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Ice Pick Through the Eye: A Narrative History of Lobotomy in America

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During the years between the two world wars, America's populace began to experience an increase in mental illness. While problems with mental health were by no means previously unknown, the advent of modern society and all the stresses associated with it had the nasty tendency to further exacerbate the issue. Thousands of soldiers returning from war found themselves institutionalized for anywhere from a few months, to the rest of their lives. While members of the military perhaps had reason enough for their mental state, the civilian population seemed to have just as many problems. The inexplicable nature of mental health prompted some psychiatrists to approach health care in a different manner than before. Instead of using only therapy for the severely disturbed, they began to question whether the brain itself was the cause of the problem. However, if the brain was to be the source of the problem, how were psychiatrists to treat this area which they knew so little about? Psychosurgery developed as one of the solutions.

The contemporary image of lobotomy has rarely been positive. Many have decried it as a barbaric practice, a horrifying mistake of 20th century medicine. However, if this procedure was so horrific, why was it widely practiced for thirty years? Why is it still practiced today in rare cases of severe schizophrenia? The historical context for mental illness in America and its treatments, or lack thereof, may answer those questions. The idea of poking around the brain, the all-important regulator of the human body sits poorly with many audiences. However, in the presence of cancer, mental illness, or trauma to the head, these hesitations are typically set aside in favor of surgery. This practical approach to brain surgery could only have come about because of an increased medical awareness of brain functions. Psychosurgery in all its variations was the first attempt to treat mental illness at the source, the brain. Lobotomy produced enough positive results to give credence to the theory of treating the brain. As was customary with any

innovation, there were examples of failure, which were frequently focused upon rather than the successes. Without this first step however, many scientific milestones, such as knowledge of the brain functions pivotal to modern medicine, may never have been reached.

The main American proponent of lobotomy, Dr. Walter Jackson Freeman II, has been memorialized in secondary works such as *The Lobotomist: A Maverick Medical Genius and His Tragic Quest to Rid the World of Mental Illness* and *Last Resort: Psychosurgery and the Limits of Medicine*. While these are some of the kinder titles in the genre of psychosurgical history, in general they portray Dr. Freeman and his colleagues as misguided and egotistical. Popular television series have done exposes on Freeman, including one titled after Jack El-Hai's book, *The Lobotomist*.¹ This television special did not focus enough attention on the context of lobotomy and the world in which its popularity arose.

The secondary sources within the field of lobotomy include narrative-style biographies by El-Hai and Jack Pressman, the latter entitled *Last Resort: Psychosurgery and the Limits of Medicine*.² Both of these works used many of the same primary sources, though El-Hai's used more interviews. *Last Resort*, as the title suggested focused on the radical nature of the surgery and its nature as a last resort to keep people out of institutions. El-Hai's book was written in a more fluid, chronological manner, while Pressman's was written about multiple physicians and their contributions. While this wider viewpoint of the medical world's efforts in lobotomy was useful, it also was frequently confusing to the reader. An older secondary source referenced by both El-Hai and Pressman was *Great and Desperate Cures* by Elliot Valenstein.³ Valenstein was

¹ Jack El-Hai, *The Lobotomist: A Maverick Medical Genius and His Tragic Quest to Rid the World of Mental Illness* (Hoboken, NJ: John Wiley & Sons, Inc., 2005).

² Jack D Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (New York: Cambridge University Press, 1998).

³ Valenstein, Elliot, S, *Great and Desperate Cures: The Rise and Decline of Psychosurgery and Other Radical Treatments for Mental Illness* (New York: Basic Books, 1986).

one of the first authors to put forth the argument that, given a better understanding of the areas and functions of the brain, psychosurgeons would have had much better results than any other contemporary solutions to mental illness. However, it was only as a result of psychosurgery and its implications to its patients' health which prompted a renewed interest in the functions of the brain.

There are also a number of secondary sources about the Kennedy family that mention lobotomy in reference to Rosemary Kennedy, the younger sister of future President John F. Kennedy. Edward Renehan's *The Kennedys at War* gave the most unbiased versions of the events which led up to Rosemary Kennedy's lobotomy.⁴ Shorter's *The Kennedy Family and the Story of Mental Retardation* mainly focused on the philanthropy for mental health.⁵ *Sins of the Father* by Ronald Kessler was written from a sensationalist point of view, however it contained multiple quotes from memoirs of the Kennedy family.⁶ Quite a few of the quotes contained in *Sins of the Father* were originally found in Rose Kennedy's memoir *Times to Remember*.⁷

While there have been works written about Dr. Freeman and his career in lobotomies, the majority were created by former patients or journalists. One of the most famous of these authors was Howard Dully, who wrote *My Lobotomy*. Dully was lobotomized at age twelve by Dr. Freeman and afterwards made a ward of the State by his father and step-mother.⁸ In his memoir, Dully said that his lobotomy by Dr. Freeman was the beginning of all his life's troubles. Given this strong statement, Mr. Dully could not possibly have told his story without involving negative emotion. Out of the other secondary works that have been produced in the past ten years,

⁴ Edward J. Renehan Jr., *The Kennedys at War: 1937-1945* (New York: Random House, Inc., 2002).

⁵ Edward Shorter, *The Kennedy Family and the Story of Mental Retardation* (Philadelphia: Temple University Press, 2000).

⁶ Ronald Kessler, *Sins of the Father: Joseph P. Kennedy and the Dynasty He Founded* (New York: Warner Books Inc., 1996).

⁷ Rose Kennedy, *Times to Remember* (New York: Doubleday, 1974).

⁸ Howard Dully, and Charles Fleming, *My Lobotomy* (New York: Three Rivers Press, 2007).

virtually all have sensationalist angles to them, many of them, based upon Dully's memoir.

While these works all contain useful information to the situation, this work will explore the facts of American Lobotomy. Understandably, Mr. Dully's work was too narrowly focused on his own encounter, while the other works focus too little on the events leading up to the popularization of lobotomy. This procedure could never have become as pervasive as it was in our society without having some success. The situation of many Americans had to be dire enough for dangerous surgery to become a viable option.

Mere months after the end of World War II, when America was still rattled from press images of Nazi atrocities, an exposé of disturbing truths was published. Albert Maisel's descriptions of two mental hospitals in America shocked the nation with images of neglect and at times, downright abuse. This time however, instead of Germany, the finger of blame was pointed squarely at the United States. While beatings were prevalent in these institutions, the far more serious problem was neglect. Thousands were fed on starvation diets, packed into, "hundred-year old firetraps in wards so crowded that the floors [could not] be seen between the rickety cots."⁹ Many of those cots were infested with lice or ticks. Most of the nation's mental health facilities were overcrowded to the point of having double the amount of patients a single hospital could accommodate. In addition to the overcrowding problem, there were not enough attendants for the patients. At times, one attendant served up to 400 patients in a shift—in such conditions it is not surprising that restraints, seclusion, and drugs became as prevalent as they did. This *Life* article served as the rallying point for a new era of American medical care for the mentally ill. Given

⁹ Albert Q. Maisel, "Most U.S. Mental Hospitals are a Shame and Disgrace," *Life Magazine*, May 6, 1946, <http://www.pbs.org/wgbh/americalexperience/features/primary-resources/lobotomist-bedlam-1946> (11 November 2011).

the increased concerns about mental health, doctors such as Freeman began turning to works outside of the United States.

The noted Portuguese psychiatrist and surgeon, Egas Moniz developed and performed the first successful leucotomy, a procedure intended to sever the connection between the frontal lobes, which was believed to be the root cause of many patient's mental problems. Moniz probably first began contemplating the idea of leucotomy (which Freeman would rename lobotomy) during the frontal lobe symposium in London, England in 1935.¹⁰ The 60-year-old doctor attended the second International Neurological Conference, alongside Dr. Freeman. The two doctors met during the conference, however Moniz took the first steps into psychosurgical history.

In a presentation at the conference, Wilder Penfield and Richard Brickner concluded that damage to the frontal lobe was more annoying than debilitating to patients. Patients could still contribute to society, a better fate than that of asylum patients without the same opportunity.¹¹ Another case study from the conference, on a pair of Chimpanzees by John F. Fulton and a junior researcher, Carlyle Jacobsen gave additional intrigue into the idea of leucotomy.¹² The chimps, Becky and Lucy were both trained to do similar mind exercises and puzzles for the first several months of the experiment. During the training portion, the researchers noted that Becky was frequently more frustrated, while Lucy was even-tempered. After completing their training, the researchers removed both chimps' frontal lobes. Jacobsen noted that while the chimps were still able to solve the puzzles, they did so at a slower rate. In an unforeseen side effect however, both chimps' reactions to frustration reversed. Lucy, the more even-tempered of the two became

¹⁰ El-Hai, 97.

¹¹ Walter Freeman and James W. Watts, "Psychosurgery: 1936-1946" (paper presented to the American Psychiatric Association, May 4, 1946), Walter Freeman/ James Watts Papers, George Washington University Archives, Washington D.C.

¹² Pressman, 48.

easily frustrated with failure, while Becky became calmer.¹³ Moniz performed the first leucotomy in 1936, a mere year after the symposium in London.

Lobotomy procedures targeted the frontal lobes of the brain, which are located, as the name would suggest, at the front of the brain directly behind the eye sockets. Doctors used case studies, such as one by Philippe Pinel in the early 1800s as examples in which injury to the frontal lobe had actually proved beneficial, in that it allowed the patient a greater quality of life. Pinel described a miniature painter, who had suffered from depressive episodes for years until finally the man shot himself in the left temple at the age of forty. Instead of killing himself, as had been his intent, he instead found himself, “absolutely cured of his suicidal mania.”¹⁴ The study by Pinel was by no means unique in its conclusion. Damage to the frontal region of the painter’s brain had actually benefitted him by altering his personality just enough that he was no longer plagued by suicidal tendencies and anxieties. Many of these case studies impacted Moniz’ theory of leucotomy.

Borrowing from Moniz, Freeman brought the surgery to America, renaming it lobotomy. Freeman’s impressions of Moniz at the 1935 International Neurological Conference would shape the American doctor’s career for the rest of his life. Freeman described his first meeting with Moniz in a very positive light. He was immediately impressed with Moniz’ scientific genius, a description which prompted him to nominate the elder physician for the Nobel Prize, which he won, in 1949.¹⁵

Moniz’ version of lobotomy was a form of surgery. Typically called Prefrontal Leucotomy or lobotomy, it involved drilling six spherical burr holes into the scalp at pre-

¹³ El-Hai, 96-7.

¹⁴ Walter J. Freeman and James W. Watts, *Psychosurgery in the Treatment of Mental Disorders and Intractable Pain* (Springfield, IL: C. C. Thomas, 1950), 18.

¹⁵ Walter J. Freeman, Unpublished Autobiography, 1970, Walter Freeman/James Watts Papers, George Washington University Archives, Washington D.C.

determined areas of the head, depending upon the diagnosis.¹⁶ After burring the hole into the side of the skull, the neurosurgeon slid the leucotome into place. The original leucotome, designed by Moniz, had a curved, blunt end that was used to push aside the white matter without injuring it, while a small retractable blade could be extended out of the blunt end to cut the desired tissue. The length with the interchanging heads was affixed to a stabilizing rod, which the surgeon held with his non-dominant hand, while angling the surgical end with the dominant hand. With both the stabilizing rod and the burr hole, the surgeon could not extend his radial motions too deep, a safeguard that was designed to prevent permanent brain damage. However, should the burr holes be placed in the wrong spot to begin with, the tandem system of the burr hole and stabilizing rod could have little effect. This method also required shaving the head, in order to draw measurements directly onto the scalp. The measurements served as guidelines to the neurologist who would be assisting the surgeon and instructing his movements.¹⁷

After inserting the leucotome using the sharp end, the neurosurgeon would begin disrupting the harmful connections by sweeping the blunt sided leucotome in an arc motion perpendicular to the floor. The leucotome was marked on the side in centimeters, and the surgeon would penetrate the instrument five centimeters during the initial piercing. The radial or arc motions could insert as much as six to seven centimeters into the brain.¹⁸ This was followed, depending on the severity of the malady, with gentle prodding motions by the surgeon in the same arc shape, typically with about five to six prods.¹⁹ After these steps, the leucotome was removed and the wounds were rinsed with saline solution and checked for an unusual amount of blood flow. The procedure was then repeated on the other hemisphere of the brain. After the

¹⁶ Walter J. Freeman, James W. Watts, and Thelma Hunt, *Psychosurgery: Intelligence, Emotion, and Social Behavior Following Prefrontal Lobotomy for Mental Disorders* (London: Baillière, Tindall & Cox, 1942), 81.

¹⁷ Freeman and Watts, *Psychosurgery: In the Treatment*, 39-41.

¹⁸ Freeman, Watts, and Hunt, 81.

¹⁹ See Figure 1

second side was operated upon, the wounds were injected with 0.5 cc. iodized oil each and sewn up with silk sutures.²⁰

Given the surgical nature of lobotomy, Freeman frequently advocated for lobotomy only in severe cases. His position on timing for treatment changed however, as he went along in his practice. In 1950, at a medical lecture, Freeman urged that lobotomy was “to be undertaken only when it seem[ed] likely that other measures will fail. This does not mean, however, that all other measures should be tried before lobotomy is considered...”²¹ Less than a decade later, Freeman’s warning against trying all options had faded. In a medical paper from 1957, Freeman stated, “It should be emphasized that no patient was lobotomized unless faced with disability or suicide and until reasonable trial of other methods of treatment had been applied.”²² Freeman discovered during his practice that the longer a doctor waited to lobotomize a patient, leaving them in hospital care, the less likely they would ever be able to go home.

Lobotomy patients were typically separated into categories depending upon their diagnosis. In the majority of Dr. Freeman’s studies on lobotomy he placed his patients into three diagnostic categories: Involutional Depressions, Psychoneuroses, and Schizophrenia. Involutional depression, an obsolete term, referred to middle-aged patients with mental illness, with particular focus on paranoid behavior. Psychoneuroses, another outdated term, referred to patients with mental or emotional disorders severe enough to disrupt their lives but without psychotic symptoms such as delusions or hysteria.²³ While these diagnoses are no longer in use, they were fundamental to the treatment of patients during the lobotomy era.

²⁰ Freeman and Watts, *Psychosurgery: In the Treatment*, 43.

²¹ Walter Freeman, “Psychosurgery” (paper presented to the American Psychiatric Association, May 4, 1950), Walter Freeman/James Watts Papers, George Washington University Archives, Washington D.C.

²² Walter Freeman, “Frontal Lobotomy 1936-1956: A Follow-Up Study of 3000 Patients from One to Twenty Years,” *American Journal of Psychiatry* 113, no. 10 (April 1957), 877-8, Walter Freeman/James Watts Papers, George Washington University Archives, Washington D.C.

²³ Freeman, “Frontal Lobotomy 1936-1956,” 882.

Schizophrenia was the most common diagnosis for mental illness from the 1940s until the 1980s, when the definition of schizophrenia changed to exclude many symptoms. A wide range of symptoms was traditionally used to define schizophrenia. Obsessive and compulsive activities that disrupted everyday life were typical symptoms of schizophrenics, along with isolation, aggressive tendencies, and auditory/visual hallucinations. In modern medicine, many of the symptoms used for schizophrenia now belong to conditions like Obsessive-Compulsive Disorder. Schizophrenia was typically found in children as well during this time. Symptoms found specifically in children included: a loss of house training; frequently shedding clothing; abandonment; and occasional torture of pets.²⁴ Symptoms such as those described are contemporarily associated with conditions such as OCD, Mental Retardation, Asperger's syndrome, or occasionally, a sociopath. No patients with these conditions have been considered for lobotomy since the 1980s.

Walter Freeman's first opportunity to perform a lobotomy came in September of 1936, when he was referred a patient named Mrs. Alice Hammatt. She was a typical patient suffering from agitated depression. Mrs. Hammatt's symptoms had reached such extremes that, without surgery, her family would have been forced to institutionalize her. Both Mrs. Hammatt and her husband preferred surgery to convalescence, though Mrs. Hammatt briefly reneged on her permission when she was informed that her scalp would be shaved. After promising to spare her hair, if possible, the surgery proceeded, and though her hair could not be saved, the surgery was in every other way a complete success. After a brief scare during the recovery period, Mrs.

²⁴ Walter Freeman and James W. Watts, "Schizophrenia in Childhood: Its Modification by Prefrontal Lobotomy" (paper presented to the Institute of Living, February 26, 1947), Walter Freeman/James Watts Papers, George Washington University Archives, Washington D.C.

Hammatt lived for another five years, which her husband claimed were some of the most enjoyable of her life.²⁵

The early years of Freeman's practice with his partner, neurosurgeon James W. Watts, were filled with triumphs as well as bitter disappointments, in terms of the medical community's reactions. The report of their first case to a local section of the Neurology and Psychiatry Society in October of 1936 was met with derision. When Freeman used the word "cured" in his presentation, the assembled doctors protested vehemently that he could not proclaim his patient cured within such a short time period. They demanded long-term proof. As a result, Freeman dedicated a great deal of his energies to long-term studies of his former patients. Undaunted by the first professional setback, Watts and Freeman continued presenting their cases to the medical community and requesting research aid. Freeman claimed to have requested aid from nine different foundations, at least ten times each. None of their requests were met, and some were not even acknowledged.²⁶ Despite the lack of aid from the medical community, Freeman and Watts continued on.

Freeman and his partner Watts used the Moniz version of lobotomy in their first twenty cases, however they found that many of the patients had to be operated on a second or even third time. Many of the patients who had shown immediate improvement had significant relapses within months of their initial surgery. To combat this problem, Freeman and his partner tested solutions such as drilling nine holes instead of six and placing the holes further back on the frontal lobe, rather than in the upper area.²⁷ Unfortunately, at this point in their experimentation Freeman and Watts discovered an embarrassing possible outcome of their surgery. If the surgery

²⁵ Freeman, Unpublished Autobiography, chapter 14 pages 3-4.

²⁶ Freeman, Unpublished Autobiography, chapter 14 page 7.

²⁷ Freeman, Watts, and Hunt, 81.

extended too far back into the frontal lobe or cut too many blood vessels, patients quite often left the operating room incontinent.²⁸

The physician duo first encountered this problem with their fifth lobotomy patient. Before the surgery, the unnamed woman had attempted suicide by inhaling gas, which caused her to pass out for half a day. In Freeman and Watt's defense, this patient more than likely gave herself brain damage during her suicide attempt, but nonetheless, when the two operated on her, they cut several blood vessels. The results were frequent seizures and a problem with incontinence.²⁹ This problem was mentioned in nursing articles on the proper care for post-operative lobotomy patients. According to one study done by Pauline Landry and Leonard Stevens, forty to sixty percent of their patients showed no incontinence while twenty to thirty percent found relief in less than a week. Only six to nine percent of patients still suffered from incontinence after two weeks of recuperation.³⁰

One of the most famous patients ever accepted by Drs. Watts and Freeman unfortunately ended up in the small percentage of permanently incontinent patients. Rosemary Kennedy was born on September 13th, 1918. The family doctor was late for the birth and Rosemary's head became trapped in the birth canal, depriving her of oxygen and rendering her mentally retarded.³¹ Rosemary was only mildly retarded, however in a highly intelligent and athletic family such as the Kennedys, her differences soon became all too apparent. Rose, as she was called by the family, had difficulty learning to read and write, but during childhood any of her learning problems were offset by her sweet disposition. Her parents sought help for their daughter with some of the greatest medical minds on the planet. When advised to put the young girl in special

²⁸ Freeman, Watts, and Hunt, 32.

²⁹ El-Hai, 113.

³⁰ Pauline Landry Bombard, and Leonard F. Stevens, "A Prefrontal Lobotomy Program," *The American Journal of Nursing* 49, no. 12 (Dec 1949), 752.

³¹ Shorter, 30-1.

schools, her mother refused. Her father Joseph on the other hand, was reportedly ashamed of his daughter and frequently sent her away to boarding schools and distant relatives.³² Around the age of 19, Rose began to lose her sweet personality and experienced harsh mood swings, which often resulted in tantrums and broken furniture. It was probably her family's neglect that caused her change in disposition.³³

At the age of twenty-two, she took to wandering the streets of Boston and Washington D.C. alone at night. Her father, fearing she would be molested, turned to Dr. Freeman for help. At the time of Joseph Kennedy's request, Freeman and Watts had performed only sixty-six lobotomies. At the age of 23, in 1941, Rosemary Kennedy was lobotomized by Freeman and Watts. According to Dr. Watts the surgery was performed with a mild tranquilizer which confused Rose, but did not render her unconscious. Dr. Watts entered through the top of the head, while Dr. Freeman asked Rose to recite the Lord's Prayer or sing "God Bless America." When Miss Kennedy started to become incoherent, Watts stopped cutting into her brain.³⁴ In Rosemary Kennedy's case it was almost immediately obvious upon her awakening that her operation had not been successful. Rose's violent outbursts were diminished but so were her basic motor skills and ability to take care of herself. The loss of skill and her incontinence made it clear to her family that institutionalization was the only recourse left for Rosemary. While her father supposedly never visited her, her mother Rose visited her every year for the rest of her life, in St. Colleta's School for Exceptional Children in Wisconsin.³⁵

In addition to the incontinence problem, Freeman and Watts noticed that there was a chance of angling the instrument wrong so that it tore at the penetrating branches of the anterior

³² Kennedy, 115-6.

³³ Kessler, 238-40.

³⁴ Kessler 243-5.

³⁵ Renehan, 198-200.

or middle cerebral arteries. This happened twice during the first twenty lobotomies performed by Freeman and Watts, both times to fatal ends. The doctors concluded the causes of death were a miscalculation of the entry point as well as the tissue damage left behind by the spherical nature of the burr holes.³⁶ Those first two fatalities led them to modify the procedure in hopes of reducing risk to patients. Experimentation with the placement of the holes revealed little improvement to results, so, it is postulated in medical history that Freeman decided to turn away from a purely Moniz approach, to one of the Italian psychiatrist, Amaro Fiamberti.

Fiamberti had made a name for himself by using the same basic principles of Moniz, with a less invasive approach—that is if one can call entry through the eye socket less invasive. Fiamberti used a cannula inserted into the top of the eye socket to inject alcohol or formalin directly into the frontal lobes. While Moniz had also experimented with the idea of injecting alcohol, his first attempts (using pure alcohol) had resulted in swift death for his patients. Fiamberti's results however, were a short-lived version of lobotomy, which significantly reduced psychotic symptoms.³⁷ Freeman almost certainly got the idea of entering the eye socket from reading Fiamberti's medical papers, which led to his infamous lobotomy adaptation in 1945.

While Freeman saw a need for innovation because of placement issues, he was also very aware of a more fundamental issue. The very nature of lobotomy made it inaccessible to those needing it most. The majority of the mental institutions in the States had no surgical bays and without the surgery, many patients would be left to convalesce in neglect. Even if an asylum had access to a surgical bay, there was no guarantee that the family of the patient could afford the surgery. In order to provide adequate care for the thousands of Americans suffering with mental illness, Freeman saw fit to modify his methods. The original leucotomy required surgical

³⁶ Freeman, Watts, and Hunt, 81-82.

³⁷ Pressman, 337.

training, tools, and multiple weeks of recovery. Freeman eventually whittled prefrontal lobotomy down to a much simpler procedure—transorbital lobotomy. Instead of drilling holes in the skull, Freeman would enter through the tear duct with an orbitoclast, a device he invented himself using an ice pick as inspiration. This version of the procedure, named a transorbital lobotomy,³⁸ required no surgical training, took 10 minutes at most, and boasted a recovery rate of one day. While the procedure had mixed results, it was the best hope many had for a life outside of an institution and until the mid-1950s, remained commonly sought after.

Freeman's most influential innovation to the field of lobotomy was his invention of the orbitoclast. Freeman discovered while practicing on cadavers that there was no surgical equipment in the 1940s tough enough to penetrate the orbital roof. Eventually, he found his best option was a common household item, an ice pick. According to an interview with his son Frank Freeman, the first ice pick came from the Freeman family's kitchen drawer.³⁹ Dr. Freeman discovered that the ice pick had the durability and strength to break through the orbital socket, as well as the precision to sever the nerves without causing too much damage. From these humble beginnings, the orbitoclast was born. Freeman's surgical tool of choice was approximately twelve centimeters long, with notches on the side marking each centimeter, up to seven. Thin and tapered, it maintained the spherical point of an ice pick, with a weighted hilt at the top. The instrument was designed to give the doctor greater control over the orbitoclast and surgeons hammer, which was used to knock through the eye socket.⁴⁰

The main technique of transorbital lobotomy was quite simple, rendering it a quick and easy procedure. The surgeon would pinch the upper eyelid and lift it off the eyeball, inserting the

³⁸ Freeman and Watts, *Psychosurgery: In the Treatment*, 511.

³⁹ Frank Freeman, interview by Howard Dully, "My Lobotomy," *NPR: All Things Considered*, 2007.

⁴⁰ Freeman, Unpublished Autobiography, 1970, chapter 14 page 13.

point of the orbitoclast into the conjunctival sac (the space between the eyelid and eyeball).⁴¹ One controlled, sharp tap with the surgeon's hammer would break through the orbital socket. Once the five centimeter mark was reached on the instrument, the handle was pulled laterally as far as the eye's orbit would allow. This movement severed the fibers at the base of the frontal lobe. Returning to the midway point between the two positions, the physician then drove the instrument to the seven centimeter mark. The instrument was then rotated towards the middle of the head by 15-20 degrees, followed by a 30 degree lateral move back to the midway point, before the instrument was withdrawn with a twisting movement, while simultaneously exerting considerable pressure on the eyelids in order to prevent hemorrhage.⁴²

The methods of lobotomy were described by Watts and Freeman in *Psychosurgery: In the Treatment of Mental Disorders and Intractable Pain*. Drs. Freeman and Watts also presented, along with methodology, the immediate and long-term effects, and follow-up data.⁴³ While Freeman gave lectures and presentations virtually everywhere he went, *Psychosurgery* served for many years as the seminal introduction to the world of lobotomy. The first edition in fact did not contain much information about transorbital lobotomy, referring mostly to the traditional prefrontal surgery. In the eight years between the first edition and second edition, Freeman and Watts re-wrote the majority of the book and lengthened their section on follow-up data. The final two hundred pages of the book, dealing with transorbital lobotomy were added by Freeman with little input from Watts. The second edition in 1950 gained better reviews for its lengthened time on follow-up studies, as well as psychometric data collected by an outsider, Dr. Mary Frances

⁴¹ See Figure 2

⁴² Freeman and Watts, *Psychosurgery: In the Treatment*, 55.

⁴³ Freeman and Watts, *Psychosurgery: In the Treatment*, 487.

Robinson.⁴⁴ However, while its reviews were better than the first edition, it was still considered to be poorly organized and confusing.

The reception from the medical community was mixed. Many doctors immediately disapproved of Freeman's work, however some such as Adolf Meyer, gave hesitant approval. Meyer believed that there was a great deal of potential in lobotomy. Meyer claimed that the positive results of lobotomy were not due to the shock to the patient's system. Meyer claimed the patients' recuperation was a logical conclusion given what the medical community was learning about the frontal lobes and their effect on the personality.⁴⁵ However the strain between Freeman and the medical community was soon overshadowed by the discord within his own partnership.

In his unpublished autobiography, Freeman cited 1946 as the beginning of a rift between Watts and himself. It was when Freeman began performing transorbital lobotomies, which did not require the help of Watts, his surgical partner that the two doctors began to argue. Freeman claimed to have read about the procedure in 1937, but did not consider it as a viable option. However, after multiple patients showed severe cases of personality change, Freeman decided that standard lobotomy was too damaging. As Freeman stated, what was needed was, "a less extensive operation to apply in earlier cases of mental disorder."⁴⁶ When Freeman invited Watts to witness one of his transorbital procedures his partner grew so upset he threatened to break off their association if Freeman continued. Afterwards, Freeman performed no more transorbital lobotomies in Washington D.C. until their partnership had officially dissolved sometime in 1947. The two doctors works remained intertwined with both contributing to separate areas of their

⁴⁴ Donald O. Herb, review of *Psychosurgery in the Treatment of Mental Disorders and Intractable Pain*, by Walter Freeman and James W. Watts, *The Journal of Abnormal and Social Psychology*, 46, no. 4 (October 1951), 608.

⁴⁵ Walter Freeman, "Prefrontal Lobotomy: Final Report of 500 Freeman and Watts Patients Followed for 10 to 20 Years" (paper presented to the Southern Medical Association, November 11, 1957), Walter Freeman/James Watts Papers, George Washington University Archives, Washington D.C.

⁴⁶ Freeman, Unpublished Autobiography, chapter 14 page 12.

joint book, *Psychosurgery: In the Treatment of Mental Disorders and Intractable Pain* and all its editions. Though transorbital lobotomy precipitated the downfall of the Watts/ Freeman partnership, many of the doctors' patients followed Freeman to his independent practice in favor of the accelerated recovery time.

As stated previously, the method for transorbital lobotomy required little recuperation time. Generally, patients went home the next day. When discharged, patients were typically given dark glasses, to cover the black eyes which developed hours after the operation. Patricia Moen and Howard Dully, two of Freeman's patients, both confirmed that they did not remember the operation itself, or the hours afterwards, an experience shared by the majority of Freeman's patients.⁴⁷ Howard Dully, who was twelve years old at the time of his operation, was not told he was receiving a lobotomy beforehand, but instead had been told he was going to the hospital for testing. It was not until a week afterwards that Dr. Freeman sat down with Howard and explained that he had had a transorbital lobotomy. In his memoir, *My Lobotomy*, Howard Dully described waking up from the operation as, "waking up in a fog."⁴⁸

Howard Dully's situation was one of the most unique to be found in Freeman's patient files. Dully was by all accounts a normal twelve-year-old boy. His only problems came from his strained relationship with his step-mother and biological father. The antagonism between Dully's stepmother and Howard led him to rebellion. Mrs. Dully reportedly went to numerous doctors asking for recommendations on what to do with her troublesome stepson. After multiple dismissals from doctors, mostly on the grounds that Howard was a normal, if resentful, little boy, Mrs. Dully turned to Dr. Freeman. Mrs. Dully gave Freeman a laundry list of complaints, including, "monkey-like gestures and mannerisms, tires easily, unresponsive,

⁴⁷ Patricia Moen, interview by Howard Dully, "My Lobotomy," *NPR: All Things Considered*, 2007.

⁴⁸ Dully, and Fleming, 99.

unreasonable...Jekel and Hyde personality.”⁴⁹ However, upon meeting Howard, Freeman found little to be amiss with the boy. Both of Howard’s parents, and even Howard himself discussed how he liked to talk to himself. After multiple meetings with Mrs. Dully—during one of which she claimed to be fearful for her physical safety—Freeman eventually concluded that Howard was schizophrenic.⁵⁰

Not long after that conversation, Dully was lobotomized in Doctors General Hospital in San Jose, California on December 16th, 1960. After the operation, Dully experienced nausea and fever, two symptoms that Freeman did not encounter frequently with his work. However, Howard recovered within five days of the procedure and was released from the hospital on December 21st, 1960.⁵¹ As Dully explained in his memoir, when his stepmother discovered that he was still sullen and rebellious towards her, she almost immediately had him sent away from home. Dully claimed that he always felt the lobotomy had stolen something from him as if some intrinsic part of himself was lost, something that he could never get back.⁵²

After being sent away from home, Dully was made a ward of the state. From there, he spent years in juvenile correctional facilities, living on the streets, abusing alcohol and drugs. Eventually, Dully married, went to college and obtained work as a bus driver. It was in 2007 that he finally addressed the issue that he felt had been haunting him his whole life, his lobotomy. He maintained in his memoir and the National Public Radio special it spawned, that the lobotomy performed upon him was the main source of all the failures in his life. While Dully probably should not have been lobotomized, it was not a fault of the procedure itself, or even its doctor.

⁴⁹ Dully, and Fleming, 84.

⁵⁰ Dully, and Fleming, 79.

⁵¹ Dully, and Fleming, 99.

⁵² Dully, and Fleming, 102.

The initial and more damaging trauma to Dully's childhood was not the lobotomy, but rather the dysfunction of his family life.⁵³

Rose Kennedy and Howard Dully's tales are the more frequently explored instances of lobotomy in modern works. And while Dr. Freeman acknowledged his failings, at least with Miss Kennedy, he maintained that his improved procedure was certainly capable of producing high-level performance in his patients. In a one-to-twenty-year follow-up study published in 1957, Freeman stated that especially after transorbital lobotomy, some patients were capable of exemplary performance in the fields of medicine, law, teaching, and nursing. He listed among his former patients a member of a celebrated symphony orchestra, a missionary in the Far-East, a fellow psychiatrist recently promoted to chief of service in a large mental hospital, and a confidential secretary in the Federal Government. Such examples were not uncommon in the myriad of follow-up studies that Dr. Freeman frequently performed.⁵⁴

Angelene Forester, the daughter of Freeman's first transorbital lobotomy patient, Ellen Ionesco, felt her mother had a very positive experience with lobotomy. Forester said that before the lobotomy, "She [Ionesco] would take me into the basement, point to the exposed wires, and say, 'This is what they torture me with.'"⁵⁵ After the lobotomy however, Mrs. Ionesco came home to her husband and children and resumed normal activities, keeping house. Before her procedure, Ionesco routinely suffered from hysterical breakdowns during the day. Afterwards, she was able to live her life uninterrupted by panic attacks. In Forester and her mother's case, there were legitimate mental health issues, as well as experience with the other methods of treatment used in the 1940s. The electroshock therapy Mrs. Ionesco had received clearly did not

⁵³ Dully, and Fleming, 200.

⁵⁴ Freeman, "Frontal Lobotomy 1936-1956," 877.

⁵⁵ Angelene Forester, Interview. *The Lobotomist*, American Experience, 2008.

alleviate her symptoms but instead, exacerbated them to the point of inducing seizures.⁵⁶

Freeman's first transorbital lobotomy patient lived a better life post-operatively than she could have, had she continued with the traditional therapy of her time.

Another patient of Dr. Freeman, Ann Krubsack had a similar experience to Ellen Ionesco with her lobotomy. Krubsack was a severely depressed housewife with a small child. Before her lobotomy, Mrs. Krubsack was very anxious and frequently forgot things. She and her husband visited several doctors for help with her depression until they met Dr. Freeman. Krubsack said that she bonded with Freeman and trusted him almost immediately. Afterwards, Mrs. Krubsack was also able to return home and continue her life. While she claimed, "to have lost a part of herself to the operation," she did not regret it, as it allowed her to live her life outside of an institution.⁵⁷

Patricia Moen was another patient of Freeman's who benefitted from lobotomy. In 1962 at the age of 36, Moen was referred to Freeman after a suicide attempt. Mrs. Moen described herself as "mentally no good" and claimed she was crying all the time. Freeman told the Moen's that the last chance for Mrs. Moen outside of an institution was lobotomy. He also informed them that there was a chance of Moen dying or coming out of the operation a vegetable, Mrs. Moen recalled that at the time, she was miserable enough to not care about the possible consequences. Like Dully, Moen did not remember the surgery or afterwards. Her reaction to the lobotomy was clear though: "[she] was a freer person after [having] it... [She] just went home and started living."⁵⁸

Many of Freeman's patients benefitted greatly from their procedures however, the invention of psychotropic drugs reduced the popularity of lobotomy down to a trickle. The new

⁵⁶ Angelene Forester, Interview. *The Lobotomist*, American Experience, 2008.

⁵⁷ Ann Krubsack, interview by Howard Dully, "My Lobotomy," *NPR: All Things Considered*, 2007.

⁵⁸ Patricia and Glen Moen, interview by Howard Dully, "My Lobotomy," *NPR: All Things Considered*, 2007.

drugs were introduced and marketed as chemical lobotomies. Designed as less invasive forms of psychological assistance, the pharmaceutical companies quickly stole the vast majority of Freeman's potential patients. In one paper from 1957 Freeman acknowledged the benefit of psychotropic drugs and barbiturates in patients, however he also cautioned against them. He claimed that most doctors felt the greatest benefit to patients came from introducing large quantities of drugs into the system. While contemporary doctors start patients on low doses and work their way up if needed, the process was reversed in the '50s. Most mental patients already self-medicated with alcohol and tobacco. Freeman felt that the combination of self-medication and massive doses of drugs were dangerous to patients' health as an overdose was highly possible.⁵⁹ The movement towards drug treatments prompted Freeman to move his practice from the east coast to the west coast in the late 1950s. During the last two decades of his life, Freeman traveled the country offering his services to families and hospitals, while conducting multiple follow-up studies on his patients.

Dr. Freeman never considered his operation a cure to mental problems, rather as a way to improve his patient's quality of life. Like so many medical pioneers before, Freeman had to come up with his own method of evaluating the success of his patient lives post-operation. According to one of his medical papers published in 1957, the greatest determinate of the success of a surgery was the duration of hospitalization. The longer a patient had been having mental problems, the longer they were likely to have been hospitalized and thus convalesced. Since many of the mental treatments before lobotomy were not effective enough to allow patients to return home, they instead spent years in hospitals, mentally deteriorating.⁶⁰ Freeman considered

⁵⁹ Walter Freeman, "Surgery Versus Drugs in the Treatment of Severe Neuroses" (paper presented to the Fresno County Medical Society, February 12, 1957), Walter Freeman/James Watts Papers, George Washington University Archives, Washington D.C.

⁶⁰ Freeman, "Frontal Lobotomy 1936-1956," 878.

four main categories for patients in follow-up studies: “employed”, “keeping house”, “at home”, and “hospitalized”. “Employed” was used to refer to anyone who was engaged in some occupation outside of the home. This could range from helping to manage the family business to doing part-time charity work, or attending school. “Keeping house” referred to patients who remained within the home as the lead authority, though the housework could be done by another family member or domestic servant. “Hospitalized” speaks for itself, although Freeman noted that some of the patients who were “hospitalized” could have been at home if their families were capable or willing to take care of them. Freeman also noted that while the “hospitalized” patients were at varying stages of health, he had not created another category for them because, “The degree of improvement in hospital adjustment [could not] be determined in statistical fashion since so many criteria and so many judges [were] involved.”⁶¹

A shorter five-year follow up of patients from an Athens, Ohio hospital in 1962 revealed out of the 205 patients from 1953 to 1955, two-thirds of the patients were no longer in hospitals and institutions. Freeman noted in his study that the most remarkable statistic was the number of patients at home with a history of 2-10 years of hospitalization. Of the 33 patients that had been hospitalized for 2-5 years, 9% were employed, 18% were keeping house, 21% were home, and 52% were hospitalized at the point of the study. More remarkable though were the results of those who had been hospitalized for 5-10 years: of 26 patients, 25% were employed, 14% kept house, 14% were home, and 47% were hospitalized. While these statistics may seem bleak, it was better than the alternative of all 59 patients being hospitalized. The figures for patients who

⁶¹ Freeman, “Frontal Lobotomy 1936-1956,” 879.

had spent less time in the hospital were more drastic. Of the 24 patients who had been hospitalized less than six months, 42% were employed, and 29% were home.⁶²

Freeman's follow-up studies were not enough to satisfy many of his critics. In 1962, after a long-time patient, Helen Mortenson, suffered a cerebral hemorrhage during her third lobotomy, Freeman was stripped of his medical license. While Freeman spent his remaining ten years visiting former patients, it was not enough to redeem him in the eyes of many. In recent years a movement by the families of former Freeman patients to strip Egas Moniz of his Nobel Prize, has renewed interest in lobotomy. Dissenters argued that Moniz' Nobel Prize legitimized a barbaric procedure. The proposals to posthumously strip Moniz of his title have thus far been unsuccessful. The Nobel prize committee claimed that the modern perspective of a scientific discovery could not dismiss the historical and medical significance of the procedure. The attempt on Moniz' prize was an example of how contemporary opinions color the interpretation of history.⁶³ Moniz' discrediting began as an attack on his greatest admirer, Walter Freeman. Without the legitimization that the Nobel Prize gave lobotomy in 1949, Freeman's practice would not have gained as much popularity.

Dr. Walter Jackson Freeman II ushered in a new era of mental health in the United States. Prior to his lifelong foray into psychosurgery, the most the medical profession could do for the mentally disturbed was place them in institutions or torture them with repeated treatments, few of which had positive effects on their symptoms. While lobotomy may not have had a perfect

⁶² Walter Freeman and Hubert H. Fockler, "Transorbital Lobotomy: Five Year Follow-Up at Athens State Hospital" (medical report, 1962), 7, Walter Freeman/James Watts Papers, George Washington University Archives, Washington, D.C.

⁶³ Madeline Brand, "Profile: Nobel Panel Urged to Rescind Prize For Lobotomies," *Day to Day (NPR), Newspaper Source Plus*, EBSCOhost (accessed October 23, 2011).

record for success, it had enough of one to prompt its own rise in popularity. That same rise brought attention to the entire foundation of psychosurgery—that mental illness originated in the brain. For the first time, a treatment promised enough chance for success to prompt patients to submit to surgery, and it was this trend that prompted research into the psychotropic drugs which so many of us use today.

Appendix

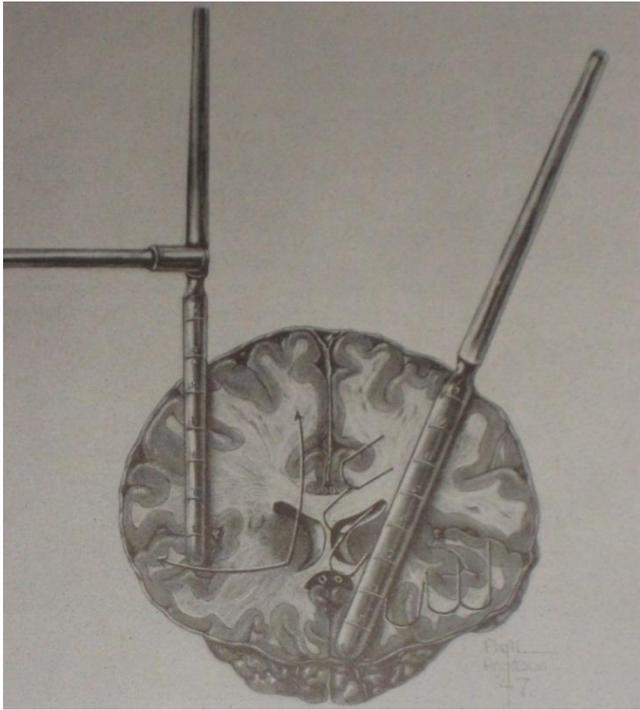


Figure 1: Medical sketch of a prefrontal lobotomy using the original Egas Moniz leucotomes
Walter J. Freeman, James W. Watts, and Thelma Hunt, *Psychosurgery: Intelligence, Emotion, and Social Behavior Following Prefrontal Lobotomy for Mental Disorders* (London: Baillière, Tindall & Cox, 1942): 49.

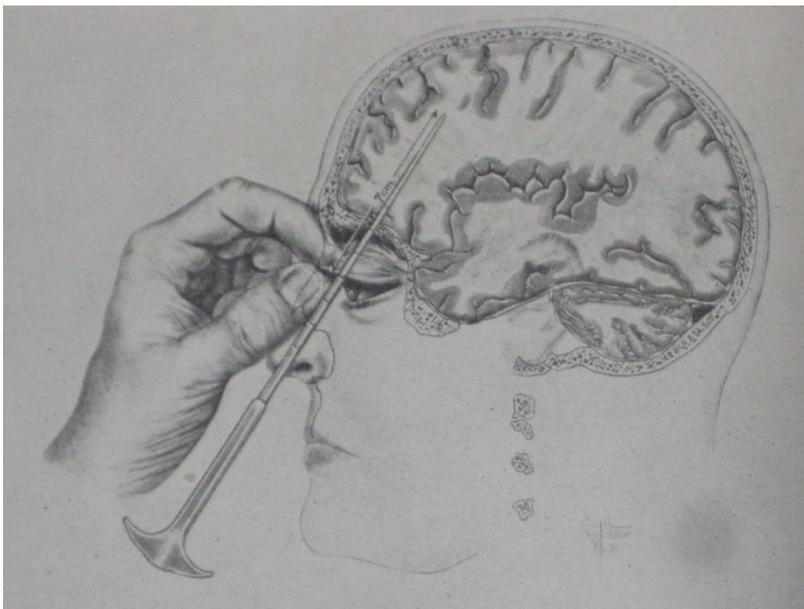


Figure 2: Medical sketch of transorbital lobotomy using Walter Freeman's orbitoclast
Walter J. Freeman, James W. Watts, and Thelma Hunt, *Psychosurgery: Intelligence, Emotion, and Social Behavior Following Prefrontal Lobotomy for Mental Disorders* (London: Baillière, Tindall & Cox, 1942): 52.

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