

**Do No Harm:**  
**The Destructive History of Pharmaceutical Psychiatry and Its Bedfellows—**  
**Electro Shock, Insulin Shock, and Lobotomies**

by Robert A. Berezin, MD

The one thing we learn from history is that we don't learn from history. This is never more pertinent than in the hidden story of somatic psychiatry. To fully appreciate the danger of its current incarnation, psychiatric drugs, we must take somatic psychiatry out of its state of amnesia. Its predecessors—insulin shock therapy, lobotomies, and electroconvulsive therapy—should serve as a reminder, a morality tale, for the excesses and depravity to which conventional psychiatric knowledge and practice can easily sink. The underling theory of somatic psychiatry is that the source of human struggle is considered to be the brain itself, rather than the person. Treatments that follow from this simplistic, mechanistic, and reductionist notion have been to act directly on the brain, always with violating and destructive outcomes. The real source of human suffering is not the brain. It is in the person, the human being, in the context of damage to the play of consciousness. My life's work has taught me that the art, the science, the discipline, and the wisdom of psychotherapy attends to this damage. Tragically, over the course of one generation, psychotherapy has become almost extinct and has been replaced by drugs. There are no miracles and no shortcuts, as drugs, like the other somatic therapies, always promise. We have repeated the same mistakes over and over again, and we are doing so today.

Somatic psychiatry originated with seizure therapy, or its first modern incarnation, insulin shock therapy (IST). It actually had its roots in the sixteenth century and was used psychiatrically around the time of the American Revolution. It was refined in 1927 into insulin shock therapy, when insulin was used to induce seizures as a treatment for drug addiction, psychopathy, and schizophrenia, with claims of a 50 percent remission rate. Papers were published in the *American Journal of Psychiatry*, starting in 1937. IST was widely used through the 1940s and 1950s. Its founding etiological

principle was the (false) idea that seizures were the opposite of schizophrenia. Induce a seizure, and you balance out psychosis. In the 1930s, a more refined scientific explanation was developed for the (phantom) curative power of seizures. Its science proclaimed that psychiatric problems came from the autonomic nervous system. IST was said to work by blocking the nerve cells of the parasympathetic nervous system, thereby intensifying their tonus and strengthening their anabolic force. This restored the nerve cell, and the patient recovered. The corollary theory was that patients were jolted out of their psychiatric condition.

Next, we have lobotomies, originally called leucotomies. Lobotomies came onto the scene in the 1930s, having been invented and promoted by Antonio Egas Moniz. When I was a psychiatric resident, lobotomies were still fresh in psychiatric memory. The practice had only ceased in the early 1960s, after over twenty thousand people received this “treatment.” Let’s see ... what was the science? The source of psychiatric problems was located in the brain, specifically the prefrontal cortex. The treatment of choice, then, was to ream out the prefrontal cortex with an ice pick. Respected MDs had a miracle cure and were the vanguard of the field. Science proved that lobotomies cured not only schizophrenia but anxiety, depression, low self-esteem, obsessive/compulsive disorder, and the unwanted behavioral problems associated with mental retardation (this is code for sexual behaviors). It was respected and celebrated in the psychiatric literature and validated in journals with documented studies and peer-reviewed scientific evidence. Lest you think this is an exaggeration, Moniz won a Nobel Prize in 1949 for his great and wonderful discovery.

Eventually, the validating follow-ups were shown to be fabricated and deluded, with self-promoting lies and half truths. Only after a great deal of harm were they debunked. And the ice picks were thrown into the trash heap of psychiatric history. We need to add that after lobotomies gradually attenuated, no one stopped and said, “What in the world did we just do?” How could sticking an ice pick in someone’s brain ever have been even a remote consideration? What was going on that such a grotesque medieval mutilation was actually adopted as a good thing to do? And how could it have been publicly and professionally embraced? However, as always seems to happen, amnesia

quickly set in, and we forgot the brutal inhumanity that was so recently celebrated. And the considerable body of discredited scientific validation was never scrutinized for its contribution to and for having promoted such harm. Instead, science moved on to support the next somatic treatment in exactly the same way.

Next, we have electroconvulsive therapy (ECT), which came along soon after IST, in 1938. ECT was still a part of the curriculum in my own psychiatric residency in 1971. Entire psychiatric hospitals, built exclusively for ECT, were still operating, with no empty beds. Scientific studies and respected journals provided documented validation for placing electrodes on patients' heads and applying huge jolts of electricity to generate seizures. Apparently, the jolt theory had gained traction. So we shocked the brain, instead of reaming it out. How humane. In addition to everything else, ECT also was touted as a cure for depression. It was allegedly proved that ECT was a safe, effective cure, with few, if any, drawbacks. The resultant memory loss not only was initially downplayed but was trumpeted as being therapeutic. (By the way, drugs are being developed today to chemically erase memories with the idea that this is therapeutic for trauma—same thing.) Later, under public pressure, ECT was refined to cut down on memory loss. The history of electroconvulsive therapy followed the same trajectory as lobotomies. Eventually, ECT showed itself to be the ineffective and violating practice that it is. But don't get overconfident. Incredibly, in recent years, ECT has made a comeback and is being promoted once again, when its progeny treatments, antidepressants, don't work.

Finally, we come the current incarnation of somatic psychiatry, neurobiological psychiatry, and its treatment—drug therapy. Psychiatric drugs are next in the lineage of “treatments” whose focus is to act upon the physical brain. History is repeating itself. Our contemporary science has now apparently proven that human problems come from genetic or developmental neurobiological disorders of the physical, anatomical, biochemical brain. The somatic treatments for these neurobiological, genetic, synaptic hormonal neurotransmitter diseases are brain drugs—psychoactive drugs. Would you be surprised if the actual history of drug “treatments” has itself followed the very same pattern as the other somatic therapies?

The first psychiatric drugs were introduced in the mid-1940s—Thorazine, an anti-psychotic for schizophrenia, and lithium, a mood stabilizer for manic depression. It is noteworthy that both Thorazine and lithium, like with the discovery of penicillin, were discovered by accident, not by research. They did not come from multimillion-dollar pharmaceutical labs or experts in scientific research with validating and substantiating studies in quest of psychiatric drugs. Phenothiazines (the drug family of Thorazine) were developed as antihistamines in the early 1930s and used as an aid to anesthesia for surgery. In 1947, Thorazine was given to patients as an antihistamine in a mental hospital, where it surprisingly showed its antipsychotic effects.

Similarly, lithium had a long and accidental history. It was initially developed for gout in the 1800s. It was even used as a tranquillizing ingredient in an early form of the familiar soft drink, “7-Up Lithiated Lemon Soda,” soon to become 7-Up, when soft drinks were still concocted to be popular medicinal cure-alls. Lithium was removed from 7-Up at about the same time as cocaine was taken out of Coca-Cola. Notice that their names purposely advertised lithium and cocaine as their active ingredient. Medicinals have always postured as an elixir of life, bringing eternal youth, happiness, no disease, physical strength, superior intelligence, sexual potency, etc. We can be gods. Lithium was found accidentally to work as a mood stabilizer for manic depression in the late 1940s, when an Australian psychiatrist injected mice with lithium urate when testing whether uric acid created mania. Instead, to his surprise, he found the incidental ingredient in his test—lithium—calmed the mice. It is a salt. Li is one row up on the periodic table from sodium, the prime ingredient of table salt. To this day, no one knows how it actually works.

Schizophrenia and true manic depression differ from all the rest of the psychiatric conditions because they actually manifest a brain disturbance embedded in a personality disturbance. Consequently, in addition to psychotherapy, a brain drug is a relevant component in the treatment of the personality of a person with these conditions. However, despite the claims of contemporary somatic psychiatrists, all the rest of psychiatric issues are not brain disorders. They are the result of damage to the personality. Whereas of course a damaged personality is reflected in the organization of

the play consciousness in our brains, there is no actual brain problem. When the damage to the personality heals, this likewise is reflected in the brain. After Thorazine and lithium, there has been a continuous stream of allegedly curative psychiatric drugs. In each case, brain-based biochemical psychiatric diseases have been invented or co-opted to create the “need” for these pharmaceutical cures. There has not been a positive contribution from psychiatric drugs ever since. There has been a great deal of harm.

I will briefly review the hidden history of psychiatric drugs. They all follow the same trajectory as the other somatic treatments. Each drug arrives in the market with great acclaim. Each one is advertised to be efficacious, with no side effects, no addiction, no habituation, no drug tolerance (requiring higher and higher doses), and no high. Then, each in turn shows itself to be horribly addictive, with terrible side effects, with considerable drug tolerance, and significant habituation, while the highly acclaimed efficacy shows itself to have been fraudulent. And they end up being used simply for their considerable “highs.” Keep in mind, when each drug gets discarded, new ones appear to take its place, with the same false promise—efficacious, no side effects, not addictive, no habituation, no drug tolerance, and no high. We move so quickly to the next new drug that we don’t seem to remember the travesty that had just transpired.

In my lifetime, we started with bromides and chloral hydrate. Then Milltown appeared, with devastation in its wake. We then moved to the barbiturates—secobarbital (Seconal), street names are Reds, red birds, and red devils); Pentobarbital, (Nembutal) known as Yellow jackets; amobarbital (Amytal), known as Blue heavens; amobarbital-secobarbital (Tuinal), called Christmas trees, and rainbows; and zopiclone (Imovane). They unfortunately turned out to create poor concentration, fatigue, confusion, and impaired coordination, memory, and judgment. They are highly addictive, with life-threatening respiratory failure during withdrawal. They have caused more deaths from overdose and have been used in suicidal overdoses more effectively than any other drug. Eventually, the once ubiquitous barbiturates were relegated to the back shelf, except for their place in the ever-present street market for the purposes of drug highs.

Without a pause, in came the benzodiazepines with great fanfare—you know, efficacious, non-addictive, no side effects, no habituation, no drug tolerance, no high—

starting with Librium and Valium. The benzodiazepines were prescribed for anxiety (and still are). Unfortunately, these turned out to be as destructive and addictive as the barbiturates, with an even better high and greater habituation and major drug tolerance. In fairness, they are less lethal than barbiturates when you overdose. As always, the initial reports of problems were themselves discredited and scorned. Information about a significant psychoactive drug effect was suppressed for a long time - rage-reactions. When acknowledged, they were termed, “paradoxical” rage reactions. Finally, the suppressed evidence came out and was irrefutable that Librium and Valium are extremely addictive and habituating, never mind creating significant highs. Valium turned into a nonentity. What ever happened to all the studies, all the papers, all the research that validated it? How could they have been so wrong? How can that be?

But fear not. Immediately new benzodiazepines popped right up to take their place—Xanax, Klonopin, Ativan, Versed, Serax, Restoril, et al. These, of course, are still touted as safe and efficacious. Worldwide sales in 2011 for benzodiazepines was \$21 billion, never mind the black market (e.g., all over the Internet). I wonder why? Probably for that pesky neurobiological genetic brain disease, anxiety disorder.

Then we move onto the sedatives and hypnotics, also known as sleeping pills. Sales of prescription drugs alone in 2011 was \$19 billion. Don’t you want a full night’s sleep with no insomnia? Don’t you to wake up healthy, happy, and refreshed in the morning? We have Halycion (actually a benzodiazepine in disguise), Ambien, Lunesta, Sonata, and Rozerem, each with the promise of blissful tranquility, free and easy. Not so. Each gets discredited in turn—addictive, habituation, considerable drug tolerance, and very bizarre psychoactive side effects like sleep driving or sleep eating. But let’s not learn from our mistakes. No need for concern; the new one is the real item. There never has been a safe prescription sleeping pill. But I’m sure the next one will be.

Now we’ll turn to amphetamines, concocted by the Nazis for their pilots to fly all night when bombing England and their soldiers to need no rest for the Blitzkrieg: amphetamine (Adderall); atomoxetine (Strattera ); dextroamphetamine (Dexedrine and Dextrostat); laevoamphetamine (Benzedrine), methamphetamine (Desoxyn, Methedrin),

street names: crystal, meth, ice, speed, glass, chalk, crank; and methylenedioxymethamphetamine - street names Ecstasy, MDMA, E, or X.

Speed was touted as an “up,” our first antidepressant, as well as an appetite suppressant for weight loss, with no need to diet or exercise. They were widely used by college kids for “all-nighters.” For the most part, they were used to get high, with massive addiction. Mental hospitals in the 1960s and 1970s were filled with amphetamine psychoses. Amphetamines were correctly discredited and pretty much disappeared from psychiatric and medical usage.

But then a strange thing happened. A new medical-psychiatric genetic brain disease got invented: ADHD. And what was the treatment of choice? You guessed it. Suddenly, speed was safe again, non-addictive, no side effects, and it didn't generate psychoses anymore. Its sordid history went right back into amnesia. Apparently, the past didn't happen, so we certainly don't have to learn from it. I guess the significant percentage of inpatients suffering from amphetamine psychoses when I was a psychiatric resident was a figment of my imagination. We are currently doping a generation of our children with speed. Sales have reached \$1.5 billion a year, never mind the black market. And the good news is, it's been discovered that adults have the same ADHD disease and should be on speed too. How is it that we can see the alleged ADHD brain disease disappear during any episode of the *Super Nanny* on TV? One witnesses a transformation of these genetically neurobiological diseased children into normal children every week, with no amphetamines.

Finally, we come to the latest and greatest, the antidepressants—the SSRIs, Prozac and friends. “Clinical depression,” of course, has now been transformed into a medical, biological, chemical brain disease. Any debate about this has now been settled and deemed to be conclusive. All the research, studies, and journal articles show, with irrefutable scientific proof, that this is real. And once again, it is accepted that the treatment is to act on the brain—no longer with icepicks, no longer with electricity, but now with psychoactive chemicals. It is a brave new world indeed. We have fulfilled Orwell's prophecy of Soma, written eighty years ago. He took the name for his fantasy pill from the ancient Indo-Aryans happiness elixir, Soma. Prozac is the modern

incarnation of the ancient human fantasy of a happiness pill. Legal sales of antidepressants topped \$11 billion in 2011. We should mention that the black market for SSRIs on the Internet matches the frequency of black market Viagra offers.

Here's the list:

Selective serotonin reuptake inhibitors (SSRI's):

citalopram (Celexa).

escitalopram (Lexapro),

paroxetine (Paxil, Seroxat),

fluoxetine (Prozac)

fluvoxamine (Luvox), sertraline (Zoloft, Lustral)..

Here are the rest of the antidepressants:

Serotonin antagonist and reuptake inhibitors (SARis)

etoperidone (Axiomin, Etonin),

lubazodone (YM-992, YM-35,995),

nefazodone (Serzone, Nefadar) (Desyrel)

Serotonin-norepinephrine reuptake inhibitors (SNRIs)

desvenlafaxine (Pristiq),

duloxetine (Cymbalta),

milnacipran (Ixel, Savella).

Serotonin/norepinephrine reuptake inhibitors (SNRIs)

venlafaxine (Effexor)

tramadol (Tramal, Ultram)

Sibutramine (Meridia, Reductil) These two couldn't get antidepressant clearance so they are marketed for other conditions, like weight loss and cigarette discontinuance:

Norepinephrine reuptake inhibitors (NRIs) –

reboxetine (Edronax),

viloxazine (Vivalan),

atomoxetine (Strattera)

Norepinephrine-dopamine reuptake inhibitors (NDRIs) –

bupropion (Wellbutrin, Zyban),

dexmethylphenidate (Focalin),

Amphetamine class drugs used as Antidepressants:

Methylphenidate (Ritalin, Concerta).

And then there are the original anti-depressants:

Tricyclic antidepressants (TCAs) –

amitriptyline (Elavil, Endep),

clomipramine (Anafranil),

desipramine (Norpramin, Pertofrane),

dosulepin [dothiepin] (Prothiaden),

doxepin (Adapin, Sinequan),

imipramine (Tofranil),

lofepramine (Feprapax, Gamanil, Lomont),

nortriptyline (Pamelor),

protriptyline (Vivactil),

trimipramine (Surmontil)

Never mind that these psychoactive drugs barely perform better than placebo. Never mind that suppressed studies are finally coming out that show the anti-depressants are proven to promote suicides and homicides in children as well as young adults. I promise you it will come out that the same applies to older adults as well. It is even hidden that Prozac is hugely addictive. Commonly, when someone tries to discontinue Prozac, he feels “depressed” again. The conventional thinking is that his “biological” depression returns, so he has to get back on the drug. And this is used to prove the efficacy and necessity of the treatment. Looks like our patient will have to stay on Prozac for his disease for the rest of his life. What is actually happening is that the user has become habituated to the extra drug-induced supply of serotonin in his synapses. When the drug is discontinued, his natural ability to create serotonin is diminished and insufficient, due to biofeedback loops. Not only this, but users commonly have horrific withdrawal symptoms that are almost never publicized. An array of frightening neurological symptoms appear when trying to detox off this psycho-active brain drug—vertigo, lightheadedness, burning or tingling sensations in the skin, difficulty with gait and balance, blurred vision, tremors, twitches and restlessness. Sometimes there are hallucinations. Patients, understandingly, get terrified from these symptoms and conclude that something really is dangerously wrong with their brain. As a result they don’t dare to stop the Prozac. Thank God they are taking it in the first place and blocking these horrible neurological symptoms that are part of their brain disease. To discontinue an SSRI has to be done very slowly and carefully over the course of a year.

In fact, it is quite common that through drug tolerance, the serotonin-boosting effect attenuates, and its so-called anti-depressant effect diminishes. The expert pharmacological psychiatrists then add one or two more specially selected antidepressants into the mix, and an anti-anxiety pill for good measure, or maybe even an antipsychotic. Sometimes, we even have to shock some patients when their “disease” is deemed simply too pathological. Prozac is the latest of these false and destructive psychiatric drug therapies. It too is following the same sad and tragic pattern as the rest

of them. We never learn. Most important, despite the fact that our society is so acutely conscious of the dangers of drugs, our psychiatric drug epidemic is seen not only as okay but as a really good thing.

Sad to say that one of the great culprits in the sorry history of somatic psychiatry has been faulty science itself. Its brain theories have been substantiated by the science of today and validated in the professional journals. Scientific studies have apparently demonstrated their efficacy, while assuring there is little or no downside. The point here is that these practices are not only ineffective but harmful and destructive, almost 100 percent of the time. In the best tradition of science, one exception proves the rule. Once a theory is shown to be faulty, it is discarded. This never happens in the somatic psychiatry and pharmaceutical establishment. What kind of science can this be? How can the science be right when its outcomes are so wrong. A science that validates and promotes a lie is bad science.

The real history of somatic psychiatry show the science to be faulty in method and fraudulent in its application. In addition, the multibillion dollar pharmaceutical industry and its influence peddling in academic psychiatry finally has been exposed as financially corrupted and manipulated. They have engaged in study suppression, falsification, strategic marketing, and financial incentives. Yet the methods and practices of this very deficient science are never questioned. Instead, it continues to get a free pass and remains the respected authority. We move right along. Our sacrosanct science continues to validate that the next new and improved drug will cure what ails us. Unless we learn from our experience, we are doomed to repeat it.

The preceding is an excerpt from Robert A. Berezin, MD, *Psychotherapy of Character: The Play of Consciousness in the Theater of the Brain* (2013).