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Medicalization and Irresponsibility

Lecture from June 29, 2010, at the congress „The real person", organized by the University of Preston (Lancashire), Institute for Philosophy, Diversity and Mental Health, in cooperation with the European Network of (ex-) Users and Survivors of Psychiatry (ENUSP) in Manchester within the Parallel Session „Psychiatric Medicalization: User and Survivor Perspectives" (together with John Sadler, Professor of Medical Ethics & Clinical Sciences at the UT Southwestern, Dallas, and Jan Verhaegh, philosopher and ENUSP board-member, Valkenburg aan de Geul, The Netherlands).

Abstract: Through the example of an adolescent, who reacts on the divorce of her parents with emotional problems, receives the diagnosis of „schizophrenia" and then insulin- and electroshock and all kind of psychiatric drugs with the consequence of severe suicidality and vegetating in psychiatric clinics for years due to the iatrogenic traumatization, possible consequences of the medicalization of interpersonal familiar problems can be identified: Production of medical and social consequential charges; refusal of appropriate support; rejection of any responsibility on the side of the treating psychiatrist as well as the professional associations. Bioethical and legal consequences should be taken to prevent further uninhibited unethical medicalization of mental problems that are largely of a social nature.

„Each human being in the entire world loses,
if even one single person allows himself
to be lowered for a purpose."
(Theodor Gottlieb von Hippel the Elder, 1741-96, German enlightener)

Beside imbalance and use of power, medicalization—the social definition of human problems as medical problems—is the basic problem of the psychiatric discipline in the opinion of many social scientists, of users and survivors of psychiatry and even of 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 topics are connected with medicalization. So we can move from talking 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 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 1969-79, he was director of the Neuropsychiatric Clinic of the Johannes-Gutenberg-University Mainz, from 1979-96, director of the Clinic for Neurology and Psychiatry at the University of Cologne. From 1991-94, 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 end of 2003, now he has a function as Editor Emeritus. And 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 (at the top of the illustration below) honoured his colleague Fritz Reimer (at the top of the illustration: Peters below) for his merits in psychiatric proceedings and reforms (Figure 1). As the peak of his psychiatric proceedings and 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 had to bury his special approach finally.

Bei der Laudatio auf Fritz Reimer: Der neugewählte DGPN-Vorsitzende Prof. Dr. Uwe Hendrik Peters.

Das Symposium war dem 60jährigen Geburtstag von Prof. Dr. Fritz Reimer, Direktor des Psychiatrischen Landeskrankenhauses Weinsberg bei Heilbronn, gewidmet. Der neu gewählte Vorsitzende der Deutschen Gesellschaft für Psychiatrie und Nervenheilkunde (DGPN), Prof. Dr. Uwe Hendrik Peters, faßte die Verdienste des Jubilars in einer Laudatio zusammen:
Reimer sei maßgeblich an der Entwicklung der Psychiatrie-Reform beteiligt gewesen und habe die Enquete zur Lage der Psychiatrie mitverfaßt. Der Wissenschaftler Reimer hat 320 Publikationen verfaßt und 160 Vorträge gehalten, „in denen sich farbgetreu die psychiatrische Entwicklung der letzten 30 Jahre widerspiegelt". Dank Reimers Organisationstalent sei für Weinsberg jahrelang die niedrigste Verweildauer der Patienten möglich geworden. Zudem verfüge die Region jetzt über ein bedarfsdekkendes Netz an nachgehenden Einrichtungen.
Als erstes Landeskrankenhaus habe Weinsberg unter seiner Leitung die nationalsozialistische Vergangenheit aufgedeckt und in einem kleinen Museum der Öffentlichkeit zugänglich gemacht. Reimer ist Mitherausgeber des „Spektrum" und Gründer der „Krankenhauspsychiatrie". Er sei unbeirrbar, unerschrocken und unbequem, neige aber auch zu Eulenspiegeleien (Dr. Biersnyder) und Valentiaden. Er kenne nur eine Ideologie - „daß jede Ideologie verboten sein sollte". „Ein kontrastreicher Mensch", urteilte der Redner, „und ein sorgfältiger Verhüller seiner Person, aber der Mensch spiegelt sich in seinen Taten".
(ub)

Das Symposium war ihm zum 60. Geburtstag gewidmet: Prof. Dr. Fritz Reimer, Direktor des PLK Weinsberg.

Figure 1: Report about Uwe Henrik Peters and Fritz Reimer, two experts for medicalization

K.K., Victim of Medicalization

K.K. is 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 is self-employed as fiction author and project-advisor.

Figure 2: K.K. before medicalization (Summer 1975)

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, psychological problems of a social nature: under the contradictory behaviour of her parents during their separation and divorce phase. 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, into which her parents moved, and she hates even the dialect people in this area are speaking. 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 she swallows the sleeping pill from the previous evening after an insulin administration in the morning, 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", P.L.] turns to a „schizophrenic", whom he, in shortest time, administers neuroleptics, antidepressants, tranquilizers, barbiturates, antiparkinsonians, insulin coma & electroshocks in an excessive way—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 find out, which enormous amounts of psychiatric drugs, beside electro- and insulinshock, should expel the life, the mind and the memory. In altogether 125 days I came into the benefit of following excessive psychiatric drug and shock therapy:

December 12, 1975 – April 25, 1976

	Trade name	**Active ingredient**	**Total dose**
Neuroleptics	Triperidol	trifluperidol	1,515 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 dragées
	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 of a „crisisful pubertal development“ in the following three

years in different madhouses tried to end her trauma, which was set 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 on sweets, which can be satisfied well with chocolate. On 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 on 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 and 'have reactions'. In the ideal case I slip thereby into a coma and produce epileptic cramps" (ibid., pp. 55-56).

In 1997, Peters writes in his *Dictionary of Psychiatry and Medical Psychology*, in psychiatric circles a highly respected book, about such a 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.
>
> *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 read or writing. It is still difficult, because the electroshocks burned large holes into my memory, so I lost probably 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 desperately to find a human and therapeutical support for her daughter. Psychosomatic clinics like the Clinic Heidenstein refuse to admit a patient with the diagnose „psychosis", others like psychiatrist Günter Ammon from the German Academy for Psychoanalysis („Dynamical 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 the above mentioned Fritz Reimer tries to convince her that K.K.'s treatment in the Clinic Mainz is correct, and surely, when the time has come, also 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 activated neurological service of the cantonal hospital Münsterlingen attributes the breakdown to an organic brain damage after insulin and electroshock. The nurse, who observes her walking through the park in the next weeks, calls her an „alive 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, P.L.], 4,000 drops Glianimon [benperidol], 25,000 mg Entumin [clotiapine, P.L.] and 9,000 mg Nozinan [methotrimeprazine, P.L.]. In addition 1,200 mg Valium, regularly barbiturates, in the first three months an antiepileptic and almost constantly Akineton [biperiden, P.L.] and cardiovascular drugs" (Kempker, 2000, p. 68).

Soon also hallucinations appear.

Now I go on to describe the medicalization's result:

From despair she ignites her hair and her dresses, unscrews bulbs from the lamp holder in order to hurt herself, jumps out of the window with the consequence of doubled pelvic fracture. She swallows all drugs of the medication tray, drinks her entire cosmetics, puts her body on the train tracks, jumps out of the window again and breaks her leg, tries to slit her arterial veins, tries to be rolled over by a train again but the emergency breaks stop the train one meter before her maltreated body. She wants to jump from the balcony, but is drawn back. Then she is shifted to next madhouse. This is 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 suicide failure she uses beating her head at the bathroom tiles until the loss of 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 book—a quarter of a century after the beginning of the treatment.

Summarizing the result of this example of medicalization of interpersonal family problems: The patient suffers from physical damage of all kind, obesity, brain damage, epileptiform seizures, hallucinations, substantial traumatization with the consequence of detention in madhouses for years and ongoing

attempts to kill herself to get rid of the traumatization and humiliating situation. It must have taken myriads of guardian angels to keep her alive.

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 additionally are executed obviously without informed consent, can be brought to account towards 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.

Back to the example: All in this case psychiatrically involved individuals and the organisations they belong to face such a scandalous treatment completely indifferently.

Now exactly ten years have passed since the case of Uwe Henrik Peters has been made public in Germany. There is not the all-smallest sign that a psychiatric organisation feels forced to dissociate itself from Peters. In 2004, he received the honour to become honorary doctor.

- The German Society for Psychiatry, Psychotherapy and Neurology (DGPPN, formerly DGPN), of which Peters was president from 1991-92, put him on its advisory board in 2010, in order to receive his advice on ethical issues and “to use his expertise, experience and engagement” (DGPPN, 2010), according to DGPPN leader Frank Schneider. The organisation surely profited from Peters’ expertise and ethical wisdom when they announced two years later to promote preventive, early and subsequent (“maintenance”) electroshock in Austria, Germany, Italy and Switzerland (Grözinger et al., 2012).
- 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 WPA congress in Prague on September 24, 2008, where he was personally informed also about his meaningful personal involvement in the described events.
- The current director of the Neuropsychiatric Clinic of the Johannes-Gutenberg-University Mainz, Klaus Lieb, reacted even 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; but he did not react indignantly to Peters’ treatment of that defenceless teenager, he only reacted indignantly because he did not want to hear this case.
- The Thieme Publishing House in Stuttgart with its editor Peters, informed by Peter Lehmann about Peters’ treatment methods, remained mute.
- The World Psychiatric Association (WPA), whose personal honorary member Peters is, remained mute. Also Ahmed Okasha, Past WPA-president and Chair of the WPA Review committee, as well as Donna Steward, his colleague in the mentioned committee, had no opinion about Peters’ cruel treatment methods, after they have been informed in detail directly and personally on October 20, 2010. They and whole WPA seem to be rather proud having a colleague like Peters in their WPA personal honoary membership group.

Consequences of Medicalization and Irresponsibility

Result: 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 an alienation with practical consequences—independently from the question, if you can distinguish human rights violations in bigger and smaller ones and then accept the latter ones 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 bad 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). And 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, P.L.] including families) respecting the diversity of their perspectives” (Mezzich, 2007b).

But afterwards, he informed representatives of the self-help movement that key leaders within the WPA were—nearly without exception—reluctant to have dialogue. This shame for the whole world of psychiatry should be addressed at each possibility. The question is, which exceptions from the society of psychiatrists are willing to use their influence so 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 the wards (those entrusted in their care)—public confession and discussion of misuse—, should also be possible in the psychiatric field. But as long as psychiatrists behave like a monolithic—or better—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 but are ignored.

Beyond that, my example of a medicalization of psychological problems of 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 ‘normal’ patients is; how important the demand for compensation for treatment damages and legal prosecution of psychiatrists who violate the criminal law is; how important it is for users and survivors of psychiatry joining 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 mental and emotional well-being and 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 did not bring any meaningful change in the psychiatric practise or a meaningful dialogue about human rights violations. David Oaks sums up:

> „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 nonviolent direct resistance through creative civil disobedience" (Oaks, 2011, p. 209).

Recalling the Convention on the Rights of Persons with Disabilities, which was adopted by the General Assembly of the United Nations at the end of 2006 and came into force in May 2008, we should build a coalition to combat cruel, inhuman or degrading treatment. And, coming to the end, my example of a medicalization of psychological problems of social nature shows, how important the development of alternative and less toxic psychotropic substances and a ban of insulin coma and electroshock are, also alternatives beyond psychiatry and strategies toward implementing human 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 impairs in the course of psychiatric treatment, recovery from medicalization is possible if you dissociate yourselves from psychiatry in time. Other choices bringing improvement from psychic problems of 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 (see Stastny & Lehmann, 2007, pp. 409-410)! 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!

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Illustrations

(1) in: Der Eppendorfer—Zeitschrift für die Psychiatrie, Vol. 6 (1991), No. 2, p. 5

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About the Author

Born in 1950 in Calw (Black Forest), Germany. Education as social-pedagogist. Living as independent publisher and author in Berlin. In 1986, foundation of Peter Lehmann Publishing and Mail-Order Bookstore (Germany), in 2003, founding of a branch in UK, 2004 in USA. In 1980, co-founder of a

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