea to be normal” (22).

The island’s valorization of peace and conformity comes at a price. Those Mandunji who are troubled by mental devils are subjected to a procedure called “Mandunga,” which Ubu defines as a verb that means “to chase the devils from the head” (22). For the Mandunji, lobotomy has a social value in addition to its therapeutic use. Mandunga is performed not only on those villagers troubled by mental devils (described by Martine as “anxieties” and “tonus”) but also on the village’s “troublemakers.” Ubu describes one woman as having the “riot… drained from her body” and later comments, “a sleepy man does not break his uncle’s nose” (5, 7). The patients who have undergone Mandunga, called “Mandungabas” by the island’s residents, become passive and relaxed “to the point of falling apart: heads lolling, mouths loose and hanging open, arms and legs flung like sacks of maize on the pallets” (7).

Martine notes that he was originally “horrified” by the use of Mandunga on the island; however, once he sees that many Mandungabas have died as a result of sepsis,
gangrene, and “primitive” surgical techniques, he reasons that his training as a lobotomist will allow him to step in and save lives (50). Martine’s stated benevolence is shadowed by lure of human experimentation without ethical obligations: “To anybody with a streak of the messianic in him… the chance to carry out a wild mass experiment in reshaping human clay, with no moral responsibility for the experiment—was almost irresistible” (50).

The novel doesn’t dwell on Martine’s experiments with the Mandunji. In the second chapter, a ship arrives on the island, filled with passengers Martine immediately recognizes as American. Martine and the Mandunji observe a strange feature of these “queer-limbed” invaders: many are double or quadruple amputees, and each is outfitted with high-tech prostheses, which allow them to perform extraordinary feats of athletic ability. Intrigued by what has happened to his country since his desertion, Martine leaves the Mandunji and catches a freighter back to America. He discovers that in the last war, American had been bombed to the point where its coastal areas have become uninhabitable, and the nation’s population has shifted to the center of North America, now called the “Inland Strip.”

Most shocking, however, is Martine’s discovery that many of the nation’s men have voluntarily amputated their limbs as part of a pacifist movement called “Immob”—a political initiative to immobilize the population through a pun on “disarmament.” The Immob movement has identified human limbs as the cause of the world’s predilection to war and conflict, and seeks to live peacefully with the Soviet Union, whose citizens (now called “Unioneers”) have also voluntarily “disarmed.” The utopic mission, however, ultimately collides with what Wolfe sees as the bellicose telos of human nature, and at a
meeting of the Immob Olympics (engineered to be free of competition), the Unioneers reveal a new set of limbs outfitted with guns. Within a matter of minutes, the two nations are again at war, presumably to fight until the nuclear annihilation is complete.

Wolfe hints that the scenario he paints, as well as the contemporary crisis it satirizes, could be fought by harnessing, not repressing, the human tendency toward aggression that Immob and Mandunji both seek to suppress in their desire to “truncate” man and “whittle down his humanness” (413). In the last chapter of the novel, Wolfe returns us to the Mandunji, who are having a tribal meeting. Martine’s son rises to address the elders of the village, and reads from his father’s notebook:

This village is built on a lie. The lie is that the healthy ones are without aggression. They cut off many of their human qualities, to pretend that they are not men but gods. Gods stuffed with tapioca… But there is a worse lie yet… Despite all the precautions taken by the normal ones, all their aggression is not stilled. Some comes out even so, in a disguised form. The one great disguised aggression of our normal ones is known by a very polite name—Mandunga. It means, to drive the devils from the skull. But with the devils go the men… It is a punishment, not a help—it calls itself therapy but it is inspired by murderous venom. The venom of the less-than-human, pretending to be more-than-human, for the all-too-human” (422).

For Wolfe, lobotomy is only one manifestation for “destructive self-tinkering” borne of “masochistic” desire (435). The masochism motivating the lobotomy, voluntary amputation, and pacifism in Limbo Wolfe also identifies in other practices of “self-tinkering” in human societies, such as the castration of choirboys, corset-wearing, and
foot-binding. Furthermore, Wolfe also suggests that the masochistic desire for
annihilation drive both “the communist yearning of the proletarian herd [and] the
American yearning for the oblivion of the Jonesian herd,” in which the individual is
subsumed into the mass. Each of these examples, Wolfe declares, are proof that “man,
whatever else he may be, is certainly the self-maiming animal”; each method allows
people to avoid “standing on their own two feet, of living with the impossible anguished
tension of humanness” (414, 434). 37

Although Wolfe uses lobotomy as a metaphor in the novel to stand in for
humanity’s death drive, remember that in 1950, the use of lobotomy had reached its apex
in American medicine—a point that also does not escape Wolfe’s comment. 38 In the
author’s note, Wolfe writes that voluntary submission to “lobotomy is presented in this

37 The many ways in which disability is used as trope in Limbo demand an analysis of its own,
which is regrettably outside the scope of this dissertation.

38 According to Hayles, Wolfe’s use of lobotomy in the book likely follows his enormous (and
acknowledged) debt to Norbert Wiener, the MIT mathematics professor who coined the term
“cybernetics,” and who offered a “devastating” critique of lobotomy both in his famous
Cybernetics (1948) and in a short science fiction story entitled “The Brain” (Hayles 116). In
Cybernetics, Wiener describes lobotomy as a “violent… surgical intervention into the brain,
leaving behind it permanent damage, mutilation, and the abridgement of the powers of the
victim.” Wiener writes that “prefrontal lobotomy does seem to have a genuine effect on
malignant worry, not by bringing the patient nearer to a solution of his problems, but by
damaging or destroying the capacity for maintained worry, known in the terminology of another
profession as the conscience.” Lobotomy, Wiener comments, is currently in “vogue” in the late
1940s, “probably not unconnected with the fact that it makes the custodial care of many patients
easier. Let me remark in passing that killing them makes their custodial care still easier” (173).
story as yet another technique for destructive self-tinkering.” Yet Wolfe lets the reader know that while voluntary amputation may be a “storyteller’s fiction,” in the case of lobotomy, “the imagination is reality’s straggler.” He then offers an example of a 1951 story from the *Saturday Evening Post* as “gruesome” evidence that people have been voluntarily seeking out the operation (435).

**Lobotomy as a Political Tool: The American Brainwashing Panic**

In 1949, the trial of Hungarian Cardinal Josef Mindszenty captivated the American public. Mindszenty became a Hungarian national icon during World War II, when he was imprisoned by the Nazis for vocally opposing the occupation forces and providing shelter to Jewish refugees. After the communist takeover of Hungary in 1948, Mindszenty once again occupied the position of political dissident until his arrest for charges of treason, espionage, and black marketeering. After a highly publicized show trial, which garnered tremendous international sympathy for his plight, Mindszenty was tried and imprisoned for seven years by the People’s Republic of Hungary for crimes he confessed to, but did not commit.

Though Mindszenty’s full confession (that he was “guilty in principle and in detail of most of the accusations made”) disturbed many people, it also came as no surprise (“Cardinal”). Before the trial, Mindszenty secretly released a letter in which he

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39 Wolfe’s argument is mirrored in Carl Elliot’s recent *Better than Well* (2003), an analysis of contemporary methods of “enhancement” biotechnology, with an entire chapter devoted to apotomnenophilia, or the voluntary amputation of one’s limbs (208-236).

40 For more on the *Saturday Evening Post* article “The Operation of Last Resort,” see my analysis in the next chapter.
warned that any confession he might make would be the result of coercion, and should be considered “forged or false.” During the trial, Mindszenty recanted the letter as he had predicted, reporting to the courtroom, “when I wrote [the letter] I did not see certain things as I see them now” (“Cardinal” 1, 3). Media reports immediately speculated about the methods by which Mindszenty’s captors had extracted his confession: had he been tortured? Had he been subjected to drugs? *Time* wondered,

how the Communists managed it no one in the West knows. (To this day no one knows the secret of the 1937 purge trial confessions in Russia.) Somehow they broke Joseph Mindszenty, man of burning courage. Somehow they made him say things he had denied with the utmost vehemence, and with full knowledge of the consequences, until his arrest 40 days before (“Their Tongues Cut Off”).

A 1950 article in *The New York Times* suggested one method the Communists may have used to break Mindszenty: to induce his confession, the Cardinal may have received a lobotomy. “Generally,” the article reports, the operation is “performed by cutting nerve fibers on either side of the brain, thus separating the rear part of the brain from the front.” “Normally,” the article continues, lobotomy is used to “quiet hopelessly insane people”; in the hands of Communists, however, the operation could be used as a tool of political repression. Biologist Charles Pomerat speculated Mindszenty and other political dissidents might have been subjected to transorbital lobotomy, which “leaves no outward scar” and thus would be undetectable to the naked eye (“Confession to Reds Laid to Surgery”). In 1956, a tabloid publication, *Suppressed*, also propagated the Mindszenty rumor in a story about other supposed Communist uses of lobotomy. The article suggested “a comparison of pictures taken of the cardinal before and during his trial is
like looking at two different and separate personalities,” and was visual evidence of the Mindszenty’s lobotomy (5). Interestingly, the Cardinal’s visage in the “after” picture—gaunt, drawn, and obviously worried—looks more like photographs of actual lobotomy patients before the operation, not after. There was no evidence that Mindszenty had ever received a lobotomy—or that he was subjected to drugs or other mind-altering agents for that matter (Rév)—so why might these articles have speculated that it was lobotomy that led to Mindszenty’s confession? To answer this question, I would like to turn to the brainwashing panic that swept America shortly after Mindszenty’s conviction.

Although America “bled for the gaunt, tortured prelate,” in the late 1940s, the threat of coercive persuasion remained on the other side of the world (“Easing Out”). When North Korea invaded South Korea in 1950 and America entered its first armed conflict of the Cold War, however, the “Mindszenty treatment” suddenly became a dread possibility for captured American soldiers. After stories began to circulate about American soldiers who had renounced their citizenship, signed false confessions of germ warfare tactics, and made themselves available for use in Communist propaganda campaigns, the coercive persuasion and ideological indoctrination long suspected of Communist regimes suddenly became a threat to American citizens (West “U.S Air Force Prisoners”; Biderman).

“Brainwashing,” wrote one New York Times reviewer in 1956, “the word and the technique, burst like a bombshell upon the American consciousness during the Korean War” (Adams, emphasis mine). There are a number of excellent histories on the
brainwashing phenomenon, and I will not rehearse them here. For my purposes, the brainwashing phenomenon in America is interesting for two reasons. First, brainwashing discourse hinted, loudly, that the procedure was connected to the profession of psychiatry. Second, representations of “brainwashed” Americans bore a striking resemblance to representations of lobotomy patients, which created fertile associational ground for a connection between the two practices of personality change.

The American vanguard of the brainwashing panic was CIA operative-turned-journalist Edward Hunter, who coined the term “brainwashing” in 1950 to describe techniques of psychological manipulation and political indoctrination used by Communist China on its own people. Hunter worked as a journalist in Asia during the 1940s, and turned his research about Chinese practices of thought reform, self-criticism meetings and ideological indoctrination into a series of newspaper articles and wildly popular books such as Brain-washing in Red China (1951) and Brainwashing: the Story of the Men Who Defied It (1956). In Brain-washing in Red China, Hunter warned that the mass indoctrination used by Chinese Communists threatened to spread beyond its borders: “this is psychological warfare on a scale incalculably more immense than any militarist of the past has ever envisaged. This is what has to be stopped and counteracted and the mentally maimed must be cured if we ourselves are to be safe… from ‘brain-washing’ and ‘brain-changing’—and ‘liquidation’ and ‘evaporation’” (302). Novels and

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41 On the history of the brainwashing, see Scheflin and Opton; Marks; Zweiback and Taylor. On the representation of brainwashing in fiction, see Seed.

42 “Brainwashing” was listed as a new word in a 1952 issue of American Speech (in addition to other neologisms like “carpet bombing,” “litterbug,” and “thermonuclear”). See Russell.
films also took up the brainwashing scenario painted by Hunter with great aplomb. *The Manchurian Candidate*, perhaps the most vivid example, imagined that brainwashing could be used to create unwitting assassins, puppets of Communist imperialists who used psychiatric techniques as tools of mind control.

The flood of popular discourse about brainwashing aggrieved social scientists Albert Biderman and Robert Jay Lifton, who decried its tendency to rely on “inadequate knowledge” about the situation in Korea, as well as “pseudoscientific” information about the human personality. Wrote Lifton:

> the American press and public have been greatly concerned about [brainwashing], and rightly so. But too often the information made available about it has been sensationalist in tone, distorted because of inadequate knowledge, or obscured by the strong emotions which the concept of brainwashing seems to arouse in everyone. Its aura of fear and mystery has been more conducive to polemic than understanding (5).

Biderman, in his article “The Image of Brainwashing,” lodged a more pointed critique: not only did a fictional image of brainwashing dominate popular writing, but this image influenced scientists as well, whose research on the American POWs lagged behind their representation in popular culture:

> social scientists, too, relied on bad information and incorrect interpretations. Some of them were woven into theoretical works and textbooks material that is clearly erroneous in the light of knowledge… a great deal of pseudo-scientific speculation was authoritatively disseminated, seriously claiming that
‘brainwashing’ was ‘really’ conditioning ala Pavlov’s dogs or was accomplished by using drugs, hypnotism, or the sensory deprivation effect (552).

As a result of the “public confusion, anxiety, and mystification” that soaked public discourse on the subject, Biderman concludes, “brainwashing” became a diffuse, imprecise term of “questionable utility,” and was burdened with “almost ineradicable connotations” (549).

One connotation that pervaded brainwashing discourse in both popular and scientific writing was a mysterious connection to the field of psychiatry, as Biderman noted. In one 1963 article, psychiatrist Louis West complained about the representation of psychiatry in popular writing about the brainwashing phenomenon: “sometimes the psychiatrist is envisioned as a member of the brainwashing team, either on the scene or lurking in the wings.” Furthermore, West writes, this representation contributed to the “rapidly growing associated idea that the psychiatrist and the psychiatric hospital are likely participants in conspiracies against the freedom of the individual” (845).

In Brainwashing in Red China, for example, Edward Hunter drew explicit parallels between Chinese brainwashing techniques and American psychiatry. Hunter wrote that while interviewing one dissident, Chi Sze-chien, he experienced a “weird unnatural feeling” that the techniques described by Chi were somehow “familiar.” He recalled an incident regarding a friend who had suffered a nervous breakdown and received treatment in “a most modern sanitarium,” attended to by a staff of “psychologists, doctors and surgeons” (5). While visiting his friend, Hunter spoke to one “proud” and “happy” psychiatrist at the institution, who had just “won a glorious victory—the fight for a man’s mind.” While in China, Hunter realized with horror that
“the feelings that had come over me in that most modernized institution were the same as those I felt as I listened to Chi’s story: the same disquieting sense of probing into dangerous fields…it was as if that most advanced mental hospital with its staff of psychiatrists had stopped treating the insane and had begun treating only the sane” (6-7). American psychiatry and Chinese techniques of brainwashing, Hunter concluded, both “had something to do with controlling the brain. Our age of gadgets and electronics had discovered the brain, and we were learning how to manipulate it.” Hunter connected his “journey to the East” with “fascinating stories in the [American] press” about the development of computers (“a mechanical brain”) and news of “extremely delicate brain operations”—presumably, lobotomy. Hunter eventually identified the disquieting feeling as the taboo against “tampering” with the “divine creation” of the brain, which, he writes, cannot be done “without paying a dreadful price.”

The violation of the sacred human brain was akin to violating nature by splitting the atom—“such discoveries can be utilized, like primitive fire, for good or for evil, to help bring our earth closer to paradise… or to destroy it in an ultimate holocaust” (11).

43 Freeman and Watts dismissively described a similar tendency in their critics: “there is still a tendency to consider the brain as the ‘temple of the mind,’ the ‘seat of the soul,’ and the ‘greatest gift of God,’ and to decry any suggestion that such a holy structure is being tampered with. The shackles of medieval thought are difficult to strike off” (qtd. in Frank 19).

44 In a second book, Brainwashing: The Story of the Men Who Defied It, Hunter also makes this connection: “the methods used to make ‘learning’ and confession palatable and workable are borrowed freely from … psychiatry and science. The language and ideals of each other these fields were taken over and given new meanings and new interpretations in accordance with communist need. Brainwashing is a combination of this… quack psychiatry in a setting of false science” (202).
threatened America from outside its borders, mind control—for Hunter, embodied in both brainwashing and psychiatric practice—threatened America from within the bodies of its citizens.\footnote{Psychoanalyst Joost Meerloo, in a book about brainwashing entitled The Rape of the Mind, echoes Hunter’s concern about the severity of the brainwashing threat. Meerloo intones that “the danger of destruction of the spirit may be compared to the treat of total physical destruction through atomic warfare. Indeed, the two are related and intertwined” (14). Meerloo’s preferred term for brainwashing was “menticide”—a crime, he argues, worse than genocide (“Menticide”). As a threat to the most basic of liberties—being able to control one’s own body and thoughts (Gutmann and Thompson)—many writers like Hunter and Meerloo worried in their pages that brainwashing might be the insidious danger America had ever faced. Like Hunter, Meerloo connects brainwashing with psychiatry. However, perhaps owing to his profession as a psychoanalyst, Meerloo directs his critique at somatic psychiatry in particular: “the good will that people invest in their leaders, doctors, and administrators is tremendous and can be used as a weapon against them,” Meerloo writes. “Even modern brain surgery for healing the mind could be misused by modern dictators to make zombies out of their competitors” (71).}

The connections between lobotomy and brainwashing also were illustrated by a similar characterization of their behavioral effects in both scientific and popular discourse. For example, in a 1957 article in Sociometry, I.E. Farber, Harry Harlow (famous for his simian experiments on motherhood and attachment) and Louis West analyzed “the collapse of certain ego functions” in former Communist prisoners. This effect

bears an interesting resemblance to some aspects of the postlobotomy syndrome.

The latter, too, is characterized by apathy and the disturbance of the self-concept or self-regarding tendency. The frequency and degree of flattened affect and self-deprecation in the confessions of prisoners under Communism have probably
been overestimated, but to the extent they have occurred, the observed behavior has much in common with that of some brain-damaged individuals (275, my emphasis).

While Farber, Harlow and West noted the similarities between patients of lobotomy and victims of brainwashing in their “flattened affect” and “disturbance of the self-concept,” the 1956 film *The Invasion of the Body Snatchers* (1956) freely envisioned the social implications of the forced change of the human personality through the allegory of alien invasion. Although Jack Finney, author of the original Collier’s serial on which *Body Snatchers* is based, denied that his story should be taken as “a cold war novel or a metaphor for anything” the film is frequently read as a parable for Cold War anxieties—in particular, the susceptibility of American minds to control (LeGacy 287).

In *Body Snatchers*, members of a small town are replaced quietly, one by one, with alien “pod people.” The pod people are completely indistinguishable from those they have replaced; those closest to them are able to tell that something is missing, however, even if they’re not able to articulate what it might be. In one of the first scenes of the film, protagonist Dr. Miles Bennell visits a woman named Wilma, who is convinced that there is something wrong with her uncle. “How is he different?” asks Miles. “That’s just it,” Wilma insists, “there is no difference you can actually see. He looks, sounds, acts, and remembers like Uncle Ira.” If Ira looks the same, sounds the same, behaves the same, and remembers the same—what is missing? Ira’s personality, an intangible internal quality that differentiates Uncle Ira from other human beings: the pod people are like their originals in every way, but devoid of emotion. When concerned family members express similar fears about their loved ones in *Invasion of the Body
Snatchers, they are taken to the local psychiatrist, who diagnoses and dismisses their fright as psychotic delusion. In the film, the psychiatrist, Daniel Kaufman, appears to be one of the pod leaders.

In one of the final scenes of the film, Miles and Becky are confronted by Kaufman in a doctor’s office, who comments further on the difference between human beings and their pod counterparts. Kaufman informs Miles and Becky that they have “no choice” whether or not to become pod people, and also explains that the life the pods offer, an emotionless life of conformity, is a simpler existence. “No emotions!” exclaims Miles, “and no feelings! Only the instinct to survive. You can’t love or be loved, am I right?” Kaufman replies, “you say it as if were terrible. Believe me, it isn’t. You’ve been in love before. It didn’t last. It never does,” and then, in a striking echo of Psychosurgery, the psychiatrist explains what the pods will remove: “Love, desire, ambition, faith. Without them, life’s so simple, believe me.”

One review of Body Snatchers appears to speak directly to the connections between pod life and the lobotomized life. Body Snatchers, writes Hollywood Reporter critic Jack Moffitt, “seems to be saying that modern man, tired of facing the mental problems of our intricate age, is prone to welcome the irresponsible life of a human vegetable. This is a sobering and shocking thought” (13). Instead of reading Body Snatchers simply as a Cold War metaphor, Moffitt finds within Body Snatchers a related criticism of how America deals with the “mental problems” of its time. Moffitt’s use of the term “human vegetable” is telling—it was (and continues to be) one of the most common metaphoric descriptors of post-lobotomy patients.
Although there is no evidence that any communist country (nor any political regime, for that matter) used lobotomy as a tool of political indoctrination or repression, the brainwashing scare of the 1950s provided rich ground for the association of lobotomy with the imagined Communist techniques of mind control. The connection of psychiatry with Communist brainwashing laid the groundwork for what would become a systematic criticism of the field in latter decades: a suspicion that the benevolent intentions of psychiatry could be made to serve malevolent ends. “Relax,” one of the pod people tells Miles and Becky in the psychiatrist’s office, “we’re here to help you.” Just as Hunter worried that the splitting of the atom—tampering with the divine creation of matter—could lead to a nuclear holocaust, tampering with the divine creation of the brain could lead to the “ultimate holocaust” of the individual. Furthermore, similarities between the effects of “brainwashing” and the effects of lobotomy made for easy speculation that the two practices might be related or at least cut from the same ideological cloth. Hunter pointed to the similarities between psychiatry and communist “brainwashing” in order to warn that that they might be similarly motivated (by “the fight for a man’s mind”). The ultraconservative movement against psychiatry in the 1950s took the connection one step further: it sounded an alarm that psychiatry and communism were one in the same, and claimed that lobotomy was Communism’s most insidious weapon in the fight for American minds.
It is amazing and appalling how many supposedly intelligent people have been duped by such COMMUNIST SCHEMES as...“MENTAL HEALTH” especially since both the AMERICAN LEGION and the D.A.R. have publicly branded “Mental Health” as a COMMUNIST PLOT to take over our country!

A billboard in Long Beach, California: July, 1958

In 1957, Stephanie Williams, a California housewife and ultraconservative political activist, published an article entitled “Lobotomy is a Dangerous Weapon” in the American Mercury. Filled with inaccuracies and outright fabrications, Williams’ screed warned her readers about the political threat of the operation that “can turn a man into a living corpse.” According to Williams, not only did Hitler perform “mass lobotomies” on Germans, creating “approximately 10 million morons… so that they could be put to simple but useful tasks,” but “medical men Germany, France, and Italy have [also] added another 3 million to that deplorable number,” and Stalin, in particular, “is supposed to have had over 10 million slaves turned into living zombies” (141-2). Lobotomy, writes Williams, “is an essentially fascist technique” (142).

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46 Image reproduced in Marmor, Bernard and Ottenberg (333).
47 I’ve found no evidence that lobotomy was in use in Nazi Germany, although the timing would be right. Even the book Psychiatrists: The Men Behind Hitler, published by a wing of the Church of Scientology—not known for its adherence to facts with regard to psychiatry—admits that lobotomy was not “immediately connected to the Nazi era,” though it does conclude that
Williams was part of a grassroots coalition of McCarthyist ultraconservatives who banded together in the 1950s to fight what they saw as the growing communist influence within American society. The group Williams founded, the American Public Relations Forum, was a women’s political organization that, along with the Minute Women of the USA and organizations like the John Birch Society, sponsored a number of campaigns against state and federal mental health legislation. Ultraconservatives’ anxiety about mental health stemmed from a perception that the psychiatric profession was anti-religious and leftist, and for some segments of the movement, controlled by a Jewish and/or Communist and/or “one world government” conspiracy. “As the mental health field gained stature in the medical community and received unprecedented amounts of government funding,” writes historian Michelle Nickerson, “McCarthyite conservatives charged that more sinister forces were at work behind it all,” labeling psychiatrists “head shrinkers” and “brain tinkerers” and “accus[ing] them of using their medical expertise to advance a left-wing political agenda” (117-8). Groups like the APRF and the Minute Women self-published regular bulletins, as well as articles like Williams’ American Mercury piece, newspaper editorials, and other writings that claimed that the field of mental health was a “Trojan horse” for a secret Communist plot to take over the United States (Nickerson 119). While it was the broadly defined field of “mental health” or “mental hygiene” that was of general concern to these activists, lobotomy was identified as a particularly brutal weapon of the supposed communist-psychiatrist conspiracy.

lobotomy shares “a recognizable tradition of barbarism and the psychiatric philosophy of the Third Reich” (212).
However “ludicrous” the statements of ultraconservative mental health opponents might seem, wrote UCLA psychiatrist Alfred Auerbach to *The American Journal of Psychiatry* in 1962:

the fact remains that millions of Americans are being exposed to them over and over again. In addition to thousands of pamphlets and brochures repeating them there are many radio and television stations across the United States which routinely broadcast this philosophy, although in a more subtle manner. The attack on mental health is coupled with attacks on our educational system, churches, minority groups, and governmental institutions amongst others” (108).

Auerbach recommended that psychiatrists take the ultraconservative critique seriously—not their arguments, of course, but their power to shape American public opinion of their profession. Although most historians, with the exception of Michelle Nickerson, largely have ignored the ultraconservative critique of psychiatry in the 1950s as the ranting of a few paranoid conspiracy theorists on the “lunatic fringe,” it is clear that, however outrageous they might seem, these fictions found a wide audience and are worth a closer look.

One pamphlet distributed by Stephanie Williams’ American Public Relations Forum and a host of other ultraconservative organizations in the 1950s is a tract usually entitled *Brainwashing: A Synthesis of the Russian Textbook on Psychopolitics*. Psychopolitics claims to be the blueprint of a secret Soviet plan to infiltrate America’s system of mental health (a document “revealed” to the public much like the anti-Semitic hoax “The Protocols of the Learned Elders of Zion,” which had been in circulation for

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48 To avoid confusion with the texts of the previous section, I will refer to the booklet as *Psychopolitics*, rather than *Brainwashing*. 
decades in many of the same political circles in which Psychopolitics found its greatest purchase).

Psychopolitics quite certainly is a piece of American, not Soviet, propaganda, and its author is likely not, as some of its versions claim, Lavrentiy Beria, the architect of Stalin’s “Great Purge.” Many versions of Psychopolitics were circulated in the 1950s, which feature different covers, prefaces and conclusions, although most of the “Russian textbook” portion is roughly the same. The copy I will refer to was printed and distributed by Kenneth Goff, an ultraconservative activist and minister of the Christian Identity movement, a loose grouping of churches and individuals that preached racialized theology and white supremacy (Kaplan). Although it’s hard to know for sure, some critics have pegged the Psychopolitics pamphlet as Goff’s handiwork (Kominsky), and others suspect that the pamphlet’s repeated use of the term “dianetics” in addition to the pamphlet’s emphasis on the dangers of somatic psychiatry, indicate that the pamphlet was written by none other than L. Ron Hubbard, founder of the Church of Scientology (Introverne).

Goff claims in the “editor’s note” that he is a former “card-carrying” Communist Party member who later testified against his former comrades before the House Un-American Activities Committee (HUAC) in 1939. In the editor's note, Goff writes that he was trained at the Eugene Debs labor school in Milwaukee, Wisconsin in “all phases of warfare, both psychological and physical, for the destruction of the capitalistic society

49 In his book The Hoaxers, one of the only published works that includes information on the Psychopolitics booklet, Morris Kominsky leaves “no stone unturned” in his analysis of its authenticity. Kominsky sent the pamphlet to a number of government officials and experts on Soviet psychiatry, interviewed Goff himself, and comes to the conclusion that the book is an “unmitigated fraud” (542).
and Christian civilization.” After his political and religious conversion from young atheist communist to wizened Christian anticomunist fighter, Goff became a prolific speaker and writer, publishing over 28 books and tracts and bulletins on a host of ultraconservative issues of the day: fluoridation programs, the “narcotizing” of America’s youth, the United Nations, and the faked death of Hitler, among many others (Kaplan).

Goff claims to have received the Soviet textbook during his time of Communist instruction. “Psychopolitics,” Goff defines, is “the art of capturing the minds of the nation through brainwashing and fake mental health -- the subjecting of whole nations of people to the rule of the Kremlin.” Psychopolitics was brainwashing applied wholesale to the American public, a mass conversion that needed the support of institutions, not just individuals, to accomplish its goal. Goff writes that he is publishing the pamphlet not to warn his readers of what might happen if Communists began their psychopolitical plot to overthrow America, but to sound an alarm that it already was taking place:

  first in the brainwashing of our boys in Korea, and then in the well-financed drive of mental health propaganda by left-wing pressure groups, wherein many of our states have passed Bills which can well be used by the enemies of America to subject to torture and imprisonment those who preach the gospel of our Lord and Saviour Jesus Christ and to oppose the menace of communism (n.p).

One of the bills to which Goff refers is the 1956 Alaska Mental Health bill, which proposed a 12.5 million dollar grant to the Alaskan government so that the state could provide hospitalization for its citizens, who usually had to be moved to the Continental states in order to receive psychiatric care. The program was to be funded long-term by
the transfer of one million acres of federally owned land to state control. In *Psychopolitics*, Goff argues this bill seeks to

establish a mental Siberia in Alaska… A careful study of this Bill will make you see at once that the land set aside under the allotment could not be for that small territory, and the Bill within itself establishes such authority that it could be turned into a prison camp under the guise of mental health for everyone who raises their voice against Communism and the hidden government operating in our nation (n.p).

The “mental Siberia” line was not of Goff’s own making; it was a frequent slogan of the ultraright campaign to kill the Alaska bill, which its opponents characterized as “a concentration camp for political prisoners under the guise of treatment of mental cases” (Nickerson 118). Primary opponents of the Alaska bill were the Stephanie Williams’ APRF and the Minute Women of the USA, whose Leigh F. Burkeland “exposed” the bill’s diabolical intent in a letter to the Santa Ana Register entitled “Now—Siberia, U.S.A.”

But the creation of a “mental Siberia” was not the primary danger to the American public from psychopolitical operatives, according to the pamphlet. The ultimate goal of psychopolitics was to replace every psychiatrist, psychologist and other mental health professional with Communist agents in order to achieve “psychopolitical rule” (6). To achieve full control over the minds of Americans, *Psychopolitics* directs its Communist operatives to produce “maximum chaos in the fields of mental healing” until “every teacher of psychology unknowingly or knowingly teaches only Communist doctrine” and
“every doctor and psychiatrist is either a psycho-politician or an unwitting assistant to our aims” (3).

According to the manual, the American mental health profession was a perfect breeding ground for psychopolitics. First, the fields of psychiatry and psychology contained obtuse terminology unfamiliar to the general public, which provided a kind of communicative shield for the psychopolitical operative:

The cleverness of our attack in this field of Psychopolitics is adequate to avoid the understanding of the layman and the usual stupid official, and by operating entirely under the banner of authority, with the oft-repeated statement that the principles of psychotherapy are too devious for common understanding, and entire revolution can be effected without the suspicion of a populace until it is an accomplished fact (25).

The indecipherable jargon of psychiatry and psychoanalysis was more than just a common joke, but was apparently a real concern to the mental health profession. Psychoanalyst Joost Meerloo wrote that he deliberately avoided the “jargon” of his colleagues in order to reach a “lay” audience in his book on brainwashing *The Rape of the Mind*. The *American Journal of Psychiatry* routinely carried articles in the

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50 See Kelley as well as the unsigned *AJP* comment “Psychiatry for the Reading Public,” for example. In 1957, the *Chicago Daily Tribune* republished the following joke:

Don Wilson: But you know I've tried everything to lose weight. I even went to see that psychiatrist last week. He gave me every kind of a test and then he said my tendency toward obesity was caused by psychosomatic obsessions which might be terminated by a pre-frontal lobotomy provided my alter ego repressed my subconscious tendencies.

Lois: What does that mean?

Don Wilson: It means I eat like a pig (Wolters).
mid-century about how best to relate to the public by speaking in terms its audience would understand. *Psychopolitics* capitalized on the popular distaste for the profession of psychiatry and characterized the field’s technical jargon as a deliberate ruse: should any psychopolitical operative come under investigation, the pamphlet instructs, “a great complexity should be made of psychiatric, psychoanalytical and psychological technology. Any hearing should be burdened by terminology too difficult to be transcribed easily” (51).

The psychiatrist’s ability to diagnose insanity, that “despised and disgraced state,” also supported the psychopolitician’s goals, because it had the power to nullify political action: “an insane person has no rights under law. No person who is insane may hold property. No person who is insane may testify” (24-5). Furthermore, the diagnosis of insanity may be leveled at entire groups of people, “or even a government,” which may cause its people to disavow it (25). In an echo from *Invasion of the Body Snatchers*, the manual directs that “one of the first and foremost missions of the psychopolitician is to make an attack upon Communism and insanity synonymous” (25).

In *Psychopolitics*, psychiatrists are characterized not simply as communist operatives and brainwashers, but as violent political terrorists whose “brutalities are committed in the name of science,” and whose ultimate goal is obedience, not cure (31). The pamphlet lavishes praise on somatic psychiatric treatments such as electroshock and psychosurgery, described as “Russian developments” throughout the text.\(^{51}\)

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\(^{51}\) The U.S.S.R. forbade lobotomy in 1950 by order of the Soviet Ministry of Health, the *American Journal of Psychiatry* claimed in an editorial in 1953. The report reveals more than a little of the ideological leanings of its author: “there was unanimous agreement that foreign theories re psychosurgery were unsound and diametrically opposed to the clear teachings of
“obedience is the result of force,” these two procedures are heralded not for their therapeutic potential, but for their “brutality” and their effectiveness as punishment (29). “It is the violence of the electric shock and the surgery which is useful in subduing the recalcitrant personality… In that a well-regulated state is composed of organisms, not personalities, the use of electric shock and brain surgery is clearly demonstrated” (20). As deliberately violent attacks against patients, electroshock and psychosurgery are spoken of in concert with “sexual attack,” in order to “create in that person a psychopolitical slave subject” (23). For the purposes of obedience, *Psychopolitics* found lobotomy particularly useful, as “it has no statistical data to recommend it beyond its removal of the individual personality” (20).53

In a chapter entitled “Violent Remedies,” the manual suggests that it will be necessary to assuage the concern that will follow the publicized use of these brutal treatments. The public generally understand that a certain amount violence is “reasonable” in the care of the insane, *Psychopolitics* attests, and so “starting from a relatively low level of violence, such as straight-jackets and other restraints, it is

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Pavlov. The dutiful Soviet psychiatrists registered their unswerving adhesion to the official version of Pavlovian doctrine and their emphatic opposition to the reckless, capitalistic surgical adventuring of Western doctors.” (“No Psychosurgery in the U.S.S.R.”) See also Galach’yan and Kiev, who both mention the ban on lobotomy in the Soviet Union.52 The Milgram experiments on obedience were not conducted until 1963.

53 The psychopolitical operative was directed to *promote* somatic treatments as “therapeutic and necessary” by listing “large numbers of pretended cures” to support the argument for their use (31). “[He] must have to hand innumerable documents which assert enormously encouraging figures on the subject of recovery by reason of shock, brain surgery, drugs, and general treatment. Not one of these cases cited need be real, but they should be documented and printed in such a fashion as to form excellent court evidence” (50).
relatively easy to encroach upon the public diffidence for violence by adding more and more cruelty into the treatment of the insane” (54). Further, these treatments should become the norm in the care of the mentally ill:

Brain operations should become standard and commonplace… It is very doubtful if anyone from the lay levels of the public could tolerate the observation of a single electric shock treatment. Certainly they could not tolerate witnessing a prefrontal lobotomy or a trans-orbital leucotomy. However, they should be brought to the level where this is possible, where it is the expected treatment…

The more violent the treatment, the more hopeless insanity will seem to be. (55).

The pamphlet concludes: “continuous and increasing advertising of the violence of treatment, the public will at last come to tolerate the creation of zombie conditions to such a degree that they will probably employ zombies, if given to them” (55). 

*Psychopolitics* thus functioned as a hybrid piece of propaganda, connecting anxieties about the invisible menace of Communism within America’s borders with the public’s distaste for the psychiatric profession.

*Psychopolitics’* paranoid fiction about the Communist infiltration of American psychiatry was not limited to circulation in small communities of conspiracy theorists, but also found its way into the hands of legislators, and was referenced and reproduced in government publications. On June 13th, 1957, for example, Representative Usher Burdick (R-ND) entered an article entitled “Beware of Psychiatrists” into the *Congressional Record*, which warned about the danger lobotomy posed to the United States, supported
with “evidence” from the Psychopolitics pamphlet. “One way to destroy any people is to destroy their health,” wrote Burdick: “the destruction of the mind is less obvious and not an open act of murder, but the millions who have had their minds destroyed… are as dead as they ever will be.” After briefly explaining the technique used in transorbital lobotomy, Burdick, like Stephanie Williams, attested that “Hitler used this method on millions of his subjects and Stalin had over 10 million slaves or prisoners operated upon and turned into mere beasts of burden.” Then Burdick described the terrible result of the “five minute” operation. A person lobotomized, he wrote, “loses his animation as a living object and becomes a zombie.” Afterward, “the subject does not know what has been done to him.” Even further, Burdick wrote, “his productive organs wither up and he is incapable of resistance” (9060).

Furthermore, in keeping with the title of the piece, “Beware of Psychiatrists,” Burdick directed his audience’s attention to the dangers of the doctors performing the operation: “in the United States today a large percentage of the psychiatrists are foreigners, most of them educated in Russia. The percentage runs as high as 80.” To

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54 Burdick had previously given a speech in 1954 entitled “The Great Conspiracy to Destroy the United States” on the floor of the House of Representatives, which leaves little doubt as to his connection with the ultraconservative movement. In the speech, Burdick attests that “there can be no doubt that there now exists a widespread understanding and agreement between the agents of this Government and the United Nations and the North Atlantic Treaty Organization to build a world government…[which] will result in the total destruction of our liberty” (5698).

55 Contrast Burdick’s figures with the testimony of John Kasper, a white nationalist and anti-fluoridation activist who testified against the Alaska Mental Health Bill: “Psychiatry is a foreign ideology; it is alien to any kind of American thinking…its history began with Sigmund Freud who is a Jew…almost 100% of all psychiatric therapy…and about 80% of the psychiatrists are
support his argument, Burdick then quoted directly from the Beria “speech” used to preface the *Brainwashing* booklet: “upon these people can be practiced shock and surgery so that never again will they draw a sane breath.” “There you have the Communist assault on the minds of men,” Burdick concluded, “is this the practice his country is going to follow in mental health cases?” (9061).

Psychiatrists were acutely aware of anticommunist attacks against their profession. Auerbach’s article in *The American Journal of Psychiatry*, which excerpted Jewish…one particular race is administering this particular thing” (qtd. In Marmor, Bernard and Ottenberg 341). For more on anti-Semitism and critiques of psychiatry, see Stephen Frosh.

The “zombie,” “robot,” and “human vegetables” descriptors used to describe lobotomy patients were also repeated in medical discourse. Walter Freeman wrote a “Psychosurgery” column for the *American Journal of Psychiatry*’s annual “Review of Psychiatric Progress” section, beginning in 1950. By 1955, he indicates, “psychosurgery is beginning to make itself felt in the state hospitals of this country.” Within this report, he includes a “revealing” presentation on lobotomy’s effects the Third Research Conference on Psychosurgery:

the average patient increased in total interaction with the environment, in his socialization with other patients and with the leader, in verbal interchange, friendliness and responsiveness...he displayed more positive affect, participated more in group interchange by giving suggestions, opinions and orientation and he was altogether more productive.

What Freeman says immediately after, however, bears special consideration: “Zombies and human vegetables take note!” Freeman includes the case study of the “average lobotomy patient” as a direct rebuttal to popular representation of the patient as a “human vegetable” and “zombie.” Freeman also challenged the representation of lobotomy patients as “robots” in an article published in *Diseases of the Nervous System* in 1961. Freeman states that the purpose of the paper “is to enter another wedge of doubt, constructive doubt, into the opinions commonly expressed, that lobotomy kills the soul, converts the patient into a robot...and alters the personality so greatly that the patient can never thereafter function adequately in society (555). Freeman continued to write his yearly column for the *American Journal of Psychiatry* until 1965, when he declared that a metaphoric “moratorium” had been declared on lobotomy in the United
lengthy portion of the *Psychopolitics* booklet, warned that although the profession assumes that “educated” Americans pay no attention to the ultraconservative campaign against psychiatry, “regrettably, this is not the case” (108). He advised psychiatrists not to ignore their ultraconservative critics, but to “be prepared to respond immediately” when they appear by writing “dispassionate rebuttals” to the editor, and creating “fact sheets” to send to “members of legislative bodies, newspaper editors and columnists.” “The issues at stake,” Auerbach concluded, “no longer permit psychiatrists to remain uninvolved” (111). In another article about the anti-mental health movement in the *American Journal of Orthopsychiatry*, three psychiatrists worried that “when the social climate renders the risks especially great, as during the height of McCarthyism, not only may the public be deprived of the applications of scientific progress, but that progress itself may be hampered by the extension of the inhibiting forces into certain areas of research.” Specifically, they suggested, “some of those in the health professions retreat into less controversial areas of work” (343). It is hard to say whether or not the numbers of psychiatrists began to decrease in the 1950s as the result of these attacks on their profession, although this is clearly a matter that warrants further study.

Vernacular discourse about science and medicine, writes Katherine Pandora, may not be endowed with institutional authority, but nonetheless “generates powerful effects, both in terms of its ability to create memorable images infused with emotion that persist across social space and generational time and in the speed with which it can travel and proliferate across diverse venues” (492). The numerous associations between psychiatry

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States (“Psychosurgery” 653; Sargant). It was his last publication in the journal, and the last time psychosurgery had its own heading under the yearly “Report of Psychiatric Progress.”
and Communism in vernacular discourse suggests that in the anxious years of early Cold War America, mental health in general was an area of biomedicine that became socially and politically problematic. Furthermore, at a time in America’s history when the mere suspicion of Communist association was enough to blacklist thousands of people from jobs in government, entertainment, and a host of other professions, it is reasonable to assume that the specific position of lobotomist was a career choice that carried ominous overtones, especially once alternative treatments became available. Walter Freeman was just one of many psychiatrists profiled by the FBI. Fictions may not map neatly onto the historical record, but they can powerfully shape scientific and medical practice, as the Orthopsychiatry psychiatrists suggest. Although most histories of psychiatry confine their analysis of the rise and fall of lobotomy to use within American medical practice, the repeated association of psychiatry, generally, and lobotomy, specifically, with Communist practices of mind control in Cold War America suggests a rhetorical situation in which psychiatry may have had great incentive to welcome the demise of lobotomy.

57 Nothing eventually came of the investigation, which took place during the 1940s. The FBI report reproduced in the GWU archives reads, “Conclusion: Subject’s friends and associates do not doubt Subject’s patriotism, nor his integrity, character or discretion; they regard him as an unusually ambitious and equally capable professional man.”
That which an age considers evil is usually an unseasonable echo of what was formerly considered good—the atavism of an old ideal.

_Nietzsche, Beyond Good and Evil_

As I argued in the previous chapter, in the 1950s, lobotomy became associated with fears of Communist mind control and anxieties about psychiatry that echoed throughout public discourse in the mid-1950s. The early years of the Cold War created a discursive atmosphere in which the permanent change of the American individual’s personality took on a significant political meaning. In this chapter, I examine another set of texts that presented lobotomy to the public: the popular press. In his unpublished _History of Psychosurgery_, Walter Freeman states unequivocally: “no account of lobotomy would be complete without a discussion of the effect that newspapers and popular magazines had upon the development of the procedure. There is little doubt that without the enthusiasm and occasionally embarrassing efforts of interpreting our work to the reading public there would have been a much slower tendency for lobotomy to develop along the lines that it has” (n.p.). In the first fifteen years following the introduction of lobotomy to American medicine in 1936, the press reported that lobotomy was a “miracle cure” for mental illness that heralded a “new era” of psychiatry and promised a new life for its patients outside the horrors of the state hospital system.
Freeman does not mention is that in the years during lobotomy’s peak use within medical practice, those stories began to take on a negative tone well before lobotomy was “abandoned” by medicine in 1955.

The press’s initial enthusiasm about the promise of lobotomy’s “cure” was later tempered by qualifiers and then replaced by outright skepticism in many newspapers and magazines. Of course, this shift is marked by discontinuities: there are a few positive stories about lobotomy in the 1950s, and a few negative stories about lobotomy in the 1940s. The general trend in the stories’ tone, however, exhibited a marked change from positive to negative in the early 1950s. In the only study of lobotomy and the popular press, Diefenbach et. al. conclude that the shift was the result of a more “objective” style of journalism practiced by science reporters, who began to include dissenting voices from the medical profession in their stories:

Both the quantitative and qualitative analyses support the conclusion that early popular press articles on lobotomy were positively biased. The quantitative analyses indicated that the average tone of articles remained positive until the 1950s, the number of benefits of lobotomy listed per article was highest in the early years, and the number of negative side effects listed per article started low in number and increased with time (at least until the mid-1950s). In addition, the qualitative analysis uncovered many instances of misrepresentation and sensationalized reporting in the early years. The portrayals of lobotomy remained positive despite the availability of opposing viewpoints in the medical community, which provided a basis for balanced coverage. Although early
publications were biased with positive portrayals, the reporting styles became increasingly balanced, and eventually negatively balanced, through time (61).

In this description, the tonal shift from positive to negative is attributed to a more “balanced” style of journalism by science reporters, who corrected the “misrepresentations” and “sensationalism” of early stories. But what did early stories misrepresent, and how? What or, more importantly, who, was “portrayed” in accounts of lobotomy? How were lobotomy’s results interpreted as “benefit,” “side effect,” or later, “damage”?

If we consider press stories not simply as vehicles of correct or incorrect information about medical practice but as arguments, I suggest that we can identify the shift in lobotomy’s representation in the media not just as one of tone, but also as a shift in claim and evidence. In early stories, this claim was often explicit: lobotomy was a triumph of modern medicine that cured its patients and returned them to normal lives. In later stories, the claim was more implicit: lobotomy was a procedure of questionable medical merit that had a detrimental effect on the patient, as well as the family and the larger social order.

As the meaning of the operation began to change in public discourse from miracle cure to medical malevolence, a phenomenon I detailed in the previous chapter, the media’s interpretation of evidence used to support lobotomy’s evaluation began to shift in a curious way. Early stories about lobotomy relied primarily upon case histories of women to support a positive evaluation of lobotomy, while later negative stories relied
more often on case histories of men.\textsuperscript{58} Within these stories, the personality changing effects of lobotomy were interpreted through gender-specific norms of behavior. Although the more frequent use of women’s case histories in early stories might be explained by the fact that women were disproportionally represented in the lobotomy patient population, the later shift in gender suggests that the selection and interpretation of particular patient cases was a rhetorical choice, not a reflection of medical reality.

In the first section of this chapter, I explore lobotomy’s unique relationship with the press, and consider the concerns of the medical community that “unwarranted” positive coverage of lobotomy could be dangerous. In the second section of this chapter, I consider some of these stories in more detail, beginning with stories of lobotomy as “miracle cure,” and concluding with stories that raised serious questions about the personality-changing effects of the operation, in order to analyze the shifting use of gendered case histories to support these claims.

\textit{Lobotomy and the Popular Press}

During his career as the most vocal proponent of lobotomy in America, Walter Freeman became something of a medical star.\textsuperscript{59} Biographer Jack El-Hai explains that

\textsuperscript{58} No story I’ve found to date mentions patients’ race or ethnicity. There is a dearth of information on race in medical histories of psychosurgery, a gap that clearly calls out for more research. Race does become a factor in debates over psychosurgery in the 1970s, which I discuss in Chapter 5.

\textsuperscript{59} Freeman describes one example in his \textit{Autobiography}: “both Watts and I had letters from a lady in the far West asking privilege for our photographs which she could arrange along the wall with Douglas Fairbanks, Roosevelt, and Al Capone.”
Freeman frequently received fan mail, and reporters followed his every move across the country. The press’s fascination with Freeman was not coincidental, however: it was a calculated move on the part of the media-savvy lobotomist. Freeman explains:

I had gotten over being gun shy of reporters in the eight or ten years that preceded the announcement of psychosurgery and was quick to realize that they played a very definite part in the development of a scientific subject by virtue of their ability to catch the imagination and enlist the sympathy of the public, to disseminate information in such a way that members of the profession are almost obliged to subscribe to the newspapers and periodicals to keep abreast of recent developments (History). 60

The media’s interest in lobotomy was synchronous with its introduction to American medicine. In 1936, Freeman and Watts presented their first paper on lobotomy to the Southern Medical Association conference in Baltimore. Freeman writes that after he and James Watts finished their initial series of six operations and were preparing to present their work, “we realized that this could well be a subject for headlines in the newspaper” 60

60 Freeman’s last comment was confirmed during a roundtable discussion of lobotomy at a meeting of the American Medical Association in 1941, when one of the panel members, neurologist Roy R. Grinker explained (perhaps facetiously), that he had prepared for the meeting by “reviewing…all the medical literature that has been available, including the Saturday Evening Post” (“Neurosurgical Treatment” 177). In a letter to Colonel John M. Caldwell, Chief of Psychiatry at Walter Reed Army Hospital Freeman also critiqued his medical colleagues for relying only on popular press accounts of lobotomy: “sooner or later when these doctors go into practice, they will come in contact with psychosurgical problems. They should have more of an acquaintance with the situation than is afforded by The Saturday Evening Post and Reader’s Digest.” (WF to JC 19 Nov. 1952).
Concerned the media might distort his research, Freeman called Thomas Henry, the science writer for the *Washington Evening Star*, a week before the conference:

“Tom,” I asked, “Would you like to see some history made?”

His ears pricked up. I continued:

“We’ve done a few brain operations on crazy people with interesting results. Would you like to see one?”

Henry came down to Freeman and Watts’ clinic in Washington D.C. “saw an operation, saw some patients before and after, and wrote his story, submitting it to us for approval and editing” (*History*). Freeman and Watts were so impressed by the quality of Henry’s story (jointly written between the three men) that they used some of Henry’s language in their paper for the Baltimore conference. When the surgical team reached Baltimore, they were besieged by journalists who clamored for details about the new surgery for the insane. After an impromptu speech to reporters before the presentation, Freeman recalls he had to “plead” with them to let him go in order to give the paper, where he found the room crowded with both medical professionals and journalists (*History*; Macmillan 249).

While an operation to intentionally damage the frontal lobes was a drastic proposal, it also wasn’t completely out of step with the psychiatric treatment paradigm in the mid-1930s. In Baltimore, Freeman and Watts faced an audience largely sympathetic to dramatic somatic interventions: Metrazol shock, insulin coma and hydrotherapies were widely used in asylum psychiatry in 1936 (ECT was not developed until 1938 and the psychoanalytic “revolution” in America didn’t hit until nearly a decade later). Freeman

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61 “We also followed some of his own expressions in writing the final draft of our paper” (*History*).
reported that the paper was generally “well received” by most in attendance, although there was a heated exchange during the question and answer period following the presentation (WF to Egas Moniz, 26 Nov. 1936; “Prefrontal Lobotomy” 22). One audience member’s opinion, however, mattered more than most: Adolf Meyer.

Often called the “dean of American psychiatry,” Adolf Meyer was undoubtedly the most famous American psychiatrist in 1936. Meyer advocated a holistic view of mind and body combined with an emphasis on one’s social surroundings known as “psychobiology.” Mental illness was not due to the malfunction of a particular organ, Meyer asserted, but a maladaption of the “total” individual to his or her environment.62 Meyer’s psychological leanings did not prevent him from embracing somatic treatments for mental illness, however. To illustrate, historian Edward Shorter references Meyer’s support for psychiatrist Henry Cotton, who removed patients’ teeth and large bowels in order to “cure” their insanity. Meyer had once praised Cotton’s work as “the remarkable achievement of the pioneer spirit” (Shorter 111-12). It thus may not have

62 Meyer described the goal of psychobiology in his presidential address to the American Psychiatric Association in 1928:

Today we use this critical common sense as ‘controlled experience with the experiments of nature’ first and last, and solid training and proficiency in the entire field of intensive study of the various levels of integration, structural and functional. We work with total function (psychobiology) and part functions (physiology)—and physico-chemical, individual and social. We work with the facts contained in the life history and family history and the results of our examinations, with the individual assets and maladjustments, and the individual and social adjustments open to us” (24).

Pressman writes that in American psychiatry in the 1930s, “the catchwords were pragmatism and eclecticism: whatever worked was fine” (38). Meyer’s emphasis on the individual’s relationship with his or her environment was certainly reflective of the larger pragmatism movement, and found echoes in the work of contemporaries like George Herbert Mead, for example.
come as a surprise to the Baltimore audience that during the discussion section following Freeman and Watts’ paper, the “dean of American psychiatry” did not condemn prefrontal lobotomy:

I am not antagonistic to this work, but find it very interesting. I have some of those hesitations about it that are mentioned by other discussants, but I am inclined to think that there are more possibilities in this operation than appear on the surface… The available facts are sufficient to justify the procedure in the hands of responsible persons… at the hands of Dr. Freeman and Dr. Watts, I know that these conditions will be lived up to (“Prefrontal Lobotomy” 22).

Freeman later commented, “had it not been for his sympathetic and helpful discussion, the advance of lobotomy would probably have been much slower than it was,” and proudly reported Meyer’s approbation to Egas Moniz in a letter describing the paper’s reception (Autobiography; WF to EM, 26 Nov. 1936).

After the “dean of American psychiatry” blessed the new procedure, Meyer concluded his remarks with a stern warning. Addressing his mixed audience of physicians, biomedical scientists, and newspaper reporters, Meyer cautioned:

I should hesitate to promise that we could remove distraction and worries by operation. To call attention to what is possible might start an epidemic of hasty human experimentation… The available facts are sufficient to justify the procedure in the hands of responsible persons, but it is important that the public should not be drawn into any unwarranted expectations (“Prefrontal Lobotomy” 22).
Meyer’s comment reveals an anxiety about the control of biomedical information disseminated through the intermediary of the press. Informed of lobotomy’s potential, the public might begin to interfere with biomedical research and clinical practice—demands for lobotomies, he worried, might “start an epidemic of hasty human experimentation.” An anonymous writer for the *Journal of the American Medical Association* echoed Meyer’s concern in 1941: “in the present experimental stage there is no excuse for dissemination of discussions or of any statements laudatory of this procedure to the general public” (“Frontal Lobotomy” 535). Three years after that, a neuropsychiatrist wrote in *The Journal of Mental Science*, “it seems a pity that such a technical matter as prefrontal leucotomy should be discussed in the lay press, and we can only deprecate very strongly the action of medical men who have encouraged this” (Fleming 486).

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63 This publicity eventually came to haunt the lobotomy team professionally, a matter which must have been especially troubling to James Watts, who did not seek the limelight as much as his partner. During the first executive meeting of the American Neurological Association in 1947, writes Freeman,

> Doctor Ernest Sachs of St. Louis, walked down the aisle brandishing a copy of the *Saturday Evening Post* and demanded an investigation with possible punitive action, and there was informal talk about expulsion from the Association of both Watts and myself (*History*).

The *Post* story to which Sachs refers is a gushing 1946 article, “Turning the Mind Inside Out,” by Waldemar Kaempffert, which quoted the two doctors by name and also featured photographs of the team in surgical action. Sachs’s fury stemmed from long-held professional mandate that physicians should not advertise for their services—a directive written into the original American Medical Association’s code of ethics in 1847. This prohibition was loosened somewhat in 1976 after physicians challenged the ban on the basis of First Amendment rights; however, in 1936, it would have been enforced by the AMA at national and state levels (Candby and Gellhorn). No
Despite protestations like these from the medical profession, the media enthusiastically reported about lobotomy for more than ten years, often exaggerating the operation’s potential as cure. In their original Baltimore paper, Freeman and Watts emphasized that, despite the positive results of their first few operations, they made “no claims whatsoever to having a cure for any mental diseases” (“Prefrontal Lobotomy” 21). In Thomas Henry’s story (which, if you recall, was vetted by Freeman and Watts) repeated this qualified claim: “Drs. Freeman and Watts stress the statement that they make no claims whatsoever to having a cure for any mental diseases.” Henry also includes another cautionary note from Freeman and Watts toward the end of the article:

We wish to emphasize also that indiscriminate use of the procedure could result in vast harm. Pre-frontal lobotomy should at present be reserved for a small group of specially selected cases in which conservative methods of treatment have not yielded satisfactory results. It is extremely doubtful whether chronic deteriorated patients would be benefited. Moreover, every patient probably loses something by this operation, some spontaneity, some sparkle, some flavor of the personality, if may be so described (Henry).

As news of the surgery began to spread across the country, however, headlines began to tell another story: “Brain Surgery by D.C. Doctors Cures Insane”; “Doctor Cuts Worry out of Brain with Knife”; “Surgery is Curing Insanity”; “Miracles of Brain Surgery”; “Reformed By Brain Surgery”; “Brain Surgery Abolishes Fears”; “Surgeon’s Knife Restores Sanity to Nerve Victims”; “Wizardry of Surgery Restores Sanity to Fifty Raving

disciplinary action came of the Post controversy, but Freeman and Watts’ professional reputation certainly suffered from the media attention.
Maniacs”; “Surgery Restores ‘Incurably Insane.’” How are we to make sense of this radical change in claim?

In her influential article “Accommodating Science: The Rhetorical Life of Scientific Facts,” Jeanne Fahnestock argues that scientific discourse “accommodated” for a lay audience undergoes a striking rhetorical transformation. In a contemporary application of Aristotle’s tripartite division of rhetorical discourse, Fahnestock argues that scientific writing for scientific audiences is primarily forensic, as it seeks to establish the validity, nature, or cause of the matter under consideration (333). Scientists writing for other scientists are held to stylistic norms that demand careful qualification of claims, narrowness of scope, and consistent attention to refutation. Conventions of scientific argument foreclose bold claims of significance—what a discovery might mean is “largely understood” by a scientific audience (333). When the audience for scientific discourse changes from scientific to nonscientific, Fahnestock explains that the argument’s genre shifts from forensic to epideictic, because its “main purpose is to celebrate rather than validate” (333). Because popular science writers “cannot rely on the audience to recognize the significance of information,” it is important that the writer “[adjust] new information to an audience’s already held values and assumptions” (334). Scientific discourse for a scientific audience is primarily discourse about fact, Fahnestock contends; “accommodated” scientific discourse for the public is primarily discourse about value, given meaning and weight by its situatedness in a community at a particular time.64

64 Critics have rightly suggested that by celebrating orthodoxy, epideictic ultimately serves to strengthen hegemony, a point with which I agree, but is beyond the scope of the current chapter. See Poulakos.
According to Fahnestock, popular science writers have “at bottom only two basic appeals to make their epideictic arguments,” appeals she terms “the wonder” and “the application,” drawn loosely from deontological and teleological approaches to ethics. Deontological arguments suggest something has intrinsic value, a good in and of itself; Fahnestock writes that “all references to the amazing powers and secrets of nature, the breakthroughs and accomplishments of the scientists themselves” are deontological appeals to wonder, as are claims that something is the first of its kind (walking on the moon, mapping the human genome, communicating with primates, etc.) (334). Teleological arguments claim something’s value by suggesting that it will lead to further benefit; medical breakthroughs have enormous application appeal, as do scientific developments that will save public money or increase public safety. New developments in fields without an obvious connection to their wonder or application rarely make the news.

The qualifications offered by Freeman and Watts in their paper for a medical audience, qualifications which appeared when they had some measure of control over the writing (as with Henry’s story), were removed as science writers emphasized the significance of the new surgery. Freeman comments that “some of these articles were well written but most of them conveyed the idea that there was a brand new method, infallible, that could be applied in all sorts of nervous and mental disorders without danger and with good prospects of restoration of the suffer [sic] to normality” (History). A 1937 article in *The New York Times* illustrates the kinds of claims Freeman critiques: the story enthusiastically and confidently claimed that lobotomy “cuts away sick parts of the human personality, and transforms wild animals into gentle creatures” (Laurence).
Time reported in 1942, “some 300 people in the US have had their psychoses surgically removed” (48). Baltimore’s Evening Sun reported that “brooding patients” have been “cured” (44). In 1946, Time asserted, “most cases are cured or greatly improved. So far, neurologists have discovered no seriously harmful effects” (67). The American Weekly continued the praise in 1946, calling lobotomy “the brain operation that severs nerves painlessly to cure many types of insanity” (11). Your Life also stated in 1946, “surgery is curing insanity. Psychosurgery offers, to the mentally ill, a new hope for returning to a normal life” (32). Fahnestock comments:

in the space limits of a short notice in a magazine of popularized science, there is no room for the qualifications a more knowledgeable audience would demand, qualifications that show the author’s awareness of the criticism and refutation that an expert audience could raise against his inferences. To protect himself from such refutation, the scientist-author has naturally hedged his account. But because he fears no such challenge, the accommodator is far more certain of what is going on… (338).

Yet as arguments, even arguments of celebration, these stories of miracle cure required evidence to support their positive evaluations, which came in the form of brief case histories of patients who had benefited from the operation. Many case histories, it seems, were drawn from presentations at annual meetings of medical associations or from published material in professional journals. The brevity demanded of press stories demanded that journalists present details only relevant as support for the article’s claim of value. In the fifteen years that lobotomy was heralded as a miracle cure for mental illness, the majority of case histories used to support this claim were case histories of
women or men perceived to be feminized. In these stories, lobotomy was argued to bring about “amazing results” for restoring norms of gender behavior—replacing aggressive behavior in women with docility, and replacing docile behavior in men with assertiveness.

_The Miracle of the “Miracle Cure”_

In his book _Mental Ills and Bodily Cures_, a study of somatic therapies in California hospitals, historian and psychiatrist Joel Braslow argues that a prescription of lobotomy was intimately tied to a patient’s gender. Of the 241 lobotomies carried out at Stockton State Hospital, for example, 205 (85%) were performed on women. In addition, Braslow found that of the 14 patients subjected to _multiple_ lobotomies at Stockton, 13 were women (154). Braslow suggests that this shocking disparity reflected a larger national trend in which women received lobotomies at a much higher rate than men. Furthermore, Braslow writes, the very criteria by which women’s behavior was judged to be pathological, and the criteria by which lobotomy judged a success, were also explicitly gendered. “Foul” language, consumption of alcohol, aggression, and the neglect of house and family were all signals of mental illness in women. Women were referred to as “bad girls” and “good girls” in transcripts of clinical meetings; men were never “bad boys” (158).¹⁶⁵ Physicians at Stockton frequently cited sexual behavior in women, including

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¹⁶⁵ Braslow reproduces one clinical conversation in which a woman is reprimanded by her doctor for her “foul” language:

_Dr. Baron_: What’s the matter with you?

_Patient_: I don’t know
homosexuality and masturbation as grounds for a lobotomy intervention. One particularly disturbing effect of the pathologization of women’s sexual behavior, Braslow found, was the use of clitoridectomy on five of Stockton’s women patients, four of whom also had received lobotomies. Male patients, in contrast, were never castrated. Braslow argues that the increased preference for surgical intervention in women patients stemmed from the dominant medical opinion that women’s mental ills could be located in their bodies (168).

Early press accounts reproduced these norms of gender behavior in their claims about lobotomy’s potential to cure, emphasizing women’s aggressive and “animal-like” behavior pre-surgery, and docile, obedient, childlike behavior post-surgery. One story in Newsday describes the behavior of “the meanest woman in the building,” who is characterized pre-lobotomy as a “hopeless case”: “she kicked, shouted and spat at her attendants, stripped off her clothes in the dining room, and required forced feeding by three husky attendants.” Two weeks later, the story reports, the “woman went home—made almost childlike by her operation, but full offriendliness and docility.” She is now a “mild, well-liked woman, completely competent for her limited job” (Burton). The American Weekly calls another woman an “incorrigible criminal… mentally unbalanced” who became a “rational, decent person” after surgery. Lobotomy is said to produce a “natural” emotional state, and the story later describes the woman’s post-operative condition as “much like a little child” (Lal). In a story in the Washington D.C. Times-

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Dr. Baron: Be a good girl and talk to us.
Patient: No.
Dr. Baron: If you are a good girl, and don’t use such bad language, we will talk to you.
Patient: Shut up (152).
Herald, the woman whose case history is used to support the claim that lobotomy produces “amazing results” was “irrational,” “violent,” and “frequently flew into rages” before surgery; she also “couldn’t keep her clothes on” (“Brain Surgery by DC Doctors”). In these case histories, the women’s mental illness has thrust them into an abject state—lobotomy is claimed to restore their subjectivity by restoring their femininity, or in the New York Times’ words, “transform[ing] wild animals into gentle creatures” (Laurence).

One story from the Seattle Post-Intelligencer reported that doctors at Western Washington State Hospital “are watching the unfolding of what gives promise as a medical miracle.” The article explains that lobotomy had been performed on eight women and five men. Four of the men were “cured” enough to go home, yet the story mentions none of them specifically, focusing instead on the changed results in the female patients. Three of the women “came into the operating room in straitjackets. They had to be restrained for fear they would attempt homicide or suicide.” One “cracked up in her sophomore year at college,” suffered from delusions, and “was given to clawing and scratching at hospital attendants because she was suspicious of everyone.” After lobotomy, when asked if she wanted to leave the hospital, she responded “pertly,” “that’s up to the staff and I never debate with the staff.” The article explains that “her suspicion had changed to trust; her anti-social behavior to cooperation.” The second woman, one of the patients who entered the operating room in a straitjacket, was “normal” after surgery, “except that she still refuses to recognize she ever suffered from a mental disease.” And the third, “completely apathetic” before lobotomy, said “brightly” after her operation, “Oh, doctor, I want to do anything you ask. I’m so grateful to you. You’ve done so much for me” (Cohen).
In 1946, the case history of one woman from Michigan (often referred to as “Case 1000”) was the subject of a number of celebratory articles about lobotomy’s potential not just to cure, but also to prevent criminal behavior. The *Time* article “Kill or Cure,” describes Case 1000 as a “nice-looking young woman” who began stealing at the age of four, spent years in reform schools and prisons, “had been thrown out of bordellos for injuring patrons, had hustled outside Army camps, boasted two murders.” The next section of the story, entitled “The New Woman,” explains the changes in her behavior after surgery. The patient is “neat,” “demure,” “polite,” “friendly, cooperative, seriously interested in the future… Previous aggressive sexuality has apparently vanished…” (ellipses in original). This brief article raises a number of questions, beginning with its title, “Kill or Cure”: who is in danger of being killed? The article’s positive tone, and omission of any data about the possibilities of surgical complications suggests that the “or” linking these two terms does not refer to the two possible outcomes of the surgery—the woman is not in danger of being killed or cured by lobotomy. Rather, the choice is between the “cure” of lobotomy, or letting the woman, who had “boasted two murders,” fully realize her homicidal potential. The article suggests that in addition to a reduction in aggression, the woman’s sexual urges have also been curbed. If the

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66 For other stories about Case 1000, see Lal and Ruch. In Lal’s story, “Reformed by Brain Surgery,” an illustration of the woman is captioned, “The Young Woman Wheeled $200 from a Man, Then Tore the Bills Into Bits and Threw Them Away.” After surgery, the story reports, “she is more relaxed… in contrast to her previous defiant attitude, she shows genuine embarrassment about her past conduct.”

67 The use of “New Woman” to describe Case 1000 is a marked contrast with its use to describe the “new woman” of the early feminist movement, who challenged traditional gender roles. Thanks to Susan Squier for this observation.
surgery is successful, her psychiatrist explains to *Time*, the woman’s “abnormal desires” will either disappear or “lie dormant in the brain instead of being expressed in actual behavior.” The conclusion of the article suggests that the operation may have a social application as “a new avenue of attack on sex crimes,” although Case 1000’s sex crime, as *Time* implies, seems to be only a history of prostitution.

Although the majority of specific case histories cited as evidence for lobotomy’s power to cure were women, case histories of men also sometimes appeared in support of this claim. Like women, the effects of lobotomy were explicitly tied to the restoration of gender roles. One 1953 story from the *Los Angeles Times* claims in its headline that “Brain Surgery is Seen As Aid for Christine,” a reference to Christine Jorgensen, who received national attention after seeking gender reassignment surgery in Sweden in 1952. Walter Freeman, asked if lobotomy might have “helped” Jorgensen, commented, “I'm not positive about Christine… but 1500 operations performed under my direction indicates the operation has a good chance to cure people of abnormal behavior. It should be of value in restraining men from their drive to dress in women's clothes” (Barton A1).

Although the article admits that lobotomy may not be a “sure cure” for “abnormal” sexual behavior, it unequivocally “doesn't destroy the normal sex drive.” The article continues by providing a brief case history of another of Freeman’s male patients:

a business executive who, because of trouble with his wife, fired six shots into his head. He survived and the operation was performed. At first this patient was very disagreeable. But he divorced his wife. After that he received several promotions, the last of the presidency of an oil company (A1).
At no point does this story mention anything about the man’s mental illness. His attempted suicide is attributed to marital discord, not to underlying psychopathology. This is no “wild creature,” but rather a creature tamed and driven to suicide by marriage. Oddly, the patient’s choice to divorce his wife (framed here as a unilateral decision) seems to be the precipitating factor in his eventual success – almost more so than the lobotomy, which made the patient “very disagreeable” at first. In this story, the breakup of the man's marriage is seen as a positive effect. The man not only “recovers” from his bad marriage, but, with the help of a lobotomy, becomes the paragon of financial success.

“Miracles in Brain Surgery,” which ran in the magazine *American Weekly* in 1946, also features a man as its primary case. Unlike the representations of women described above, and in keeping with the unhappily married man from the previous story, the man of the story is not described as mentally ill. He’s a “shy mousy bookkeeper” who is “the butt of office jokes” (Lal). After lobotomy, like the man in the previous example, the bookkeeper transforms into “a Gregarious Hail-Fellow-Well-Met Type, Who Could Sell Anything to Anybody,” and later becomes “president of the company.” The “pathology” represented in the “Miracles” case history is not the abject insanity represented in women’s case histories; rather, the man’s only infirmity appears to be a chronic case of shyness and, as the illustration suggests, an emasculated position at the office. Lobotomy has the power to restore the bookkeeper’s masculinity, and the erect cigar in his hand in the “after” illustration suggests that it has been restored indeed.

68 It is possible that the man represented in “Miracles” and the man represented the Christine Jorgensen story may be the same case, even though they’re seven years apart. However, the “Miracles” story mentions nothing about a suicide attempt, nor makes any comment about the man’s marital status.
The illustration accompanying the story speaks of a second miracle. In the “before” illustration, we see the office’s prankster secretary, who has pinned a “kick me” sign to the bookkeeper’s back. After lobotomy, this same secretary sits demurely, legs crossed, taking notes at the command of the newly “gregarious” company president. The real miracle of lobotomy in this article is that it has the power to render an aggressive woman docile—even though the operation was performed on someone else! As if to solidify this point, “Miracles” features a diagram of the brain for the audience’s neurological education; however, it is not the mousy bookkeeper’s brain that we see. The diagram is perched inside the head of what looks to be the prankster secretary.

As Fahnestock suggests, positive stories like these drew on both the application and wonder appeals demanded of science writing for the public. Framed as a certain cure for mental illness of all kinds, lobotomy would certainly have appealed to a public concerned with the swelling numbers of asylum residents who, it was well known, lived in dreadful conditions: “the shame of the states.” Lobotomy would have inspired wonder as the first surgery of its kind; in addition, it seems that the surgical restoration of imbalanced gender roles was a major “miracle” of the “miracle cure.”

In the early 1950s, however, the media’s claims about lobotomy’s value began to change. One reason for the shift, according to Diefenbach, may have been the increasingly “balanced” style of reporting that more accurately represented dissent about the operation from within the medical community. Another factor may have been the highly publicized shift in operational technique that happened around 1950: Walter

69 See Deutsch. Deutsch’s incendiary The Shame of the States (1948) was only one of many exposés about the inhumane conditions at state hospitals that appeared every few years in American media. That these exposés continue to this day is shameful indeed.
Freeman’s development of transorbital lobotomy, which he promoted in state hospitals across the country. Few stories about transorbital lobotomy were able to resist the sensational lure of the “icepick” descriptor. If positive stories about lobotomy lauded the triumph of biomedical technology, the brutal image of a psychiatrist hammering an ice pick through a patient’s eye socket may have inspired horror, not wonder.

As I suggested in the previous chapter, however, the connection of lobotomy to communism in the early 1950s shifted the individual personality from a medical concern to a political concern. If we look closely at the case histories used in these later stories—which were, admittedly, fewer in number—we see an interesting shift in evidence that accompanied the shift in claim. First, as I’ve mentioned, men’s case histories were used more frequently than women’s case histories. Second, we see a related shift: if lobotomy was praised in earlier stories for its restoration of traditional gender roles, lobotomy was blamed in later stories for their reversal. If lobotomy was praised for transforming wild, animal-like women into gentle children and transforming hen-pecked, emasculated men into assertive titans of industry, negative stories of lobotomy switched the characters in these narratives. Women show up less frequently in these stories, replaced by men, formerly independent, intelligent, “normal” citizens transformed by the operation to criminals or worse—into dependent, docile children. This second characterization found echoes in political concerns about a perceived decline in masculinity in the 1950s, a phenomenon that, following historian K.A. Cuordileone, I argue was articulated with many of the Cold War anxieties I discussed in the previous chapter. If, as Braslow suggests, men had not begun to receive the operation in greater numbers, the choice and interpretation of these case histories served a rhetorical effect.
“A Different Human Being Forever”

Unlike the cure stories, what we might call the “failure” stories of lobotomy were fewer in number and featured far fewer case histories. In the instances when case histories were used to illustrate lobotomy’s failure, however, they tended to be case histories of men. Positive stories about lobotomy emphasized the surgery’s ability to make docile women out of “wild creatures”; negative stories, in contrast, emphasized lobotomy’s role in exacerbating violent or criminal behavior, framing one of the surgery’s failures as a threat to public safety. In other instances, case histories emphasized lobotomy’s dangerous potential to transform men into docile children. In cure stories that featured women, a patient’s docility was evidence that the operation had been a success; in men, the production of docility was used as evidence of its failure, a claim empowered by a climate in which both masculinity and the individual personality were perceived to be under threat.

In 1952, a story about a man named Millard Wright attracted the attention of national news media. Like Case 1000, the woman who had been reformed by lobotomy, Wright submitted to the operation in order to “cure” his criminal tendencies—specifically, burglary. Notably, although “Case 1000” was referred to by gender in

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70 In one of the only negative stories that used an example of a woman, lobotomy is said to produce the opposite behavioral effect claimed of it in the cure stories. In a story about lobotomy from the Chicago Daily Tribune in 1956, psychiatrist “Dr. Bailey reported that he was ‘frankly appalled,’ by the results of a surgical procedure called lobotomy, in which a dull knife is employed to sever nerve pathways in the front part of the brain… After a lobotomy had been performed on one of his patients, the woman turned to her husband “and launched into a tirade so filthy that it would have made a sailor blush”’ (Gibbons 5).
headlines, Wright was identified only as “burglar” and “thief.” After receiving the surgery, the Chicago *Daily Tribune* reported, Wright married and found employment. “Police assumed that the surgery had made him a good citizen until a routine pawnshop check,” the article explains, until it was discovered that Wright had begun to steal again—at a greater scale than before. As he awaited trial, Wright hanged himself. “I am sentencing myself to death for my evil deeds,” Wright confessed in a suicide note, “I die in sincere sorrow.” In addition, the story reports, Wright had also composed a letter to his former surgeon, in which he “begged his forgiveness for ‘reverting to crime’” (“Surgery ‘Cure’ Fails”). In the case of Millard Wright, lobotomy is characterized not only as a threat to the individual patient, but by exacerbating his criminal behavior, lobotomy became an issue of public safety as well.

A 1953 *Newsday* story was also skeptical of lobotomy’s promise as a miracle cure. The story begins by detailing the story of a lobotomy success (a woman), whose aggressive tendencies were “cured” by lobotomy. She emerged from the operation “full of friendliness and docility,” and was gainfully (and “modestly”) employed as a telephone switchboard operator. In the next paragraph, however, the story takes a turn: “That is a pleasant story, conjuring up visions of a medical miracle, but the results are not always so pleasant.” The subject of the article’s title, “How to Prevent a Murder (Sometimes)” is the case of Theodore A. Trent-Lyon, a lobotomy patient who killed his former psychiatrist, Lewis Thorne. In contrast with the abject, “wild” women of the cure stories, Trent-Lyon is described before the operation as a “brilliant student” at the Harvard Divinity School, who was elected president of the student body before becoming mentally ill. Lobotomy was performed in order “to remove his aggressive drives—which
is what the operation is supposed to do. It didn’t.” After receiving his surgery, Trent-Lyon made a list of people to kill, with his former psychiatrist at the top. During the trial, Trent-Lyon was found “criminally insane, and he has been committed to another state hospital for the rest of his life.” Like Millard Wright, lobotomy not only failed Trent-Lyon by making his condition worse, it also subjected the public to a post-surgical homicidal rampage.

The next paragraph indicates that many psychiatrists currently disapprove of the operation; they “protest that too little is known about the brain to permit promiscuous surgery go on there.” The story then quotes a “noted” psychoanalyst, who bluntly states that lobotomy “cures nothing.” After lobotomy, the best a patient can hope for is to emerge “unambitious, unimaginative, shallow and lethargic, much like a child” which, in the case of the “meanest woman in the building,” is cause to consider the operation a “medical miracle.” In a strange turn, however, the Newsday article concludes with the story of a man whose aggressive and violent tendencies were abated by lobotomy, but whose case is still considered a failure.

Violent before the operation, [the patient] became an amiable idiot afterward, dissipating the family’s modest fortune on Canadian gold stocks, phony oil wells, and flowers for his friends. He is as happy as a clam, and can’t say too many nice things about the pre-frontal lobotomy. The family is now wondering if there isn’t some way to sew his brain back together and make him into the same old violent Pa they used to visit at the State Hospital (66).

In a letter to his surgeon cited by the article, Violent Pa’s son writes, “frankly, I know no way to cause the deterioration of a whole family more effectively than through a pre-
frontal lobotomy” (66). In this article, lobotomy not only is characterized as a threat to public safety, illustrated by the homicidal Trent-Lyon, but in the case of “violent Pa”, lobotomy is explicitly figured as a threat to the patriarchal family structure, as a father (even a violent, institutionalized father) is replaced by an irresponsible child.71 “Literally,” the story explains, “lobotomy is a surgically-induced childhood” (66).

In 1951, the *Saturday Evening Post* published a feature story by Irving Wallace entitled “The Operation of Last Resort” which, considering the circulation and national audience, would have been read by an impressive number of Americans. Interestingly, only five years prior, the *Post* had published Waldemar Kaempffert’s glowing article about lobotomy, “Turning the Mind Inside Out,” which featured pictures of Freeman and Watts and mentioned the pair by name (see footnote 63). While “The Operation of Last Resort” reflects the man-into-child concerns raised by the previous article, it also positions the implications of lobotomy’s personality change as a much more ominous threat.

Wallace’s article focuses entirely on the case history of “Larry Kennedy,” a former patient of Freeman and Watts. Unlike the early cure stories, which provided little information about patients unrelated to their illness and surgery, Wallace’s story

71 A 1953 story in the *Los Angeles Times* also comments on the downside of a patient’s reversion to “childlike” behavior. The negative tone is reflected in the article’s qualified title: “Operation May Help Mentally Deranged.” Although the article uses no specific case histories, they do refer to the limitations of the operation in men, specifically: “no man such as a dentist, physician, writer or musician, who works with his brain, and has to meet the public…is likely to get back to work after a lobotomy. The operation does such harm to the fore part of the brain so that, after it, a man’s abilities to create, to use good judgment, and to get along easily with people are likely to be impaired” (Alvarez 8).
describes Kennedy’s condition in great detail before the procedure. Before lobotomy, Kennedy is described much like Trent-Lyon: a man of privilege and Ivy-league education who spiraled into suicidal depression after entering Princeton (attributed, by one family member, to Kennedy’s discovery of Schopenhauer). Creative and “brilliant,” with an IQ over 150, Kennedy was in the “near genius category” who finished in the top ten of his class and then worked as a writer until drafted into the army (“officer material”) in 1942 (79). Wallace spends half of the article detailing Larry’s descent into depression; however, unlike the brief case histories of the women I’ve described above, abjected to a point where the audience cannot possibly identify with them, Larry Kennedy is painted as a sympathetic, multi-dimensional character, a stylistic move that only serves to amplify his personality change after the operation.

The operation, Wallace explains, “unquestionably” made Larry happier, but his happiness, like that of Violent Pa’s, came at a price. Like many lobotomy patients, he gained weight: “his face is round, young, cherubic, and he’s getting plump around the middle.” His depression subsided, replaced with a “carefree” and “happy-go-lucky” attitude. While Wallace reports that Larry retained most of his cognitive capacity, his now “dulled” brilliance was “erratically mixed with terrible streaks of childishness,” an effect presumably enhanced by his now-cherubic face. Lobotomy “badly scrambled” Larry’s memory, but he still remembered all of his friends and relatives, “though without much depth of feeling toward them one way or another.” “People who meet him for the first time,” Wallace writes, “always accept him as a perfectly normal citizen. They regard him as intelligent, jovial, though somewhat egotistical and impatient.” However,
“after they meet him a second or third time, they begin to suspect something is wrong with him…” (94).

The article also builds the audience’s identification with Kennedy’s family, particularly his brother Jack, who authorized the operation. The decision to lobotomize the violent, over-sexualized women seems to be no decision at all; we do not hear from their families, only from their physicians. In contrast, the audience agonizes with Jack over the choice to lobotomize his brilliant brother. As Larry is wheeled into the operating room, we hear Jack’s inner conflict about his decision:

_I will never see him again as I’ve known and loved him all my life. He will soon be returned from that room, the same name, the same face, the same body, but a different human being forever, for the rest of his life and ours_ (90 italics in original).

To secure our identification, Wallace asks his audience to stand in Jack’s place in the final lines of the article:

About this time on Saturday nights, Jack is always tired, and he reaches up to turn off the lamp. He walks through the darkened house to his room, with Larry’s heavy breathing following him. Were they right or wrong about Larry? Jack will never know. Anyway, it’s a helluva thing to answer at two o’clock in the morning.

After all, Jack asks, ‘What would you have done?’ (95).

“The Operation of Last Resort” reads much like the pulp novels and sentimental films Larry has traded for Schopenhauer after his surgery, and the melodramatic last line calls out for our sympathy—for Larry, for Jack, for the gut-wrenching decision that has
changed his brother’s personality forever. After opening his eyes, Larry whispers to his brother, “Who am I?”—a question that Jack is unable to answer. Larry has retained some of his old personality, Jack remarks, but he is a “different human being forever” (94).

Finally, we learn that although Kennedy’s intelligence seems only mildly impaired by the operation, he has nonetheless lost something crucial: his ability to form a reasoned opinion. Before the operation, Larry would not “[express] an opinion until he’d read all sides of a subject, and even then he’d always say he wasn’t sure.” After the operation, “in arguments with other patients, he forms flash opinions from glancing at a headline and is extremely dogmatic” (93). Later in the article, patients who have undergone lobotomy are said to “make up their minds too quickly and to enunciate opinions without considering the various implications” (95). Before lobotomy, Larry Kennedy is described, despite his bout with depression, as a “perfectly normal citizen” (93); after the operation, he is childlike, uncreative, irrational, and unable to form an independent opinion. As the result of lobotomy, Larry Kennedy becomes wholly dependent on his family and also is stripped of the cognitive faculties that would allow him to participate fully in democratic life.

Toward the end of the article, a Dr. Stanley D. Porteus imagines a nightmare future which lobotomy is applied on a mass scale: “Undoubtedly, if everyone in the world were to be simultaneously lobotomized, it would spell the end of all progress. Industry, except at the simplest levels, would cease. A population of cheerful drones could hardly carry on the complex business of modern living” (95). In this scenario, concerns about the individual patient disappear. The concern about lobotomy is not whether it is effective as a cure; rather, what concerns Wallace is what this cure means.
when measured against the American God-Terms of autonomy, individualism, and progress. While Porteus’s critique may have been hyperbolic, it is worth comparing his nightmare vision of mass lobotomy with a short article one year later in *Time*, entitled “Mass Lobotomies.”

The article is an unflattering description of Walter Freeman’s promotion of transorbital lobotomy across the nation’s state hospitals.72 Under a picture of Freeman, the caption reads: “Icepicks in the eye sockets.” The article explains, “many doctors still doubt the wisdom of Dr. Freeman’s surgery. ‘Lobotomy,’ explained one psychiatrist last week, ‘is an operation of deduction rather than addition.’ It does irreparable damage to that part of the brain which is believed to control reason and judgment.” In one small point in its favor, the article admits, lobotomy may release a number of patients from hospitals, which is Freeman’s “main objective”:

But for the rest of the patients, and even those who are discharged from the hospital, the operation may be too ‘successful.’ Free from anxiety, they may become, instead, irresponsible, tactless, indolent. They will probably have trouble making up their minds… Worse than that, some may regress into placid animals, helpless for the rest of their lives (87).

Twenty years prior, transforming patients “from wild animals to gentle creatures” was interpreted as a benefit of the operation in stories that featured women as the primary

72 An article a year later commented that Freeman, “as the father of psychosurgery in the U.S. … bears a heavy burden of responsibility, both medical and moral.” Lobotomy in this article is described as “drastic,” “hotly debated,” with “hazards” for the patient. Freeman is described as a “devotee” of transorbital lobotomy, having “fallen completely out of love with the prefrontal lobotomy…” (“Looking Backward” 46).
examples. In the early 1950s, the fact that patients may “regress into placid animals” is characterized as lobotomy’s worst possible outcome.

Why might men’s case histories have been used more frequently in these later stories? In an analysis of the gendered rhetoric of Cold War politics, historian K.A. Cuordileone suggests that anticommunist anxieties were intimately bound up with a perceived crisis in masculinity that began to surface in publications lamenting the “decline of the American male”:

American males had become the victims of a smothering, overpowering, suspiciously collectivist mass society—a society that had smashed the once-autonomous male self, elevated women to a position of power in the home, and doomed men to a slavish conformity not wholly unlike that experienced by men living under Communist rule (523).

The subsumption of the individual into the mass was a recurring theme in anti-communist anxieties, suggests Cuordileone, reflected in popular books like Arthur Schlesinger’s famous polemic The Vital Center, which called for a liberal politics that would resist the seductive lure of communism while standing firm against charges of anticommunism from the right, a work that Cuordileone argues is suffused with gendered imagery.73 One of the chief characteristics of totalitarian societies, Schlesinger maintained, was the erasure of the individual in favor of the mass. In fact, he writes, “the whole thrust of totalitarian indoctrination is to destroy the boundaries of the individual personality” (Schlesinger 55). The boundaries of the individual served as a synecdoche for the country’s own borders; protecting the sanctity of the individual thus became more than

73 See also May (10-11).
just a medical concern—it also became a matter of national security. In an American postwar political climate in which masculinity and the individual personality were perceived as under double threat, an operation like lobotomy, an operation that surgically entered the body of its patient in order to induce childlike dependence, docility, and decreased critical capacity took on a very different meaning than it had before the Cold War.

Press stories about lobotomy’s medical efficacy did not simply reflect medical practice or medical controversy about the operation, but also made claims about the operation’s worth enabled by the interpretation of lobotomy’s personality-changing effects within different discourses of value. In early stories, epideictic claims about lobotomy’s potential as miracle cure were supported by emphasizing the operation’s production of docility in its female patients and to a lesser extent, lobotomy’s production of assertiveness in its male patients. In these positive stories, lobotomy was celebrated for restoring its patients to traditional norms of gender behavior. Norms of gendered behavior had not changed by the early 1950s—in fact, anxiety over traditional gender roles was heightened during this time (Cuordileone; May). As the meaning of lobotomy began to change in the American public imagination during the early years of the Cold War, however, the rhetorical situation in which press stories evaluated lobotomy also began to change. The trend in negative stories was to use case histories of men rather than case histories of women, and to emphasize the transformation of men into public enemies, or even worse, according to some of the stories, the transformation of men into docile children. The relationship between medicine and the media is not just a matter of “accurate” or “inaccurate” reporting on medical practice, as the Diefenbach study
suggests. By looking closely at the rhetoric of press stories about lobotomy, it becomes clear that the popular press’s coverage of lobotomy, as well as the cure and failure it claimed, found meaning and value within a complex network of historically and culturally situated discourses.
Words which formerly were simple terms become slogans; sentences which once were simple statements become calls to battle. They no longer influence the mind through their logical meaning—indeed, they often act against it—but rather they acquire magical power and exert a mental influence simply by being used.

Ludwik Fleck, *Genesis and Development of a Scientific Fact*

Jesus, didn’t they think it might do some damage?  
Didn’t the public raise Cain about it?

Randle P. McMurphy, in *One Flew Over the Cuckoo’s Nest*

In 1972, shortly before he died, Walter Freeman wrote a letter to the *American Journal of Psychiatry* in what seems to be an attempt to rewrite his legacy. Freeman wrote that the majority of his patients were “aging in comfort and decency”: some were married, some had children and grandchildren, some were professional men and women who had returned “competently” to their careers after surgery. Freeman claimed three major successes for the operation he had promoted for nearly four decades: “lobotomy relieves suffering,” “lobotomy gets them home” and “lobotomy relieves wear and tear” (1315). Despite these descriptions of success, Freeman admitted that some of his past surgeries had failed. Freeman attributed these failures not to the operation, but to “a poor
choice of patients” on the part of surgeons and “incisions into the frontal lobes that were too extensive and erratic.” The lobotomy failures that “continued to accumulate in the hospitals” cast a pall on the procedure and “a wave of pessimism set in.” Yet the era of lobotomy had not ended, Freeman added hopefully, it was just in “limbo” (1315).

While lobotomy had been abandoned almost entirely by the time Freeman wrote this letter, in the late 1960s, the general practice of psychosurgery began to emerge once again, bolstered by theoretical developments in neurobiology and innovations in surgical technique and technologies. Unlike lobotomy, which was celebrated as a cure for mental illness for nearly fifteen years after its introduction, the new psychosurgeries of the late 1960s and early 1970s were met almost immediately by public controversy. Negative representations of psychiatric technology in popular fiction like One Flew Over the Cuckoo’s Nest, The Terminal Man, and A Clockwork Orange combined with press stories about programs of experimental prison psychosurgery, and fomented public concern that psychosurgery could be used (or was currently in use) as a method of social control. At the forefront of the controversy was psychiatrist Peter Breggin, who undertook a public campaign to eradicate the practice of psychosurgery in the United States, an effort that contributed to state and federal investigations, Senate hearings and a five-year comprehensive study of psychosurgery by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.

Peter Breggin is a fascinating figure. Trained as a psychiatrist at Case Western Reserve University, Breggin has been an outspoken critic of biological psychiatry for nearly forty years, taking somatic treatments like psychopharmacology, electroshock therapy, and psychosurgery as his biggest targets. Despite his prominence in the
campaign against psychosurgery in the 1970s, Breggin is notably absent in most histories of psychosurgery, with the exception of a brief reference in Jack El-Hai’s biography of Walter Freeman (341). I suspect that Breggin’s absence in these histories is not due to his unimportance, but reflects his current status in the field of psychiatry. Breggin is a notorious gadfly to the biologically oriented psychiatric community—his recent book titles include *Talking Back to Prozac*, *Brain-Disabling Therapies*, *Toxic Psychiatry* and *Your Drug May be Your Problem*. Breggin’s hostility to biological psychiatry has led some of his prominent colleagues to label him a “flat-earther,” an “outlaw,” and a “pariah” (Gorman). Breggin’s case for professional legitimacy is not helped by the fact that he once had ties with the Church of Scientology or that he appears in public forums like *Oprah*. The profession simply doesn’t take him seriously. When in conversation with one psychiatrist, I casually mentioned that I was writing a chapter on Peter Breggin. He laughed.

Even if these aspects might devalue Breggin’s work as a scientist or physician in the eyes of the profession, they do not change the fact that he has been tremendously effective at getting people to listen to him. Breggin’s participation in the psychosurgery controversy helped to spark a national conversation about the ethics of psychiatric intervention that took place in popular and medical media and even in the halls of Congress, and for this reason he is worth our critical attention.

I begin this chapter by first placing the psychosurgery controversy of the 1970s in context, detailing some of the changes in surgical technique and technology that were the hallmarks of the new psychosurgeries, in addition to theoretical developments in neurophysiology that shifted the attention of psychosurgery from the frontal lobes to the
limbic system. I then briefly describe how these biomedical developments became articulated with social and political issues. The second section of the chapter explores Peter Breggin’s role in this controversy, and specifically his frequent argument that “lobotomy” had returned. I argue in this section that Breggin’s assertion that “the lobotomy has returned” did not rely on a medical definition of lobotomy, but a troped association between “lobotomy” and its behavioral effects. The chapter concludes by considering the role of public discourse in the controversy over psychosurgery, as well as the implications of Breggin’s arguments for contemporary psychiatric practice. The controversy over psychosurgery in the 1970s was not just a struggle over a surgical practice, I argue, but a struggle over the meaning of that practice enabled by public understanding of lobotomy’s history and its articulation with contemporaneous social concerns.

New Technologies, New Controversies

Although psychopharmacology had become the dominant treatment option for biologically-oriented psychiatrists by the mid twentieth century, in the late 1960s, some psychiatrists and neurologists began experimenting once again with psychosurgery—although on a much smaller scale than the lobotomy era. Supported by developments in neurophysiology and neurosurgical technique, instrumentation, and technology, the new psychosurgeries were different from lobotomy in a number of ways.

First, new developments in surgical technique resulted in greater precision. Prefrontal and transorbital lobotomy were performed by blindly inserting a leucotome
through both gray and white matter of the brain, damaging much tissue en route to the
connecting fibers between the thalamus and the frontal lobes. Early psychosurgeons
plotted their incisions through the logic of anatomical norms, using areas of the skull as
external landmarks that corresponded to the location of internal structures. Although
most human brains are laid out in roughly the same way, they vary in shape and size.
And so, in addition to their numerous other drawbacks, the lobotomies of Freeman and
Watts’ day relied on an imprecise surgical method with drastic effects of
miscalculation—severing arteries was only one of the many potentially fatal risks of the
operation. In contrast, stereotaxy, a technique that came to dominate neurosurgery in the
1960s, relied on a three-dimensional system of coordinates and internal, rather than
external landmarks. Surgeons used a large metal frame that wrapped around the skull,
electrodes, and periodically revised “atlases” to plot brain structures in three dimensional
relation to internal rather than external points of reference (Gildenberg 1). This technique
relied on the same “landmark” logic of anatomical norms; however, ventriculography,
developments in electroencephelography (EEG), and computerized tomography (CT 
scans) eventually allowed surgeons to “see” the individual brain upon which they
worked, improving their ability to locate and target a particular area in the brain.74

74 Catherine Waldby describes the function of this increasing technologized vision of the body:
“each of these technologies transluminate the body in some way, open it to the incursion and
projection of light or some other radiant spectra, so that its tissues become readable and
interpretable as projected images, traces on a page or a screen. Each technical innovation seeks to
correct the ‘deficiencies’ of the kind of vision it replaces—the CT scan, by making a depthless
optical ‘cut’ through the body’s tissues it seeks to correct the superimpositions found in the
radiograph, for example” (25). The current practice of functional magnetic resonance imaging
(fMRI) seeks to improve upon magnetic resonance imaging (MRI) by injecting it with a kind of
A number of surgical instruments also were invented to make the ablation of brain
tissue less traumatic: although some surgeons still used Moniz’s leucotome, it quickly fell
from their favor as new techniques such as localized injections of alcohol and liquid
nitrogen, focused ultrasound beams, high-frequency sine wave generators, and various
techniques of irradiation (like the “gamma knife”) were introduced to surgical practice
(Gildenberg 5-6). In addition, some surgeons began to abandon tissue destruction
altogether in favor of the implantation of electrodes, which were used first to identify the
location of neurological function, and then to stimulate particular areas.

Perhaps the most interesting feature of the new psychosurgeries, however, was
that they targeted different areas of the brain. Lobotomy, if you recall from the second
chapter, targeted the connecting fibers between the frontal lobes and the thalamus. Most
of the newer psychosurgeries, in contrast, targeted areas of the limbic system: the
thalamus, cingulum, hippocampus, hypothalamus, and the amygdala, structures nearest to
the brain stem.\footnote{According to Ernst Haeckel’s now discredited theory that ontogeny recapitulates phylogeny, the limbic system is often referred to as the “oldest” part of the human brain. This is the area of the brain that develops first in the fetus, and the patterns of development roughly follow evolution from “lower” to “higher” animal life forms. For more on the history of Haeckel’s theory and the subsequent scientific and political controversies it provoked, see Gould.} The limbic system figures prominently in neurobiological theories of
emotion and thus is sometimes referred to as the “emotional brain.” In the late 1960s,
some prominent neuroscientists drew on theories of limbic system function in order to
argue that this area of the brain was not only the locus of emotional behavior, but violent
behavior as well—a claim with profound social and political implications.

vitality and color worthy of its organic subject matter. It is Oz to the black and white Kansas of
MRI and CT scanning. For more on fMRI and “biological personhood,” see Joseph Dumit.

\footnote{According to Ernst Haeckel’s now discredited theory that ontogeny recapitulates phylogeny, the limbic system is often referred to as the “oldest” part of the human brain. This is the area of the brain that develops first in the fetus, and the patterns of development roughly follow evolution from “lower” to “higher” animal life forms. For more on the history of Haeckel’s theory and the subsequent scientific and political controversies it provoked, see Gould.}
In the wake of a number of political assassinations, riots, and a perceived rise in “senseless” acts of violence, American public concern about violence was at a frenetic pitch in the late 1960s and early 1970s. In 1970, for example, Edward Kennedy identified violent crime as one of the biggest issues facing America, calling “the threat of the criminal…[a threat] that all of us feel directly and daily. It is a threat that we all sense is growing. It is one that we all as individuals feel powerless to deal with, a disease beyond our control, an infection which we cannot really protect ourselves against” (*A People* 23).\(^76\) Kennedy’s description of crime as a “disease” became more than a metaphor in the late 1960s, as research into the etiology of violence flourished not only in social sciences like sociology, psychology and criminology but also in biomedical sciences like neurology and psychiatry. Claims about the biological underpinnings of criminal and/or violent behavior were not new. In the 19th century, for example, Cesare Lombroso developed an intricate taxonomy of anthropological criminality based in part on the criminal’s body. Unlike Lombroso’s system of physiognomic identification of the “born criminal” (which included such “criminal” embodiments as facial asymmetry, broad jaw line, and dark hair) the detection of criminality in the 1960s was directed inside, rather than outside, the skull.\(^77\)

One major event that connected violent behavior to organic brain pathology was the case of Charles Taylor Whitman, who, after killing his wife and mother, shot and killed 14 people from the clock tower at the University of Texas in 1966. After the

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\(^76\) See also Kennedy, *Decisions for a Decade* (81-99).

\(^77\) See Lombroso and Lombroso-Ferrero. For more on contemporary biological criminology, specifically the use of genetics in identifying the “born criminal,” see Rose.
murders, authorities found a suicide note in which Whitman complained that he had been a “victim” of persistent, violent thoughts in the months leading up to his suicide. “After my death,” Whitman directed, “I wish that an autopsy would be performed on me to see if there is any visible physical disorder. I have had some tremendous headaches in the past and have consumed two large bottles of Excedrin in the past three months” (“Suicide Note”). Texas governor John Connally convened a massive team of psychiatrists and neuroscientists to find an explanation for Whitman’s mass murder. After the autopsy, it was reported that a malignant tumor had been found close to Whitman’s hypothalamus. The grand jury hearings convened after the shootings concluded that the tumor in Whitman’s brain “undoubtedly caused him much mental pain and possibly contributed to his insane actions” (“Can a Tumor?” 155).

In their 1970 book Violence and the Brain, psychiatrist Frank Ervin and neurosurgeon Vernon Mark suggested that Whitman’s horrific act was a “preventable public catastrophe” that might have been prevented had he received a “routine” scan of his brain. Ervin and Mark also identified other high-profile murderers such as Richard Speck (who killed eight nurses in Chicago in 1966) and Lee Harvey Oswald as violent individuals whose “eventual murders could have been predicted” if their brains had been examined (148). Violence and the Brain took aim at theories that attributed violence to social causes such as poverty or discrimination, or as the result of insufficient police work, arguing that neither of these explanations made a “serious effort to understand or treat the violence-prone individual” (xi).

In 1966, Ervin and Mark, with colleague William Sweet, published a letter in the American Journal of Psychiatry that made a similar argument about the need to study the
“violent-prone individual.” The racially charged example used to frame their proposition was the recent spate of “urban” riots, which may have originated not just in “poverty, unemployment, slum housing, and inadequate education,” but also may have been the result of “brain disease.” To attribute the riots solely to social causes, they wrote, “is to overlook some of the newer medical evidence about the personal aspects of violent behavior.” Although they admitted that the “urban rioter” did not have a “monopoly on violence,” “the real lesson of urban rioting is that, besides the need to study the social fabric that creates the riot atmosphere, we need intensive research and clinical studies of the individuals committing the violence.” The point of the research would be to “pinpoint, diagnose, and treat those people with low violence thresholds before they contribute to further tragedies” (895). While the claim that violence might be located in the brain was itself a controversial assertion, the racial overtones of the JAMA letter and Mark and Ervin’s later prescription of psychosurgery for “brain diseased” people rightly alarmed a great many people, particularly because their research had received federal funding (158-9).78

Mark and Ervin’s research might have remained a small blip on the public radar if it wasn’t for Frank Ervin’s former medical student, Michael Crichton, who fictionalized their research in his second bestselling novel, The Terminal Man (1972). In the novel, Harry Benson, a patient with psychomotor epilepsy, is subjected to psychosurgery, specifically, electrode stimulation, to treat his aggressive behavior. Rather than “cure”

78 Ervin was later sued for medical malpractice in 1979 by the mother of one of the patients whose case was discussed in Violence in the Brain. See Dietz. For more on the racial implications of Ervin and Mark’s theories, see Mason, who asked in 1973 if psychosurgery was a “new threat to blacks?”
his violence, the electrodes stimulate his brain at a faster and faster rate until Benson goes on an uncontrollable killing spree. Crichton drew material for his book directly from the research of his former professor—the book’s surgeon, John Ellis, even cites the three examples of Whitman, Speck and Oswald in his explanation of the biological basis of violence (248). To emphasize the timeliness of his novel, Crichton included an author’s note and a bibliography in order to make sure his audience knew that *The Terminal Man* was not a futuristic work of science fiction, but a commentary on the present state of biomedical affairs:

> Research in neurobiology is spectacular enough to appear regularly in Sunday supplements. But the public has never really taken it seriously. There has been so much ominous talk and so much frivolous speculation for so many years that the public now regards “mind control” as a problem removed to the distant future: it might happen, but not soon, and not in a way that would affect anyone alive (xv).

Provoked by novels like *The Terminal Man* and *A Clockwork Orange*, public concern that psychosurgery might be used as a form social control was heightened even further when a story broke that three inmates in a California prison had received psychosurgery to “treat” their aggressive behavior (Valenstein 287; Aarons). Shortly thereafter, another story hit the press about a program in Michigan that proposed to surgically “rehabilitate” sexual offenders incarcerated in an institution for the criminally insane. Although “John Doe,” the initial patient in the study, consented to the experimental procedure, a lawsuit on his behalf was filed by civil rights attorney Gabe Kaimowitz against the Michigan
Department of Mental Health. Kaimowitz argued that the prisoner’s incarcerated status made him incapable of providing informed consent:

a state-held inmate can hardly decide when to go to the bathroom, much less go for a walk or exercise rights of protest while under state control. How then can a prisoner voluntarily, knowingly, and competently consent to participate a subject in a state-financed and -directed research to permanently alter his behavior?

(Kaimowitz 511).

The circuit judges in Michigan agreed with Kaimowitz, concluding “involuntarily detained mental patients cannot give informed and adequate consent to experimental psychosurgical operations on the brain” (qtd. in Shuman 443). Strikingly, in the middle of the trial, “John Doe” changed his mind about the surgery that would have irreversibly changed his mind (Salpukass).

One of the experts brought in to testify in Kaimowitz v. Department of Mental Health was psychiatrist Peter Breggin. Although relatively young, having received his M.D. in 1962, Breggin had made waves in his field by allying himself with what is now called “anti-psychiatry” movement. The term “anti-psychiatry” is “imprecise and often more confusing than revealing,” comments historian Norman Dain; it joins together disparate figures, ideas, and arguments under a broad umbrella (415). Although psychiatry has faced opposition from a number of different fronts, and for a host of disparate reasons, anti-psychiatry activists of the 1960s were “primarily interested in the power and influence wielded by the psychiatric profession, not only over the mentally ill but over society as a whole” (Dain 416). Psychiatrist Thomas Szasz, for example, a

79 Kaimowitz later wrote that when he first learned of the program in Michigan, “echoes of Terminal Man began to sound in my head” (516).
prominent voice in the anti-psychiatry movement, described the psychiatrist’s role as a “social engineer or controller of social deviance,” akin to “priest and policeman, arbitrator and judge, parent and warden” (260). In Szasz’s critique, mental illness has no biological substrate, but rather arises out of social conventions that cast certain behaviors as normal and others as pathological. Breggin worked from a similar paradigm, often repeating Szasz’s description of “so-called mental illnesses” in his writing. While Szasz took on the entire profession of psychiatry—both psychoanalysts and biopsychiatrists—with works like The Myth of Mental Illness, Peter Breggin focused his critique on biopsychiatry, and in particular, its somatic methods of treatment. 80

Breggin had his first encounter with biopsychiatry at Metropolitan State Hospital in the mid-1950s, “an old-fashioned snakepit” where he worked as a student volunteer while a freshman at Harvard (Toxic 3). Breggin writes that he became convinced that the hospital’s method of “treating” patients through electroshock therapy, insulin coma and high doses of the new “miracle” drugs were not just brutal to watch, but also ineffective and unnecessary. After becoming a leader in the volunteer program, he convinced the

80 For a rhetorical perspective on Szasz’s theory of mental illness, see Richard Vatz. The early 1970s were also a point of tremendous upheaval with regard to the legitimacy of psychiatry as a medical science. In a famous experiment, psychologist David Rosenhan and eight other healthy “pseudopatients” presented themselves to psychiatrists with vaguely psychotic symptoms and all were diagnosed with schizophrenia. Rosenhan’s experiment, “On Being Sane in Insane Places,” published in Science in 1974, rocked the field of mental health. Rosenhan concluded:

based in part on theoretical and anthropological considerations, but also on philosophical, legal, and therapeutic ones, the view has grown that psychological categorization of mental illness is useless at best and downright harmful, misleading, and pejorative at worst. Psychiatric diagnoses, in this view, are in the minds of observers and are not valid summaries of characteristics displayed by the observed (251).

For a contemporary repeat of Rosenhan’s experiments, see Slater 64-94.
superintendent of the hospital to let him pilot a team of students, who each took charge of one of the “burnt-out schizophrenics,” permanent residents of the back wards, who had been written off by the hospital administration as lost causes. During the year, student volunteers “treated” patients by taking them for walks, talking with them, and having them fitted for false teeth, eyeglasses, and new clothing. They treated them as persons, Breggin writes, rather than patients. At the end of the experiment, 11 of the students’ 14 patients were released from hospital (*Toxic* 5-10).\(^{81}\)

In 1966, after completing his training as a psychiatrist at Case Western Reserve Medical School, Breggin was appointed as a full-time consultant at the National Institute of Mental Health. At that point, he writes,

psychiatry was well on the way toward its wholesale conversion to biochemical and genetic theories and to technological interventions, such as drugs and electroshock. Ironically, the “new psychiatry” was not at all new to me, because it resembled nothing so much as the old state mental hospital psychiatry, where patients were considered biologically and genetically defective and subject to degrading, damaging treatments. Tragically, what was once the psychiatry for the poor—biopsychiatry—was now becoming the psychiatry for everyone (*Toxic* 10).

What Breggin describes is the turf battle between psychoanalysts and biopsychiatrists, a war over professional sovereignty that had been raging since the 1940s. Psychoanalysis famously lost the fight, which culminated in the biological rewriting of the third edition of the Diagnostic and Statistics Manual (DSM) in 1980.\(^{82}\) Breggin refused to ally with

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\(^{81}\) The student’s experience was later published as a book. See Umbrager et. al.

\(^{82}\) For an excellent history of the paradigm shift from psychoanalysis to biopsychiatry that focuses on the development of antidepressants, see Healy. For an analysis of the role of rhetoric in this
either the biopsychiatrists or the psychoanalysts, preferring his own brand of holistic therapy, which stressed care instead of “cure.” In addition to treating patients in private practice, Breggin was active in bringing his concerns about biopsychiatry to public attention: he founded the Center for the Study of Psychiatry, worked with the American Association for the Abolition of Involuntary Mental Hospitalization, The Citizens Committee for Human Rights, and was the founder and director of a group called The Project to Examine Psychiatric Technology, the sole purpose of which was to eradicate surgery from the psychiatric armamentarium.

Breggin’s campaign against psychosurgery began when he noticed an increasing number of references to surgical treatments in the psychiatric literature in the late 1960s. In an effort to collect information, Breggin sent out surveys to practicing psychosurgeons, inquiring about their methods, results, and rates of use. On the basis of these surveys, Breggin estimated that 400-600 psychosurgeries were being performed in the United States each year; even further, he reported with alarm, each of the surgeons reported that their rate of psychosurgery was increasing (“Lobotomies: An Alert” 98). Breggin first tried to mobilize his psychiatric colleagues in order to “stem the ‘second wave’ predicted by the psychosurgeons”; when he brought his concerns to the psychiatric community, however, he found strong resistance, even from psychiatrists who were “personally opposed” to psychosurgery (“Brain-Disabling Therapies”17). Convinced that his medical

shift, see Kirk and Kutchins. For more on the “pendulum” metaphor often used by historians to describe this shift, see Sadowsky.

83 The CCHR was, and continues to be, the political wing of the Church of Scientology’s campaign against psychiatry.
colleagues were neither able nor willing to resist psychosurgery’s “second wave,”
Breggin took the campaign public.

**The Rhetorical Return of Lobotomy**

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 the Congress should demand an immediate halt, to be followed by
an independent investigation into the therapeutic claims of psychosurgery...

Peter Breggin and David Greenberg, “Return of the Lobotomy”

Breggin might have fought against psychosurgery in a number of ways—he might
have continued to lobby psychiatrists and other medical professionals in order to
encourage resistance to psychosurgery from within the profession. He might have
focused his public critique on somatic psychiatry in general, and advocated for the
holistic, noninvasive therapies he believed were more ethical in principle and more
effective in practice. Breggin’s main strategy, however, was to sound a public warning
about psychosurgery in order to “rally many community and political leaders” and to
force intervention into medical practice (“Brain-Disabling Therapies” 468).

Since Breggin’s ultimate goal was to motivate his audience to take action in order
to stop the resurgence of psychosurgery, it was necessary that they shared both his
evaluation of the new surgeries and his sense of urgency that they must be stopped.
However, his public audience would not have been familiar with amygdalotomy
(severing of fibers in the amygdala), thalamotomy (severing of fibers in the thalamus), or bilateral cingulotomy (severing of fibers in the cingulated gyrus). Even the general term “psychosurgery” would have been unfamiliar to many people outside of the medical community. “Lobotomy,” however, would have been immediately recognized by any audience, and it came complete with a value judgment. Lobotomy was doubly damned by the end of the 1960s. It was first burdened with connotations of Communism in the 1950s, as I discussed in the previous chapters; these authoritarian associations were continued in the 1960s by representations of the operation in popular fiction like Suddenly, Last Summer (1958), One Flew Over the Cuckoo’s Nest (1962) and Planet of the Apes (1968) as a punitive, not therapeutic, intervention. In addition, lobotomy was an outmoded medical technology, replaced by the drugs that saturated psychiatric treatment by the late 1950s. In both popular and medical opinion, lobotomy was a thing of the past, consigned to the medical failures bin somewhere between leeches and phrenology machines.

Consider just a few of Breggin’s titles from his media campaign: “Lobotomies are Still Bad Medicine”; “Lobotomies: An Alert”; “The Return of Lobotomy and

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84 The use of lobotomy in Planet of the Apes brings together nearly every critique of the operation. In the confrontation between Charlton Heston’s Taylor and Dr. Zaius, lobotomy is described as a “final disposition” to induce a confession of heresy, which will remove Taylor’s speech as well as his “identity.” Zaius describes “final disposition” as “emasculating to begin with. Then, experimental surgery on the speech centers, on the brain… eventually a kind of living death.” As he is dragged out of the room, Taylor yells, “all right, you can cut pieces out of me. You’ve got the power. But you do it out of fear, remember that! Remember that! You’re afraid of me! What are you afraid of, doctor?”
Psychosurgery”; “Return of the Lobotomy”; “The Revival of Lobotomy.” The use of terms like “still,” “return” and “revival” assumes not only that the audience knew something about the history of lobotomy, but also assumes that their judgment of that history would be negative. “Lobotomy” was thus a potent symbol both for biopsychiatry’s suspicion-worthy ideological alliances as well as the failures of medical technology. It was a word that had become a slogan, to return to the passage from Ludwik Fleck I used as the epigraph to this chapter: in Breggin’s argument, lobotomy served not just as a point of historical reference, but also as a rhetorical call to battle.

One article Breggin co-authored with David Greenberg, “Return of the Lobotomy,” published by the Washington Post in 1972, illustrates a number of methods by which Breggin connected the new psychosurgery with the old practice of lobotomy. The article begins with a narrative about a nine year old boy subjected to psychosurgery in order to treat what his doctors described as “hyperactive, aggressive, combative, explosive, destructive [and] sadistic” behavior. Although the boy’s behavior “markedly improved” after multiple surgeries, his surgeon commented, “intellectually… the patient is deteriorating.” Breggin and Greenberg write that this narrative “might strike some as a tasteless satire, inspired perhaps by an over-excited reaction to the film ‘A Clockwork Orange.’” But, they warn, what they describe is not fiction: “the operations… 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” (C1). Breggin and Greenberg continue the substitution of “lobotomy” for “psychosurgery” set in place by the article’s title by leaving out one important qualifier: “popularly known in the form of lobotomy.”
Breggin and Greenberg continue the connection by using the term “lobotomist” to refer to all psychosurgeons, a word they wield as an epithet. They describe contemporary psychosurgeons as a secret cabal of lobotomists who have laid in wait for their operation to return:

[Although] it was apparent to even the most rabid lobotomist that carving up the frontal lobes frequently quieted the patient at the cost of turning him into a tractable vegetable… the lobotomists… did not disband. Though it was clear that surgical intervention in the human brain was on a par with firing bullets into the hood of a car to remedy a knock—with occasional success—they had experienced enough ‘success’ to arouse the belief that less mutilating, more precisely placed interventions were what was called for (C4).

The collapse of all psychosurgery to lobotomy and all psychosurgeons to lobotomists serves one purpose in this article: to connect present medical progress to past medical ignorance and failure, to call into question the psychosurgeons’ claim that “the lobotomy era of psychosurgery is in the past and the advent of stereotaxic surgery has brought about a new era in this field of medicine” (Orlando Andy, Quality 352). By connecting the new psychosurgeries with the old, Breggin charges that medicine was not progressing; rather, it was regressing. The associational effect is amplified by one of the article’s illustrations, a woodcut that depicts a medieval surgeon boring into a man’s head with a bit and brace.

Breggin frequently and freely substituted “lobotomy” and “psychosurgery” in other pieces of writing as well. For example, in one article submitted by Representative Cornelius Gallagher (D-NJ) to the Congressional Record, Breggin frequently calls
mentions of psychosurgery in medical discourse the “lobotomy literature” (Quality 455-6, 466). In another paragraph, Breggin decries the promotion of psychosurgery in medical media, and writes that JAMA and the American Journal of Psychiatry have been “offering pro-lobotomy articles based upon inadequate scientific studies” (Quality 455). In another paragraph in the same article, Breggin describes a case study from Mark and Ervin’s Violence and the Brain, a woman “brought in for psychosurgery, specifically thalamatomy.” Breggin then comments, again substituting the two terms, “this is the only detailed case report I have found in the entire current lobotomy literature” (466, emphasis in original).

A comprehensive analysis of the psychosurgery literature of the 1960s and 1970s has led historian Elliot Valenstein to conclude that by 1970, “almost no standard prefrontal lobotomies or transorbital lobotomies were being performed” in the United States (284). According to Valenstein’s definition of lobotomy, which relies on a denotative match with the specific operations performed by surgeons like Freeman and Watts, Breggin’s claim that “lobotomy has returned” is false, or at least a careless conflation. It seems highly unlikely that Breggin would have accidentally conflated “lobotomy” and “psychosurgery,” however; not only was he trained as a psychiatrist, but he also was clearly familiar with the psychosurgery literature, as his lengthy bibliographies indicate. Breggin’s use of “lobotomy” therefore seems to be a rhetorical tactic. Instead of walking his audience through complicated surgical technology in order to condemn the efficacy of psychosurgery on medical grounds, or to argue against somatic psychiatric interventions on ethical principle, Breggin’s arguments relied on a rhetorical shortcut. Radically simplified, his argument might read as follows: all
psychosurgery is lobotomy; all lobotomy is bad, therefore, all psychosurgery is bad. As a categorical logical argument, of course, this fails. All psychosurgery is clearly not lobotomy—thalamatomy and amygdalotomy are also kinds of psychosurgery. However, this argument fails only when “lobotomy” is used to denote the specific operation: the severing of fibers between the frontal lobes and the thalamus. A closer examination of Breggin’s other uses of “lobotomy” reveals a very different definition of lobotomy than that of Valenstein or the psychosurgeons he opposed.

In many instances, Breggin’s definition of “lobotomy” relies on the connection between lobotomy and its behavioral effects. For Breggin, anything producing a similar behavioral effect to lobotomy can be called a lobotomy, something along the lines of the “if it looks like a duck, quacks like duck…” adage. In the Congressional Record article, for example, Breggin references the work of one psychosurgeon, Petter Lindstrom, who used ultrasonic beams of energy in his operations:

Lindstrom apparently balks at being called a lobotomist. He says that he has been able to titrate his doses of energy so that he can reach a point where the damage is not grossly perceptible and hence does not constitute a lobotomy. *But if he’s getting a behavioral effect, he’s done a lobotomy, even if it’s merely a lobotomy by disruption of the brain chemistry* (464, emphasis mine).

Breggin couldn’t be clearer—for him, “lobotomy” has nothing to do with surgical technique, but rather the behavioral effects of that technique. Using this definition, the new psychosurgeries, which produced similar effects, could be called “lobotomies,” as
could chlorpromazine, which Breggin describes as a “pharmacological lobotomy” (“Brain-Disabling Therapies” 476).\(^{85}\)

What are the behavioral effects that Breggin identifies as qualifying for lobotomy status? In an article in *Medical Opinion* entitled “Lobotomies are Still Bad Medicine,” Breggin writes that although the techniques of contemporary psychosurgeons “may be much more precise than those used by early lobotomists, who won a reputation as ‘hatchet men’…the outcome is basically the same”: “at worst, they are irreversibly damaging the patient’s ‘self,’ the very qualities of insight, creativity, judgment, etc., that separate man from the lower species. At the very least, they are blunting the patient’s emotional response” (32). If you recall from the first chapter, Breggin’s description is actually a remarkably succinct paraphrase of Freeman and Watts’ description of the effects of lobotomy in *Psychosurgery*.

This metonymic definition of lobotomy is one of its most dominant contemporary meanings, as illustrated by a swarm of contemporary popular images in which “lobotomy” stands in for something akin to *brain damaged* or sometimes just *stupid*. An Internet image search on “lobotomy” returns a number of results like these, including t-shirts that allege lobotomies on leading political figures of all partisan stripes. The use of “lobotomy” as a trope for its effects is not confined to representations in popular culture. Consider a 2004 *Neuroscience* article entitled “Lobotomy of Genes,” which isn’t about lobotomy—or even psychosurgery—at all. The article reports on a recently developed process to inhibit gene expression using artificial double-stranded RNA, which allows researchers to determine gene function. Lobotomy shows up nowhere in the article.

\(^{85}\) Breggin is not alone in this comparison. See, for example, H.E. Lehmann’s description of chlorpromazine as a “pharmacological substitute for lobotomy.”
except for its title. Here “lobotomy” seems to be used as a trope corresponding to a play on the word “expression.” These aspects of RNA are unable to express themselves, much like how lobotomy stunts the expression in patients post-lobotomy (Holen and Mobb).

As one might expect, psychosurgeons were outraged by Breggin’s characterization of their work, particularly his description of their practice as lobotomy. After Breggin wrote an article in Medical Opinion in which he repeated the metonymic association of lobotomy and psychosurgery, called out a number of practicing psychosurgeons by name, and ended with the claim that “psychosurgery is a crime against humanity, a crime that cannot be condoned on medical, ethical, or legal grounds,” a number of psychosurgeons wrote back with strongly-worded rebuttals (36).

Robert Heath, a surgeon who used electrical stimulation of the brain, wrote that Breggin has never visited our laboratories, has not seen the work we have under way, and has not interviewed any of our patients. I do not share the views he has expressed in his anecdotal article. I wonder how much he knows about the subjects he has reviewed, and what his own background training and experience have been. In any event, he has a right to his opinion, regardless of how he developed it” (13).

William Beecher Scoville, president of the International Society of Psychosurgery, minced no words in his condemnation of Breggin’s article and its claims. Like Heath, Scoville charged that Breggin had never studied his patients, and furthermore, “as a scientist and a physician, I am disturbed by the emotional fervor with which Dr. P.R. Breggin damns an accepted form of treatment for intractable mental and emotional illness.” Scoville claimed that his patients “have returned to their homes and to high
executive positions, are happy and cheerful in the midst of their families. They are in no way comparable to the old lobotomy patients” (13).

Petter Lindstrom, the surgeon Breggin tagged as a “lobotomist” for his use of ultrasonic energy, also wrote to *Medical Opinion*, charging that Breggin’s article had “no significance except as a vehicle for an emotional and biased judgment of psychosurgery.” Lindstrom complained that Breggin had irresponsibly collected information for the surveys on which his article was based and had used quotations from the “lobotomy literature” that were nearly thirty years old. As a whole, Lindstrom wrote, the article relied on “distortion and misinterpretation of facts and figures” which “are so striking that it is meaningless to attempt an analysis.” Lindstrom also took particular offense with the description of his own research as “lobotomy.” Referring to Breggin’s psychosurgeon survey, Lindstrom writes, “he received from me numerous articles and references clearly indicating that present-day procedures have little to do with the old techniques. I do not know of a single physician who in the last 10 years has performed any of the radical lobotomies of 20-30 years ago.” And, he continues, “with respect to the prefrontal sonic treatment (PST) which I introduced 15 years ago, Dr. Breggin refers to it as a ‘lobotomy,’ which it specifically is not. It does not involve any surgery of the brain” (17). The surgeons find numerous faults with Breggin’s arguments—they claim that he misrepresents their data, that he’s too “emotional” in his arguments, that he hasn’t done his research, that he’s simply “wrong.” But nowhere in their responses is a strong argument that counters Breggin’s charge: if he’s getting a behavioral effect, he’s done a lobotomy, even if it’s merely a lobotomy by disruption of the brain chemistry.
For these psychosurgeons, lobotomy was irrelevant to their practice, except as a point of comparison of how much psychosurgery had changed—their definition of lobotomy was a historically specific medical practice: we do not do that anymore, we do something new. Breggin, however, relied on lobotomy as a trope, defining lobotomy as anything that produced a similar effect of lobotomy. Breggin’s focus on the similar effects of lobotomy and the new psychosurgeries allowed him to craft a critique in which the new techniques and altered biological targets of psychosurgery mattered little. This focus on behavioral effect rather than technique enabled Breggin to make potent political claims about the connection between psychosurgery and behavior control, a point that drove much of the discourse in the Senate Hearings about psychosurgery in early 1973.

**The Senate Hearings on Psychosurgery**

There are those who say the new behavioral research will enable us to realize our full potential as a nation and as a people. There are others who believe that the new technology is a threat to our most cherished freedoms… Scientists have developed some very powerful tools, tools that have the potential to affect, and perhaps even alter, each of our lives. We must as a society decide how these tools are to be used.

Edward Kennedy, at the start of the *Quality of Health Care* hearings

The early 1970s was a time rife with public debate about the ethical limits of biomedical research and practice: in addition to the concerns about psychosurgery, various scandals about medical abuses of the highest order broke in successive waves in
the national media. In 1972, ABC News aired an exposé on the Willowbrook State School, an institution for children with cognitive disabilities. The report detailed the severe overcrowding and unsanitary conditions of the school’s facilities, and reported that abuse of the children by staff members was routine. The 1972 public also learned that nearly 400 African American men in and around Tuskegee, Alabama, had been intentionally denied syphilis treatment so that researchers could study the progression of the disease over their lifetimes, an event that finds echoes in many African Americans’ distrust of systemized health care (Reverby).

In response to growing public concern about the lack of regulative safeguards on biomedical research, the Senate’s Health subcommittee, chaired by Edward Kennedy, began a series of hearings on the subject, which led to passing of the National Research Act in 1974, the formation of the National Commission on the Protection of Subjections of Biomedical and Behavioral Research, and the drafting of the Belmont Report in 1979—the founding document that still guides most internal review boards with regard to human experimentation. The subcommittee’s first meeting, however, was about the practice of psychosurgery.

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86 The school had provoked a previous public outcry when it was discovered that between 1963 and 1966, researchers had been intentionally infecting the otherwise healthy children with hepatitis in order to study the treatment effects of gamma globulin.

87 Although it was never mentioned in the hearings, Kennedy had a very personal connection to the practice of psychosurgery—his sister Rosemary had received a lobotomy from Freeman and Watts in 1941, with tragic results. She spent the remainder of her life at St. Coletta School for Exceptional Children in Jefferson, WI, until she died in 2005. Whether or not Rosemary had been mentally ill, mentally “retarded,” or simply headstrong remains a contentious issue among historians. I cannot speak with certainty, but from my research of the lobotomy literature, it seems unlikely (though not impossible) that Freeman or Watts would have performed the
Called to testify were Peter Breggin, Bertram Brown, director of the National Institute of Mental Health (NIMH), psychosurgeons Orlando Andy and Robert Heath, bioethicist Willard Gaylin, and controversial behaviorist B.F. Skinner. While the psychosurgeons focused primarily on the results of their operations, making familiar arguments about the use of psychosurgery as a “last resort” for desperate patients, Peter Breggin once again focused his arguments on psychosurgery’s behavioral effects, connecting them again with lobotomy, and drawing out the political implications of the surgery in hyperbolic detail.

NIMH director Bertram Brown was the first to testify. Brown began by providing the committee with a brief history of psychosurgery in which he explicitly separated the lobotomies of the past and the psychosurgeries of the present. “Unfortunately,” Brown commented, “it is the lobotomy that the public associates with psychosurgery—a procedure in which the ‘cure’ was sometimes worse than the disease. And I think I can state unequivocally that no responsible scientist would condone a classical lobotomy operation” (340). Brown advocated a “middle stance” on the use of psychosurgery, perhaps best illustrated by his response to one of Kennedy’s final questions. When Kennedy asked Brown directly, “do you think psychosurgery is a valid technique to treat behavioral disorders; and if so under what conditions,” Brown refused to either endorse or condemn the procedure: “My answer is a crisp ‘maybe.’ And under what conditions? I would say that only when extensive attempts have failed and the situation is very equal or desperate, and only under the most carefully controlled conditions” (Quality 346-347).

operation on a person with mental retardation. For more on Rosemary Kennedy, including excerpts from her writing before the operation, see Gibson and Latham.
Orlando Andy, a practicing psychosurgeon and one of Breggin’s frequent targets, provided the committee with a number of case histories in which psychosurgery had relieved his patients of their distress. Like Brown, Andy explicitly drew a distinction between lobotomy and his current practice: “the lobotomy era of psychosurgery is in the past and the advent of stereotaxic surgery has brought about a new era in this field of medicine” (352). Robert Heath, the second psychosurgeon called to testify, never mentioned lobotomy specifically; however, he described the aim of his practice as “the development of less-injurious—and more effective and specific—treatments for severe mental and nervous system diseases, which have been untreated” emphasizing again the difference between current and past practices of psychosurgery (364).

When Breggin addressed the committee, he directly challenged the surgeons’ claims that the lobotomy era was in the past. “Lobotomy is still with us,” he told Kennedy bluntly. “Do not believe what you have been told today, Senator, about the demise of lobotomy. There is a great deal of lobotomy going on in this country right now” (358-9). And again, Breggin made this argument through the metonymic association of an operation and its effects:

[William] Scoville and most of the knowledgeable psychosurgeons admit that all of the newer procedures do the same thing: they are partial lobotomies. Let me review one quote, from 1972, from a very well-known psychosurgeon:

After the operation, there develops a sense of fear. In cases that are still mildly troublesome, the threat of punishment quiets them… the patient became more cooperative and obeyed commands.
Dr. Brown is not telling you the facts when he tells you that this procedure is not closely related to lobotomy. Ruth Anderson… says that the newest operations have the same effect as lobotomy: emotional blunting, passivity, reduced capacity to learn” (360, emphasis mine).

Breggin’s focus in the hearings was not just to call psychosurgery “lobotomy,” but to draw out the political implications of the effects like “emotional blunting” and passivity, implications he calls “the real problems that we are facing today” (Quality 358). The ultimate goal of any psychosurgery, testifies Breggin, is not cure, but “tampering with the brain” …“in the interest of controlling the individual” (358). Breggin then linked the research in psychosurgery to the work in behaviorism, which he calls “mechanistic, anti-individual…and anti-spiritual,” in order to make his boldest claim of the day:

The psychosurgeons here today, represent the greatest future threat that we are going to face for our traditional American values, as promoted in the Declaration of Independence and the Bill of Rights. This totalitarianism asks for social control, including social control of the individual, at the expense of life, liberty, and the pursuit of happiness… If America ever falls to totalitarianism, the dictator will be a behavioral scientist and the secret police will be armed with lobotomy and psychosurgery (358).

Breggin’s claim that America would succumb to a Skinner-like dictator, armed with an army of leucotome-wielding Freemans, is precisely the kind of statement that has led people to dismiss his work. However, Breggin’s statement was not completely out of touch with the tenor of the hearings. For the rest of the hearings, Kennedy repeatedly
returns to the question of whether psychosurgery might be employed as a method of mass behavioral control:

Senator KENNEDY. How important is the application of this technique for mass behavioral control?

Dr. BROWN: I think it has no role at all in mass behavioral control.

Senator KENNEDY. Could it be used for that frightening purpose?

Dr. BROWN. Yes. I can picture scenarios under certain kinds of authoritarian or totalitarian situations where it could be used for such purposes. I think they would be dreadful—and un-American (347).

Interviewing psychosurgeon Robert Heath, Kennedy was even more direct, pressing him to declare the difference between his practice and “behavioral control”:

Senator KENNEDY. What you are really talking about is controlling behavior.

Dr. HEATH. I am a physician and I practice the healing art. I am interested in treating sick behavior—not in controlling behavior. The tools can be misused, whether misuse of treatment by drugs or any other medical procedure…

Senator KENNEDY. As you pointed out, this has great implications in terms of behavioral concepts, but how are we to know they are always going to be used constructively, positively?

Dr. HEATH. For one thing, about a million dollars worth of equipment is required for our studies, as well as a large number of highly skilled personnel…

Senator KENNEDY. Should we not be concerned about mass application?

Dr. HEATH. I do not see any cause for concern of mass application (367-8).
When Kennedy interviewed bioethicist Willard Gaylin, he returned, again, to the question of the political implications of psychosurgery. Gaylin began by directly referencing Breggin’s suggestion that psychosurgery might be used in a totalitarian takeover of the United States:

it seems unlikely, if there were some plot to take over the country by a totalitarian, to use some of the ideas suggested today that psychosurgery would be the method of choice. I doubt that they would find the most efficient technique for mass control would be planting electrodes on a population of 200 million, or psychosurgery, when they have access to a limited national television, and to schools with compulsory education, to psychological inputs and to drugs, all of which afford a more convenient, cheaper, economic mass method of manipulation (374).

Although Breggin’s outrageous statements in the Senate hearings seem exaggerated, a familiar echo of the anticommunist rhetoric of two centuries before, his testimony did precisely what his articles accomplished—these claims got people talking about psychosurgery on his terms. Much of the Senate hearings on psychosurgery focused not on surgical technique, nor patient case studies, nor the numerous differences between lobotomy and the newer psychosurgeries, but about the political implications of the effects of psychosurgery. In short, Breggin was able to shift the rhetorical terrain of the debate over psychosurgery from a medical concern to a public concern.
Conclusion

What are we to make of Peter Breggin’s campaign against psychosurgery? First, if we are to take public discourse “seriously” in the history of science or medicine as Celeste Condit advocates (12), then we certainly should not discount the contributions of Peter Breggin. Instead of writing Breggin off as a “pariah” or wild-eyed conspiracy theorist, I argue that it is important to ask why it was that people listened to him: what was he saying, how was he saying it, and under which conditions did his arguments resonate? In 1977, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research released their report and recommendations on the use of psychosurgery, and Breggin’s name was prominently featured throughout the document. The first line of the report explains that the formation of the Commission was “in response to widespread public concern” (26318). Later in the report, under a section entitled “Rise of Public Concern,” the Commission directly addressed Breggin’s pivotal role in fomenting that concern:

Coinciding with the development of refined techniques for psychosurgery, the climate of political unrest in the 1960s, general fear of behavior control and concern about abuse of minorities provided the background against which Dr. Peter Breggin… began to publish articles warning about the ‘new wave of psychosurgery’ and the ‘return of the lobotomy’ (26319). Breggin is mentioned a number of other times in the report, particularly his concerns about psychosurgery’s social implications: the report states that Breggin “has voiced deep concerns that psychosurgery will be used (or misused) as a social or political tool,
applying socially determined definitions of ‘abnormal’ behavior to justify controlling
dissidents or subduing individuals whose behavior is disruptive or otherwise bothersome”
(26320). The Commission also highlighted the powerful role of the representation of
psychosurgery in popular fiction: *A Clockwork Orange* and *The Terminal Man* are cited
specifically as “fuel to the fire” of public concern (26319).

Ultimately, the Commission decided with Bertram Brown that the answer to the
question of psychosurgery was a “crisp maybe.” The Commission recommended a
 stricter policy with regard to systems of peer and public review, advocated a consistent
method of data collection on surgeries, suggested that psychosurgery should not be
performed on children or prisoners, and in general, simply requested that the practice of
psychosurgery be carefully monitored by various internal review boards. These
recommendations, however, comments Elliot Valenstein, “serve only as guidelines; they
have never been translated into federal legislation or regulations” (289).

I do not share Breggin’s belief that there is no biological substrate for mental
illness. To take his role in this controversy “seriously” does not mean that one need agree
with the content or conclusions of his arguments, but it does mean that we acknowledge
their rhetorical power. Furthermore, Breggin’s critiques of psychosurgery raise questions
not just about how new medical interventions are different than past interventions—how
they have “progressed” in biomedical technology or theory—but also how they are
similar. Breggin relied on a *physical* similarity of the effects of the old psychosurgery
and the new; I would ask that we consider not just similarities in technique or physical
effect, but similarities in rhetoric as well. For example, how were/are patients chosen for
psychosurgery? Rather than rely on similar symptomology or diagnosis, I would direct
our attention to similarities in the deployment of words like last resort, which was applied equally to lobotomy patients and psychosurgery patients of the 1970s. “Last resort” also finds currency in contemporary psychiatric rhetoric, particularly with regard to new forms of psychosurgery like vagus nerve and deep brain stimulation, used for patients labeled “treatment resistant,” as I will discuss in the next chapter. In addition, what similarities might we find in rhetoric used to frame the risks of the particular somatic interventions—how were/are the negative effects of psychiatric interventions weighed with their social use value? How were/are the “successes” and “failures” of psychiatric interventions framed, and by what evaluative metric? And finally, to return to the question that threads throughout this dissertation: how does the public discourse about medicine—even from an imperfect messenger like Peter Breggin—work to shape biomedical research and clinical practice? These are important questions that exceed the traditional boundaries of history or medicine, questions that I believe a rhetorical perspective is equipped both to ask and to answer.
Conclusion

Echoes of Lobotomy

What is history? An echo of the past in the future; a reflex from the future on the past.

Victor Hugo, *The Man Who Laughs*

When I’ve presented portions of this work at conferences and informal gatherings, one of the most frequent questions I receive is *do they still do that?* With regard to the specific lobotomy operation, the answer is no. With regard to the general practice of psychosurgery, however, the answer is yes. Psychosurgery has returned to the 21st century psychiatric armamentarium in the form of electrical neuromodulation like deep brain stimulation (DBS) and vagus nerve stimulation (VNS). Like the psychosurgery of the 1970s discussed in Chapter 5, these contemporary psychosurgeries are different than the lobotomy operation in technique as well as their more limited indication. Rather than ablate brain tissue, surgeons using DBS and VNS implant electrodes and stimulate portions of the brain and surrounding nerves in order to alleviate affective symptoms of depression and obsessive-compulsive disorder.

Like the psychosurgeries of the past, contemporary psychosurgeries also have attracted considerable public controversy. Instead of worrying that Communists have

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88 Other psychosurgeries like those I discussed in the previous chapter, such as thalamotomy, bilateral cingulotomy, and amygdalotomy, also are still used on rare occasions.
their hands in the implants, critics charge that corporate interest is at the helm of the renewed interest in psychosurgery, particularly in the case of VNS. The device used in VNS was created and patented by Cyberonics, Inc., a company that obviously has a financial stake in its widespread use and has funded some of the researchers and studies that make claims about its efficacy (“Electronic Device”). In 2006, Cyberonics petitioned the Center for Medicare and Medicaid Services (CMS) for a national coverage determination for VNS for use in treatment resistant depression. As they deliberated over the decision, CMS opened a forum on their website that invited public comment. Over the course of one month, CMS received 1843 comments from people with depression, their families, Cyberonics representatives, and hundreds of health care professionals, including psychiatrists, neurologists, neurosurgeons, and nurses. 1831 of these commentators wrote strongly in favor of coverage. Despite this overwhelming show of support, CMS ultimately denied the petition, concluding that VNS was neither “reasonable nor necessary” in the treatment of depression (CMS).

89 The leading opponent of the CMS determination has been the nonprofit consumer advocacy group Public Citizen, which was founded in 1971 by Ralph Nader. In an open letter to CMS issued as a press release, the group detailed a number of points at which regulatory measures failed with regard to VNS:

Even the full-court press of misleading advertising, training sessions in its use for physicians, presentations at the American Psychiatric Association annual meeting, case managers to help secure reimbursement for individual patients, abuse of FDA employees, misleading clinical trial write-ups, ghost-written review articles and company-generated favorable local media coverage cannot disguise what is lacking and what insurers are increasingly realizing: There are no convincing data of the device’s effectiveness, let alone, in CMS terms, that it is “reasonable and necessary.” To reimburse for an ineffective device (and an expensive, surgically implanted one at that) does no favors for those suffering from TRD” (“Letter…”).
organizations like Blue Cross Blue Shield have followed suit—very few private insurance companies cover the procedure. If one of the arguments over psychosurgery in the 1970s was a patient’s right to be free from experimental psychosurgical intervention, one of the major arguments expressed in the CMS public commentary concerned a patient’s right to access an experimental psychosurgical intervention. Lobotomy was often performed on poor patients in the service of reducing state hospital costs; in a strange reversal very much reflective of the contemporary system of managed health care, the new psychosurgeries, which cost between $15,000 and $30,000, typically are available only to patients with the means to pay for it out of pocket.

Like the psychosurgeries of the past, DBS and VNS have also found their way into the paper and web pages of the popular press. Many of these stories describe the advent of stimulation technology as heralding a “new era” in the research and treatment of mental illness, following the claims of its most vocal proponents in the medical field: “I believe we have opened up a totally new field of research,” comments surgeon Alim-Louis Benabid, “The number of labs which are entering the field is increasing extremely quickly. We will probably see in the next five to 10 years a number of exciting new applications” (Stein). In another article, surgeon Rees Cosgrove proclaims, “deep brain stimulation has and will revolutionize functional neurosurgery in the next decade” (Goldberg). Ali Rezai, director of functional neurosurgery at the Cleveland Clinic Foundation, claims, “we’re really in the beginning of a new era for the treatment of neurological and psychological disorders that are intractable to medication and other treatments… with time, it will become a more routine part of the armamentarium of
therapies for patients… in the future, neural prostheses and smart systems for the brain will be applied more and more” (Stein).

Rezai’s clinic and the US Department of Health and Services Office on Disability recently co-sponsored a conference on DBS entitled “Brain Pacemakers: A Promising Approach and a New Era of Hope for Neurological Disorders.”90 The “pacemaker” moniker makes a frequent appearance in discourse about DBS and VNS. One article about DBS in the Cleveland Plain Dealer quotes Rezai, who calls deep brain stimulation’s medical moment “similar to where heart pacemakers were 30 or 40 years ago” (Zeltner). An article about VNS in Wired magazine, of all places, claims in its headline that the “Brain ‘Pacemaker’ Tickles Your Happy Nerve” (Graham). The Washington Post writes: “modeled on heart pacemakers routinely implanted in people’s chests to automatically regulate heart rhythms, brain pacemakers were first developed in the late 1980s to treat Parkinson’s, a devastating brain disorder in which victims inexorably lose control of their muscles” (Stein). Associating DBS and VNS with the cardiac pacemaker produces a much more respectable medical lineage than attaching these treatments to the history of psychosurgery.

The connection of DBS and VNS with their original indications of neurological disorders like Parkinson’s disease and epilepsy is yet another way to reframe their genealogy. DBS and VNS were not developed as psychiatric treatments, these articles make sure to remind us; their positive effect on mood is something of a happy accident, if you’ll pardon the pun. “If it was only restricted to neurological disorders, DBS would not be a topic of ethical debate,” comments neuropsychiatrist Perminter Sachdev (68).

90 The “Brain Pacemaker” conference, which claims in its title that it explored “new hope for neurological disorders,” contained a panel devoted to DBS for psychiatric disorders as well.
Neurosurgery on the “abnormal” brain arouses far less controversy than neurosurgery on the “normal” brain—one doesn’t often see newspaper articles that question the removal of brain tumors in cancer patients or the severing of the corpus callosum in epilepsy patients on principle.

As the press looks forward to this “new era” of psychiatric treatment, however, it also looks back to psychosurgery’s tragic past. Lobotomy hovers as a cautionary specter over contemporary psychosurgery, and the history of lobotomy’s “dark legacy” is deployed in a number of ways in both popular and medical media (Stein). One way the press evokes lobotomy is to differentiate the new procedures from the old. An article in *Slate* comments, “DBS may be a far cry from the days when lobotomies robbed patients of the ability to feel emotions like love and compassion” (Richards). An article from *Psychiatric News* brings together psychiatrist Benjamin Greenberg and medical ethicist Joseph Fins to claim, “dramatic changes since the early days of psychosurgery—in technological acumen, knowledge and understanding of brain circuitry, regulatory strictures, and appreciation of the importance of informed consent and other ethical considerations—make the current environment vastly different and more conducive to safe investigation” (Moran). Fins, in an interview with the *Washington Post*, continues this differentiation, stating that “researchers are very sensitive to the historical legacy of psychosurgery… today’s iteration is far more discreet, less toxic and easier to study than its predecessor” (Stein). *Time* uses the history of lobotomy in much the same way: “the practice of psychosurgery has long been dormant — tarnished by the notorious brain-scrambling lobotomies of the 1940s and ‘50s — but it has recently reclaimed a bit of its luster, thanks to a relatively new and much more benign technique called deep-brain
stimulation” (Song). Psychosurgery of the present finds validation when it is compared to psychosurgery of the past: “new” psychosurgery is “much more benign.” Changes are “dramatic.” The regulative environment is “vastly different” and “safer” than that of the lobotomy era. These stories reference lobotomy as a comforting touchstone of medical progress. DBS might be a form of psychosurgery, they affirm, but it’s not lobotomy. We’ve come so far since then.

Yet media stories about DBS and VNS also use the history of lobotomy to warn against the too-hasty embrace of surgery to treat psychological distress. One story from Vancouver magazine The Tyee asks if DBS is “the new lobotomy?” and finds similarities in physiological rationale:

Deep brain stimulation is meant to interrupt specific pathways between the frontal lobes and the deeper emotional parts of the brain, essentially ‘rewiring’ the brain. It's the same physiological rationale used to describe lobotomies and their modern counterparts, known as psychiatric neurosurgeries, which are said to be making a comeback at select centres round the globe… (Egan).

With regard to DBS, Slate comments, “the legacy of psychosurgery is not exactly reassuring…” (Richards). In one article about DBS in the Guardian, David Beresford, who received DBS to treat Parkinson’s and benefitted from the positive mood change, also references the history of lobotomy. Beresford “[offers] up a short prayer to the international neurocommunity: ‘Please, guys, just don't screw it up this time.’” Because last time the screwup was spectacular, thanks to Freeman and Moniz” (Beresford). A story in the Boston Globe cautions, “surgeons must be supremely careful to avoid re-creating some of the mistakes of the past” (Goldberg). Psychiatry News writes, “one
psychiatrist involved with studying the new procedures acknowledged the caution with which researchers approach the subject… in part because of the disastrous experience with frontal lobotomies performed on thousands of patients in the 1940s and 1950s” (Moran).

The “new era” of psychosurgery thus is intimately bound to its past, which stands as a “historical threshold,” according to surgeon Rees Cosgrove, who states, “[psychosurgery] needs to be done well and properly and be above reproach, or we’ll never have another opportunity” (Goldberg). What does Cosgrove mean by “historical threshold”? DBS “needs to be done well and properly,” presumably for the benefit of its patients. DBS also needs to “be above reproach” or researchers like Cosgrove will “never have another opportunity” to explore psychosurgery, presumably because of the force that public perception can exert on biomedical research and practice, as we saw in Chapters 3 and 5.

Some in the medical community suggest that one method to contain the association of psychosurgery with lobotomy is to change the name. ‘There is a history associated with the term ‘psychosurgery,’ and it is not a good one,” bluntly states psychiatrist Benjamin Greenberg, who studies the use of DBS in obsessive-compulsive disorder (Moran). Presumably because of this “bad” history, Greenberg explains, “the term ‘psychosurgery’ is eschewed today in favor of ‘neurosurgery for psychiatric disorders.’” But eschewed where? Last summer I presented some of my dissertation research to a gathering of psychiatrists and neurosurgeons at the Pennsylvania State University’s School of Medicine, where I was invited to sit in on a meeting of the psychosurgery reading group, which focused on recent studies of VNS. “Psychosurgery”
didn’t carry a negative connotation with this group, who were aware of the difference between new techniques and old. Many of the physicians, surgeons and student residents viewed my discussion of lobotomy as an historical curiosity, and were surprised when I asked if patients ever mentioned lobotomy when considering the stimulation technology. Moreover, the term “psychosurgery” frequently is used in medical journals to describe the techniques of DBS and VNS.

Neuropsychiatrist Perminder Sachdev, in a recent article in *Australasian Psychiatry*, argues that the term “psychosurgery” should be abandoned because of “the emotive nature of the term… The bad press for psychosurgery originated from the period of ‘lobotomy,’ which involved the removing or lesioning of large parts of the frontal lobes and which is thankfully behind us” (97). Although Sachdev focuses, like Petter Lindstrom from Chapter 5, on the technical difference between stimulation and ablation, he also makes it clear that the primary reason driving the name change is the “pejorative connotations” psychosurgery received during the lobotomy era. He recommends, with Greenberg, that the term ‘psychosurgery’ be “firmly replaced by “neurosurgery for psychiatric disorders’” (98, my emphasis). Whether DBS or amygdalotomy are termed “psychosurgery” or “neurosurgery for psychiatric disorders” seems to have little impact in the direct treatment of patients. Where the name does have impact, however, as Sachdev suggests, is in the allocation of monies for research in particular countries, and “the ‘special regulatory constraints placed on its practice in many jurisdictions’” (97). In other words, the concern of Sachdev and Greenberg over the term “psychosurgery” is not a medical concern, but a rhetorical one. Sachdev writes:
words can have great power, and it would be easy to tar DBS with the lobotomy brush if it were to be regarded as psychosurgery. Because of the prohibition on psychosurgery in many jurisdictions, the development of DBS as a new therapeutic technique would be severely thwarted. Despite the rapid advances in psychiatric treatments, a significant minority of individuals suffer from intractable disorders that result in untold misery. A careless approach with our terminology can have adverse consequences on the future health of these individuals” (98, my emphasis).

Words can have great power indeed.

Christine Hamilton, whose story I used to begin this dissertation, has called the psychosurgery name change “Stalinesque,” and sees the name change as part of a larger refusal of psychiatry to “[acknowledge its] past mistakes.” To compare, she references the example of the Cold Spring Harbor Laboratories, one of the leading genetics research facilities in America, which also has a dark past as the “epicenter” of the eugenics movement in America:

Much to the Lab’s credit, they have fully and completely owned up to their mistakes. They make their eugenics archives available to researchers. They do not hide their involvement. They have often helped writers and the public understand why the “science of eugenics” was a huge mistake not just in social terms, but also in scientific terms. They have re-examined their data and make their research flaws known. They cooperate with journalists and make it a point to teach their graduate students about their past errors in a required ethics class (“What Psychiatry Could Learn”).
With regard to the name change, Hamilton comments, “whether you call it psychosurgery or neurosurgery for mental disorder, the operations are still highly questionable.” What Hamilton does not mention is that the American Eugenics Society also proposed, successfully, to change its name in 1972 after the word “eugenics” had fallen into disrepute. It is now known as The Society for the Study of Social Biology; its journal was also renamed from *Eugenics Quarterly* to *Social Biology*.

It is hard not to see echoes of lobotomy in contemporary discourse about the new forms of psychosurgery. Lobotomy, too, was heralded as the “new era” of psychiatric therapy. As one reads time and time again that DBS and VNS only should be used as “last resort,” it is hard not to hear an echo of Freeman and Watts, who wrote in *Psychosurgery*, “prefrontal lobotomy is the last resort, the end of the line” (1950, 203). There’s a reason why Jack Pressman took this phrase as the title of his book: the “last resort” rhetoric used to justify the risks of lobotomy can be found in nearly every publication about the surgery in both public and medical discourse. It is hard not to see echoes of Walter Freeman in the arguments of the most vocal psychosurgeons, who frequently grant interviews and praise psychiatry’s “new era,” even as they defer to the lessons demanded by psychiatry’s past. It is difficult not to see echoes of the “miracle cure” in today’s headlines, even as the press has learned to qualify its claims: “Implanted Devices May Alter Treatment of Many Disorders” (Stein); “Brain Device Offers Hope For Some Mental Disorders” (Goldberg); “Researchers Say That Electrical Brain Stimulation May Help Severely Depressed Patients” (Zwillich). Although there are a number of technical differences between the old surgeries and the new, one striking

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91 Recall Freeman’s description from the *Psychosurgery* book jacket: “this volume inaugurates a new era in the treatment of mental disorders, a surgical era.”
similarity emerges: the language used to describe them.

As I argued in Chapter 5, the stimulus for federal intervention and regulation of psychosurgery came not from medicine, but from public concern. Sachdev’s concern over the “psychosurgery” moniker similarly highlights the power of public perception of science and medicine to influence research and clinical practice—not just public “understanding” of medicine’s present, but public memory of its past as well.

Contemporary psychosurgery, comments surgeon Daniel Tarsy, likely “will recapitulate the whole history of ablative surgery in psychiatry” (Goldberg). As it should. The recent medical concern over the public perception of DBS and VNS only underscores the need for more dialogue between science, medicine and the public—not so that medicine can properly inform the public (as is suggested by “deficit” models of the public understanding of science) but so that each might productively learn from the other. I would hope that public discussion of DBS recapitulates not only the history of lobotomy in medicine, but also the role that nonmedical discourse has played in that history—both in its development and in its decline.

I do not wish to “tar DBS with the lobotomy brush,” as Sachev worries. After reviewing some of the medical literature on these techniques, hearing from surgeons about the positive effect they have seen in their patients, and reading testimonials by patients and their families in the public commentary on VNS, I have come to believe that DBS and VNS do seem to be promising treatments, even if not a miracle cure. To deny this treatment to patients only because it shares a medical lineage with lobotomy would be a mistake, akin to abandoning all genetic research because of its historical ties to eugenics. I disagree that contemporary psychiatry has learned nothing from the lobotomy
era—I believe that the fact that psychosurgery researchers are willing to acknowledge psychosurgery’s ties to lobotomy in both medical and public forums is surely a step in the right direction. To change the name and to sever psychosurgery’s lineage with lobotomy would also be a mistake, however; this lineage should serve as a permanent note of caution to physicians, biomedical researchers and a public anxious to embrace miracle cures for mental illness.  

I also disagree with the motion to remove Egas Moniz from Nobel’s roster of laureates. To do so would be to paper over the uncomfortable fact that lobotomy, as Pressman argues so well in *Last Resort*, was once in the medical “pantheon” (4). Perhaps the answer that would satisfy both Pressman and Christine Hamilton would be to attach a more prominent asterisk to Moniz’s name than Nobel’s essay provides, an asterisk written not by a psychiatrist, but by someone like Christine Hamilton or Howard Dully. As Hamilton powerfully argues, it is crucial that we acknowledge that the methods and the material with which we construct narratives of the past influence not just our understanding of medicine’s history, but also shape our vision of its future.

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92 Valenstein comes to a similar conclusion (291).
References


____. “The Great Conspiracy to Destroy the United States.” Congressional Record. 28 April 1954: 5698-5700.


Harlow, John M. “Passage of an Iron Rod through the Head.” *Boston Medical and Surgical Journal* 38 (1848): 389-93.


Jacobsen, Carlyle F., J.B. Wolf, and T. A. Jackson. “An Experimental Analysis of the


<http://nobelprize.org/nobel_prizes/medicine/articles/moniz/index.html>


<http://www.psychosurgery.org/index_files/page0046.htm>

Johnson, Linda. “Relatives of Lobotomy Patients Want Nobel Prize Revoked.”


Kaempffert, Walter. Rev. of *Psychosurgery: Intelligence, Emotion and Social Behavior*


Kuhn, Thomas S. *The Structure of Scientific Revolutions*. 2nd ed. Chicago: University...


“Southern Doctors.” *Time* 30 Nov. 1936: 66-68.


Zweiback, Adam. “'Turncoat GIs': Nonrepatriations and the Political Culture of the 

Zwillich, Todd. “Deep Brain Stimulation Helps Depression. Researchers Say Electrical 
Brain Stimulation May Treat Severely Depressed Patients.” *WebMD*. 6 May 
brain-stimulation-helps-depression>. 


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