Holes In The Head: Psychosurgery in the 21st Century

What would you do if a lobotomy was your only hope for happiness? Today the procedure is called psychosurgery and it continues to be prescribed to treat mental illness, though many psychiatrists argue the mentally ill need it like a hole in the head.

BY DANIELLE EGAN

“I remember when I was having the surgery, they had put a lot of drugs in me and I was feeling heavily drunk. They said, ‘How do you feel?’ I said, ‘I feel drunk.’ They were trying to put this jig on my head, and these guys couldn’t get it on. I’m going, ‘Oh my god, what am I doing here in this operation room? This is crazy. You’re going to drill holes in my head and you can’t get this thing on!’ I didn’t think it was funny. I was a lot worried.”

Bruno (not his real name) and I are having lunch at a Chinese restaurant on the main drag of a small town just south of Edmonton. The neatly dressed 33-year-old speaks in a loud, calm voice as he describes a psychiatric neurosurgery, or psychosurgery, performed on him in November 2002 as a last resort treatment to curb his obsessive-compulsive disorder (OCD). The disorder appeared as excessive hand-washing when Bruno was 10, but eventually became debilitating. He dropped out of university during his third year and started seeing Dr. Lorne Warneke, an Edmonton psychiatrist who specializes in OCD. They spent the next 10 years trying dozens of pharmaceutical treatments, in addition to cognitive behaviour therapy, while Bruno worked on and off selling insurance. But Bruno, like about 20 percent of people who try the standard methods of treatment for mental illness, found they didn’t help him. So Warneke told him about a type of surgery that could treat his OCD by destroying pathways in his brain thought to be overactive in people with anxiety disorders.

“At first I couldn’t think of someone drilling a hole in my head and frying my neurons, you know,” says Bruno, letting off a loud booming laugh. “I talked about it with Dr. Warneke. Finally, I guess, I thought that’s what I should do.”
Performed at University of Alberta Hospital in Edmonton, the surgery, called a stereotactic bilateral anterior capsulotomy, is one of four psychiatric neurosurgeries used around the globe to treat people with severe depression and anxiety disorders. Specialists in the field aren’t sure how or why these surgeries work, and all four operations target different parts of the brain. The goal is to interrupt the neural pathways between the frontal lobes—known as the seat of personality and the brain’s CEO because they’re involved in higher functions like problem-solving, motor-control, language, memory-sorting and impulse-control—and the so-called “lower” areas of the brain, including the thalamus, amygdala and hippocampus, which initiate mood, hormones and emotions ranging from sexual pleasure to fear.

With the anterior capsulotomy, the target is the internal capsule, an area dense with nerve connections between the frontal lobes and the thalamus. About four such procedures have been done each year at University of Alberta Hospital since Warneke started referring some of his most severe treatment-resistant patients to neurosurgeon Dr. John McKean in the early 1990s. In order to be referred, the patients must have failed a number of years of standard treatment, including pharmaceuticals and psychotherapy, and be “considerably debilitated.” Psychosurgery, Warneke explains, is “a very simple procedure that effectively cuts nerve fibres. It’s a bit like cutting some wires in a telephone trunk line to reduce the amount of messages getting through.”

His explanation is similar to that of Portuguese neurologist Dr. Egas Moniz, who developed the first psychosurgeries (then called prefrontal leucotomies) in the 1930s. Moniz claimed the procedure was necessary to “change the paths chosen by the [dysfunctional] impulses … and force thoughts into different channels.” While tools and technologies have certainly evolved over the years, the premise of severing pathways in order to treat psychiatric illnesses remains the same as it was back in the early days of lobotomy.

The “jig” placed on Bruno’s head is a large metal device that makes it easier for surgeons to pinpoint the coordinates of the spots to be destroyed. When the neurosurgeon arrived and showed the attendants how to work the stereotactic frame, “there was a sigh of relief,” Bruno says, laughing heartily before taking a few bites of his buffet lunch. Bruno’s skull had already been locally anaesthetized so that he
wouldn’t feel pain from the drill, and two spots on the top of his head just above the hairline had been shaved. The brain itself doesn’t feel pain, so Bruno was wide awake as doctors drilled two dime-sized holes in his skull. “I remember the sound of the drill, but no pain, just a little pressure. Then I remember the doctor going, ‘How many fingers?’ It felt like I was only there 15 minutes. I was in and out.”

The surgery actually took about an hour. The neurosurgeon inserted an electrical probe a couple of millimetres wide into one of the holes and guided it through one side of Bruno’s frontal lobe to the internal capsule. The probe was heated to about 65 degrees for one minute to destroy a pea-sized piece of his brain. The same procedure was repeated on the other side.

The next thing Bruno remembers is waking up the following morning to nurses telling him he could go home. “I remember phoning my dad and saying, ‘Come get me.’ It was about 6:30 in the morning. But then I went AWOL, I just left. That’s not the kind of thing I do.” It’s hard to imagine this mellow guy ditching the hospital as if fleeing a crime scene. “I don’t know what the hell I did that day. I remember being in the [university] book store and I had no money, but my brother said I told him I had lunch [on campus]. Don’t know how I did that. I don’t remember what else I did.”

According to Bruno’s dad, Jack (not his real name), about 10 hours after Bruno left the hospital, and with his family searching frantically, a man returned to his car on the university grounds and found Bruno in the back seat with an IV needle still stuck in his arm. Bruno was confused and incoherent, and didn’t remember the surgery. Eventually he remembered his phone number and the man used his cell phone to call Jack. When Bruno noticed his head wounds, he thought someone had tried to sew a blanket to his head. They brought him back to the hospital, where he stayed for 10 days under 24-hour security. “He was antsy and at the first chance would have left,” says Jack.

Transient confusion and memory loss are common following psychosurgery, with specialists reporting that these effects are usually temporary and resolve themselves within a week. But patients have reported a variety of long-term effects, ranging from cognitive deficits to extreme fatigue to aggression. As a result, these surgeries aimed at treating dysfunctional minds are often as controversial now as they
were in the heyday of lobotomy in the 1940s when it is estimated that
tens of thousands of lobotomies were performed globally, and later in
the 1970s. Today, it’s estimated that about 300 psychiatric
neurosurgeries are performed worldwide, but it’s impossible to know
just how many since there are no national databases tracking the
numbers. Though proponents are cautious about selecting only
consenting patients with severe debilitating mental disorders,
specialists are expressing a “renaissance of interest” in psychiatric
neurosurgery, calling for “careful optimism” and claiming the
procedures may even be more “cost-efficient” than
psychopharmaceuticals and psychotherapy. Some say neurosurgery to
treat mental illness is ready to “stage a comeback.” A 1999 poll of
American Psychiatric Association members shows that psychiatrists are
becoming more open to this physically invasive treatment model: 74
percent said they would consider neurosurgery for their patients. With
about 20 percent of the population suffering from depression, and 25
percent suffering from anxiety disorders, according to the World
Health Organization, this buzz about psychiatric neurosurgery may be
leading us into a third wave of psychosurgery.

The first wave began in the late 1930s, largely as a reaction to a surge
in psychiatric hospital admissions. The increase was partly attributed
to soldiers returning from the Second World War with post-traumatic
stress syndrome, and the identification of mental illnesses such as
schizophrenia and mood disorders like depression and anxiety.
However, also commonly institutionalized were epileptics,
homosexuals, drug addicts, unruly children and women who liked sex
either too much or too little. Lobotomy became a method for
managing the sheer number of patients and, ideally, returning them
home. Ironically, lobotomy and a variety of other physical treatments
for mental illness, such as insulin and electroshock therapy, were ways
for psychiatrists to legitimize themselves in the medical community
and link psychiatric illnesses with biology. The surge in the US was due
largely to the promotional zeal of Dr. Walter Freeman, a psychiatrist
who travelled the continent in his “lobotomobile,” teaching other
psychiatrists his own method of non-surgical lobotomy. The early
procedure involved inserting an icepick-like instrument above the eye
socket and into the frontal lobes. The use of lobotomy was scaled back
by the mid-1950s with the invention of antipsychotic pharmaceuticals.
The procedure had also become associated with a wide range of
disturbing post-operative complications, from zombie-like apathy and aggressive behaviour to death. Lobotomy did make some patients manageable docile but others became childlike, requiring spoon-feeding, potty-training and lifelong care at home.

Most neurosurgeons and psychiatrists realized that these crude lobotomies were doing more harm than good. But a handful of specialists continued to believe that there was benefit to disconnecting the pathways between the frontal lobes and the deeper brain. They kept performing these operations under the label psychosurgery and claimed to use stricter patient selection criteria and more specific brain targeting, described as “precision bombing.” Opponents say this second wave of psychosurgery was even more dangerous than the first, with the ultimate goal of behaviour control. Indeed, in the 1970s and ‘80s, specialists around the world operated on school kids with attention deficit disorders, sexual deviants, drug addicts, violent criminals, and even suggested psychsurgery pre-emptively on “slum dwellers.” Political pressure from civil rights groups resulted in government investigations and new legislation mandating informed consent and the banning of the surgeries at state and provincial mental institutions and prisons.

Today, these procedures are recommended as a last resort only for OCD, depression and, to a lesser degree, body dysmorphic disorder and anorexia. In the United States, several established centres continue to endorse and perform surgery, including Harvard University in Boston, whose clinic at Massachusets General Hospital (MGH) is run by Canadian neurosurgeon Dr. Rees Cosgrove, and Brown University in Providence, Rhode Island, whose psychiatrists and neurosurgeons work out of nearby Butler Hospital and Rhode Island Hospital. Overseas, there are the Karolinska Institute in Stockholm, Sweden, and seven centres in the UK. In Canada, the University of British Columbia opened a neurosurgery centre at Vancouver General Hospital (VGH) in 2000, University of Toronto neurosurgeon Dr. Andres Lozano performs psychiatric neurosurgeries, and the Montreal Neurological Institute has plans to open a centre.

These centres describe highly selective candidate criteria, assessment boards and strict follow-up studies. Some are concerned that the patients they reject will find a willing neurosurgeon in their home state or province or seek out a private clinic such as the San Diego Gamma
Knife Centre, which offers drill-free neurosurgery. “I have knowledge of other hospitals doing [psychiatric neurosurgery] without appropriate knowledge. I’m scared to know how many,” says Dr. Gerhard Friehs, a neurosurgeon with the Brown University team, which does several anterior capsulotomies annually and accepts one in 10 applicants who have exhausted standard treatments. “This surgery should only be done as research,” Friehs warns.

Psychiatric neurosurgery is considered experimental in the US and isn’t covered by medicare or insurance plans. But in Canada, all of these surgeries are covered by provincially funded health plans. That should make it easier to track the number of procedures performed here, but different coding at different hospitals makes it difficult to make comparisons. Because of a coding glitch, Warneke had trouble finding the files for many of his patients who had been capsulotomizzed at University of Alberta Hospital and Edmonton’s Grey Nuns Hospital over the past 10 years—codes included frontal lobotomy, leucotomy and total ablation of the thalamus, and one hadn’t even been recorded as having had surgery.

After 10 days in hospital, Bruno returned to his parents’ home, where he still lives today. “With the exception of a few incidents,” Jack says, “he’s been fairly trouble-free.” Bruno says he sometimes feels down and momentarily and mildly bothered by the OCD, but in his first post-op year he started working out on a regular basis, dropped some weight and started curling. His father adds, however, that “he was quite happy with us making decisions [for him]” immediately after surgery. Bruno spent a full year recuperating, and started working in November 2003. Before the OCD hit him hard he was studying to be a teacher. Immediately before the surgery, though, he couldn’t work at all. “He can now do an eight-hour shift,” Jack says.

Bruno works the night shift as a janitor in an industrial plant. “I clean floors, basically. It’s not hard work, really, but I’m busy the whole time. I don’t like it,” he laughs. “I get home at 2 a.m. and I’m always tired. I sleep, work, eat.” He still takes a cocktail of antidepressants and anti-anxiety medications. “After awhile, you don’t even look at the pill bottle to see what the heck you’re taking. Effexor? Yeah. I’m taking Luvox, I think it is, and Drexedrine, I think that’s an amphetamine. And also a sleeping pill type of antidepressant thing. Get home, pop a few of those, have a beer and it knocks you out. I probably won’t go off
them anytime soon. I don’t want to take them but I’ve given up fighting. My energy level can be low at times. I’m not that ambitious.”

Depression, apathy and fatigue have been reported in post-op follow-up studies dating back to the 1950s. Past literature touted as much as a 70-percent post-op success rate but rarely looked at the negative side effects. Studies were mired by researcher bias, poor testing criteria and an absence of double-blind controlled trials (which compare people who receive medications, placebos or no treatment) and sham testing (which compares patients who receive surgery with those who do not but are led to believe they did). Further muddying the study waters is that different surgery centres use different operations that target different parts of the brain. Anterior cingulotomy targets the frontal lobe’s cingulum, an area thought to be involved with executive planning, motivation and risk assessment. It was the target of surgeries dating back to the 1940s, when destroying a small area of this part of the brain was believed to reduce anxiety. It is also the procedure of choice at MGH and U of T. Anterior capsulotomy is practised at VGH and Karolinska. Subcaudate tractotomy and limbic leucotomy (tractotomy and cingulotomy combined) are preferred in the UK.

All of these surgeries claim similar efficacy rates and, less often, similar negative effects based on testing done by psychiatrists and self-assessments by patients. The most recent data on anterior cingulotomies from MGH suggests that, even though less than half of patients improve post-op, “no serious adverse effects were found.” But a comprehensive 2000 UK report from the Royal College of Psychiatrists dug deeper into that data and found that, in one 1995 MGH study, 56 percent of cingulotomized patients had “emergent or significantly worsened symptoms” and nine percent experienced seizures. A 1987 MGH survey found that nine percent of patients committed suicide after surgery.

On the capsulotomy front, the VGH team claims an efficacy rate of between 60 and 70 percent in five patients (four severely depressed women and one man with OCD) operated on in the four years the clinic has been open. “Two people had very good outcomes, one person had a moderate outcome and one person has less depression, but she has fatigue from the surgery which I consider a bad outcome,” says Dr. Trevor Hurwitz, the team’s medical director. “The person with
OCD says he’s 70 percent better.”

Brown psychiatrist Dr. Ben Greenberg reports “rare adverse changes in personality” of between one and five percent. Studies at the Karolinska Institute have found a wild assortment of post-capsulotomy complications, including “frontal lobe syndrome” in 33 percent of one cohort of patients. In another cohort, it found perseveration (the inability to switch tasks) in 50 percent of patients and depression in 33 percent, even though 93 percent had previously been rated as “fully or markedly improved.” A 2003 study at the same hospital found that more than a quarter of patients had “significant adverse events” including apathy, memory problems, addiction problems, disinhibition (talking or acting inappropriately) and criminal behaviour ranging from theft to rape.

“I do not believe in psychosurgery at all,” says Dr. Susanne Bejerot, a Swedish psychiatrist who works in the neuroscience department at Karolinska and studied data from several centres. “What I saw changed my view radically,” she says. Bejerot became a bellringer last year when she published a paper in the Swedish medical journal *Acta Scandinavia*. She wrote that negative post-op effects including emotional shallowness, severe alcoholism, aggressive tendencies, lower performance IQ and poor impulse control “may only represent the tip of an iceberg [of possible effects] because of decline in executive functions after surgery.” There is a general bias against publishing negative results, she added, pointing out that physicians often interpret weight gain, a common effect of surgery, as a positive effect related to the patient’s supposed increased ability to enjoy life. Patient self-assessments are similarly unreliable, she says, “considering that the very capacity to do so resides in the frontal lobes.”

Warneke acknowledges this data, but tells his patients “the procedure has no negative effects—in other words, if it does not help it does not harm.” He says there are the usual risks associated with surgery, such as infection and a one-percent risk of post-op seizures that can be controlled with medication. “About a third [of patients] get major improvement, about a third get moderate improvement and the remainder are not helped,” he says. If they are not helped by the surgery, Warneke may recommend repeat surgery, adding that “in some cases this has been done up to three times.”
A triple-procedure patient of Warneke’s had her third surgery by the age of 19 after suffering from debilitating OCD through much of her teen years. She’s now 22 and still has OCD, along with depression, suicidal ideation, extreme fatigue, seizures and “inappropriate” and aggressive behaviour. Warneke contemplated a fourth procedure for her, and since such a large part of the woman’s internal capsule has been destroyed, he was considering a new target. But this past summer, the young woman’s parents read literature on the adverse effects of repeat procedures and decided against more surgery. Warneke now acknowledges the woman is showing signs of frontal lobe apathy and is odd and impulsive in behaviour, but he contends that “she’s healthier in some ways, is no less functional and is suffering a lot less [than before surgery].” In general, as many as 45 percent of psychiatric neurosurgery patients require repeat procedures. Bejerot found that “the patients that have been re-operated on seem to do the very worst” because larger portions of their brains are destroyed in the process, resulting in increased cognitive and personality deficits.

“These surgeries cut thousands of nerve connections and have the same effect as a lobotomy,” says Dr. Peter Breggin, a New York psychiatrist who has written a dozen books on the dangers of pharmaceutical drugs and biopsychiatric treatments. Breggin has evaluated five cingulotomy patients from the MGH program; four of them were left legally incompetent after surgery. “The most sensitive aspects of the human being—the ability to think, reflect, have an abstract conversation, to care, to love, share, relate empathetically—those higher social and spiritual aspects of personality are blunted with psychosurgery. Everybody gets worse and there’s no rationale for putting a hole in the brain. That’s stupid,” says Breggin, whose work as a US Congressional consultant into psychosurgery in the 1970s resulted in bans at state facilities. He believes that psychiatrists and neurosurgeons are motivated by money, power and “the ability to tinker with the brain like auto mechanics,” and that the only organic physical damages in patients with mental illness are caused by psychiatric drugs and other invasive techniques like electroshock therapy and surgery.

“Psychosurgery is based on a flawed and impoverished vision of the relationship between brain tissue and psychological disorder,” wrote
Dr. Raj Persaud, a psychiatrist at Maudsley Hospital in London, England, in the *British Journal of Psychiatry* in 2003. “It is unlikely that any psychiatric problem can be located in one so-called abnormal brain region.” Persaud called for a moratorium on neurosurgery and warned that in a “profession that has come to be viewed with particular suspicion and antagonism, it may be particularly appropriate for psychiatry to focus primarily on doing no harm rather than just doing something.”

Though the only rationale for surgery is empirical and intuitive, proponents such as Hurwitz of VGH say neurosurgery saves lives and brings psychiatry back to its roots. Meanwhile, research continues to emerge about the psychological roots of mental disorders. While researchers use words like “may” and “might” when discussing possible biological and genetic factors in mental illnesses, other studies have found psychosocial links, such as patients with anxiety disorders reporting their parents were overprotective and unaffectionate. Some studies have shown that children learn their phobias from their parents and that traumatic experiences like schoolyard bullying trigger mental disorders.

Bruno and his family were sold on Warneke’s claim that OCD is 90 percent biology. To fully appreciate why he eventually resorted to surgery, it’s important to look at his long and difficult history and the crippling aspects of his OCD. The trouble started when Bruno was about four years old. “He’d have temper tantrums, so we took him to a behaviour modification program,” Jack says. “We noticed the hand-washing when he was about nine or 10.” But Bruno always had many friends, a long invitation list for birthday parties and as a teen was active in sports and went out to clubs every weekend. “But that stopped when things fell apart at university.”

The second child in a family with four children, Bruno was a good kid, never skipped school and never did drugs, though his sister and one of his brothers were rebellious. By university, he says, the OCD was interfering with his life. “Like having to do things over and over again until they seemed right.”

Bruno was enrolled in a university physical education program and thinking about becoming a teacher. His grades were in the low 70s. “I did OK. I didn’t do great. But in the third year I dropped a few classes
and then I think I started my third year and just had a breakdown.” he laughs. “I guess you know.” He dropped out of university.

It’s not easy for Bruno to articulate what the OCD was like. “Like going over things in my mind, having to redo everything, did I do up my zipper on my pants? Stuff like checking. I remember going out once and the whole time I couldn’t get it out of my mind about checking something at home. I can’t remember what it was: Did I lock the door on my car or the house? Something silly like that but it was all I could think about. It drove me nuts. How can you have a good time? I was functionally sick.”

Bruno’s obsessive thoughts would often lead to a crippling fear that something terrible was going to happen, like the time he was out playing basketball in the driveway “and the basketball went under my dad’s car and I thought my dad could have an accident, and that would go over and over in my mind. It was painful. It was a mind-boggling experience. For somebody that doesn’t have OCD, it’s hard for me to figure they can honestly know what hell I was going through. I don’t really like talking about it.”

He started seeing Warneke about a year after the breakdown in university. They tried a host of medications over the next 10 years, including intravenous clomipramine, which commonly causes tremors. He also saw a few psychologists over the years. “It was good to talk to someone about these things. I went to some group therapy thing but, I don’t know, I didn’t enjoy it or find it helpful. I didn’t see any benefits, so I quit going I guess.” More than 30 open controlled trials, mostly in the US, have shown that behaviour therapy can be more effective than drugs in the long term, with no side effects. In one study, 80 percent of medicated patients relapsed after one year, compared with only 25 percent of those receiving cognitive behaviour therapy. But there’s a shortage of behaviour therapists in North America, so it can be difficult and expensive to find one.

Bruno was hospitalized a few times during those years. He also worked at an insurance company and later at a large bank selling insurance and mutual funds, which required an insurance licence. Passing the certification test wasn’t “that difficult,” he says. “I didn’t find them hard concepts to grasp.” Bruno quit that job in 2001 and was unemployed for a year.
By the time he decided to have surgery, he was feeling “pretty carefree,” he says. “Just another thing they’re gonna try.” He says he understood from Warneke that the only risky part of the procedure was the surgery itself, that it was very minor surgery. “The fact that it is your brain, yeah, OK, I guess it’s serious. But as far as the procedure goes, it was very elementary, not high-risk at all. I remember Dr. Warneke saying it’ll either work or it won’t. It’s not going to make you worse. It’s not gonna hurt. So we went for it.”

Warneke was drawn to the neurobiological approach early on in his career. As a medical student, he “hated” psychiatry and the “airy-fairy kind of analysis” popular in the 1970s. He started working in the field to pay off debt. Then he met a British neuropsychiatrist who had trained at the Maudsley Hospital and studied what Warneke describes as the neurological basis for psychiatry. While working at Alberta Hospital in the mid-’70s, Warneke looked after a violent patient who had murdered two people. The man was given an amygdalotomy (a surgery that destroys a small portion of the amygdala—an area of the brain thought to stimulate aggression). “Afterward, [he] was quite complacent and had better quality of life,” says Warneke. He could walk on the grounds and go to parties in the hospital.” Twenty years later, Warneke started recommending psychosurgery to his most severe OCD patients.

“I’m a bit of a lone wolf,” says Warneke. He acknowledges that some of his colleagues question his support for psychosurgery, but says, “it’s because they don’t understand the severity of the illness.” Like other proponents, he firmly believes that he is improving the quality of his patients’ lives and that neuroscience will eventually unlock the biological secrets of the mind with the help of emerging technologies in brain mapping.

But whether the practice is actually improving lives is still an open question for some neuroscientists. Many are calling for extreme caution interpreting brain scans such as SPECT imaging (which reveals blood flow and brain activity) because results for the mentally ill often fall within the range of results for people with no mental illness. “We still don’t have a clear picture of the functional changes to the brain in psychiatric illness,” says Dr. Lesley Fellows, a neurologist at Montreal Neurological Institute who studies the emotional and cognitive effects of frontal lobe brain damage. “The level of evidence in support of the
effectiveness of psychosurgery is still relatively weak.”

That may be why some neurosurgeons refuse to speak about the practice. Dr. John McKean, the Edmonton neurosurgeon to whom Warneke refers his patients, was unwilling to speak about his work with psychiatric neurosurgery and had a staff member say he’d leave commentary in “Dr. Warneke’s capable hands.” Cosgrove of MGH has also been unwilling to comment about his work in Boston and his plans for a Montreal Neurological Institute psychosurgery centre, even though a Montreal Neurological Institute media representative told me to contact him for more information about the centre. Dr. Lozano of the University of Toronto said he won’t speak about his program until he has published papers on the topic. Many who agree to speak admit a limited understanding of how the procedures actually work. Dr. Chris Honey, a neurosurgeon at VGH, says he thinks the surgery works though he admits he would love to know why. “Beats me,” says Friehs of Brown, when asked, and admits to “limited knowledge of all the data.”

Yet the interest in psychiatric neurosurgery grows, even though specialists are still no closer to understanding how it works. “There’s increasing interest among psychiatrists and neurosurgeons,” says Dr. Ben Greenberg, head psychiatrist for the Butler team. “When you’re used to success with treatments and run into people you can’t help, then people want to try other research.” Does he believe that the number of people receiving the procedure will increase? “It’s possible. The burden on society will increase and access to treatment may be easier…. But then, standard treatments will continue to improve too.”

Psychologists, therapists, neuroscientists and psychiatrists who are less likely to accept the biological model for mental illnesses are meanwhile looking at how life experiences affect brain chemistry and function, and they are studying the benefits of talk and behaviour therapies to help patients in the long-term without drugs and invasive treatments. “The question is, what causes human unhappiness?” says Breggin. “Life suffering, the condition of childhood, the story of an individual’s life.”

With his birthday fast approaching, Bruno jokes that he feels 29 again and that he likes spending time with his nephews because “I’m more of a kid myself.” What about plans for the future? “I gotta work on the
pudge. I’m 204 pounds and could lose 20.” He has a few old friends who, his dad says, make a point of keeping in touch with him because Bruno rarely returns phone calls.

Has he seen images of his brain post-surgery? “No, I didn’t ask. I might like to see it. It might shock me. It’s my file. I should get to see the whole bloody thing. Actually, I have an appointment with Dr. Warneke coming up. I’d like to see it.” Bruno sees Warneke every few months. “He asks how things are going, I tell him, ‘All right.’ ‘Problems with OCD?’ ‘No, not really.’ Some of the drugs I’m on, like Dexedrine, I like that one, that’s a good one, need that one. It’s a pretty short visit these days. Quick $500.” Bruno lets off another booming laugh.

I ask Bruno who he shares his problems with. “I don’t share ‘em with anybody,” he says and excuses himself to go to the washroom. I do the same and the facilities are pretty grotty. Bruno’s gone for quite a while and I have to wonder if his old hand-washing habit resurfaces in a situation like this. When he returns, I ask him if he worries about the OCD coming back.

“No. I don’t really. Well I do. I think about going back to school and I go, ‘Ah, that’s a lot of stress.’ I think, how did I get through it? I don’t know what to do with the rest of my life. I’m just kind of scared, I guess.”

Jack hopes Bruno will be able to live independently one day. “I say, ‘One day my wife and I will go to the old folks home and you won’t be able to come with us. I hope you make plans.’ He nods his head and that’s it.” I mention some of the post-op personality deficits cited in various reports and his dad says Bruno may have some perseveration and apathy. “He has problems sometimes with multi-tasking and with motivation. Dr. Warneke maintained that the worst thing that could happen was [surgical] infection. He assured us there wouldn’t be repercussions. If we knew there might be, I’m not sure the surgery would have happened. [Bruno] would not have gone for that.”

Bruno has a different opinion. “I probably would have had the surgery anyway,” he says. He agrees that he has trouble organizing his life and even getting basic tasks done, like laundry. Breggin mentioned that psychosurgery recipients have a lot of trouble answering the question ‘Who are you?’ So I ask Bruno how he would describe his personality.
“That’d be tough, oh man,” he says. “Ah, hard to explain. That’d be a tough one.” I throw out some adjectives like friendly, thoughtful, curious, and Bruno responds, “I’m not really a curious person.” I tell him that his dad described him as kind, gentle and thoughtful. Bruno nods and says, “I suppose. I wouldn’t disagree with that.”

Our fortune cookies arrive. Mine reads, “Your mentality is alert, practical and analytical.” Bruno’s reads, “Happy events will take place shortly in your home.” He laughs and says, “Well I don’t own my own home.” I ask for his address and he has to pull out his driver’s licence, saying, “You’d think I’d remember the place I’ve lived for over 20 years.”

We go outside to our cars and a man stops us and asks for money. Bruno nods his head sympathetically and listens to the man’s story, which gets increasingly complicated and, in my mind, suspect. Bruno hands him five bucks. When I pull away they’re still standing on the sidewalk together, with Bruno listening intently to this complete stranger as if they’re long lost friends.

A few weeks after our lunch meeting, Bruno leaves his job at the industrial plant. Months later, he gets a job as a pallet driver in a food storage facility and begins seeing a psychotherapist. “It’s helpful to talk to somebody,” he says. “I don’t have time to worry too much. Just playing it by every week.”

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