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Combined therapy: inadequate model; as policy, unethical?

Now is an incredibly exciting time to be practicing psychiatry. Neuroimaging allows us to see a thought, to know the anatomy, physiology and chemistry of a hallucination (which incidentally greatly increases the value and necessity of accurate history and description of signs and symptoms). It allows us to see the brain changes wrought by psychotherapy as well as pharmacology, and shows that they may be quite similar. Epidemiology, particularly high risk studies and cohort studies of normal populations, has demonstrated the precursors of adult psychopathology; what's true and not true about psychoanalytical theories of child development; risk factors for schizophrenia, (genes, paternal age, urban birth and upbringing, intra-uterine and early life infections, head injury and most interestingly disrupted home - or perhaps a really good home protects the genetically at risk child). Genes are being discovered for the major illnesses, for personality (and so indirectly for life events), for drug metabolism (and so for response and side effects), for protection from adverse events (genes determine if loss events cause depression). Whether their effects show is being found increasingly to depend on multiple environmental factors. Genetics was never destiny but now we are learning just how nurture alters nature. Animal models are very exciting: mice with Huntingdon's gene do not get the disease if fed essential fatty acids to the mother from before conception; rat models of childhood neglect or abuse show very specific learning disabilities; and good mothering is passed from mother to daughter, but not by genes. We are learning exactly how the 'bio', 'psycho' and 'social'

influences interact. Most of these advances in knowledge have not yet been translated into treatment but they surely will be.

But there have been some significant advances in treatment. The demonstration that certain specific psychotherapies are effective and for specific conditions is enormously important: cognitive therapy for depression and psychotic symptoms of schizophrenia and OCD, multiple family therapy for schizophrenia, dialectical behavior therapy for borderline personality disorder, interpersonal therapy for depression, desensitization for phobias, supported work for schizophrenia, psycho-education for schizophrenia and so on. Psychopharmacological advances have been great but no silver bullet for schizophrenia yet and there is an ever-increasing awareness of side effects, medical complications and interactions with other medications, (which makes it truly absurd for psychologists with no medical training to be prescribing medications.) The World Health Organization has clearly demonstrated that psychiatric conditions are some of the leading causes of disability in the developing world as much as in the developed. Treatment of psychiatric conditions in poor countries is not a luxury that can wait until HIV, malaria and tuberculosis have been cured.

Do these advances in knowledge affect the way we practice psychiatry?

The May-June edition of Synapse had two articles on changes in the practice of psychiatry. Although psychoanalysis was never widely practiced except in urban centers in Europe and the Coasts of the US it was enormously influential and I think Andrew Hornstein is right in emphasizing its

lesson of listening. The other article, by Alan Tuckman also highlights the importance of psychiatrists knowing well what's going on in their patient's lives as well as with their



medication, and of having a therapeutic relationship with their patients. He rightly criticizes the practice of signing for medication without knowing or fully assessing the patient.

There is however throughout Dr. Tuckman's article an implication which I think must be challenged: that is that "psychotherapy and where needed, medication" with "45-50 minutes session", what I call in my title 'combined therapy', is the ideal and that alternatives may be unethical. I strongly disagree. Combined therapy suggests a model of psychiatric illness that is wrong and as a practical treatment it is limited.

Before explaining why it is wrong I must emphasize that I believe all doctors, seeing any patient, should listen very carefully to

Continued on page 3 

In This Issue...

- 2 Subpoenas Revisited
- 4 Lipman Award
- 6 Walter Freeman

Subpoenas Revisited

Every psychiatrist for many years has known about the "Tarasoff Warnings," a legal doctrine that evolved from a case in California, "Tarasoff v Regents of the University of California," in which a psychiatric patient killed a former girlfriend and her estate brought suit against the therapists and their employer, the University of California, for not interceding in some fashion to prevent this harm. Interestingly, while we all know that patients routinely

make overt or veiled threats against others during psychotherapy, most therapists will never activate a "Tarasoff Warning" throughout their practices, since discussions with the patient invariably lead to the patient modifying or withdrawing the threatening statement.

Despite the Tarasoff concept being written about repeatedly in the psychiatric literature, there has never been any scientific evidence to prove that the "duty to warn" has any proven benefit. And, as a matter of fact, and it may even do harm through frightening "potential victims" who will, in almost every single case, never become victims while potentially doing harm to the patient-therapist relationship as a result of the breach of the patient-therapist confidentiality. Obviously, once a therapist breaches the confidential relationship in order to warn an unsuspecting "intended victim," it is not likely that the relationship between the psychiatrist and patient will remain a trustworthy one, or even continue. Despite all of these problems though, after 28 years (Tarasoff was decided in 1976), a statute remains on the books of most State laws without any actual, proven benefit.

As background, the Tarasoff "duty" seemed to evolve from a concept called the "dangerous patient exception," which allows psychiatrists to testify at commitment hearings about a patient's otherwise privileged communications about future violence. We all know that there are certain exceptions which allow psychiatrists to breach patient confidentiality, including several commitment hearings, suspected child abuse and where an individual in a legal action submits their mental state as part of their claim. In reality, the "duty to warn" (Tarasoff) is really an exception to the physician-patient confidentiality while the "dangerous patient exception" refers primarily to the breaching of "testimonial privilege," requiring or enabling psychiatrists to testify at commitment hearings. Yet, the distinction between the

two has been blurred in many cases.

This brings us to a fascinating extension of the Tarasoff doctrine which was described in an article by Paul Herbert, MD, JD, in the *Journal of the American Academy of Psychiatry and Law*, Vol. 32, #1, 2004, titled "Psychotherapy as Law Enforcement."

Dr. Herbert describes a chilling extension of Tarasoff in which a psychiatrist, fearing that a patient will harm or kill another individual, breaches the doctor-patient relationship and takes steps to either warn an intended victim or protect the patient from doing harm, as well as protecting the intended victim. These steps can include increasing the number of therapy sessions, increasing or changing the patient's medication, bringing in family members, or committing the patient civilly. All of these, to one degree or another, do maintain the confidential communications between the therapist and the patient, unless the psychiatrist then takes the additional step of notifying an intended victim. At that time, a very chilling series of events may ensue, which places the psychiatrist in the role of an extension of the police or more seriously, as a witness against their own patient.

This might occur if one's patient voices a thought to do harm to another individual; the psychiatrist notifies the police and/or the intended victim, and the police then, if the patient follows through with the threat, enlists the psychiatrist as a witness for the prosecution. Arguing that the confidential doctor-patient relationship has already been breached, the District Attorney may then have the psychiatrist testify about the patient's threats in order to aid the prosecution in the conviction of the patient/defendant. As the article describes,



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SYNAPSE designed by Lydia Dmitrieff

Continued on page 6 

Combined Therapy, cont'd

what the patient says; should have some understanding of the patient's circumstances and history and mental state. I was fortunate to have been at a medical school where as students throughout our medical rotations we had a weekly meeting with a famous psychoanalyst to discuss the psycho-social situation of our patients and where for two years I attended a student group with Michael Balint discussing the same things. This interplay of the 'bio-psycho-social' is of course the essence of psychiatry. Although assessing this each time we see a patient and listening to the patient's issues may be psychotherapy (? "supportive psychotherapy") it is not 'formal' psychotherapy and does not usually need 45 minutes.

The patients we see as psychiatrists are enormously variable, as are the causes of their conditions and the state of their brains. There is no evidence that all psychiatric patients need formal psychotherapy, as Dr Tuckman suggests in

the quote above. It implies that all psychiatric conditions are caused by psychological factors or respond to psychological treatment. Clearly they are not and do not. That is why I say "combined therapy" is an inadequate model.

For example the majority of patients with depression get better treated by general practitioners or internists with antidepressants or by psychologists, social workers and other psychotherapists. Only if they do not do well are they referred on to psychiatrists who may then add therapy or medication as indicated. This is the way it should be. There will never be enough psychiatrists to see all those patients. Of course those other professions need training, and the availability of consultation and support from psychiatrists. Increasingly psychiatrists will be seeing the complex and difficult cases. This is their area of expertise, to assess and advise treatment for such cases.

Given all the advances in psycho-

pharmacology and psychotherapy to expect every psychiatrist to be skilled in every treatment is impossible and dangerous. I mentioned a formidable list of psychotherapies above to which could be added group and couples therapies and probably several more. Psychiatrists should be familiar with them all and if they are interested practice one or two but they cannot be skilled in them all. There are other professions specifically trained in these therapies, and doing them regularly, and at lower cost. I believe it is the ideal for them to do the formal psychotherapy of our patients. We should concentrate on the medical aspects of the patient, which means especially but not only psychopharmacology: "the exercise of professional medical judgment." The psychiatrist is absolutely responsible for his patient but not for the psychotherapist, who is independently responsible for what he or she does. They should communicate

Continued on page 7 

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Walter Freeman, M.D.: The Ice Pick Lobotomist

Phineas Gage was the foreman of a railway construction gang working on the railroad bed near Cavendish, Vermont. On 13th of September 1848, an accidental explosion of a charge he had set blew his tamping iron through his head. The iron was 3 feet 7 inches long and weighed 13 1/2 pounds. It was 1 1/4 inches in diameter at one end and tapered to a diameter of 1/4 inch at the other. The tamping iron went in point first under his left cheek bone and completely out through the top of his head, landing about 25 to 30 yards behind him. Phineas was knocked over but did not lose consciousness. He was treated by a young doctor John Harlow of Cavendish and returned home ten weeks later apparently recovered.

As far as is known Gage never worked as a foreman again because his personality had changed. Before the accident he had

been a capable and efficient foreman. Now he was fitful, irreverent, showed little respect to his fellow workers and was grossly profane, obstinate and vacillating. His friends noticed he was no longer the Gage they had known. He ended doing odd jobs in a variety of locations. In February 1860, he started having epileptic seizures. He died on 21st of May 1860.

Late in 1867 his body was exhumed and his skull, and the tamping iron were sent to Dr. Harlow. Harlow reported his findings, including the estimate of the brain damage. The shattered skull and the tamping rod are now on display at Harvard's Library of Medicine. Gage became an object of intense medical curiosity, here was an evidence of altering human behavior by physically interfering with the frontal lobes of the brain.

M.D. an aspiring neurologist, attended a neurological conference in London. He was an enterprising young doctor who believed that the field of



mental illness rightfully belonged to the neurologists. He derided the use of talk therapies, psychoanalysis and such other approaches used by the psychiatrists. Freeman, who was 40 at the time, listened to the leading speakers attentively and drew inspiration from their learned presentations. In the symposium John Fulton from Yale University brought two chimpanzees from which he had completely removed the frontal lobes of the brain - a lobectomy. The procedure had radically changed the behavior of the two animals from aggressive agitation to docility. Fulton also mentioned that now he was unable to induce experimental neurosis in these animals. This resulted in heated discussions about the functions and significance of the frontal lobes of the brain.

Also present in the symposium was Dr. Egas Moniz, the Portugese neurosurgeon, who had pioneered in cerebral angiography by injecting contrast materials in the arteries of the brain. Egas Moniz raised the question: "If the frontal lobe removal prevents the development of experimental neurosis in animals and removes frustrating behavior, why would it not be possible to relieve anxiety states in man by surgical means?" Freeman listened carefully and was impressed and encouraged by Moniz's remarks.

Back in Lisbon, In September 1935, Moniz, with the neuro-surgeon Almeida Lima, proceeded to destroy the frontal lobes of an agitated, difficult to manage

In 1890 Dr. Gottlieb Burckhardt, the superintendent of a mental hospital in Switzerland, drilled holes in the heads of six severely agitated patients and extracted sections of the frontal lobes, altering their behaviors with varying degrees of success. Two of those patients died. Burckhardt's surgery was considered reprehensible, but his work was not forgotten. Phineas and his iron bar had started a trend that was to continue into the next century.

In July 1935 Walter Freeman,

Continued on next page 



mental patient by injecting alcohol in both the frontal lobes. After the surgery the woman was less agitated and less paranoid but, Moniz admitted, more apathetic and frankly duller. He tried this procedure on three other patients from the asylum with similar outcomes, including loss of sphincter control, sluggishness and disorientation. Despite this, Moniz thought the results were impressive and felt encouraged. However, the superintendent of the Asylum was unwilling to supply any more subjects to him. Egas Moniz used his considerable charm and persuasive powers to obtain patients elsewhere and continued his work developing several variations on the techniques. He was careful to withhold for a while the outcome of his work.

Finally he did publish his results in six countries simultaneously. Dr. Freeman was watching and following every bit of information coming out of Lisbon and

popularized in Paris and other centers in Europe. He obtained the full monograph on Moniz's techniques. As Freeman did not have any surgical background he teamed up with a neurosurgeon James Watts, M.D. The two obtained Moniz's leucotomes, the cutting instrument, specially designed for the operation. They practiced on cadavers for one week and felt confident that they were ready to work on living patients.

Their first patient was a 63 year old woman from Kansas who suffered from agitated depression. Faced with a choice of a mental institution or surgery, she and her husband opted for surgery, which was presented to them in glowing terms of ease, speed and safety. The operation was carried out on September 14th, 1936. Six holes were drilled on the patient's head. When she woke up from surgery the sense of calm she exuded was in contrast to her former state of terror.

Freeman and Watts were thrilled; they had created medical history! A week after surgery the woman began to behave strangely. She talked incoherently, being stuck on certain syllables, repeating them endlessly and jumbling up her sentences. She could no longer recite the days of the week, when asked to write she made nonsensical constructions on the paper. A few days later, her speech had largely cleared and she went placidly home,

showing neither eagerness nor apprehension. A docile zombie bereft of emotions, wit or humor.

The two proceeded to operate on five more patients over the next six weeks. In November 1936 they published a report in which they wrote: "In all our patients there was a ...common denominator of worry, apprehension, anxiety, insomnia and nervous tension, and in all of them these particular symptoms have been removed to a greater or lesser extent." They also claimed that in some patients disorientation, confusion, phobias, hallucinations and delusions had been relieved or had altogether disappeared. In that paper they cautioned against the indiscriminate use of the procedure. They also warned: "every patient probably loses something by this operation, some spontaneity, some sparkle, some flavor of the personality." Privately, however they felt exuberant and triumphant. The indiscriminate use that they had warned against was the hall mark of their practice and the practice of those who were inspired by them.

They continued to experiment with different approaches to reach the brain and also modified their cutting instruments repeatedly. Finally Freeman hit upon the idea of using the ice pick and a mallet to pierce through the skull and reach the soft, butter like, tissue of the brain. From this emerged the Freeman-Watts standard lobotomy, which they proudly claimed to be the "precision method." Then Freeman decided to change the access to a more direct and efficient approach – the trans-orbital way of entrance. Simply stated the upper eyelid was lifted and the ice pick pushed over the eye balls, the tip of the ice pick was placed on the orbital plate and a few taps with the mallet forced the crude instrument inside. Once there, a few side to side sweeps, like that of a windshield wiper, was all that was needed to sever the frontal lobe from the rest of the brain. The procedure was then repeated on the other side. The only anesthesia used were three short bursts of

Continued on page 7 



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Wynona M. Lipman Award

In celebration of Women's History Month, Governor McGreevey and Department of Community Affairs Commissioner Susan Bass Levin announced the recipient of the 2004 Connie Woodruff Award and the recipients of the Wynona M. Lipman Awards on March 30, 2004 at the Governor's house in Princeton, NJ. The awards honor women throughout the state whose contributions have improved the lives of fellow New Jerseyans.

A psychiatrist, Bharati Palkhiwala was among the 16 awardees acknowledged. Dr. Palkhiwala works with and advocates for women who have mental health issues and medical concerns, particularly in the Indian American community. She is active in the Federation of Indian Americans, and is the former president of the Association of Indians in America for New Jersey, the oldest and largest organization for Indians. Both Governor McGreevey and Commissioner Levin stressed what an impact women in history have made for us this day in age. "The purpose of Women's History Month is to commemorate what women have done in the past, and look forward to what we can achieve in the future," Commissioner Levin said. The recipients of these awards were praised for their commitment as women of strength, vision, and character that contribute to the advancement of women throughout New Jersey.

Dr. Palkhiwala is board certified Psychiatrist, in private practice, in Paramus. She is mother of two grown children and married to a cardiologist Dr. Arun Palkhiwala. ▲



Bharati Palkhiwala, MD past president of N.J. A.I.A. receiving the Wynona M. Lipman Award from Governor James E. McGreevey, and Susan Bass Levin, Commissioner, Department of Community Affairs.

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Subpoenas, cont'd

if the patient had voiced a threat to a judge or other elected official, simply threatening these individuals may be a crime in and of itself for which the patient could be prosecuted, utilizing the information from the psychiatrist who could be compelled to testify on the basis that all confidential obligations of the therapist had been waived by the therapist's notifying the intended victim.

Unfortunately, there is no easy solution to this Tarasoff dilemma since courts up to the Supreme Court (in a footnote to another case) have supported the requirement for breaching confidentiality to prevent alleged future harm. Certainly, should this disturbing problem befall any of us, a significant consultation with learned colleagues must occur prior to taking any of these actions. ▲

Alan J. Tuckman, M.D

Combined Therapy, cont'd

as necessary but it does not usually need to be very frequently. In general each is treating different aspects of the person: the psychiatrist the illness, the psychotherapist the personality or inter-personal relationships.

Why might combined therapy be unethical as policy? I organized two somewhat related symposia this year. One on 'Providing services where there is a shortage of psychiatrists' with speakers from all over the world, including London and The Bronx. The other on 'Serving the underserved in North America' with speakers who all happened to be from New York. What was striking was that even in New York with probably more psychiatrists per person than anywhere else there are large populations with a shortage

of psychiatrists: the elderly, prisoners, the severely mentally ill, the homeless and people in rural areas. And that some of the ways of providing services where there is a shortage (using traditional healers, nurses, briefly-trained mental health volunteers, peer counselors, for example) were very successful and for some people and some conditions may be more successful than our traditional 'Combined therapy'. With such a shortage of psychiatrists, if combined therapy were pushed as policy even more very ill patients would get no service and this clearly would be unethical.

To sum up: psychiatry is advancing in many exciting ways. It is a challenge for the psychiatrist to keep up with the advances. But his or her essential role remains the

same: assessing and integrating the biological, psychological and social contributions to patient's problems and ensuring the best treatment. Formal psychotherapy may or may not be part of that treatment. Other professions may be more skilled at many types of formal psychotherapy, and they should do it. No other profession is trained for or able to provide psychopharmacology. Psychiatrists must be experts in that. Combined therapy has a place, but not for most patients. It is an inadequate model and impractical as policy. To promote it as policy is unethical because more patients would be left unserved. ▲

Nigel Bark, M.D.

Walter Freeman, cont'd

electricity delivered by wires on the sides of the forehead. These sufficiently stunned the patient for the doctors to complete the procedure.

This was a time when other shock therapies were being tried on mental patients, e.g. metrazol, sodium Amytal and Insulin-coma. Lobotomy fitted well with these other onslaughts on the brain. The psychoanalysts and psychiatrists raised muted protests but Freeman effectively countered these by manipulating the media, going public with his crusade for lobotomy. He traveled extensively and gave public demonstrations of his performance. He proved to be a skillful manipulator of the media inviting newspaper reporters to "come witness medical history being made."

The overcrowding in state mental hospitals had reached scandalous levels. The superintendents of these institutions were strapped with limited budget with which to provide long term custodial care to increasing numbers of inmates. With no relief in sight, they were disarmed with the economic argument: a lobotomy could be done for as little as \$250 while it could cost \$35,000 or more a year to

maintain a patient in the hospital.

In 1949 Egas Moniz received the Nobel Prize for his work in the field of brain surgery and related work. This proved to be a boon for those pushing the lobotomy movement. More people were lobotomized in three years after Moniz received the prize than in the previous fourteen years. Nearly twice as many women as men were lobotomized.

Freeman and his followers were advocating the use of lobotomy as the first line of treatment for a variety of conditions where the patients were deemed 'unmanageable.' Even problem children were being lobotomized in some places.

Strong outcries were raised by prominent psychiatrists. The Director of the New York State Psychiatric Institute, Nolan Lewis, M.D. asked: "Is quieting a patient a cure? Perhaps all it accomplishes is to make things more convenient for those who have to nurse them...the patients become rather childlike...they are as dull as blazes. It disturbs me to see the number of zombies that these operations turn out...it should be stopped."

Freeman was sold on the brilliance and

feasibility of his technique. He believed anybody, with a brief training, could do lobotomy, without the involvement of a surgeon. He had been trying his skills single handedly since 1945 without telling Watts. This resulted in the break up of their partnership.

In 1948 he was elected president of the American Board of Psychiatry and Neurology. Lobotomy was being performed on tens of thousands of disturbed, and not so disturbed, patients worldwide. Freeman had achieved celebrity status with his work freely publicized by the media. He took advantage of his status to promote trans-orbital lobotomy on TV, radio, and in newspapers. He even made several movies showing him in action; these were widely distributed for educational purposes. That year he performed a lobotomy on the talented movie star and political activist Frances Farmer.

Lobotomy was promoted by some enthusiasts for the control of the society's misfits, e.g. schizophrenics, homosexuals, communists, etc. Paradoxically, in 1951 the Soviet Union

Continued on back page 

Walter Freeman, cont'd

was the first country to ban the use of lobotomy on ideological grounds.

Finally, in 1952, chlorpromazine, the first of the new generation of tranquilizers and anti-psychotic medications, was tested in France. It signaled the end of Walter Freeman's enterprise. From now on, he would be "the ice pick lobotomist," with a rapidly diminishing clientele and shrinking reputation. At the 1960 World Psychiatry Congress Freeman presented the results of his follow up study claiming they showed that 85% of his private lobotomy patients were now at home, and two third of them "usefully occupied." His data were so anecdotal and subjective that they were not taken seriously. At the same time a ten year study on British patients was released which did not make such encouraging reading. In 1962, *One Flew Over the Cuckoo's Nest* by Ken Kesey was published damning the physical assaults on the patients in the name of therapy.

In 1967 he used his ice pick for the last time. This patient was actually one of the original ten on whom he had first tried the trans-orbital approach in secret in his office in 1946. This was the third time he administered ice pick lobotomy to this woman. He made the usual deep frontal entry, but this time the old magic failed: he tore a blood vessel in the brain. She died within hours. Freeman had his surgical privileges removed. On May 1972 he died of cancer at age 77. ▲

Syed Abdullah, M.D.



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