Peter Lehmann

Medicalization and Irresponsibility*

Through the example of an adolescent harmed by a variety of psychiatric procedures this paper concludes that bioethical and legal action (involving public discussion of human rights violations) should be taken to prevent further uninhibited unethical medicalization of problems that are largely of a social nature.

> Each human being loses, if even one single person allows himself to be lowered for a purpose. (Theodor Gottlieb von Hippel the Elder, 1741–1796, German enlightener)

Beside imbalance and use of power, medicalization – the social definition of human problems as medical problems – is the basic flaw at the heart of the psychiatric discipline in the opinion of many social scientists, of users and survivors of psychiatry and critical psychiatrists. Like everywhere, in the discussion of medicalization there are many pros and cons as well as intermediate positions. When we discuss medicalization, we should have a very clear view, what medicalization can mean in a concrete way for an individual and which other factors are connected with medicalization; so we can move from talk to action.

Medicalization and irresponsibility often go hand in hand. Psychiatry as a scientific discipline cannot do justice to the expectation of solving mental problems that are largely of a social nature. Its propensity and practice are not

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appropriate, and have to use force, which constitutes a threat. Its diagnostic methods obstruct the view of the real problems of individuals.

This I will show through an example – the medicalization of Kerstin Kempker (K.K.) by Uwe Henrik Peters.

Uwe Henrik Peters, medicalizer

Peters is professor M.D, specialist in psychiatry and neurology. He is one of the most well-known psychiatrists in the world and the honorary member of numerous specialized organisations in Europe, North and South America, Near and Far East. From 1969 to 1979, he was director of the Neuropsychiatric Clinic of the Johannes-Gutenberg-University Mainz, from 1979 to 1996, director of the Clinic for Neurology and Psychiatry at the University of Cologne. From 1991 to 1994, he was president and vice-president of the German Society for Psychiatry, Psychotherapy and Neurology. At the Thieme Publishing House in Stuttgart, Peters was editor of *Fortschritte Neurologie Psychiatrie (Proceedings Neurology Psychiatry)* until the end of 2003, now he has a function as Editor Emeritus. He still is honorary member of the World Psychiatric Association (WPA). In 1991, as Chairman of the German Society for Psychiatry and Neurology (DGPN), Peters honoured his colleague Fritz Reimer for his achievements in psychiatric practice and reform. As the peak of these reforms, Reimer tried to re-introduce insulin coma treatment in modern Germany (Erben, *et al.,* 1993); but the staff's resistance against this exceptionally brutal method was too big, and in 1996 he finally had to bury his special approach.

K.K., victim of medicalization

K.K. was born 1958 in Wuppertal (FRG), and has two adult daughters. She lives in Berlin. From 1996–2001, she worked as leading social worker at the Runaway-house Berlin. Since 2002, she has been self-employed as a fiction author and project-advisor.

In my example of medicalization from autumn 1975, K.K. is a 17 ½ year-old teenager who lives with her family in Mainz, where she goes to high school. She suffers from family tensions and problems of a social nature during the contradictory behaviour of her parents during their separation and divorce. She suffers under her weak mother. She hates her father, who behaves like a demi-God and rejects his children. Like many at her age she does not like her body. She hates the city, to where her parents moved, and she even hates the dialect spoken by local people. In her catholic school the nuns do not understand her and are not interested in her situation. She refuses to attend the school and finally she refuses to speak.

Diagnosis as the first step on the way to medicalization

In December 1975, K.K. is admitted to the Neuropsychiatric Clinic of the Johannes-Gutenberg-University Mainz, first on a psychotherapeutic ward, then she is ends up on a psychiatric ward led by Peters. After an insulin

administration in the morning she swallows the previous night's sleeping pill because she wants to sleep instead of having breakfast. Peters imputes suicidal intentions to her. According to him, the teenager with the preliminary diagnosis 'Crisisful pubertal development (ICD: 301.8)' [belonging to 'Other personality disorders' in the 'International Classification of Diseases'] turns into a 'schizophrenic', to whom he, in the shortest time, administers neuroleptics, antidepressants, tranquilizers, barbiturates, antiparkinsonians, insulin coma and electroshock – an example of successful medicalization. A quarter of a century later, K.K. writes:

> 'Years later, after I came into the possession of the records by a theft, I discover the enormous amounts of psychiatric drugs, beside electro- and insulinshock, which expel the life, the mind and the memory. In 125 days I had the benefit of the following:

December 12, 1975 – April 25, 1976

	Trade name	Active ingredient	Total dose
Neuroleptics	Triperidol	trifluperidol	1515 drops
	Lyogen	fluphenazine	240 mg
	Melleril	thioridazine	17025 mg
	Atosil	promethazine	350 mg
	Leponex	clozapine	75 mg
	Haldol	haloperidol	1540 drops
	Neurocil	methotrimeprazine	1650 mg
	Inofal	sulforidazine	1 ampule
Antidepressants	Sinquan	doxepin	2600 mg
	Pertofran	desipramine	1650 mg
	Pertofran infusion	desipramine	825 mg
Tranquilizers	Valium	diazepam	635 mg
	Tavor	lorazepam	305 mg
Barbiturates	Medomin	heptabarbital	29 tablets
	Luminal 0,1	phenobarbital	45 tablets
Shock	Old-Insulin i.m.	insulin	2764 units
	Old-Insulin i.v.	insulin	4260 units
	Electroshock	alternating current	6 x
Antiparkinsonians	Akineton retard	biperiden	118 tablets
Cardiovascular drugs	Effortil-Depot	etilefrine	36 tablets
	Ordinal retard	norfenefrine + octodrine	135 droplets
	Dihydergot	dihydroergotamine	5520 drops

(Kempker, 2000, pp. 49–50)

Medicalization and its consequences

Forty insulin coma administrations, electroshock, psychiatric drugs en masse – who is surprised that the teenager who started with the diagnosis 'crisisful pubertal development' in the following three years in different madhouses tried to end her trauma (produced by the medicalization) by jumping out of all possible windows, throwing herself in front of trains or swallowing all kinds of poison and chemicals?

I come back to the time where she still is medicalized. She describes the consequences of the insulin coma administration:

> The substantial sugar withdrawal by high insulin doses creates an unrestrained hunger for sweets, which can be satisfied well with chocolate. At the peak of my insulin-caused overweight I am sent into the gymnastics group: a bloated, nasty monster, covered in spots, moving only slowly and uncoordinatedly, with spit running out of the mouth, the fingers mutated to immovable sausages. (…) fed with more than 7000 units of insulin to an immovable meat loaf, my last visitors a long time ago escaped frightened, and I can hardly handle my despair and disgust. (…) Until this peak of my physical disaster they inject insulin for 40 days, in the morning before breakfast, first intramuscularly, then intravenously. If the breakfast is distributed and I don't receive it, then I know that the syringe comes. I must remain lying down and 'have reactions'. In the ideal case I slip thereby into a coma and produce epileptic cramps. (ibid., pp. 55–6)

In 1997, Peters writes in his *Dictionary of Psychiatry and Medical Psychology* (in psychiatric circles a highly respected book) about such maltreatment:

> *Insulin shock.* Coma or sub-coma caused by unphysiologically high tissue concentration of insulin and a lowering of the blood sugar level. The condition is mainly characterized by sweating, salivation, restlessness, automatic muscle twitching and blurred consciousness. It can be caused intentionally in the context of an insulin coma treatment or be spontaneous result from hyperinsulinism.
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> *Hunger excitement.* Condition of high-grade psychomotor excitation during the insulin coma treatment. (Peters, 1997)

K.K. goes on to describe the medicalization's result:

> People who see me in such a way and did not know me before must think they face a high-grade cretinous person. (…) For me, in my fragmented memory of this time, the insulin syringes and their consequences are still worse, more dissolving, more killing than everything else, even the electroshocks. Since I swallowed at the same time large quantities of a great variety of psychiatric drugs, it is hard to attribute the loss of my modes of expression and my body only to the insulin. It was impossible even to think of reading or writing. It is still difficult, because the electroshocks burned large holes into my memory, so I probably lost whole chains of events. (Kempker, 2000, p. 57)

Due to the treatment K.K. sees herself as a jellyfish-like flabby monster, and concludes:

> I do not want to live any more, I hang yammering around on the corridor and undertake half-hearted attempts to cut myself with fragments of glass. Peters reacts to this in each case with electroshocks. (ibid., p. 58)

In his *Dictionary of Psychiatry and Medical Psychology* Peters characterizes the described treatment in these words:

> *Electro-convulsive treatment*. Production of a generalized epileptic seizure as treatment procedure. Technology: With the help of a convulsator an alternating current from 70 to 100 V and about 150 mA is lead through the head of the anaesthetized – rarely the awake – and muscle relaxed patient for 1 to 9 sec. With the release of seizure the treatment is finished. (Peters, 1997)

From spring 1976, K.K.'s mother tries desparatedly to find a human and therapeutic support for her daughter. Psychosomatic clinics like the Clinik Heidenstein refuse to admit a patient with the diagnosis 'psychosis'; others like psychiatrist Günter Ammon from the German Academy for Psychoanalysis ('Dynamic Psychiatry'), the German humanistic psychotherapist Josef Rattner or Gaetano Benedetti, also standing for an humanistic therapeutic approach, from the Psychiatric University Clinic Basel, Switzerland, encourage her not to give up. Only Fritz Reimer tries to convince her that K.K.'s treatment in the Clinic Mainz is correct, and surely, when the time has come, psychotherapy would start. Fortunately K.K.'s family does not wait any longer, and so in May 1976, K.K. is finally transferred to the Swiss madhouse Bellevue, led by Wolfgang Binswanger, son of the famous existential-philosophical psychiatrist Ludwig Binswanger. At the door of that madhouse she breaks down. The alerted neurological service of the cantonal hospital Münsterlingen attributes the breakdown to organic brain damage after insulin and electroshock. The nurse, who observes her walking through the park in the next weeks, calls her a 'living corpse' (cited in Kempker, 2000, p.67).

K.K. goes on to describe the medicalization's result:

> In the Bellevue madhouse in nearly two years I swallow 40,000 mg Melleril [thioridazine], 4,000 drops Glianimon [benperidol], 25,000 mg Entumin [clotiapine] and 9,000 mg Nozinan [methotrimeprazine]. In addition 1,200 mg Valium, regularly barbiturates, in the first three months an antiepileptic and almost constantly Akineton [biperiden] and cardiovascular drugs. (Kempker, 2000, p. 68)

Soon hallucinations appear.

The result of medicalization

From despair she sets light to her hair and dresses, unscrews bulbs from the lamp holder in order to hurt herself, jumps out of the window and incurs a double pelvic fracture. She swallows all the drugs from the medication tray, drinks her cosmetics, lies down on the railway tracks, jumps out of the window

again and breaks her leg, tries to slit her veins, tries to die under the train wheels again but the emergency brakes stop the train a meter from her maltreated body. She wants to jump from the balcony, but is drawn back. Then she is shifted to the next madhouse, led by Niels Pörksen, the president of the German Society for Social Psychiatry (DGSP). But nothing changes. K.K. tries to kill herself with barbiturates. After this failed suicide attempt she tries beating her head on the bathroom tiles until she loses consciousness.

Fortunately K.K. begins to dissociate herself from psychiatry, she starts to despise and hate it, she recovers gradually from the treatment damage and trauma, finds her way back into life and publishes in 2000 her report as a book – a quarter of a century after the beginning of the treatment.

To summarize the result of this example of medicalization of interpersonal family problems: The patient suffers from physical damage of all kinds, obesity, brain damage, epileptiform seizures, hallucinations, substantial traumatization resulting in detention in madhouses for years and ongoing attempts to kill herself to get rid of the traumatization and humiliation.

And the result of the medicalization of interpersonal family problems for the psychiatrists? The problematic teenager is called 'mentally ill'. Complex treatments, which appear medically completely senseless and are executed without informed consent, can be paid for through the private insurance of the father and might bring solid incomes to the psychiatrist. The medical and social consequences of the medicalization are highly visible.

Now exactly ten years have passed since the case of Uwe Henrik Peters has been made public in Germany. There is not the smallest sign that a psychiatric organisation feels forced to dissociate itself from Peters. In 2004 he was made an honorary Doctor.

- The German Society for Psychiatry, Psychotherapy and Neurology (DGPPN, formerly DGPN), whose president and vice-president Peters was, remained mute.
- The German Society for Social Psychiatry (DGSP) remained mute after the lecture 'Blind spots in the social-psychiatric perception' by Peter Lehmann on November 2, 2000 in Berlin, when he addressed the case of Peters and also of the former DGSP-Chairman Niels Pörksen, who was not able to understand K.K.'s condition as the result of Peters' brutal treatment (Lehmann, 2001).
- Uwe Henrik Peters remained mute, after he bought K.K.'s report at the World Psychiatric Association (WPA) congress in Prague on September 24, 2008, where he was personally informed about his personal involvement in the events described here.
- The current director of the Neuropsychiatric Clinic of the Johannes-Gutenberg-University Mainz, Klaus Lieb, reacted indignantly when he (within a conference lecture by Peter Lehmann on October 8, 2009) had to

listen to the report about Peters' deeds in 1975/76 at that Clinic. He did not react indignantly to Peters' treatment of the defenceless teenager, he only reacted indignantly because he did not want to hear about it.

- The WPA (Peters is an honorary member) remained mute.

Consequences of medicalization and irresponsibility

Medicalization and connected human rights violations are not of interest to organized psychiatrists. If someone contradicts and calls the example extreme, he or she should be aware, that the next question would be: How extreme must a human rights violation be to trigger practical consequences –independently from the question, if you can distinguish human rights violations as bigger and smaller ones do we accept the latter without a problem?

So political and legal consequences are needed to protect human and civil rights of psychiatric patients.

Within the psychiatric system there should be established public panels on all levels – locally, regionally, nationally and internationally – to address human rights violations and other consequences of medicalization. This was promised at the congress 'Coercive Treatment in Psychiatry: A Comprehensive Review', run by the WPA, Dresden, Germany, June 6–8, 2007 by Juan Mezzich, then the President of WPA, who publicly committed to be open to dialogue for all in the psychiatric field, including those who are raising difficult issues involving human rights violations (see Lehmann, 2009, pp. 38–39; Mezzich, 2007a). Three months after that conference he wrote:

> A renewed commitment to the clinician-patient relationship appears crucial as well as building an effective dialogue with patient and user groups (as well as trialogues [meetings of users and survivors of psychiatry, carers and psychiatric workers] including families) respecting the diversity of their perspectives. (Mezzich, 2007b)

But afterwards, he informed the leaders of the self-help movement that key leaders within the WPA were – nearly without exception – passionately opposing dialogue. This shameful truth concerning the whole world of psychiatry should be addressed at every possibility. The question is, which exceptional psychiatrists are willing to use their influence to support publicly and meaningfully the demand for a public discussion of human rights violations? And which ones are able to criticize their professional associations for denial of dialogue?

What is possible in the Catholic church after misuse and maltreatment of those entrusted to their care, should also be possible in the psychiatric field. But as long as psychiatrists behave like a Stalinist block and refuse discussion about human rights violations, users and survivors of psychiatry and their families and friends should be aware that human rights violations can occur all the time in the psychiatric field only to be ignored.

Beyond that, my example of a medicalization of problems of a social nature

shows how important the commitment for developing adequate and effective assistance for people in emotional distress is; how important safeguarding civil rights in treatment on a par with general medical patients is; how important the demand for compensation for treatment induced damage and legal prosecution of psychiatrists who violate the criminal law is; how important it is for users and survivors of psychiatry to join forces in cooperation with other human rights and self-help groups. David Oaks, Director of MindFreedom International, an independent non-profit coalition defending human rights and promoting humane alternatives for emotional well-being now accredited with the advisory status of a non-government organization at the United Nations, offers dialogue and calls for demonstration at the same time, knowing that psychiatric offers of dialogue until now have not brought any meaningful change in psychiatric practise or a meaningful dialogue about human rights violations.

> Those of us who have allied ourselves with the less powerful side of the imbalance inherent in coerced psychiatric procedures, need to learn from other social change movements throughout history who have turned to non-violent direct resistance through creative civil disobedience. (Oaks, 2010)

Recalling the Convention on the Rights of Persons with Disabilities, adopted by the General Assembly of the United Nations at the end of 2006, coming into force in May 2008, we should build a coalition to combat cruel, inhuman or degrading treatment. Further, my example of a medicalization of problems of a social nature shows the importance of developing alternative and less toxic psychotropic substances. A ban on insulin coma and electroshock are only the start in moving towards alternatives beyond psychiatry and strategies toward implementing humane treatment and human rights protection.

Alternatives beyond psychiatry exist, and they serve as an impetus and guidepost for everyone who wants to extract him – or herself from being dependent on psychiatry and damaged by medicalization. Examples of medicalization as well as alternatives beyond psychiatry are also a wake-up call. Listen up, users of psychiatry, if you have the impression that your condition worsens in the course of psychiatric treatment, recovery from medicalization is possible if you dissociate yourselves altogether from psychiatry. Other choices bringing improvement from psychic problems of a social nature are definitely possible! Listen up psychiatric workers and friends, all you thousands who have followed the lure of power, money and theoretical or scientific acquiescence, other choices are definitely possible! Alternatives to medicalization are essential and can be successful with enough dedication and a reasonable degree of financial stability. Humane ways of helping people with emotional problems of a social nature do exist and there is no need to shock them and pump them full of chemicals (see Stastny & Lehmann, 2007, pp. 409–10).

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