Psychiatric Drugs: Hazards to the Brain

Peter Roger Breggin, M.D.

Springer Publishing Company
New York 1983
the introduction of the phenothiazines, the main methods of control were brute force, insulin coma, electroshock, physical restraints, isolation, and a variety of relatively ineffective drugs. The so-called "continuous treatment wards" of the hospital were long, dungeon-like corridors in which a hundred or more patients at a time were packed with nothing more than a few hard benches and a couple of heavy wooden chairs. Day after day, they had nothing to do but sit in the hot stench of summer or the chill of winter, while an occasional attendant stood guard and intervened in physical conflicts. If a doctor appeared at all on the ward, it was to check for "trouble," and the attendants managed the lives of the inmates from day to day. Under such conditions, it was no surprise that the patients often conducted themselves in a degraded manner with little concern for their own dignity or well-being. But they also displayed their humanity in their desire for contact and attention. Everywhere volunteers went in the hospital, patients begged for attention and affection, or any kind of response they could get. Many pleaded to be remembered to friends and relatives on the outside. Sometimes messages for the relatives or even gifts for the volunteers were pressed into the hands or stuffed into the pockets of volunteers on the way out the door (Breggin, 1962; Umbarger et al., 1962).

With the advent of the major tranquilizers, all this changed. Most of the overtly degrading acts were suppressed, but so were the overtly expressed desires for love, contact, or attention. The patients continued to live in relative squalor and degradation with nothing to occupy their time, but now they were easier to manage and especially easier to ignore. It became possible to forget that no human services, not even companionship, were being offered to them. Thus, the major tranquilizers solved the state hospital management problem as no other "treatment" had done. They created robot-like inmates able to respond to simple commands but, like surgical lobotomy patients, relatively unable to resist or to initiate spontaneous conduct.

**Suppression of Nursing-Home Inmates**

The proposition that the major tranquilizers are brain-disabling, mind-leveling agents is nowhere more strongly bolstered than in the range of patients and nonpatients who are controlled by these drugs in many types of institutions. As we shall see, the major tranquilizers have been used and are used in virtually every setting in which
docility, passivity, and emotional indifference are the top priorities. The paradigm for this is the state mental hospital, where many diverse individuals are confined. But the drugs are also used extensively in other institutions, including nursing homes, institutions for the retarded, prisons, and, in the Soviet Union, political prison-hospitals. The effect of these drugs, far from being specific for “the treatment of schizophrenia,” is everywhere the same—the enforcement of conformity to authority within the institution.

One of the most tragic uses of the tranquilizers takes place on a routine basis in the typical nursing home. In many the major tranquilizers are the most frequently prescribed drugs, and in some nearly all the patients are made listless and docile until death overtakes them. There is no pretense at diagnosing “schizophrenia” in order to justify drug administration; management needs are the frank, blatant criteria for drug administration.

Criticism of the use of tranquilizers to subdue the inmates of nursing homes is not new, although it appears to have had little effect. A decade ago, Nelson H. Cruikshank, president of the National Council of Senior Citizens, declared “Exclusive use of the tranquilizers can quickly reduce an ambulatory patient to a zombie, confining the patient to a chair or bed, causing the patient’s muscles to atrophy from inaction, and causing general health to deteriorate rapidly” (quoted in Rogers, 1971).

Rogers (1971) indicts the pharmaceutical houses as well as the doctors in their suppression of the elderly with phenothiazines:

One ad that appeared in medical journals shows a smiling, elderly woman sitting in a wheelchair, playing cards with other old persons. “SHE IS GOING STEADY WITH HER PHENO­THIAZINE TRANQUILIZER,” says the headline. The ad obviously implies that phenothiazine will promote sociability. But research, ignored by this ad, shows that one of the undesirable side effects of these drugs is that they reduce one’s desire and ability to interact with other people.

Hughes and Brewin (1979) provide a popularized but accurate description of the use of the major tranquilizers to turn people into docile inmates:

The use of high-potency [major] tranquilizers and antidepressants is so common—often persons are automatically put on these drugs upon admission, regardless of physical or emotional condition—that senility is chemically induced
by medication in many instances, thus justifying the use of
even more drugs. Case histories of such abuses abound in
the files of federal, state, and local health and welfare
agencies.

They describe “the manufacture of the ideal nursing home pa­
tient” through the use of drugs. This patient is both docile and
qualified for maximum insurance reimbursements.

### Suppression of the Mentally Retarded

Robert Plotkin and Kay Rigling (1979) have written eloquently and
thoughtfully about the plight of the mentally retarded in a law re­
view article entitled “Invisible Manacles: Drugging Mentally Re­
tarded People”:

... between 150,000 and 190,000 [retarded] persons cur­
rently are confined to long-term care facilities. Some 50 per­
cent of them are children. Although the straightjackets and
solitary confinement rooms of yesteryear largely have dis­
appeared, they have been replaced by a subtle modern
form of restraint and control—legally sanctioned drug
abuse.

They cite large-scale use of major tranquilizers, particularly Thora­
zine and Mellaril, to control behavior in understaffed, oppressive
institutions throughout the country. Their observations wholly sup­
port the brain-disabling hypothesis. They have supported the fol­
lowing statements with numerous scientific citations:

Phenothiazines suppress cognitive abilities not only in re­
tarded persons, but also in children of normal intelligence.
Thus, rather than restoring “handicapped persons to the
fullest physical, mental, social, vocational and economic
usefulness of which they are capable,” institutions seem
“willing to sacrifice some degree of learning on the part of
the patient to achieve efficient institutional management.”

In addition to cognitive impairment, the two most fre­
quently observed effects accompanying the treatment of
mentally retarded persons with phenothiazines are drowsi­
ness and lethargy. Lethargy and drowsiness do serve insti­
tutional management concerns because tranquil, “quietly
indifferent” patients pose no control problem.
Plotkin and Rigling go one step further in using language very similar to my own: “Phenothiazines satisfy the institution’s need to reduce objectionable behavior by reducing virtually all behavior.”

James Clements has been in charge of a state-operated residential facility for the mentally retarded, and has served as a consultant to a variety of organizations including the American Association on Mental Deficiency, the ACLU, and the Justice Department. In 1975 he testified before Congress on the use of drugs to control the mentally retarded. His observations were drawn directly from his visits to 15 or more institutions housing approximately 20,000 mentally retarded, and reflected, he felt, the overall status of approximately 150,000 institutionalized mentally retarded throughout the country. His experience also indicated that conditions varied little for the “millions of retarded people living outside the large institutional settings in natural homes, group homes, foster homes, nursing homes and other living arrangements.”

According to Clements, the major psychiatric drugs are administered to suppress various kinds of behavior that result not from retardation but from the deprived, wretched conditions of incarceration. He observes that “the very behaviors that drugs are given to alleviate [such as] . . . sleep disorders, head rolling, head rocking, head banging, picking, pulling and rubbing habits, teeth grinding, masturbation and disruptive behavior—frequently the target for drug control—are due to the general environment in which the drug therapy is being utilized.”

In one institution of 750 inmates, Clements found 70 percent were taking major tranquilizers. According to Clements, and consistent with my experience in state mental hospitals, the personnel administering the medications either had little or no humanitarian orientation, or, frequently, could not converse in English and thus were unable to provide much supportive interaction.

Suppression of Prisoners

Very little information is available concerning the use of the major tranquilizers in prisons. A recent exception appeared in the American Journal of Psychiatry, in which Kaufman (1980) described the use of major tranquilizers for outright purposes of inmate control in juvenile and adult penal institutions. In addition, occasional newspaper scandals and reports made by former prisoners indicate that the control of nonpsychotic unruly inmates with the major tranquilizers
is widespread (Breggin and Breggin, 1974; Coleman, 1974; Mitford, 1973). The ACLU recently brought a suit against the Virginia penal system for physical damages resulting from the administration of the long-acting injectable phenothiazine, Prolixin. The drug was at times administered by other prisoners acting as aides in the prison hospital without supervision of a physician. The case resulted in a $518,000 settlement (Greenhouse, 1979; McDonald, 1979b). A vivid personal description of abuse with major tranquilizers in a prison was published as a letter in the Berkeley Barb (Oregon State Prisoner, 1971). The use of psychiatry and the major tranquilizers to control prisoners in New York City’s “Tombs” has been described in the New York Times (Morgan, 1974). Legislation aimed at preventing the use of the major tranquilizers for nonpsychiatric purposes in California’s prisons was vetoed by Governor Brown (San Francisco Chronicle, 1977).

Often some attempt will be made to redefine prisoners as “mental patients.” Sometimes this is accomplished by transfer to the medical wing of the prison. On occasion an individual may actually be transferred out of the institution to a state hospital facility for the criminally insane. Several years ago I met with a group of prisoners who had been transferred from a state prison in Maryland to a maximum-security mental hospital. Each of the men had been involved in a hunger strike over conditions within the prison.

On other occasions prisoners will be drugged without any attempt to redefine their status from prisoner to patient. Nonmedical prison personnel may be empowered to give injections of the major tranquilizers to any inmates of a cellblock who are making trouble. In a manner that approaches outright torture, prisoners confined in solitary may be forcibly given large, mentally disruptive and physically painful doses of the drug. Prolixin is frequently used (see Zander, 1977), because the long-acting effect of the drug in its injectable form makes it a particularly efficient means of control.

Psychologist and lawyer Edward Opton has shown great concern about the use of psychiatric treatments as punishment in prisons. Opton (1974) describes a prisoner’s reaction to his treatment with Prolixin intramuscular injections every two weeks for six weeks. The prisoner complained of the various extremely unpleasant physical effects, “so bad you can’t stand it,” including spasms, cramps, difficulty controlling the tongue and facial muscles, and “an itching type ache” that made resting impossible. Of still more relevance to the brain-disabling hypothesis, he described mental dysfunction as well:
Your thoughts are broken, incoherent; you can’t hold a train of thought for even a minute. You’re talking about one subject and suddenly you’re talking about another... Your mind is like a slot machine, every wheel spinning a different thought.

To skeptical readers this may seem like a gross exaggeration for propaganda purposes. Yet similar descriptions of commonplace drug reactions can be found in the psychiatric literature (e.g., Van Putten, 1974, 1975b). As we examine the various neurologic and mental effects of the major tranquilizers, the reader may wish to return to this description, realizing that each of this prisoner’s complaints has a corresponding technical psychiatric term. He is describing several classes of extrapyramidal symptoms, including akathisia, acute dystonia, various dyskinesias, and manifestations of dysphoria.

Suppression of Political Dissenters

If political dissenters can be subdued and controlled by the major tranquilizers, and if they report subjective effects similar to those reported by mental patients, on what basis can psychiatry claim that the drugs have specificity for schizophrenia?

Leonard Frank, a former psychiatric inmate and a vigorous critic of psychiatric oppression, has helped to publicize the fundamental similarity between the use of the major tranquilizers in the American psychiatric system and in Soviet political prisons. He has broadened this perspective by reminding us that these same drugs were used to subdue and control dissidents in a hospital facility in the Jonestown commune under the dictatorship of the Reverend Jim Jones (Frank, 1979).

The lobotomy-like effects of the major tranquilizers have been described by those protesting the use of these drugs on Russian political dissidents. Harvey Fireside, in *Soviet Psychoprisons* (1979), describes the incarceration and forced drugging of a Russian dissident poet, Olga Iofe, a 19-year-old so free of traditional “symptoms” that one psychiatrist was forced to testify that “A mild schizophrenia does not presume a personality change apparent to one’s associates.” She was singled out for treatment because of protests against the resurrection of Stalinism:
The massive drugs she was forcibly given were, in Dr. Norman Hirt's opinion, "in fact a chemical lobotomy," in light of reports that, on her release, Iofe "appears to be permanently damaged, an altered person."²

The punishing effects of psychiatric drugs have been described firsthand by victims of Russian psychiatry and by those who have taken up their cause. Alexander Podrabinek, a Russian political dissident whose friends had been subjected to psychiatric treatment, wrote *Punitive Medicine*, a pamphlet smuggled from Russia and republished in Fireside's *Soviet Psychoprisons*. Podrabinek (1979) describes the use of various major tranquilizers, especially haloperidol, to suppress and control political dissidents in Russian prison-hospitals. He focuses on the "extrapyramidal derangement" that causes extreme anguish to these victims:

Political prisoners treated with haloperidol have mainly complained of constant desire [sic] to change the position of their bodies, of their inability to find any comfortable position. "It is difficult to think, to walk, to sit; it is impossible to lie," in the words of one. Many complain of "unimaginable anxiety, groundless fear, sleeplessness."

The identical use of psychiatric drugs is described in detail in Sidney Block and Peter Reddaway's *Psychiatric Terror* (1977). One of the authors, Block, is a British psychiatrist; he is trapped by the irony that drugs that he promotes in Britain for "the mentally ill" are used to torture and subdue political dissidents in Russia. In defense of the psychiatric drugs, Block and Reddaway write that "most psychiatrists . . . respect the inestimable value of the tranquilizers in treating psychoses . . . " Furthermore, "From all accounts, Soviet psychiatrists employ the tranquilizers in a similar fashion to their counterparts in the West."

After making these observations, Bloch and Reddaway nevertheless are forced by the massive evidence in their hands to conclude that these same wonder drugs are used to torture and subdue political dissidents. At the conclusion of their discussion, they admit:

More generally, we conclude that the indiscriminate use of the powerful drugs on dissenters derives from the punitive and intimidatory powers which they provide to the treating

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²Norman Hirt is a Vancouver, British Columbia, psychiatrist concerned with the political use of psychiatry in Russia.
psychiatrist. Here is a potent weapon to wear down the
dissenter and neutralize his “reformist” thinking, his social
dangerousness. The drugs have the potential of inducing a
state of apathy, lethargy, depression and physical deterio-
ration. In the face of high doses the dissenter will hopefully
“throw in the towel” and make the full-scale recantation
which is the KGB’s prime goal.

But if the drugs are the same, how can this description of their
effects and their function be reconciled with promotion of the drugs
as a treatment for psychosis? Why is it that the “mentally ill” are
helped by the treatment, while political dissenters are reduced to a
“state of apathy, lethargy, depression, and physical deterioration”? Bloch and Reddaway offer no explanation. There is no explanation.

In 1976 U.S. News and World Report published the story of Russian
dissident Leonid Plyushch, who held a press conference after
seeking asylum in the West. Here is Plyushch’s description of his
lobotomy-like response to “treatment” with the major tranquilizers:

I was horrified to see how I deteriorated intellectually, mo-
rally and emotionally from day to day. My interest in politi-
cal problems quickly disappeared, then my interest in scien-
tific problems, and then my interest in my wife and children.

In addition, he observes, “My speech became jerky, abrupt. My
memory deteriorated sharply.”

The press conference was excerpted in the New York Times
(1976), where Plyushch specifically describes the initiation of his
treatment with small doses of haloperidol: “I was prescribed haloper-
idol in small doses. I became drowsy and apathetic. It became diffi-
cult to read books. I started to spit out tablets secretly.” His reaction
to the drugs, and his attempts to stop taking them, are identical to
those of millions of institutionalized individuals every day through-
out the United States, and probably in every other nation in the
world (see Chapter 3).

Suppression of Rebellious Children

The best critiques of the abuse of children with psychiatric drugs can
still be found in popular books, especially The Myth of the Hyperactive
Child (1974) by Peter Shrag and Diane Divoky, The Tranquilizing of

3Some psychiatrists will object to my characterizing aggressive children and unruly
adolescents as “rebellious.” They are supposed to have “diseases.” This is not the