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Abstract

By the Second World War, the neurotic symptoms of "shell shock" were replaced by "combat exhaustion" which became an umbrella term for different depressive states and neuroses with organic conditions. While in the Western countries it became more common to compensate former victims for psychological harms too, in the Soviet dominated regions the experience of being a prisoner of war was dominated by ideological principles in the public sphere. Pavlovian doctrines for example denied the duality of reactive and somatogenic psychoses, placing psycho-traumas secondary to neurological features.

In this study, the medical history of six former prisoners of war is discussed who were treated in Lipótmező in the early 1950's. A comparison of Holocaust and POW survivors shows that the latter included people of lower social status and a higher prevalence of psychotic disorders. Illness became apparent to patients or their relatives at an early stage, but psychiatric intervention came relatively late. "Captivity" was an umbrella term, and they did not specialize the location, so only other sources might help us in the identification

Keywords

History of Psychiatry, Shell Shock, Prisoners of War, Sovietization, Hungary

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The Origins of Madness

Former prisoners of war in psychiatric care in the Hungarian Stalinist era[1]

War creates situations which impose considerable psychological strain on those involved. Mass violence causes traumas whose impact remains long after peace treaties have been signed and which deeply influence the psychological recovery of survivors, if they recover at all. In the early 1960's, renowned psychiatrist István Benedek (1915–1996) expressed his views on the relationship between schizophrenia and war thus:

> Schizophrenia had caught up with this young man during the war or when he was a war prisoner. The general opinion is that such people go mad from suffering. It is a yet unresolved question whether one can go mad from anything; the medical world disagrees on this for the time being. The same war terrors have swept over millions of other people; why should only these persons have gone mad? (Perhaps) There was some inclination or propensity in them. Who can say whether they might not have become just as disturbed with no war? [2]

Benedek's extremely popular book[3] took a critical approach to the practice of psychiatry of his day, but as the citation shows, it shared traditional views on the origin of mental illness that prioritized biological factors over the effect of any traumatic experience. During the 1950s and 1960s, there was a dominant belief within the psychiatric

1 The research was supported by the MTA BTK Lendület Ten Generations Research Group.

2 Benedek, *Gilded Cage*, 85.

3 Clyne, "The Gilded Cage by Istvan Benedek", 426

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profession[4] in Hungary that madmen are mad anyway and their condition has little to do with traumatic experiences.

In this paper I will examine the effects of the psychological burden of war on a specific group of victims: prisoners of war. First, I will briefly summarize the issues of the definition of victimhood in legal terms. Then I will trace the changes in the medical discourse on the subject up to the Second World War as well as identifying how approaches to the problem in the West and in Soviet-dominated states diverged after 1945. This will be followed by a discussion of psychiatric practice based on the patient files of the psychiatric hospital at Lipótmező. These latter sources are intended to provide a "history from below" perspective on the long-term effects of the Second World War on the mental health of those involved,[5] during the early 1950s, the peak years of Hungarian Stalinism. At the same time, the cases examined offer an insight into what it meant to be socially stigmatized due to mental illness. The case studies also reveal stories that contradicted the official narrative that viewed the arrival of Soviet troops in Hungary as the first act of liberation. The life stories of the former prisoners of war recorded in the clinical interviews have two layers. Besides presenting the patients' own narratives on the war and on their illness, they also reflect the contemporary medical interpretation of these accounts.

Background to victimhood during and after World War II in Hungary: distinguishing between facts and politics

The authorities were aware of the dimensions of the traumas impacting Hungarian society. The Second World War resulted in the deaths of some 350,000 Hungarian sol-

4 We might find more permissive opinions regarding the potential occurrence of psychologically induced mental disorders. Nyírő suggested this regarding the case of schizophrenia (albeit exclusively on biological grounds). See Nyírő, *Psychiatria*, 685. Gimes discussed the traumas present in the life stories of individuals with manic-depressive disorder. See Gimes "Adatok a mániás-depressziós", 15.

5 Lipótmező is the popular name for National Center of Neurology and Psychiatry (Országos Pszichiátriai és Neurológiai Intézet = OPNI). The institutional documentation is preserved at the National Healthcare Services Centre (Állami Egészségügyi Ellátó Központ), 1088 Budapest, Szentkirályi strt. 21. For further reference on this collection, the abbreviation OPNI is used.

diers. In 1943, some elements of the Hungarian government had sought to distance the country from Germany, but these attempts failed and the Germans invaded the country on 19 March 1944. Even before the Nazi takeover, people who the Hungarian state deemed Jewish had been increasingly disenfranchised from 1938 onwards via several anti-Jewish laws modelled on Germany's Nuremberg Race Laws, and tens of thousands of Jews died in forced labour service or in mass executions in the Soviet Union as well as in Hungary. Even so, the occupation had a dramatic impact on civil society, with Jewish people being confined to ghettos and later deported to Auschwitz and other concentrations camps beginning in May 1944. In October 1944, the governor, Regent Miklós Horthy made a last attempt to declare an armistice with the Allies and withdraw from the Axis, but this effort also failed. The Arrow Cross Party came to power with Hitler's support just as the Red Army broke through the German and Hungarian defensive lines in Eastern Hungary. This was a pro-German, far-right government, which was devoted to continuing the war until the end. As a result of these failures and actions around one million people fell victim to the war between 1941 and 1945, mostly between May 1944 and March 1945. This number amounted to ten percent of the total population of Hungary at the time of the census of 1941. Notably, civilian victims of the war surpassed the number soldiers by a ratio of 3 to 1.

It is hard to estimate the number of people who experienced non-lethal violence, since many bureaucrats fled in the final months of war, so the state organizations issued documents only sporadically. In 2015, a comprehensive collection of volume county-level sources was published on the activities of Soviet troops in Hungary between 1944 and 1947, as the result of a two-year archival project.[6] As foreign embassies operated with serious limitations, external sources on this period are also very sporadic. A report prepared by the Swiss embassy that documented the atrocities in Budapest is an especially valuable source for this reason.[7] According to calculations based on various Hungarian and Soviet data, about one million Hungarian citizens – 2/3 of them soldiers and 1/3 of them civilians – were taken into Soviet captivity, including more than 15 thousand concentration camp survivors.[8]

The right to have one's victimhood recognized has been a political question since

6 L. Balogh, *"Törvényes" megszállás.*

7 Pető, *Elmondani*, 12.

8 Bognár. "1 milliónál több vagy kevesebb".

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1945. From this perspective, government decrees represented legal tools to designate victim groups, enabling them to discuss their traumas legally. Decree 1.278/1945 M.E. (M.E means Prime Minister) issued on 20 March 1945 placed the relatives of those who had "*lost their lives because of their anti-fascist behaviour [...] after 1st of April 1941"* under "national care." The wording of this legislation tended to exaggerate the anti-fascist past of Hungarian society. Later in 1945, Decree 29,000/1945 M.E. brought about a significant shift in the policy on acknowledging victims. It recognized victims of forced labour service by granting temporary aid to those citizens compelled to work by the Germans or the Arrow Cross Party. Although this was less in line with the initial stance, it provided aid for a period of three-month aid for those who had become prisoners of war before the Arrow Cross Party came to power or who voluntarily surrendered to the Soviets afterwards. No "*specific proof of political attitudes*" was needed. Moreover, "*recruitment for work by the Soviet military authorities and removal from the territory of the country"* also became grounds for claiming state aid, although this had to be proved by credible documents (for example, camp correspondence) or by two witnesses.[9]

This legislation clearly identified the state as a source of compensation for the suffering of certain groups. Former prisoners of war gained recognition of their ordeal relatively early. However, it is worth highlighting the political considerations behind defining and including certain categories of victimhood while remaining silent about other circumstances (e.g. victims of Holocaust and wartime rape)[10]. Moreover, these decrees did not specify whether injuries eligible for compensation included psychological trauma.

9 More than twenty years later, in 1966, Decree 29/1966 further extended the group of persons eligible for national care. Those who had been "crippled" during the repression of the Hungarian Soviet Republic in 1919, those who took part in the resistance in the interwar period, or those whose relatives died or were injured during the 1956 "counter-revolution" could receive it. In Poland, in 1956, military invalidity was replaced by war invalidity, widening the range of possible victims. See Bomba and Orwid, "Psychiatric Study"

10 Pető, *Elmondani*

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Concepts about the impact of war on mental health emerging in Europe, 1900–1960

"He went through hell during the war as a war prisoner, but who didn't?" [11]

Until the emergence of psychoanalysis, innate "biological" aspects were prioritized over a person's social milieu or psycho traumatic experiences in the development of madness. [12] The first war after which former combatants were treated for mental illness was the armed conflict between Russia and Japan (1904-1905)[13], but the systematic discussion of the subject started only a decade later, during and after the First World War. Psychological burdens played a secondary role in the biomedical model, which was the dominant paradigm of post-World War I psychiatry. The main tenet of this school of thought was that mental illness was a disease of the brain, and adverse environmental effects could trigger disorders when they encounter the inner vulnerability of the individual. Such environmental factors could be syphilis, fever, poisoning, and even head injuries, while psychological influences were excluded. There was a consensus within the biomedical school that "*great worry, lasting grief, intense disappointment, and mental overload were once accorded great importance. We now know that all these external influences have an effect only at the level of endogenous predisposition."* [14]

However, captivity was regarded as an exception in this model. In the late 19th century, captivity – mostly in the context of penal system – was discussed in the medical discourse as an external factor that might provoke psychiatric disorders. Prison overcrowding, malnutrition and psychological factors such as remorse or anxiety about the future could induce hallucinations, delusions and irritability in individuals with "weak resistance." [15] These symptoms also appear in psychoses, but contemporary experts did not agree whether captivity (or prison) psychosis was a real psychosis or not. While normal individuals are seen as persons whose behaviours are considered logical and

11 Benedek, *Gilded Cage*, 70.

12 Beer, *The dichotomies.*

13 Karge, "War Neurosis and Psychiatry"

14 Schaffer, *Az elmebetegségek*, 113, 124.

15 Epstein, *Háború* és *elmebaj*,28 –30

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comprehensible by their associates and whose emotions and interests are compatible with the social standards of their group, psychotics are completely unadjusted to their social group. Neurotic individuals fall in between these two groups: they are generally not well-adjusted to their social environment and their behaviour and thoughts might be peculiar, but for the most part, they are understandable.[16] According to the biomedical model, the external environment only plays a major role in the case of neurotics, as the explanations of post-First World War psychological problems demonstrated. László Epstein (1865–1923) and László Benedek (1887–1945), argued that only neuroses were affected by the war and that even if the symptoms might appear severe, neurotics could be cured relatively quickly and effectively. [17] As severe symptoms usually diminished after the end of captivity[18], captivity psychosis was considered to be more like a neurosis, similarly to shell shock. [19]

Notably, during the Second World War, there was a change in terminology. When referring to soldiers. the neurotic symptoms of "shell shock" were replaced by the term "combat exhaustion" which became an umbrella term for various depressive states and neuroses. Psychiatrists suggested that these mental disorders were the result of exhaustion: soldiers in the Second World War were therefore treated close to the front lines and sent back to their garrisons as soon as possible.[20] Importantly for this paper, the biomedical model helped the state authorities to avoid responsibility for providing compensation after the war. The medical records of soldiers and forced labourers treated at the Lipótmező in 1944–1945 almost invariably contain statements by the army that

16 Landis and Page, *Modern Society*, 9

17 Epstein, *Háború* és *elmebaj,* and Benedek "A cselekvő eugenikának*"*

18 Lunder, "Captivity psychoses"

19 Beer, *The dichotomies* argues that although this division between severe psychosis and milder neurosis seemed appealing, it became complicated when the theory turned into practice. Even during the career of a single scientist, different classifications of these mental problems might be made. This classification was by no means confined merely to theoretical debate: in certain regimes it determined people's right to live. The most dramatic example of this was the killing or sterilization of more than 400,000 patients in the Third Reich whose innate 'imperfection' was seen as posing a threat to the purity of the Aryan race. In addition to the mentally handicapped, schizophrenics and manic-depressives were the most frequently murdered or sterilized during the psychiatric genocide perpetrated in Nazi Germany.

20 Horváth Szabolcs, Juhász and Pertorini, "Háborús stressz"

mental illness developed during military service, but could not be linked to it.[21] So, László Epstein's wish, expressed during the First World War, that "*of the much love that surrounds the physical wounded of war, a little should also be given to the wounded of the mind"*,[22] was thus ahead of his time.

It was only in the 1950s that survivors of war began to be systematically studied in the Western world and this research focus significantly contributed to understanding the complexity of war losses. A New York psychoanalyst, Walter G. Niederland[23] (1904–1993) introduced the idea of "survivor syndrome", a set of psychopathological symptoms that developed because of persecution. Other clinical observations validated his findings and it became accepted that the Holocaust was a severe psycho-trauma. This led to survivors becoming entitled to compensation in West Germany where aid was provided only to those who could clinically document their health impairment. Both the scientific findings and the legal victories of concentration camp survivors gave other former captives a greater understanding of their own psychological state and helped them to articulate their wish for compensation.[24]

Futterman and Pumpian-Mindlin pioneered the study of the psychological impact of the Second World War on veterans. They reported a high incidence of war neurosis

21 E.g: OPNI 0161–M191 28th March 1944 – 15th April 1944. private first class in the infantry with schizophrenia; 1st – 8th December 1944. and 25th August 1942 – 22nd March 1944. forced labourer with schizophrenia. And: OPNI 0161-M197 22nd February 1944. – 30th July 1945: soldier with epileptic dementia. In early 1943 this soldier was beaten in the head by partisans in a "Russian theatre of operations" resulting in the loss of bone four centimetres in diameter in his skull. He interpreted the events as follows: "Then he was hit in the head by something, right where the splinter was, and he only vaguely remembers the rest. He was in several hospitals, maybe in Warsaw where his leg was amputated, but he is not sure." According to the medical officer's opinion of February 1944: "The injury to his skull, the frostbite in both legs and its consequences were caused by the peculiar nature of his actual military service, and were not due to any fault of his own. His mental disorder was in all probability due to a congenital disposition and to the serious injuries and military exhaustion he had suffered." His hospital diary revealed that at first, he seemed irritable, cursing and demanding to be sent home, but after a few days he became calmer and talked to his fellow patients about his 'experiences in battle'. His condition quickly deteriorated, however, and he became quieter and more withdrawn. During the summer he would not even accept hospital food, waiting for his wife to bring him something better. A few months after the end of the war in Europe, on the 30th of July 1945, he died in Lipótmező of consumption.

22 Epstein, *Háború* és *elmebaj*, 12

23 Niederland, "The problem of the survivor"

24 Horváth and Juhász and Pertorini, "Háborús stressz"

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five years after the war had ended. The condition was characterised by intense anxiety, combat-related dreams, tension, depressive symptoms, and aggressive behaviour. Interestingly, these symptoms occurred with greater frequency among non-combatant personnel, e.g. military medics.[25] In 1962, research by Archibald and his colleagues into former POWs highlighted that while their condition improved over time, veterans continued to suffer from sleep disturbance and were capable of lower levels of work performance due to exhaustion. The magnitude and intensity of the stressful situation patients had been subjected to and the subsequent rate of mental illness varied according to the better or worse conditions in the POW camps. [26] These findings have disproved the thesis that neurotic symptoms disappeared rapidly. Research into the impact of war on mental health during the 1950s played an important role in expanding the scope of mental illness to include cases beyond those with a risk of suicide or aggression.

Did the views of psychiatrists working east of the Iron Curtain diverge from the views outlined above? In the history of psychiatry in the Soviet satellite countries, Marxist-Leninist doctrines and the biomedical model interacted in a particular way. Both concepts rested on a materialistic view of life. Under the spell of the Marxist-Leninist vision, some Soviet ideologues went so far as to promise that their system would enable man's life to be prolonged to 150 years on average, conquering old age and allowing the resuscitation of victims of accidents. [27] Similar optimism was expressed regarding mental illness. For example, a neurologist named István Tariska (1915–1989), who participated actively in the communist movement,[28] claimed that: "*The number of the insane is increasing in imperialism, while in socialism it is decreasing. The intensified oppression of the masses in imperialism propagates the reproduction of mental illnesses, but in*

25 Futterman and Pumpian-Mindlin, "Traumatic war neuroses"

26 Horváth and Juhász and Pertorini, "Háborús stressz"

27 Kuusinen, ed. *Fundamentals of Marxism–Leninism*, 623.

28 He joined the illegal communist party in 1940. With the arrival of the Soviet troops, he became the communist party secretary of Eastern Hungary and the member of the National Assembly between 1944 and 1945. From 1948 to 1951 he was the director of Lipótmező, when he was taken from his workplace by the secret police. He was sentenced to twelve years of prison with political charges but released after a few years. In 1956 the revolutionary committee in Lipótmező re-elected him as institutional director. See Kovai, "The History of the Hungarian Institute"

socialist society this impact is expressed in a reduction."[29] Such ambitious statements were fuelled by three assumptions.

First, Soviet science was positioned as superior to bourgeois (idealist) schools in terms of understanding and curing diseases. In an interview from 1949, Tariska stated that insanity, which had previously been regarded as the result of bad luck, could now be understood as a "typical social consequence" of certain circumstances.[30] Second, communist health policy was informed by the idea that it would be possible to eliminate mental diseases triggered by external factors (such as syphilis or alcohol) by introducing effective prevention programmes. Many contemporary adherents of communism reasoned that in a capitalist system doctors are interested in making illnesses as long-lasting as possible in order to earn more money whereas under socialism doctors are motivated by the interests of society.[31] Third, communist health policymakers believed that there would be fewer neurotics as a result of reduced oppression and the resulting lack of conflict between people, alongside an increase in living standards.[32] University lecturers such as István Simonovits (1907–1985) continued to expressed such views into the 1970s, by which time most medical students listened to such explanations with an ironic smile.[33] By then, it had become evident that in the field of mental health the socialist states were unable to repeat their successes in reducing communicable diseases and that they had failed to control the spread of mental illness. There were at least three reasons for this failure.

First, ideological influences themselves may have been psychopathological factors. In interviews from the Radio Free Europe archive, emigrants often identified the public mood in Eastern Europe with nervousness. Doctors in Czechoslovakia could no longer cope with the onslaught of neurotic patients[34],,while fights between Hungarian workers

29 Bakonyi, *Téboly, terápia, stigma*, 63.

30 Pál, "Elfújja a szél"

31 Buga, *A jó egészség könyve*, 43. On the preventive work in psychiatry see Nyírő, *Psychiatria*, 307–309

32 Examples from the daily press: Pál "Elfújja a szél" or Bányász, "Küzdelem a világtól"

33 Harmat, "Az apológiától a szociológiáig", 497

34 "Nervous Disorders and General Health Conditions of Czechoslovak Population", 5 November 1955. HU OSA 300-1-2-63510; Records of Radio Free Europe/Radio Liberty Research Institute: General Records: Information Items; Open Society Archives at Central European University, Budapest.

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were caused by exhaustion from overwork.[35] These anecdotes cannot be empirically verified, but it is known that in Poland, the sociologist Jan Szczepański (1913–2004) discussed the housing shortage and the resulting housing neurosis as a consequence of the decisions of communist politicians.[36] Another verified case is that of the Hungarian medical scientist, Kálmán Sántha (1903–1956) who discussed the nervous exhaustion caused by the Stakhanovist movement. For doing so, he was deprived of his university post in a show trial. Interestingly, the doctors at Lipótmező, the most important psychiatric institution in Hungary, testified that they had never encountered such cases at their institute, but according to the patient files, many workers were treated for nervous exhaustion in the early 1950s. This shows the significant differences between contemporary public discourse and psychiatric practice.[37]

Second, despite the need to support institutions treating mental illness, the regime was not willing to spend sufficient funds on increasing the number of psychiatric beds substantially. On a national level, the number of beds in psychiatric hospitals increased above the 1938 level only by 1957. Overcrowding was particularly difficult to manage in the case of neurotic patients.[38] Ideological reasons were partly responsible for this discrepancy: the underlying belief was that creating a classless society would eradicate mental illness. Ideologues also denied that neurosis represented a major problem in socialist countries: they interpreted the disappearance of "*shellshock"* in the Soviet Union as a consequence of creating a socialist country. According to this theory, in capitalism, hysterical symptoms helped the individual to reach his goals, including receiving social support and health care. Such mechanisms in the Soviet Union were meaningless, as all the Soviet citizens had equal rights and access to the health care system.[39] However, it was seldom mentioned that war-related neurotic disorders were not referred to as "shell-shock" in the capitalist countries either but that the condition persisted under the name of "combat exhaustion" throughout the world.

35 "Some Cases of Workers Nervous Breakdown", 5 May 1953. HU OSA 300-1-2-34270; Records of Radio Free Europe/Radio Liberty Research Institute: General Records: Information Items; Open Society Archives at Central European University, Budapest.

36 "Polish Housing - "The New Neurosis"", 28 November 1961. HU OSA 300-8-3-4480; Records of Radio Free Europe/Radio Liberty Research Institute: Publications Department: Background Reports; Open Society Archives at Central European University, Budapest.

37 See Csikós, "Mennél több bolondot"

38 Bezerédyné, Hencz and Zalányi, Évszázados *küzdelem*, 285–286

39 A szovjet orvostudomány tapasztalatai

Considering these doctrines, it is not surprising that in the Communist Bloc, the issue of war neurosis was a sensitive matter to discuss.[40] Approaches to mental illness stemming from wartime trauma varied in each communist country. In the GDR, the narratives on the experience of being a prisoner of war were very strongly defined by ideological principles. [41] In contrast, in Yugoslavia – which came out of the Second World War as a winner –partisan hysteria was treated as a common psychopathology [42] In fact, the Yugoslavian methodological landscape in the 1950s was more complex than those in Hungary or the GDR, for example. [43] In spite of the radical nature of the communist authorities in the 1950s, in terms of health care the era showed several continuities with the pre-1945 world in its methodologies[44] or even individual practitioners. [45]

In Hungary until the mid-1960s, psychiatric treatment was limited to sedatives, special diets, electroshock therapy, and prolonged sleeping.[46] Psychotherapy included hypnosis and suggestive techniques based on the principles of Pavlovian reflexology.[47] Pavlov regarded speech as a human ability that works as an important stimulus in creating reflexes. He also noted that "*speech stimulations have removed us from reality,*

40 Dale, "Testing the Silence"

41 Schöhl and Hess, "War Imprisonment"

42 Antic, "Heroes and Hysterics"

43 Savelli, "Socialism, Society"

44 Marks and Savelli, "Communist Europe". In an interview, the chief doctor of Lipótmező explained that the most modern methods were imported from the Soviet Union. (Bányász, "Küzdelem a világtól") In reality, the first Hungarian experiments with electroshock preceded the Soviet occupation of the country (Angyal and Juba, "Tapasztalatok az elektroshock-kezeléssel") as did the use of hypnosis (Gyimesi, 'Hypnotherapies in 20th-century") or Pavlovian conditioning in curing alcoholism (Kő, Újabb tapasztalatok") In 1936, István Kő, a junior doctor at the Angyalföld mental hospital in Budapest, published an article on a therapy inspired by Susmann Galant's experiences in Leningrad. He gave two patients with alcoholism apomorphine to induce nausea. The success of the therapy was complete as the negative experiences stopped both patients from continuing their alcohol consumption.

45 Vargha, *Polio Across*, 9. The regime tolerated the possible pre-war political involvement of the doctors due to the acute shortage of doctors.

46 Tringer, "A Nap utca"

47 Leuenberger, "Cultures of categories". In 1897, the Russian physiologist Ivan Petrovich Pavlov had demonstrated the effect of reinforcement and aversion in modifying animal behaviour. His views were welcomed in Marxist-Leninist scientific circles, which saw these experiments as proof of the human ability to change. In psychiatry, especially in the first half of the 1950s, a biologistic perspective based on the stimulus-response pattern, conditioned reflexes, and the theory of higher neural activity prevailed.

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and we must always remember this in order not to distort our attitude to reality." [48] A practical guide to Pavlovian psychotherapy of the period emphasized the importance of authority in the doctor-client relationship, although it also stressed the importance of collecting a lot of data at the very beginning of the therapy. The patient therefore should be approached with *"understanding and the intention of help. […] (This first interview) should include the social and economic status of the patient, his informal and family relations, private life, and physical health. […]Honesty is of great importance."* [49]

Former prisoners of war undergoing psychiatric treatment, 1952 (–1971): telling their truth about captivity

In Stalinist countries, considering honesty in professional psychiatry raises the question of how "dual loyalty to both the patient and the state" was possible[50]. One of the foundation stones of the communist regime in Hungary was the axiom that the Soviet Red Army had liberated the country. Consequently, the violence perpetrated by the Soviets was a complete taboo, which psychiatrists and patients alike had to be aware of. What, then, happened in the many cases when it was clear that an illness was the direct result of war atrocities? How could the patients articulate their sufferings? Most perplexingly, how could psychiatrists simultaneously be open to patient narratives and remain loyal to the official narrative?

The following table summarizes the background and case history of the patients discussed below. (Table 1). It should be noted that in the patient files, captivity is used as an umbrella term that referred both to concentration camp survivors and prisoners of war. For this reason, I only examined those cases where the patient's status as a former prisoner of war can be clearly identified.

48 Pavlov, The conditioned reflex, 378.

49 Tokay, "A gyakorlati pszichoterápiáról", 166–167.

50 Marks and Savelli, "Communist Europe".

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Institutional stay	Year of birth	Occupation	Diagnosis	Discharge
22nd March 1951 – 23rd April 1951	1911	farmer	chronic alcoholism	cured
3rd December 1949 – 31st March 1950	1914	factory worker	chronic alcoholism	improved
2nd October 1952 – 9th October 1952	1917	director	neurasthenia	great improvement
7th March 1952 – 24th March 1952	1921	university student	neurasthenia	unchanged
9th May 1951 – 21st June 1951	1900	warehouse manager	neurasthenia	improved
20th August 1950 – 1st October 1950	1896	construction worker	paralytic dementia	deceased
5th February 1948 – 31st May 1951	1905	ship owner	paralytic dementia	deceased
11th December 1951 – 5th January 1952	1908	stoker	psychopathy	improved
31st August 1950 – 15th November 1950	1903	farmer	schizophrenia	improved / unchanged
20th May 1959 – 19th March 1960. (first stay)	1927	unskilled labourer	schizophrenia	recurring (17) admissions to Lipótmező until 1972

Table 1: Demographic data on the patients presented

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These cases illustrate that, in many cases, the survivors/patients themselves also linked their organic illnesses to their captivity.

A forty-three-year-old stoker (Case 1) is the only person with a diagnosis of psychopathy in this sample. He "*cannot control his nerves"* which meant that he was irritable, and his memory was constantly deteriorating. Some of his complaints, he said, were '*war-related'*. He recounted that he had been hit on the head and was taken prisoner in March 1945. He also added that when he returned home, "*he could not find his parents, he had nothing left. He went to work and now he's got himself together somehow*." The tests carried out following protocol found no neurological abnormalities and his diagnosis was psychopathy. He was prescribed sedatives and bromide to ease his symptoms.[51]

His narrative hints at the pathogenic nature of the prison camp, but these experiences were not well-expressed and are interspersed with other wartime events. However, the loss of his parents gives an insight into the difficulties of starting over after the war.

Paralytic dementia is a degenerative organic mental disorder that is caused by syphilis and which results in death without treatment due to the loss of brain cells. A fifty-four-year-old construction labourer (Case 2) with this diagnosis related the mental problems stemming from his wartime experiences. "*Since he returned home, he noticed that his mind was having problems. His thinking had become loose, he talked absent-mindedly, and saw soldiers and cannons in his hallucinations. He always felt fear. He was particularly afraid of airplanes and when he saw one, he went out into the corn to hide."* In 1945, he was a prisoner of war for six months. He was first treated with injections in 1949, but his condition did not improve significantly as he could not work, but just "wandered around". His treatment in Lipótmező did not bring any improvement, either. He was described in his medical records as a poorly nourished male patient whose condition had severely deteriorated, "... suffering from severe, advanced, demented insanity." He died after a month and a half after he had been admitted, on the 1 October 1950.[52]

A shipowner (Case 3) was also at an advanced stage of mental illness in 1948. "*He fought on the Hungarian front. In January 1945, he was taken prisoner by the Russians, he was a prisoner in the Caucasus, from where he returned 23 months later, in 1946. [...] He smiles jovially, explains his suffering as a Russian prisoner of war cheerfully,*

51 OPNI Institutional Stay: 11th December 1951 – 5th January 1952

52 OPNI 0161 – 007280/2 Institutional stay: 20th August 1950 – 1st October 1950

and then his face becomes sad." The cheerful style of his narration became a part of his clinical diagnosis, as the doctor (probably conveying the social consensus) unequivocally regards captivity as suffering. This was not the only surprising element of his story: he talked about love affairs with an actress and the drowning of Ferenc Szálasi, the leader of the Arrow Cross Party in the Danube. [53]

The mental disorder of schizophrenia is characterized by continuous or relapsing episodes of psychosis including hallucinations. One of the cases with such a diagnosis examined here was that of a forty-seven-year-old farmer who recounted his apparently unremarkable life story. (Case 4) He said the police had brought him to the hospital because of a quarrel with his wife. He felt fine, had a lot of friends, loved his wife, and loved to work on his 32 acres of land. The woman partly confirmed what the patient said, describing him as a "*cheerful, hard-working man*" who "*did all his work perfectly*." She had noticed a change in him after his return from captivity in September 1945. From that time on, "*he often laughed uproariously, heard voices, talked a lot, and often talked in confusion*." He developed an obsession that the neighbours, who he claimed were poking their animals with needles, so he often argued with them. The fact that he did not fulfil the compulsory agricultural delivery, thus decided not to comply with the demands of the new regime[54] aggravated his whole family's situation, and when his wife asked him to, he would beat her. "*He did his work in a disorderly way and we told him in vain: he did the farm work as he thought he should."* During another argument, he attacked his wife again and in consequence his brother-in-law tried to block his way with a pitchfork, but was also hit. The police then took him to Lipótmező. He mentioned that he had been a prisoner of war, but "*it took little time. He tells how he was tortured a lot and it makes him unable to speak."* Although his psychiatric records do not mention this his admission letter clarifies that he had been a "*prisoner of Russians"*, which caused his manic-depressive disorders, according to the local doctor.

In Lipótmező, he was diagnosed with schizophrenia and his treatment lasted from 31 August to 15 November 1950. At first, he behaved in an agitated manner, demanding to be taken home. From mid-September onwards, he received 12 electroshock treatments.

53 OPNI 0161 – 007280/2 Institutional stay: 5th February 1948 – 31st May 1951

54 The precursors of the compulsory-delivery system imposed on Hungary's peasants date back to the war economy of the Second World War. Hungary's communist government preserved this system. Individuals on the kulak list were subject to disproportionately high taxes and impossibly inflated delivery obligations. By 1950–1951, authorities had made it impossible for anyone in this category to earn a living.

"*He did not resist, although he often said that he did not need it because he was not ill. Because of the treatments, he became calmer, less irritable, and less demanding to be discharged. He does not talk about his delusions. He is emotionally bleak, and although his thinking is not inchoate, it lacks higher factors. After treatment, he is quiet and withdrawn from the other patients."* He was discharged home back to his wife in an improved condition, although this presumably only meant that he had stopped talking about his hallucinations. The medical records also show that his condition showed signs of dementia.[55]

The life history of a man (Case 5) who was taken prisoner of war at the age of eighteen can be traced right up until1990 based on his psychiatric documentation. In 1990, his niece asked the management of the Lipótmező hospital to have her uncle's institutionalization certified, as two witnesses or the original documentation of war captivity was needed to obtain a higher pension (the same requirements that Decree 29,000/1945 M.E. listed, as mentioned above). In her letter, the woman pleaded: "*Mr. Director-General! Please help me if possible. My uncle was 17 years old when he was taken from his parents' home. His life was ruined. […] From 1945 to 1958 he was a prisoner in the Soviet Union / Norilsk in North Siberia/. He was brought home in a severe depressive state – at our request – in 1958 and was taken to the Red Army Road Institute for treatment."* (There is no reference to the circumstance that Norilsk was one of the Gulag camps.)

The first document on the patient's institutional stay in Lipótmező is from 1959. According to this, his medical treatment began in the Soviet Union in 1953. He was described as an inhibited patient with poor motivation, sometimes refusing to eat. He was given vitamin treatment in Hungary and after five months, he was released on adaptation leave. However, he soon returned after a family conflict. According to his sister, "*the nagging by his father that he would never be a man triggered his relapse*." In the hospital, he lay in bed all day without speaking. His symptoms continued in the following years. When his condition improved, he would go home and work as a domestic helper, but he would occasionally go into remission. In 1962, according to the medical documentation, he "*lay motionless in bed, eyes closed, hands clasped. He does not answer questions or say why he had to be admitted*." The record also states that in 1970 he "refuses to take his medication because he believes it is poison. He did not talk to anyone at home and was admitted to our ward again because of his inactivity". His

55 OPNI 0161 – 007280/2. Institutional stay: 31st August 1950 – 15th November 1950

brother-in-law stated that: "*There was no problem with the patient, he worked hard and liked to go to work. 11 days before his admission, he was asked to take his annual leave before the end of the year. He got worse on the first day and did not like the inactivity. Later he got worse, lying down all day, doing nothing, and not talking. Later, he did not even get up to eat. Then they asked for admission to hospital. According to his brother-in-law, if the patient had not been sent on leave, there would have been nothing wrong with him*." His long history of treatment between 1959 and 1971 included electroshock, various neuroleptics, and work therapy.[56]

Some patients diagnosed with chronic alcoholism had also endured captivity. For two weeks in March 1951, a forty-five-year-old farmer (Case 6[57]) behaved in a disturbing manner: he went into the garden in his underpants to dig, sometimes at night. His brother-in-law said that he had displayed a constant "*compulsion to go out"* and spoke to his relatives in an unnerving way. When he drank alcohol, he would wander away from home. He was taken to the Lipótmező mental institute by ambulance under sedation. He was registered with a diagnosis of chronic alcoholism, as if his drinking alcohol explained his deterioration. However, his brother-in-law also reported that he had speech problems even when sober. Reportedly, the problems began in October 1946, when he had returned from captivity: "*from that time onwards he was observed to suffer convulsive states in which his hands and feet twitched, he urinated in bed, lost consciousness and then had no recollection of any of it."* A few days later, his sister added that apart from pneumonia at the age of twenty-four, she knew of no other illness he had suffered from. "*Several times during work he was noticed to twitch, but not to collapse. In such cases he stopped and did not continue his work. The twitching was like standing in one place or leaning against something and then bouncing and making twisting movements with his limbs. All of these episodes have been going on for about six months. Before they admitted him about 2 weeks ago, he fell off a chair. He was disoriented, stripped naked, and tore at his bodily hair, saying there must be something else there. Since this sickness he could not do his work: he had been walking senselessly, but he complained of nothing. He had to be looked after like a little child because he always wanted to go out. Then he acted aggressively which is why they were afraid of him and brought him to our institution."*

56 OPNI 0161 – 006563. First Institutional stay: 20th May 1959 – 19th March 1960.

57 OPNI 0161 – 007280/2 Institutional stay: 22nd March 1951 – 23rd April 1951

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According to his documentation, he was only kept under observation and when he was discharged, the head physician, Dr. Lili Hajdú Gimes (1891–1960)[58] recommended abstinence, assuming that alcohol consumption had caused all his symptoms. She described the man as calm and quiet. "*He answers questions quietly but precisely. He only becomes animated when we ask him about his work at home and the 'land' – He is precise, lively, and very colourful in his accounts of how they work at home. He used to say that they had more and better crops than any other village."*

There are conflicting explanations of psychopathology in the case of a 35-year-old factory worker. (Case 7) According to his wife, he used to "*always drink,* [even before the war] *but in moderation"*, but since returning home from American captivity he had been drunk constantly, sweating at night, sleeping restlessly, and behaving nervously. She also said that his alcoholism had led to crime as he began to steal significant sums from the rent he collected. The man, on the other hand, said that the reason for his alcoholism was that he had fallen in with the wrong group at the factory where he had taken a job. [59]

Conclusions

In summary, all but one (Case 7) of these patients perceived a link between their war-related experiences and their current mental state even though most of them were diagnosed with severe mental illnesses. Generally, "captivity" was an umbrella term, and they did not specify which camp they were held in, although sometimes (Case 5) it was stated or is clear from other sources (Case 1)

The onset of the problems was identified as the time when the ex-soldiers returned home (Case 1, Cases 3, 4, and 7). This means that the problems were detected relatively early, but it took years before a psychiatric intervention was attempted. Treatment usually started when the patients became unbearable for their families: either because of their inactivity (Case 5), because of behaviour that was perceived as physically threatening (Cases 4 and 6), or because they committed an actual crime crime (Case 7). Some of them faced new social conflicts after the war ended. In two cases (Cases 4 and 6) a former prisoner of war was also subjected to violence as a peasant farmer during the

58 For her ideological conflicts and tragic life see Borgos, *Girls of Tomorrow.*

59 OPNI 0161 – 007280/2 Institutional stay: 3rd December 1949 – 31st March 1950

collectivization campaigns. Their status was peculiar in that health care in general was available free of charge only for state employees. Until the early 1960s, more than half of the population had to finance their own health care, and medical costs were extremely high. This explains why, according to a report by Radio Free Europe, around "*7000 peasant lunatics were […] institutionalized only when they turned out to be a threat to their environment*." [60]

While the psychotic patients included in this study were of low socioeconomic status, this was not the case for neurotic patients, who were typically admitted with a diagnosis of neurasthenia. Neurasthenia, or weakness of the nerves, refers to a state of physical and mental exhaustion accompanied by a variety of physical symptoms (headache, dizziness, insomnia), depressed mood, and irritability.

The clinical interviews with patients suffering from neurasthenia usually revealed that they had pursued notable careers during the communist era. An agrarian proletarian (Case 8) returned home from a POW camp in 1947. According to his account, while in captivity "he had a bad temper and was homesick." He and his wife got married in 1944, but after his return home, they did not spend much time together: on the orders of the Communist Party, he started studying economics and went to Budapest, while his family stayed in the countryside. He reported constant tinnitus and headaches, and that although he had "studied a lot, he could not assert himself because he forgot what he had learned." [61]

Another communist party member (Case 9) became a prisoner on the Soviet Front during the War but soon joined the Hungarian Red Army. The former electrician soon became director of several companies and graduated from the Technical University of Budapest. His nervous complaint started when he refused a project on the grounds of his exhaustion and for this, he was accused of backsliding and sabotage. [62]

Similar stresses affected another patient with neurasthenia, who gave a more detailed account of his war experiences. The man, the son of a poor craftsman (Case 10), had already served on the Italian front in the First World War before starting various businesses. When he fell into the cellar while taking an inventory at a cooperative run

60 "The Simaság-Intapuszta Experimental Lunatic Asylum", 11 May 1956. HU OSA 300-1-2-70948; Records of Radio Free Europe/Radio Liberty Research Institute: General Records: Information Items; Open Society Archives at Central European University, Budapest.

61 OPNI 0161-007173/ 424 Institutional stay: 7th March 1952 – 24th March 1952

62 OPNI 0161-007173/ 424 Institutional stay: 9th May 1951 – 21st June 1951

Central European Horizons 3, no. 1–2 (2023): 148–173.

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by the Hungarian Scouts, he suffered a concussion and went blind in one eye. He sued the company for two years for the blindness, won, and received an annuity. After the accident, he worked as a manager for several cooperatives. In 1940, "he was enlisted as a soldier and was on guard duty in a Polish prison camp. In 1943, he was called up again as a soldier and was sent to the Soviet front, where he had terrible experiences. From Russia, he and his regiment were marched on foot back to Transylvania and from there to Carinthia. Meanwhile, he felt as if there was a "*very painful hornet's nest"* in his brain. He became a prisoner of the British for six months. The first two months were very difficult, but later they were treated well. On his return from captivity, he found his family well."[63]

In the 1950s, these mental problems were apparently being discussed within the field of health care in Hungary. However, the need to submit a certificate to a pension institution only became common in the 1970s and after the change of regime (Case 5). It is thus reasonable to suggest that psychiatric illness was probably not a major factor in compensation or admission to national care in the 1950s. However, more systematic research on this issue is needed. Accounts of concrete experiences from the traumatic pasts of these people were absent in most cases: unwarranted hilarity (Case 4) or hallucinations (Case 2), or just terrible memories (Case 10) appeared in their narrations.

Despite the fact that the legal recognition of the victimhood of former POWs happened very early after the war, the psychiatric discourse paid relatively little attention to this trauma in the 1950s. While there was heavy ideological pressure to publicly deny the existence of the issue, (as Tariska's statements show) in psychiatric practice the psychological damage caused by wartime experiences was recognised in many cases. Patients (and local doctors as Case 4 demonstrates) generally identified a link between their state of mind and their experiences (even in the cases of paralytic dementia of organic origin), but psychiatry practice showed that there was not a complete consensus on it. Although Dr. Gimes stated in her study that 40% of the manic-depressive patients of Lipótmező experienced long-lasting traumatizing events in their life[64], she did not specify what these were. Details of such traumas in the patient files are included only in the patients' narratives and not in their official, final report.

63 OPNI 0161-007173/ 424 Institutional stay: 2nd October 1952 – 9th October 1952

64 Gimes, "Adatok a mániás-depressziós", 15.

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