Between the Ego and the Icepick: Psychosurgery, Psychoanalysis, and Psychiatric Discourse

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SUMMARY: Between the years 1935 and 1965, tens of thousands of lobotomies were performed on Americans in order to treat mental illness. This article reconstructs the relations between the theory and practice of psychosurgery and a dynamic approach to mental illness. The article claims that psychosurgical discourse adopted key concepts from psychoanalytical discourse and that psychodynamically oriented psychiatrists and psychoanalysts incorporated the basic tenets of psychosurgery into their writings. Hence a common, eclectic discourse on psychosurgery was created, used by psychodynamically oriented psychiatrists and psychosurgeons alike and containing elements from both theories. This article addresses the far-reaching effects this discourse had on therapeutic practice and on the widespread mutual acceptance of psychosurgery. The article questions the distinction between somatic and dynamic approaches to mental illness, claiming that the common psychiatric discourse indicates that a spectrum of psychiatric thought would better describe the state of the profession at the time.

KEYWORDS: American psychiatry, psychosurgery, psychoanalysis, psychiatric discourse, Walter Freeman, United States

Introduction

Between 1935 and 1965, tens of thousands of lobotomies were performed on Americans in order to treat and cure mental illness.1 Today, lobotomy is

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1. For a comprehensive account of the history of psychosurgery in the United States, see Jack D. Pressman, Last Resort: Psychosurgery and the Limits of Medicine (Cambridge: Cam-

widely discredited and is considered to be highly unscientific. Yet, during this period, it was based on mainstream psychiatric theories and supported by mental health practitioners of diverse disciplinary backgrounds and training. The fact that lobotomy was so widely supported by proponents of both organic psychiatry and of dynamic psychiatry is striking. In this essay, I will attempt to reconstruct the relations between the theory and practice of psychosurgery and a dynamic approach to mental illness. I will examine the ties between psychosurgery and psychoanalytic psychotherapy and professional discourse of members of each discipline. I shall demonstrate that psychosurgical discourse adopted terms and concepts from psychoanalytical discourse, and that many psychodynamically oriented psychiatrists and psychoanalysts were willing to incorporate the basic tenets of psychosurgery into their professional writings. Although it might seem inevitable that two such radically different approaches would ultimately form distinct and even opposing theories, as well as separate professional discourses, I shall claim that a common, eclectic discourse on psychosurgery was created. This discourse was used by psychodynamically oriented psychiatrists and psychosurgeons alike, containing elements from both theories. It had far-reaching effects on therapeutic practice; both psychosurgeons and psychodynamically oriented psychiatrists and psychoanalysts endorsed various forms of psychotherapy before and after psychosurgery, and for certain analysts, psychosurgery was a means by which to obtain more effective analysis. For patients, psychosurgery and psychotherapy or analysis could be viewed as complementary treatments with shared goals.

Although psychosurgery was a radical treatment involving the destruction of organically healthy brain tissue in order to ameliorate mental illness, very little opposition on the side of psychodynamic or psychoanalytically oriented psychiatrists was voiced. No professional group was formed to actively protest the use of psychosurgery, and very few reviews critical of psychosurgery were published. Although this lack of both theo-


2. All of the archive material cited in this essay is taken from the Walter Freeman/James Watts Collection, the George Washington University, the Melvin Gelman Library, University Archives. It is listed only in box and folder format. Walter Freeman is hereafter referred to as W.F.
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Retrospective and practical opposition has been noted by different researchers,\(^3\) a number of accounts of the history of psychiatry in the United States, and of psychosurgery in particular, tend to characterize the response of psychoanalysis as vigorous opposition. I shall attempt to reevaluate what has been characterized as opposition and criticism and claim that what was seen by a number of historians as such in fact constituted a form of implicit acceptance, and is indicative of the relations between psychoanalysts and psychosurgeons.

Current Historiography

A number of researchers have referred to the controversy between psychosurgeons and psychoanalysts and have described the criticism voiced by analysts. To the best of my knowledge, no systematic attempt at elucidating the usage of psychodynamic terminology by psychosurgeons has been published.

Paul Stepansky, in the chapter titled “A Panic Application of Magic” in his book *Freud, Surgery and the Surgeons*,\(^4\) addresses the relations between psychoanalysis and additional somatic therapies, including psychosurgery. He focuses, as he does throughout his work, on the importance of the surgical metaphor in psychoanalysis and describes the equivocal response of American psychoanalysts to lobotomy. He concludes that psychoanalysts “devised their metapsychologically ingenious explanations of the effectiveness of shock therapy,”\(^5\) including lobotomy, and describes the lack of published criticism of the procedure. In a footnote,\(^6\) he records a comment he received while presenting an earlier version of the chapter before his colleagues,\(^7\) suggesting that the material he cites is not reflec-

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3. For example, Valenstein claims that “not one group took an effective stance against psychosurgery,” despite the fact that many individuals opposed the practice: Valenstein, *Great and Desperate* (n. 1), p. 187. Stepansky writes of “the context of this cautious receptiveness to somatic intervention as a treatment option” within which prefrontal lobotomy was introduced: Paul E. Stepansky, *Freud, Surgery and the Surgeons* (Hillsdale: Analytic Press, 1999), p. 196.

4. Stepansky’s book, *Freud, Surgery* (n. 3), follows the surgical metaphor in Freud’s writings and Freud’s relations with surgery and surgeons. His final chapters depict the psychoanalytical response to somatic therapies and, especially, to psychosurgery.

5. Ibid., p. 206.

6. Ibid., p. 197.

7. Stepansky describes his presentation of an early version of this chapter before the section on the psychiatric history of the department of psychiatry at Cornell University Medical College on 7 October 1998: ibid., p. 197.
tive of American psychoanalysis. Stepansky states that to the best of his knowledge, the sources he cites “represent virtually all that American psychoanalysts had to say in print about psychosurgery in the two decades following its development,” and that, excluding the writings of Harry Stack Sullivan and Donald Winnicott, there was no published record of “outright analytic repudiation of lobotomy.”

Stepansky adds that there are no official reports or position papers of the American Psychoanalytic Association of which he is aware that might indicate that these published accounts are unrepresentative of the view analysts held at the time.

In his description of psychosurgery in the 1940s, Elliot Valenstein maps the reactions of psychoanalysts to psychosurgery, noting that “for the most part, the criticisms of psychoanalysts were ineffective,” as these were embedded in psychoanalytic language, “incomprehensible” to the ordinary psychiatrist. Valenstein presents a number of responses of psychoanalysts to psychosurgery, but claims that most were only mildly critical, recommending a “limited use of lobotomy.” In his analysis, he distinguishes clearly between a psychoanalytical approach and a somatic approach and claims that due to differences in approaches, “neurosurgeons in favor of lobotomy were not likely to be impressed by the arguments of psychoanalysts and were convinced that psychotherapy in any form had little practical to offer” for patients who were considered to be candidates for lobotomy. In this essay, I will question Valenstein’s claim and demonstrate the employment of psychodynamic concepts within psychosurgical theory. Furthermore, I will analyze how the criticisms of many of the psychoanalysts he cites in fact implicitly reaffirmed the validity of a surgical treatment for mental illness.

In his research, Jack Pressman focuses on the relations among different mental health professionals: neurologists, physiologist-researchers, and psychiatrists. Pressman, who does not dedicate much discussion to the relations between psychoanalytic and psychosurgical approaches to mental illness, claims that “Freeman received his harshest criticism at the hands of psychoanalysts such as A. A. Brill and S. E. Jelliffe” and that psychosurgery was “damned” from the analysts’ perspective. These

8. Ibid.
10. Ibid., p. 185.
11. Ibid., p. 183.
12. According to the book’s index, Pressman refers to Freud on five different occasions, and dedicates six pages throughout the book to the dispute between psychoanalysts and psychosurgeons: Pressman, *Last Resort* (n. 1).
13. Ibid., p. 366.
claims seem unconvincing to me, even in light of the quotations Pressman himself provides, which do not indicate a substantial amount of criticism, and of which some are even supportive of the basic tenets of psychosurgery.\textsuperscript{14} When Pressman quotes Freeman, who explained the mechanism of lobotomy as “whittling down the ego,” he adds that this is “no doubt one of the more egregious mixed metaphors in medical history”;\textsuperscript{15} yet he does not examine aspects of this metaphor that might be viewed as revealing of the attitudes of psychosurgeons to psychoanalytical terms and ideas.

Pressman examines the creation of the Group for the Advancement of Psychiatry (GAP), led by William Menninger and composed of psychodynamic psychiatrists.\textsuperscript{16} In 1948, the GAP published a report commissioned by the National Advisory Mental Health Council providing guidelines for future research in prefrontal lobotomy.\textsuperscript{17} Pressman reads this report as critical of lobotomy and quotes its assertion that psychosurgery “represents a mechanistic attitude toward psychiatry which is a throwback to our pre-psychodynamic days.”\textsuperscript{18} Pressman does not, however, quote the remainder of the very same sentence, which claims that this “in itself would not be of great concern if it were successful and did not harm the patient.”\textsuperscript{19} Hence, for the formulators of the GAP report, the flaw in lobotomy does not lie within its theoretical assumptions but, rather, in its results. Indeed, the report continues to outline studies that could help determine “definite clinical indications and controls so that [lobotomy’s] usefulness will not be diluted by utilization in situations where it can do little good and much harm.”\textsuperscript{20} Thus the criticism in the GAP report pertained mainly to the usage of psychosurgery and the lack of unbiased studies of the procedure rather than to the procedure itself. Although the report is critical of the “aggressive propagandizing” of those who perform the procedure, this group is described as being “equally biased” against those who are “against” the operation, and the report emphasizes the lack of “serious and scientific workers” performing research in the field.\textsuperscript{21} Pressman also

\textsuperscript{14} For example, Pressman cites the suggestion given by psychoanalyst Smith Ely Jelliffe, upon hearing of the development of psychosurgery, to excise solely the anal areas in the brain: Ibid., p. 84.
\textsuperscript{15} Ibid., p. 367.
\textsuperscript{16} Ibid., pp. 367–75.
\textsuperscript{17} Ibid., p. 385; Group for the Advancement of Psychiatry (GAP), “Research on Prefrontal Lobotomy” (Report no. 6), June 1948, p. 1.
\textsuperscript{18} Pressman, \textit{Last Resort} (n. 1), p. 372.
\textsuperscript{19} GAP Report (n. 17), p. 2.
\textsuperscript{20} Ibid.
\textsuperscript{21} Ibid., p. 1.
claims that the GAP report, which resulted in three research conferences on psychosurgery,\(^22\) led to “a new appreciation of psychosurgery’s importance as both a therapy and a research subject,”\(^23\) and hence did not ultimately constitute a significant criticism of lobotomy on the part of psychodynamically oriented psychiatrists. Indeed, Gerald Grob writes of this report that it “denigrated not the surgery, but the absence of scientific controls that might shed light on its therapeutic effectiveness.”\(^24\)

Pressman claims that the dynamically oriented psychiatrist William Menninger was not “wholly opposed” to somatic therapies and was attempting to create facilities for outpatient shock treatments, while at the Menninger Clinic, neurosurgeons performed lobotomies.\(^25\) Although Pressman describes the professional dissent between what he terms the different “therapeutic camps,”\(^26\) the fact that members of these different camps did not entirely reject the opposing therapeutic approach, and that many of the psychiatrists he cites, such as Paul Hoch, Lothar Kalinowsky, and William Menninger, in fact endorsed a dually somatic and dynamic approach is downplayed.

In contrast with Pressman’s approach, I will bring the publications of members of both “camps” and the language and main concepts used by them to the forefront in this essay as a means with which to evaluate the relations between psychosurgery and psychodynamic approaches, and to question the clear demarcation between these two groups of practitioners.

Jonathan Sadowsky refers to Harry Stack Sullivan’s response to somatic therapies, including psychosurgery and electroconvulsive therapy (ECT), which was unequivocally critical;\(^27\) yet further on in the article, he clearly states that Sullivan’s quote, “often adduced,” appears as a footnote in his published lectures: “an obscure place to be leading a psychoanalytic charge against ECT.”\(^28\) Indeed, as Sadowsky himself notes,\(^29\) Sullivan’s

\(^{22}\) For an account of these developments, see Pressman, Last Resort (n. 1), p. 385.

\(^{23}\) Ibid.


\(^{26}\) Ibid.


\(^{28}\) Sadowsky, “Beyond” (n. 27), p. 21.

\(^{29}\) Ibid., p. 7 (n. 18).
comment has been frequently cited as an example of psychoanalytic opposition to somatic therapy, although there is much to indicate that his response was the exception rather than the norm. Elsewhere, Sadowsky cites Pressman’s representations of analytic criticism, and thus terms Jelliffe an “early critic of lobotomy,” which I claim is a misreading of Jelliffe’s remarks that was perpetuated by Pressman’s interpretation. In contrast, Valenstein has followed Jelliffe’s remarks on lobotomy and has come to conclusions similar to those presented here.

In fact, Sullivan, who is often cited as an example of staunch analytic opposition to somatic therapies, might have criticized lobotomy often, and yet his published criticism is scant. The same sources are cited by several researchers, perhaps creating an impression of a larger volume of criticism, and yet the only two references cited by Pressman and Sadowsky are the aforementioned lecture and the brief, but certainly significant, criticism (two pages within a twenty-three-page editorial) in Psychiatry in 1943.

Additional authors have addressed the relations between somatic and dynamic approaches to mental illness. Edward Shorter, in his A History of Psychiatry, clearly delineates between biological and analytic approaches in psychiatry, championing the first while claiming that psychoanalysis has become “one of the dinosaur ideologies of the nineteenth century.” As Gerald Grob noted in his review of the work, Shorter begins by arguing that biological treatments are superior to psychoanalysis but ends with the statement that a dual approach has been proved to be most effective. Hence, maintaining his biological bias, Shorter does not address the interconnections between somatic and dynamic approaches, presenting two opposing camps that finally merge in the daily practice of the practitioner. In his discussion of lobotomy, Shorter presents an overview of the history of the procedure, beginning his discussion with the claim that “the idea of operating on the brain to cure madness does not seem intrinsically

32. Pressman refers to the same reference as does Sadowsky, while Valenstein and Stepansky both refer to the editorial in Psychiatry. Pressman, Last Resort (n. 1), p. 366; Sadowsky, “Beyond” (n. 27), p. 6; Valenstein, Great and Desperate (n. 1), p. 180; Stepansky, Freud, Surgery (n. 3), p. 198.
unreasonable,” continuing with a discussion of what he terms examples of “successful psychosurgery.”37 Yet he claims that “in retrospect, frontal lobotomy was indefensible for ethical reasons,” an assertion that remains undeveloped and is followed by citations of researchers who attributed a certain therapeutic success to lobotomy. In a work that focuses on the relations between somatic and analytic approaches, yet presents the history of psychiatry as the history of the conflict between the two, Shorter does not address the relations between these two approaches as exemplified through the history of lobotomy.38

Early Responses of Analysts

In characterizing the different responses, I use the term “psychodynamically oriented psychiatrists” to describe those psychiatrists who received at least basic psychodynamic training, were members of professional organizations, and published in known journals propounding a dynamic approach to mental illness. At the time, as Nathan Hale claims, the term psychodynamics, which had previously been applied to Meyerian psychobiology, was increasingly becoming a synonym, or even a euphemism, for psychoanalytic theory.39 Most psychotherapeutic treatment, though not strictly psychoanalysis, was modeled after psychoanalytic treatment, and a growing number of psychiatrists received analytic training. The term “psychosurgeons” refers to the spectrum of physicians who practiced psychosurgical techniques and published their results in different medical journals, regardless of their training. This is because different physicians of diverse surgical backgrounds practiced psychosurgery without receiving certification and without forming a psychosurgical organization.

37. Ibid., p. 225.
38. Additional works, such as anthropologist Tanya Luhrmann’s study of the theory and practice of American psychiatry, have addressed the relations between psychotherapy and biological treatments in psychiatry following the advent of psychopharmacological therapies. Authors including Jonathan Metzl and David Healy have written of the impact of psychopharmaceuticals on the shaping of American psychiatry. Metzl, through a gender-focused analysis, demonstrates that in many ways, the psychoanalytic discourse was, in fact, continued within the “scientific” pharmacological discourse, and Healy has focused on the conceptual changes in psychiatric discourse following the advent of psychopharmacology. See Tanya M. Luhrmann, Of Two Minds: The Growing Disorder in American Psychiatry (New York: Alfred A. Knopf, 2000); Jonathan M. Metzl, Prozac on the Couch: Prescribing Gender in the Era of Wonder Drugs (Durham: Duke University Press, 2003); and David Healy, The Creation of Psychopharmacology (Cambridge: Harvard University Press, 2002).
Leading American psychiatrist and psychoanalyst William Alanson White was one of the lone voices who protested vehemently against the use of psychosurgery. White, a critic of many somatic treatments, had also publicly condemned the eugenic movement in the United States in previous decades. Upon hearing of Moniz’s initial publication of his preliminary results, he expresses his distaste in a letter to Smith Ely Jelliffe, one of America’s foremost psychoanalysts:

I do not know all the details, but I think they stick in something through an opening on each side called a leucotome which is for the purpose of scooping out the white matter . . . I could express the whole matter in one word, but I do not want you [sic] to do that because it would be unmailable. However, something that is worth while in this situation may have escaped me, but you naturally know my disinclination to consider the destruction of the organ in which the difficulty lies as legitimate therapy.

As superintendent of St. Elizabeths Hospital, White refused to allow Walter Freeman to perform lobotomies there (Freeman also describes this in his correspondence and publications). Following White’s death in 1937, his successor as superintendent, Winfred Overholser, allowed the performance of lobotomies but strictly regulated the practice, as will be discussed later in this section.

White’s objection to lobotomy was unambiguous, but his colleague, Jelliffe, responded differently to the advent of lobotomy. At a meeting of the New York Neurological Society in 1938, Freeman and Watts presented their work on lobotomy, which was followed by an animated discussion on the topic. Jelliffe counters Freeman’s presentation of his work on lobotomy with the following suggestion:

Psychoanalytic psychiatry has pointed very clearly to a highly important organ libido investment in the “compulsion neurosis”. This is the cathexis of the

43. American neurologist and pathologist Walter Freeman (1895–1972) had a cardinal role in the development and active promotion of the lobotomy procedure in the United States. For a complete biography of Freeman, see Jack El-hai, The Lobotomist: A Maverick Medical Genius and His Tragic Quest to Rid the World of Mental Illness (Hoboken: J. Wiley, 2005).
anal sadistic with it massive hostility drives . . . if there could be an isolation of the frontal association wires of these anal sensory perception areas, one might do some definite cutting instead of putting the whole instrument out of commission in order to correct a difficulty that is possibly localized in only a part of it.44

In Jelliffe’s response, the appropriation of both psychoanalytic terms and medico-surgical thought is evident. He suggests using the psychoanalytic model in order to better localize the specific areas that should be surgically removed. This mixing of metaphorical localization with a concrete surgical suggestion can be viewed as an attempt to reconcile two apparent theories with different beliefs on etiology and implications on treatment in order to shape a uniform conception of mental illness. In his response, Jelliffe demonstrates his acceptance of the concept that a surgical approach can be a valid treatment of psychiatric illness and that psychoanalytic understandings can be translated into somatic interventions. In my opinion, this can hardly be seen as criticism of the concept of psychosurgery: his critique here is confined to technique and localization rather than to the notion of a surgical intervention. On this point, I follow Valenstein’s reading, in which he claims that “Jelliffe did not argue against lobotomy so much as suggest refining it to conform with psychoanalytic theory.”45

Similarly, in Jelliffe’s responses to the appearance of different somatic treatments prior to the advent of lobotomy, we can also see a mixed discourse combining somatic and dynamic ways of thought. For example, in a discussion in 1937 on the usage of hypoglycemic therapy (insulin shock), he claims that “the death threat by withdrawal of glycogen forces definite withdrawal of libido from the aggressive, hostile, anal, oral and other negativistic behavior patterns.”46

At the same 1938 discussion on psychosurgery, neurologist Kurt Goldstein, today renowned for his theories on holism,47 suggested combining psychosurgery and psychotherapy, a suggestion which later proved to be indicative of common psychiatric practice:

47. On Kurt Goldstein and the development of his holistic neurology, see Anne Harrington, Reenchanted Science: Holism in German Culture From Wilhelm II to Hitler (Princeton: Princeton University Press, 1996).
If we consider mainly the postoperative diminutions of the compulsive tensions there arises the question: Should these patients not be treated after operation by psychotherapy?... I should think that psychotherapy may be very helpful after operation. I consider this point just as important as psychotherapy after the insulin treatments in schizophrenics.48 [Italics in original]

Similarly, combined psychodynamic explanations of the mechanism of action of somatic treatments were given by a wide variety of practitioners. In a panel titled “Neurosurgical Treatment of Certain Abnormal Mental States,” published in JAMA in August 1941,49 Roy Grinker, a psychoanalyst who had trained with Freud in Vienna, was surprised to find himself in the role of the opposition in a panel composed mainly of neurologists and neurosurgeons.50 He attempts to present a competing explanation of the effects of lobotomy:

You bring your patient into the hospital ward. You operate on him. You supply him with a nurse. You pay a lot of attention to him... I should like to know how you can determine that it isn’t the effect of your new psychologic interest in this patient and not the operation you perform.51

Grinker did not, in fact, entirely oppose the operation and conceded that it had its value. He compared opposition of lobotomy because of “an emotional attitude toward an operation that destroys brain tissue”52 to the attitude of the Church toward abortion or contraception and claimed that both sides were biased against psychosurgery. He was willing to accept the idea that a procedure involving the destruction of organically healthy brain tissue might have therapeutic value in the treatment of the severely mentally ill.

Grinker was in a minority in this panel, and his therapeutic beliefs and even his manner of speaking were called into question.53 It seems

49. The invited participants were Walter Freeman, M. A. Tarumianz, Theodore Erickson, J. G. Lyerly, H. D. Palmer, and Roy Grinker. The moderator was Paul Bucy. A condensed version was published as “Neurosurgical Treatment of Certain Abnormal Mental States” in JAMA, 1941, 117: 517–26, and the entire typescript of the discussion is conserved in the Freeman/Watts archives, box 16, folder 23 (referred to hereafter as “typescript” for brevity). The citations that were not published in the JAMA version will be quoted from this reference.
50. In the original typescript (n. 49), Grinker states that “although I was not informed, I am apparently here to criticize the procedure as best I may and at least to indicate some words of caution” (p. 87).
52. Typescript (n. 49), p. 87.
53. Freeman responds to Grinker’s claims and notes that throughout the discussion, instead of saying “‘I think’ or ‘I know’ or ‘I believe,’” Grinker said “‘I feel.’” Freeman takes this as an indication of a lack of rational approach: ibid., 112–13.
that Grinker’s remarks regarding the use of psychotherapy were lost among the presentations of physiological variables, series of operations and their results, the appearance of certain neurological reflexes, and an altogether medico-surgical discourse. In accordance with this “scientific” manner of expression, Grinker was asked by his colleagues to predict “what success can be anticipated with psychotherapy in involutional melancholia and in the institutionalized schizophrenic patients.” Grinker could not offer numbers or concrete data, responding: “it depends upon the type of patient. It depends on the type of patient. It depends on the psychotherapist.”

Grinker continued, suggesting that Freeman might think that a lobotomy “may get rid” of his anxiety, but that he was “truly” anxious about psychosurgery. Yet even this anxiety concerning the procedure is qualified; Grinker was anxious about the future care of “not those state hospital patients or institutionalized patients who have had years of conservative and less radical measures, but the general group of people floating around this country with psychoses and psychoneuroses who will, if we are not very careful, be mutilated by this operation.”

Albeit jokingly, Grinker clearly cautioned against indiscriminate use of lobotomy while demonstrating his firm belief in the usefulness and necessity of psychodynamic methods of therapy. Still, he conceded the possible justification of such a procedure, and emphasized that he was not ideologically opposed to psychosurgery as a form of treatment for the mentally ill. His anxiety was limited to the use of the procedure for those patients who had not been subjected to years of persistent therapeutic attempts. Thus it so happened that, while issuing words of caution, a leading American proponent of psychoanalysis and a psychodynamic etiology of mental illness would attest to the wisdom of a surgical intervention on the brain.

The Response of Psychosurgeons

As psychoanalysts grew accustomed to the theory and practice of psychosurgery as partners in the psychiatric playing field, psychosurgeons similarly referred to and incorporated psychoanalytic theory in their professional writing. Throughout his psychosurgical career, Freeman used the phrase “lobotomy bleaches the affect attached to the ego” in order to explain how the procedure affected the patients. In many of his

54. “Neurosurgical Treatment” (n. 49), p. 527.
55. Typescript (n. 49), p. 117.
articles this phrase is reiterated, and in 1941 he published a paper on lobotomy titled “The Frontal Lobes in Their Relationship to the Ego and the Future.” In a conference in 1943, Freeman explained the effects of lobotomy on the ego:

It would seem, therefore, that prefrontal lobotomy abolishes many of the symptoms of mental disorder by bleaching the affect attached to the ego. Symptoms such as anxiety, worry, apprehension, obsessive thinking and the like are prominent in most of the psychoses at least during their inception. These symptoms have an egocentric signature. . . . By reducing the emotion expended upon the ideas relating to the self, prefrontal lobotomy reduces the significance of the self to the self and tends to abolish egocentricity.

Here Freeman clearly uses terms and concepts from a psychodynamic approach to mental illness, referring to the affect and the ego and to concepts such as threats to individual integrity. Freeman often used terminology taken from the psychodynamic disciplines rather than from the neurological and pathological discourses in which he was trained.

It was not only Freeman who incorporated terms and concepts from different disciplines. In the discussion of a paper titled “Behavior and the Frontal Lobes” given by Freeman and Watts at the New York Academy of Sciences, the respondent, S. Bernard Wortis, made the following statements:

This paper is a most important contribution to our knowledge of the functions of the frontal lobes in man. . . . The[se] superego functions, concerned with the interpersonal relations, have important relations with the frontal lobes. . . . Is the surgeon justified in depriving a person of the most important part of his intellect in order to relieve him of emotional difficulties? We have heard from Doctors Freeman and Watts that such patients after operations are often lazy, undiscriminating, and have impairment of insight. True, some lose their obsessive worries, but at the expense of impairment of the highest integrations of their conscience or superego functions. It therefore seems to me that other less drastic therapeutic methods should be used first.[ . . . ] The infant, with little association frontal lobe development, has poorly developed superego function; he socializes poorly, is egocentric. The normal adult has good frontal lobe function with some capacity to project himself into the future. This makes for social progress.  

This commentary, which combines neurological and psychoanalytical terminology, was given by a neurologist and psychiatrist who had completed his psychoanalytic training in 1936 and was a member of numerous physiological and psychodynamically inclined societies. His remarks on the effect of the operation on the patients’ ego function were given after a paper by Freeman and Watts, demonstrating how research on the effects of lobotomy could be interpreted in various manners and through the eyes of different theories. Trained in both neurology and psychoanalysis, Wortis could perceive the results of Freeman and Watts as being a “most important contribution” to knowledge of the frontal lobes—knowledge that could be expressed in various terms and that could rely on different theoretical backing. Frontal lobe function could be equated with superego function, which, in turn, could parallel social progress.

These trans-disciplinary crossovers could be seen in daily practice. In a 1947 letter to Freeman, a Chicago colleague, psychiatrist Alfred P. Solomon, presented the following clinical query:

Have you had any experience in the therapeutic results of lobotomies done on patients who are withdrawn, mute, must be tube fed, who lie motionless in bed except for occasional spontaneous activities such as urination, defecation, and even shaving, who tend to get more actively withdrawn under observation, and who respond to sodium amytal injections with the same kind of complete temporary reversal symptoms as those with real catatonia? [. . . ] During periods when he was brought out of this withdrawal state by sodium amytal or carbon dioxide gas mixture, he exhibited a good ego except for some paranoid trends. . . . Unless he is tube fed he will die of starvation. I am intrigued by the soundness of his ego revealed on sodium amytal administration.50

Thus we can see that even in this severely disabled patient, the ego function, the “soundness” of which could be revealed by sodium amytal, was a consideration in deciding whether to perform a lobotomy.

Mixed Discourse

Although very few psychoanalytically oriented psychiatrists openly criticized psychosurgery, and although those who did criticize it, like Smith Ely Jelliffe and Roy Grinker, did so in uncertain terms, quite a few psychoanalytically inclined psychiatrists published papers that supported psychosurgery and presented psychotherapy and psychosurgery as com-

60. A. P. Solomon to W.F., Freeman/Watts archives, box 1, folder 3, 9 August 1947.
plementary treatments. These papers, whose authors combined medical and psychodynamic viewpoints in order to evaluate patients, are similar in form to those published on the preceding somatic developments. Following the advent of different somatic forms of treatment, such as metrazol convulsions and insulin therapy, various dynamic explanations for the actions of these forms of therapy were offered, and these were published in a variety of leading journals in the field. Papers such as “The Effects of the Hypoglycemic Therapy on the Psychotic Process,” published in the American Journal of Psychiatry, and William Menninger’s “The Results with Metrazol as an Adjunct Therapy in Schizophrenia and Depressions,” published in the Bulletin of the Menninger Clinic, demonstrate an attempt to synthesize these two approaches. Both the American Journal of Psychiatry, in which Freeman published many of his papers, and the psychoanalytically minded Bulletin published papers that were designed to bridge disciplinary differences and enable cooperation between psychiatrists of seemingly opposing schools.

This ecumenical approach in regard to psychosurgery is evident in papers published in a wide variety of journals by various authors. In a paper titled “Some Aspects of Lobotomy (Prefrontal Leucotomy) Under Psychoanalytic Scrutiny,” physician Jan Frank of the Menninger Foundation, who was a member of numerous psychoanalytic associations and Director of the Topeka Institute for Psychoanalysis, reported his experience with over three hundred lobotomized patients. He followed their psychoanalytic treatment, evaluated their dream content, and presented pre- and postoperation drawings, reaching the following conclusions:

I think the only clinical criterion which remains available for the indication of lobotomy, considering the many variables, is the intensity and duration of the suffering to the patient. To summarize: the emotional asymbolia caused by lobotomy drains away a psychic dimension. The forebrain, so far as gross functional representation goes, is an important instrument for the integrity of the preconscious system. Lobotomy, by the subsequent defensive hypercathexis and constriction of the egoboundary, enables the psychic apparatus in some cases to ward off the flooding by id derivatives.

Frank uses psychoanalytic terms and concepts to describe the results of a medico-surgical procedure. Although he relies on psychoanalytic theory in order to explain the procedure’s result, he clearly propounds a theory based on localization—the forebrain is seen as part of the preconscious system. This can be seen an attempt to consolidate the two theories into one common approach based on the appropriation of choice concepts from each.

Frank’s paper is quoted extensively in a chapter titled “Psychoanalytic Observation Regarding the Dynamic Effects of Frontal Lobe Surgery,” by Elizabeth Zetzel, published in the study *Frontal Lobes and Schizophrenia*. The author, herself a psychoanalyst, criticizes her colleagues’ silence in face of psychosurgery, claiming that “the fairly general antipathy” of psychoanalysts towards lobotomy “has mitigated against objective research.” She explains that there have been very few reports on dynamic changes following lobotomy and that the only “strictly psychoanalytic” report was that by Frank. Thus it seems that this “antipathy” to which she refers did not make its way into professional publications but rather serves to explain the lack thereof. At the close of the chapter, she claims that lobotomy cases “provide us with an opportunity to investigate psychodynamics of organic mental states.” Zetzel sees no disjunction between psychoanalysis and somatic therapy and, in fact, argues that new knowledge in psychoanalysis can be gained through a somatic treatment.

Similarly, Lothar Kalinowsky, a leading proponent of somatic treatments for mental illness and author of numerous articles and books on shock therapy and additional somatic treatment, expresses a similar wistfulness regarding cooperation between somatic and dynamic practitioners. In the first paragraph of an article devoted to the question of transference and psychotherapy in shock treatments and psychosurgery, Kalinowsky writes:

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65. Ibid., p. 185.
66. Ibid.
67. Ibid., p. 193.
It is unjustified and regrettable that psychiatrists applying somatic treatments and psychoanalysts are often so far apart in their type of work that no systematic studies have been undertaken to evaluate phenomena such as transference and countertransference during these treatments and their importance for the subsequent handling of the transference situation in psychotherapy after the various somatic treatments. The biased opinion that somatic treatments exclude the application of psychotherapy is certainly unjustified.69

Specifically stating that psychotherapy and somatic treatments can be seen as complementary, Kalinowsky goes on to evaluate the transference relations manifested by postoperative lobotomy patients, which he claims can be “sounder” than those manifested by preoperative patients due to a reduction in anxiety.70

A zealous attempt at a psychoanalytical explanation of lobotomy’s effects is offered by Eugene Brody71 in a paper presented at the American Psychoanalytic Association in 1956. Bearing the intriguing title of “Superego, Introjected Mother, and Energy Discharge in Schizophrenia: Contribution from the Study of Anterior Lobotomy” and abundant with references to classic psychoanalytic texts, Brody’s paper offers a highly interpretive psychoanalytic explanation of the schizophrenic’s post-lobotomy condition. His writing is an apparent endorsement of the procedure, and his concluding sentence is:

In this sense, the lobotomized schizophrenic is a more successful schizophrenic in that he has achieved what he has always wanted: that oral reunion with his mother previously feared as engulfing or devouring and threatening to his identity.72

This paper, written after the development of pharmacologic treatments for mental illness, does not present lobotomy as a last resort but, rather, defines lobotomy, together with electroshock and drugs, as artificial means of producing an “intrapsychic steady state.”73 It demonstrates the author’s

70. Ibid., p. 402.
73. Ibid., p. 498.
perception of the relations between psychoanalysis and somatic psychiatry: he describes the available variety of somatic treatments but then attempts to persuade the reader that lobotomy is in fact a continuation of the same psychoanalytic ideas by other means.

It was not only the standardized “lobotomized schizophrenic” who was described; articles describing case studies of successful lobotomized patients and psychoanalytic evaluations of their postoperative functioning were published in different journals. Psychoanalytically trained psychiatrist James Cattell, author of a number of articles on the psychoanalytic aspect of lobotomy, published an article titled “The Alterations of Ego Functioning after Topectomy,” which was based on a case study, in the journal *Psychoanalytic Review*:75

Through repression, denial, isolation and undoing, she [the patient] managed to remain oblivious to her angry and erotic feelings toward parents during childhood and adolescence, in her pursuit of father-type men, and at the time of her mother’s death and her father’s remarriage. . . . A bilateral prefrontal topectomy was performed on 7-28-49 with uneventful surgical recovery. . . . [S]he was seen regularly in frequent psychotherapeutic sessions. Dependency on the therapist initially was much more marked and straightforward than preoperatively . . . Long-term studies of such patients [obsessive-phobic-depressive patients] before and after some of the less radical psychosurgical procedures can provide data which will give us a better understanding of the variations of dynamic constellations and ego functioning.

The patient’s pre- and postoperative situation are described in psychodynamic terminology, and psychosurgery seems to be presented as a legitimate therapeutic choice that might even facilitate certain aspects of psychotherapeutic treatment. The effects of psychosurgery on the superego and ego are described in psychoanalytic terms. Once again, the author patently states his expectations that the study of psychosurgical patients can contribute to the body of knowledge in psychodynamic theory, hence reaffirming the belief that dynamic understandings can be derived from organic data.

Cattell had also coauthored an article demonstrating the benefit of the use of psychosurgery for “pseudoneurotic schizophrenia” with an

74. Topectomy is a psychosurgical procedure which consists of the ablation of a smaller amount of the frontal lobe cortex than would be ablated in a lobotomy. It was performed for the same indications, mainly by neurosurgeons, as it was a more complex procedure than transorbital lobotomy.

organically oriented psychiatrist, two neurosurgeons, and a physiologist-neurologist. Similar multidisciplinary articles were published in many different journals; in the American Journal of Psychiatry, a six-year follow-up of forty-five lobotomy patients offering a dynamic interpretation of lobotomy describes the results of lobotomy in terms of ego structure. In this article, the author suggested that the disruption of intracortical pathways in lobotomy “results in a disturbance of homeostatic balance with a corresponding disruption of its dependent ego structure.” The results of the procedure were evaluated in terms of “ego resynthesis,” and the author suggests that “the use of extensive psychotherapy in the immediate postoperative period might aid the process of ego resynthesis and thus increase the possibility of improvement.”

Indeed, psychotherapy following lobotomy was common, as were patients who were in therapy up until their operation. The following letter from Freeman’s patient illustrates how patients often viewed the different treatments to be complementary and sought treatment by both methods:

Dear Dr Freeman,
Have received your Christmas Card and letter to [sic] . . . [H]ave been receiving treatment (Psychotherapy) under the case of Dr William Weisdork 8 South Michigan Ave. A lot of exploration was done regarding my childhood and my past. Learning the reason for those disturbances and with the proper application all my problems can be ironed out. . . . Please accept the assurance of my profound respect and appreciation of your very kind letter.

No conflict between treatment by psychosurgery and treatment by psychotherapy is perceived, and the patient informs Freeman of the progress he is now making with the “exploration of his childhood.” The fact that the patient is currently undergoing psychotherapeutic treatment does not lead him to form a negative opinion of the operation he had undergone or of the physician who had performed it.

The popular press showed an equal propensity to combine disciplines and terminology. On 3 March 1947, a singularly optimistic article on the “spectacular” results of psychosurgery was published in Life magazine. Accompanied by three caricatures made by Russian-born artist Boris

78. Patient M.A. to W.F., 5 February 1956, Freeman/Watts archives, box 1, folder 7.
Artzybasheff depicting the ego, the id, and the superego, together with a diagram of the brain inside a sketch of the human head, the article claimed that “[t]he surgeon’s blade, slicing through the connections between the prefrontal area (the location of the superego) and the rest of the brain, frees the tortured mind from its tyrannical ruler.” Such a mixture of concepts in the attempt to reconcile two very different theories of mental illness characterizes popular notions of both psychosurgery and psychotherapy of the time.

Collegial relations existed between many psychosurgeons and psychoanalysts. Freeman employed his junior colleagues as his assistants in his practice, and three of his four assistants ultimately pursued a career in psychoanalysis rather than in general neurological and psychiatric practice. Of these, Oscar Legault, who assisted Freeman in his dealing with lobotomy patients, went on to publish an article titled “Denial as a Complex Process in Post Lobotomy,” a copy of which was presented to Freeman with the following note:

Dear Walter, Needless to say, I deeply appreciate the tolerance and help on your part that made this paper possible. I have profited by the observation of them.

My regards to you and the family, Oscar

Legault’s article, in which he quotes extensively from the publications of Freeman and Watts, was based on a follow-up of psychiatric patients from his private practice whose operations had been performed with the Freeman-Watts technique. Legault claims that the denial of lobotomy is more than simply a result of anatomical impairment. Relying on obser-

80. Valenstein refers to this same article and reproduces the caricature within his book. He refers to its usage of psychoanalytic terminology and its claim that the lobotomy destroys the superego, and compares this to a similar article published in Time, which, he claims, “implied that the operation created a superego where apparently there had been none before,” hence, in fact, supplying the very psychoanalytic terminology he found lacking in the Life article: Valenstein, Great and Desperate (n. 1), p. 180.
81. In his unpublished biography, Freeman writes: “Of the four assistants I employed while getting them started, only Bob Groh stayed in the general practice of neurology and psychiatry. The others, Zigmond Lebensohn, Paul Chodoff and Oscar Legault took their G.I. funds to pay for personal psychoanalyses, and became so deeply immersed that I lost them. I believe they sacrificed more than they earned, except possibly in the realm of inner satisfaction with the intellectual agility they developed.” Freeman, unpublished autobiography, Freeman/Watts archives, box 9, folder 1, chapter 17, p. 1.
vations of denial of lobotomy amongst family members of patients, and
drawing from the analysis of a lobotomized patient who ultimately forms
a positive transference relationship with the author, thus obviating the
need to deny the lobotomy. Legault underlines the importance of psycho-
logical phenomena following lobotomy. Thus with Freeman’s help, based
on an extensive survey of publications by Freeman and Watts, Freeman’s
junior colleague and former assistant publishes an article examining psy-
choanalytic aspects of psychosurgery.

A Crescendo of Therapeutic Efforts

Many practicing clinicians viewed somatic and psychodynamic approaches
to mental illness to be on the same therapeutic scale. As demonstrated
earlier, psychotherapy following psychosurgery was considered to be an
acceptable approach. In a crescendo of therapeutic efforts, the psychia-
trist can employ first psychotherapy, then shock treatments and convul-
sions, and finally psychosurgery, often followed by a second attempt at
psychotherapy. This is demonstrated in various professional publications,
including the published proceedings of the first postgraduate course on
psychosurgery, which took place at the George Washington University
School of Medicine in January of 1949. Winfred Overholser, the super-
intendent of St. Elizabeths Hospital who had replaced William Alanson
White following the latter’s death, was far from being an avid supporter
of psychosurgery. His obituary claims that he “abhorred drastic treatment
methods” and “discouraged the use of electric shock and forbade the
use of pre-frontal lobotomy at St. Elizabeths Hospital.”

He continued
White’s tradition of a psychodynamic approach to mental illness. In the
postgraduate course on psychosurgery at the George Washington Uni-
versity, Overholser claims:

Psychotherapy must have been tried so far as is feasible, and if that has failed
some of the more drastic therapies such as insulin or electroshock, unless
there are clear contraindications for that procedure. In brief, our principle
at St. Elizabeths Hospital is that prefrontal lobotomy should be utilized only
as a last resort and that it should in each case be considered an admission of
psychiatric failure.

85. “George Washington University School of Medicine Proceedings of the First Post-
Hence, although Overholser views lobotomy as a method of “last resort,” it is still part of the therapeutic approach, and can be used after additional therapeutic options have been exhausted. Not only psychodynamically oriented practitioners expressed this view. Similar claims are voiced by practicing psychosurgeons; J. Lawrence Pool, a neurosurgeon who performed topectomies, claims:

[A] surgical procedure upon the brain of a mentally disturbed patient, however, should not as a rule be considered until psychotherapy, shock treatment and in some cases psychoanalysis have failed to bring lasting benefits after an adequate trial.\(^{86}\)

It is interesting to note that a neuro- and psychosurgeon advocates treatment with psychotherapy and psychoanalysis, in addition to shock treatment, before recommending surgery. This demonstrates that psychosurgeons also perceived psychosurgery to be on the same therapeutic scale as psychodynamic approaches.

**Shared Venture**

Freeman was interested in promoting psychosurgery among his psychodynamically oriented colleagues and often sent them reprints of his articles and copies of his textbook, *Psychosurgery*. To John Rosen, co-director of the Institute for Direct Analysis at the Temple University Medical Center, Freeman sent a copy of an article dealing with lobotomy and schizophrenia. Rosen responded to Freeman with the following letter:

Dear Walter, Thanks for the reprint which I read in the Journal a long time ago. The paper was warmly written and clearly presents your point of view. On the theory that schizophrenia is the consequence of environmental agents, either from within or without, these must be dealt with. I think that the much talked about genetic factor is part of the inner environment.

My own view is the external environment is at fault and this is the mother. Direct analysis attempt to set up conditions which sever ties between her and the patient the way you sever the communicating fibers in the internal environment.

With kind regards and best wishes your continued success in California, I am,

Sincerely yours,
John N. Rosen, MD\(^{87}\)

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86. Ibid., p. 425.
It is clear that Rosen and Freeman do not see eye to eye on the topic of lobotomy, with the first believing that the external environment is responsible for the onset of the disease, and the latter situating the pathology in the brain—the internal environment. Still, Rosen attempts to present their therapeutic endeavor as being analogous both in goals and in methods. Direct analysis and the severing of ties between mother and patient are compared with the severing of neuronal connections inside the patient’s brain during lobotomy. Depending on the viewpoint, psychoanalysis can be viewed as a metaphoric use of medical terms and methods, or alternatively, psychosurgery can be seen as a concrete interpretation of psychoanalytic technique.

In their classic textbook, Diseases of the Nervous System: A Textbook of Neurology and Psychiatry, White and Jelliffe open the section on psychoanalysis by claiming that “[p]sychoanalysis is a method by which the human mind is dissected, so to speak.” In medical discourse, the term dissection can be taken to refer to the surgical technique of delicate separation of tissue. Conversely, we have Jelliffe’s statement that lobotomy might be a legitimate treatment if the anal areas of the brain were cut, and Freeman himself, who describes in his autobiography how, at a talk in Germany, he had referred to “strangulierte Oedipuskomplex” when drawing an analogy between psychosis and a strangulated hernia.

Freeman himself had an ambivalent attitude to psychotherapy; he questioned neither its basic presuppositions nor its efficacy in certain cases, but was, rather, intent on affirming the value of psychosurgery as a legitimate, and often first-line, treatment in psychiatric therapeutics. For example, in an article on the use of lobotomy in adolescents, Freeman writes:

The purpose of this report is not to cast doubt upon the efficacy of psychotherapy in the average case, but rather to direct an entering wedge of doubt at the opinion commonly held today that psychotherapy is the only modality of therapy available for adolescents in distress.

In an essay titled “With Camera and Ice-Pick in Search of the Super Ego,” Freeman describes the effects of lobotomy in terms of the id, ego,

89. Freeman, unpublished autobiography (n. 81), Freeman/Watts archives, box 9, folder 1, chapter 2, p. 11.
and superego and adds a certain spin on Cannon’s theory of homeostasis to explain humankind’s incessant search for gratification, which Freeman equates to the action of the superego:

For nearly a quarter of a century I have been hunting the Super Ego, not in the conventional Freudian sense of attempting to understand all the ramifications in each individual patient but, rather, by recognizing the handicap the patient experiences from excessive elaboration of self-centered psychic exploration, and then attempting to break through the obsessive trend. . . . My own contribution to the solution of the most malignant forms of Super Ego dominance with consequent frustration has been the severing of connections at the base of the frontal lobes by means of an instrument developed from the icepick and thrust through the roof of the orbit on each side. I am busy now checking the results of some 3000 operations in many parts of the United States. The results run about 75% success in non-hospitalized patients and 35% in patients hospitalized from 2 to 44 years.

Here Freeman almost literally describes his lifework as an attempt to use an icepick in order to free the self from the superego. He uses a mixture of different terms in order to explain the effects of lobotomy and to offer a diverse theoretical framework into which these might be constructed.

Hence we can see that there was an attempt to establish the idea that, although each relied on his own methodology, psychiatrists of different theoretical persuasion were all largely performing the same therapeutic procedures. This can also be tied to the attempt to present psychiatry in general, and especially psychoanalysis, as a legitimate part of the medical profession. Thus Jelliffe, at the advent of psychosurgery, could suggest isolating the anal fibers of the brain and draw a methodological resemblance between psychoanalysis and psychosurgery that was similar to his

92. Kenneth P. Rothfield, M.D., who wrote his bachelor’s thesis on lobotomy in 1984 at Harvard University, interviewed James Watts and asked him, in a subsequent letter, the following question concerning this manuscript: “In this address, Dr. Freeman directly compared the effects of lobotomy to a Freudian model of mental illness. This is the first document I have found so far which makes this comparison explicit. I have enclosed a copy of the speech for you to read, and would appreciate any comments you might have. I am especially curious about whether Dr. Freeman ever compared the frontal lobes to the superego during your association.” No answer is conserved in the Freeman/Watts archives, and Rothfield does not recall receiving one. However, in his thesis, Rothfield states that Watts does not remember any such comparison: Kenneth P. Rothfield, “The Theory and Practice of Psychosurgery: Dr. Walter Freeman and the Lobotomy Era” (unpublished thesis), Harvard University, 1984; Kenneth P. Rothfield to James Watts, 25 January 1984, Freeman/Watts archives, box 10, folder 5; Kenneth P. Rothfield, personal communication, 18 October 2005.
previous assertion that psychoanalysis constitutes the “dissection of the mind.” John Rosen’s comparison of Freeman’s attempts to sever the connections in the brain with the severing of the connection between schizophrenics and their mothers, and Freeman’s claims that his career was, in fact, based on the quest after the superego, demonstrate once again the attempt to portray the psychiatric therapeutic endeavor as one that can be interpreted in various fashions. This is similar to the claims made by both psychoanalysts and biologically oriented psychiatrists such as Kalinowsky that cooperation between psychoanalysts and biological psychiatrists should be strengthened in order to further the state of general psychiatric knowledge. Psychoanalysis and somatic treatments for mental illness were seen as inseparable parts of the domain of psychiatry, sharing goals and methodology. Within this framework, it was possible for psychoanalysts to cooperate with psychosurgeons, for each practitioner to refer his patients to treatment by what was perceived as the “complementary” approach, and for the “ego” to become an important factor in evaluating pre- and postoperative psychosurgery patients.

Psychoanalysis within American Psychiatry

Psychosurgery reached its zenith in the late 1940s and early 1950s, a period that was also characterized by an emphasis on dynamic theories of mental illness. Psychoanalysis had become an all-pervasive theory not only in psychiatry but in general medicine, and had become ingrained in popular discourse. Professional psychoanalytic journals had been established, beginning with Psychoanalytic Review in 1913 and the influential psychoanalytically oriented Menninger Clinic in 1919. The adoption of psychoanalytic jargon in everyday American speech, and the endorsement of psychoanalysis by the pillars of popular culture such as Karl Menninger, in his immensely popular columns in Ladies’ Home Journal and Household, indicate the high degree of reception of psychoanalytic theories both in the professional and popular fields. Among those dealing with mentally ill patients on a regular basis, mainly psychiatrists, neurologists, psychologists, and psychoanalysts of different backgrounds, an acceptance of at least some of the basic tenets of psychoanalysis was prevalent. Already in 1939, psychiatrist and neurologist Abraham Myerson had published the results of a survey of professional attitudes towards psychoanalysis among 428 psychiatrists, neurologists, psychologists, and psychoanalysts, of whom

Myerson proposed four categories with which to define the participants’ attitudes towards psychoanalysis: (1) whole-hearted acceptance; (2) favorable yet retaining skepticism; (3) rejection of its tenets, but belief in Freud’s contribution to human understanding; and (4) complete rejection, and belief that Freud’s work had hindered the progress on mental disease. Among the seventy-five members of the American Neurological Association who had completed the questionnaire, an approximately equally small number completely rejected or completely accepted psychoanalysis, and the rest were divided nearly equally between categories (2) and (3). Of the 179 members of the American Psychiatric Association who had responded, ninety-four classified themselves in either group (1) or (2) or between the two. None completely rejected psychoanalysis.

Myerson also published excerpts from responses and letters from participants in the survey, many of whom were leading figures in the field, and concluded with his personal opinion on the topic. From the responses of the participants, the eclectic form of the acceptance of psychoanalysis is clear; even neurologist Bernard Sachs, who identified himself with group (4), conceded that Freud had contributed to human knowledge. Each of the respondents wrote in detail of which of Freud’s basic tenets they endorsed and which they found incorrect or incomplete. Many wrote that, although Freud had contributed many important concepts, they found the neglect of “physical” factors in mental illness troubling. Nearly all conceded the importance of some of the fundamentals of psychoanalysis in psychiatric practice but quickly added that they combined this with different theories and therapeutic practices in order to form a comprehensive approach. Myerson included his own personal opinion, in which he situated himself in group (3), with an “equal flow” toward both (2) and (4). Myerson included his own interpretation of the consciousness and the unconscious, stating, “[t]o me, the unconscious is the sum total of those drives, instincts and activities which the viscera would naturally bring into action.” Finally, Myerson listed those principles of psychoanalysis that he rejected, along with his reasons. A concrete understanding of psychoanalytic concepts is manifest; Myerson rejected the theory of infantile sexuality, stating that “the infant does not have hormones in his urine or has so little as to be almost negligible” [italics in original]. This survey, published in 1939, demonstrates the widespread influence of psychoanalytic theory among mental health professionals in the United States and the extent

95. Ibid., p. 53.
to which at least some aspects of psychoanalytic theory were accepted by a wide range of disciplines. This partial acceptance yielded a strange result: a mixed psychiatric discourse that incorporated terms and concepts from different disciplines and fields. Thus we can reconstruct the state of the mental health profession at the advent of psychosurgery in the late 1930s and the setting in which psychosurgery was conceptualized and interpreted. This already eclectic field was open to new therapies, and more particularly, to new explanations and theories on the mechanism of action of certain therapies.

Psychotherapy and Somatic Therapy

In their article on the response of the medical profession to psychotherapy, Bowman and Rose claim that psychiatrists are strongly inclined to emphasize the benefits of psychotherapy and to downplay the results achieved by physiological therapies, and “even to become apologetic about them.” This statement is echoed in comments made by Norman Brill, neurologist and psychiatrist, and one of the founding members of the American College of Psychoanalysts. Although Brill believes that psychiatrists are obliged to offer physiological treatments “if they hold some promise of being helpful,” he attributes the fact that “we are less likely to boast of cures that result from physiological therapies than of those which result from psychotherapy” to the feeling that, following successful psychoanalysis, “one feels much closer to the truth than when using so-called physiological treatments.” Indeed, as demonstrated through the psychoanalytical explanations of the mechanism of hypoglycemic shock and Metrazol, many of the somatic treatments of the early twentieth century were interpreted within a psychoanalytic framework. This is abundantly evident in the psychoanalytic discourse on lobotomy. Psychotherapy following lobotomy enabled the psychotherapist to take credit for the perceived success of the patient’s treatment. Incorporating psychotherapy into psychosurgery entitled therapists to a share of the therapeutic pie that was lobotomy. However, psychotherapists did not attempt to steal the show by presenting psychotherapy as the “real” reason for patients’ improvement, and they did not question the value of the surgical approach to mental illness. Many psychoanalysts and psychodynamically oriented psychiatrists were content to present the unsuccess-

ful therapy attempted prior to surgery and the improved postoperative psychotherapeutic relationship. The wisdom of a surgical intervention on a patient undergoing psychotherapy or analysis was not questioned; yet the results that the psychiatrists “boasted” about following surgery often pertained to the patient’s improvement in the psychotherapeutic course of treatment, in analytic terms such as Eugene Brody’s “successful schizophrenic” who attains an “oral reunion with his mother.” Thus the willingness of psychodynamically oriented psychiatrists and psychoanalysts to collaborate with psychosurgeons and to form dynamic theories on patients’ postoperative situations can be tied to their desire to attribute the perceived success of psychosurgery to their own therapeutic efforts and to reaffirm psychosurgery’s place within the psychiatric discipline. If, in fact, as Bowman and Rose’s article claims, “psychiatry” had become almost synonymous with “psychotherapy” in everyday parlance, and if “psychiatry’s main claim to distinction as a specialty rests on a system of psychotherapy based on a sound theoretical framework customarily called psychodynamics,” an appropriation of the results of psychosurgery into psychodynamic discourse would strengthen the disciplinary standing of psychiatry and its therapeutic armamentarium. A surgical procedure that was performed mainly by neurosurgeons and only later, with the advent of transorbital lobotomy, by psychiatrists, could be more firmly situated in the psychiatric domain if described by terms predominantly identified with advanced psychiatric thought.

The End of the Lobotomy Era

In 1954, the Food and Drug Administration approved the usage of chlorpromazine, which gradually replaced previous somatic therapies, including psychosurgery. Although lobotomies were still performed, they decreased in number, fewer indications existed, and the results of the procedure were no longer as positively viewed. Joel Braslow has described how “chlorpromazine dealt a fatal blow to doctors’ perceptions of lobotomy’s therapeutic effectiveness.” Indeed, by 1955 an article in the American Journal of Psychiatry described the resemblance of the behavior of a treated patient to that of those who had undergone lobotomy, noting, though, that the patient showed “none of the deficits found in the latter.”

omy fell out of favor, drug therapy in psychiatry continued (and continues) to develop, and concurrently, the volume of psychotherapy provided also increased. Hale has evaluated what he has termed the “homogenization of practice” and the creation of a therapeutic approach combining medication and psychotherapy. 102 Although today psychotherapy is practiced together with drug therapy, this does not necessarily indicate a shared discourse or common therapeutic presuppositions. Certainly an eclectic approach is ingrained in current psychiatric discourse, allowing for an orientation that is neither strictly biological nor psychotherapeutic. 103 However, this is distinct from the state of the psychiatric discourse described within this essay, in which two distinct therapeutic modalities attempted to integrate each other’s data and basic presuppositions and thus form a single therapeutic paradigm.

Discussion

Through an analysis of these excerpts and examples, I have attempted to delineate the relations between psychoanalysis and psychosurgery in order to characterize the different responses the rise of psychosurgery elicited and to reconstruct the mutual perceptions of the two professions. As I have tried to show, the dialogue between psychoanalysts and psychosurgeons was characterized by a mutual acceptance of each other’s basic theoretical assumptions. This is demonstrated in writings in which representatives of the seemingly opposed disciplines attest to each other’s legitimacy and adopt a common terminology.

Following Stepansky’s approach, I have taken the excerpts presented in this essay to be representative of the response of American psychoanalysts to psychosurgery, inasmuch as they constitute, to the best of my knowledge, the published response of American psychoanalysts. For lack of other opposition, or other publications or official reports, I take these publications to be reflective of the general atmosphere in the profession at the time. It is certainly possible that many analysts, and additional physicians, found the practice of psychosurgery to be distasteful; yet the fact remains that there are few publications documenting this. Even the GAP report on prefrontal lobotomy, which is cited as an example of psychoanalytic criticism of psychosurgery, constitutes not a critique of the technique

but, rather, of its widespread use and lack of scientific control. This is in contrast, perhaps, with the situation in Great Britain, where pediatrician and psychoanalyst Donald Winnicott addressed numerous letters to the *British Medical Journal* voicing his objection to psychosurgery.104

The examples analyzed in this essay demonstrate a concrete understanding of psychodynamic terminology both by biological psychiatrists and neurologists but also by psychoanalytically trained psychiatrists. The ego is understood as a concrete concept that can be evaluated under pharmacologically altered circumstances (e.g., sodium amytal), and can be said to have improved or not; the superego can be correlated with the frontal lobes, and psychoanalytic concepts can be quantified and measured. Similarly, in the medicalized discourse of the psychosurgeons and the biologically oriented psychiatrists, the psychoanalytic terms became endowed with literal meanings and could thus become part of the prevalent, biological discourse. Thus psychosurgeons and psychoanalysts could find a shared discourse and a similar terminology, which enabled their collaboration and the mutual acceptance of each other’s therapeutic methods, and ultimately led to suggestions of combined treatment with psychosurgery and psychotherapy.

An additional, external factor must be taken into account when evaluating the relations between psychosurgery and psychoanalysis, and that is the role of mass media. Both therapies were widely covered in the media, articles on miraculous recoveries by means of both surgery and analysis were published in leading newspapers, and, as I have demonstrated with the example in *Life* magazine, the boundaries between the two disciplines were often extremely hazy. Both psychosurgery and psychoanalysis were matters of public interest and discourse,105 and, thanks to publications in the mass media, psychiatrists were accosted by patients and their families requesting treatment for their illnesses. The wider a range of therapies and theories with which psychiatrists could prove themselves to be familiar and to actively practice or recommend, the better equipped they were to

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react to requests from patients and families. Refusing to refer to surgical treatment or openly condemning psychosurgery would have had far-reaching effects not only in relations with medical colleagues but also in relations with patients and families. This refusal could have long-lasting negative effects on patients and families, who at times specifically requested to undergo this procedure that promised immediate long-lasting relief.

Furthermore, before the onset of psychopharmacology, few effective treatments for mental illness existed, state hospitals were intolerably crowded, and little could be done for chronically ill patients. Lobotomy was seen as a scientific medical approach that offered the hope of an “active” treatment to alleviate the suffering of patients and their families, while firmly situating the field of psychiatry within the domain of scientific progress. This itself was a compelling reason for practitioners to endorse the practice of lobotomy, which, as Pressman has argued in his research, “worked” for patients at the time. Certainly the dismal state of psychiatric medicine, especially at state hospitals, was a contributing factor in facilitating a greater degree of conceptual flexibility in accepting the results of the lobotomy procedure and attempting to incorporate it within a theoretical framework.

A pertinent consideration is that of political and professional interests, which certainly motivated psychiatrists’ choices of which components of discipline to appropriate and in what degree. Clearly, for psychosurgeons, acceptance or rejection by their psychoanalytic colleagues affected their ability to perform lobotomies in certain institutions. For example, Walter Freeman’s partial appropriation of choice psychoanalytic terminol-


107. Jack Pressman makes a compelling argument for how, following his contextualized approach to the history of psychiatry, “at multiple levels, psychosurgery worked—then”: Pressman, Last Resort (n. 1), p. 428.


109. John J. Leveille describes the dominance of analysts in American psychiatry during the postwar period, writing that “analysts took over the most prestigious chairs and university departments in the 1940s,” held leading positions in the American Psychiatric Association, and set the tone in the psychiatric curriculum in medical school: John J. Leveille, “Jurisdictional Competition and the Psychoanalytic Dominance of American Psychiatry,” J. Hist. Sociol., 2002, 15: 252–80, on p. 252. John Sadowsky points out that most of the biological treatments “were developed during the period when psychodynamic theory was at its peak of influence,” Sadowsky, “Beyond” (n. 27), p. 25.
ogy can be seen as a correct understanding of the professional politics of the time, which necessitated the obtaining of hospital superintendents’ support, as well as that of the main figures in the psychiatric arena.

Conversely, for psychoanalysts, the desire to ensure their discipline’s status within the medical profession contributed to the acceptance of procedures like lobotomy. Psychoanalysts in the United States were predominantly psychiatrists, and Nathan Hale has described the “pursuit of [an] alliance with medicine” by way of an emphasis on the “biological nature” of psychoanalysis. The American Medical Association, the American Psychiatric Association, and the American Psychoanalytic Association joined forces to prevent the development of lay analysis, and the proliferation of psychotherapy by psychologists led to attempts to present psychotherapy as a form of medical treatment. Cultivating a primarily medical identity, psychoanalysts did not seem to be interested in rejecting the approaches propounded by their somatically oriented brethren.

In this essay, I have delineated the common discourse of psychosurgeons and psychoanalysts, their mutual acceptance of each other’s basic presuppositions, and their attempts to present their work as being the same. I have also questioned the current historiographical characterization of analysts’ response to psychosurgery as critical and have presented a different interpretation of this response. My claim pertains to the shared discourse of psychosurgeons and psychoanalysts, evident in the examination of writings of individual members, the combined selection of publications in leading psychiatric journals, and the cooperation among practitioners of different disciplines in the field of mental health. I have not attempted to demonstrate the creation of a joint epistemology or therapeutic framework, inasmuch as both psychosurgery and psychoanalysis remained separate, and there were, to the best of my knowledge, no joint symposia, professional training, or journals in such a combined field. While the individual practice of both analysts and psychosurgeons remained distinct, their perceptions of their therapeutic endeavors and their results were conceptualized within a shared therapeutic discourse. This shared discourse is significant in attempting to understand the widespread acceptance of psychosurgery in the United States and the lack of

111. Ibid., p. 215.
113. In fact, Paul Stepansky has claimed that American analysts “always fell back on their professional status as medical men” and hence could “ill afford to ignore an invasive procedure that . . . was emblematic of scientific medical psychiatry”: Stepansky, Freud, Surgery (n. 3), p. 194.
organized opposition on the part of psychoanalysts. One of the explanations for this lack of organized opposition could be that, in the then-current psychiatric discourse, there was no real conflict between the psychoanalysis of the time and psychosurgery; both were endorsed by the same professionals, were researched and reviewed in the same professional journals, and were part of the same professional and public arena.

In addition, as I have demonstrated in this essay, this discourse is indicative of distinct characteristics of American psychiatry at the time. Although certain psychiatrists did in fact recommend both psychoanalysis and psychosurgery for some patients, individual practice is not the focus of my interest. Rather, I have focused on general discourse in the field of psychiatry as a means with which to reconstruct the state of American psychiatry during the period in which lobotomy was widely popular. I take the fact that within this discourse, both psychoanalysis and psychosurgery were seen as valid methods with which to treat mental illness, and the existence of a mutual appropriation of terminology and concepts, to be indicative of a lack of opposition between the two fields. Furthermore, I believe that the distinction set forth by Jack Pressman, in his claims regarding two distinct “camps,” to be artificial, as members of both “camps” published articles reaffirming their acceptance of the basic tenets of the other and often propounded a dual approach that was both somatic and psychoanalytic. As lobotomy is today seen in a very negative light, one might believe that there would have been staunch opposition to the practice, at the very least on the part of psychiatrists holding distinct psychodynamic approaches. Yet through an examination of the psychiatric discourse of the time, a different picture comes to light.114 Although psychoanalysis is often viewed as a comprehensive theory of psychology and psychopathology that encompasses both etiology and treatment of mental illness,115 the excerpts analyzed in this essay do not support this perception. Leading American psychiatric practitioners propounded a singularly syncretistic approach to psychoanalysis, regardless of whether they were trained in this discipline.116 This raises the question of whether psychosurgery and psychoanalysis were, in fact, two separate disciplines or a continuum of

114. Pressman claims that psychosurgery “was damned” from the psychoanalysts’ perspective, while noting that the “polarization between the two camps” was not a necessary event: Pressman, Last Resort (n. 1), p. 367. In this article I have attempted to develop and present a different perception.


116. The eclectic trend in American psychiatry has been described by Hale, Rise and Crisis (n. 39), pp. 160, 343–44, 358.
psychiatric thought. On the basis of the material presented in this essay, the distinction between somatic and dynamic “camps” or even the idea of separate approaches to mental illness seem artificial. The common psychiatric discourse indicates that a spectrum of psychiatric thought would better describe the state of the profession at the time.

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