

## Treating mutism in Hungarian child psychiatry, 1957–60

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In April 1957, a teenage boy was admitted to Országos Ideg- és Elmegyógyintézet (National Institute of Neurology and Psychiatry). Also known as Lipótmező, this was the only child psychiatry ward in operation in Hungary at that time. The castle-like hospital was surrounded by a twenty-eight-acre park and located at the outer edge of Budapest. The boy had not spoken since 1950, when certain events caused him to have a nervous breakdown. The mother explained that her son had been an open-minded and energetic child beforehand, who began to speak fluently after his third birthday: ‘He was a calm kid, he attended kindergarten where he even recited poems.’<sup>1</sup>

At Lipótmező, the boy, now fourteen, was diagnosed with elective mutism. The uncommon syndrome was interpreted as a manifestation of an anxiety disorder, in which the person remained silent in social situations. He was treated by the most renowned Hungarian expert of mutism, Blanka Lóránd (1891–1974), who was the head of the child psychiatry department. She described the case in detail in her basic study on elective mutism, which appeared in 1961. In this study, she summarised her decade-long experience in the therapy of elective mutism. She described the syndrome as a neurotic speech disorder that could have a significant impact on the child’s subsequent mental development, social relations, and even their ‘whole future life’, as speech disorders raise the question of fitting into society. Moreover, she highlighted that the disorder always has a history and included the boy’s case in her review (Lóránd, 1961).<sup>2</sup>

Although she was a highly influential expert of her time, even called ‘the mother of child psychiatry’ (Vekerdi, 1984), Blanka Lóránd’s biography has not yet been written, and the information about her scientific career is fragmentary and scattered. Lóránd’s special interest in this case was certainly an important reason why the boy’s medical history is exceptionally detailed in its description of the antecedents and the therapeutic process. His medical history, apart from the previously mentioned study, is preserved within the collection of the National Institute of Neurology and Psychiatry. These documents otherwise rarely contain a detailed description of the therapeutic process. Generally, only the behaviour of the children within the institution was recorded, and notes can be found on the (side)effects of their medication or their interactions with peers and the hospital staff.

The exceptionally rich source material in this instance makes it possible to write a detailed case study of the boy’s diagnosis and treatment, in order to gain insight into the contemporary practice of Hungarian child psychiatry in the late 1950s. This case study is contextualised by an outline of the life paths of the boy and his doctor Blanka Lóránd, as well as by an outline of the institutional development of Hungarian child psychiatry, contemporary academic discourses within the discipline, and Hungarian political history in the 1950s.

Before analysing the case study, it is important to provide some general information on the specific situation of psychiatry in Hungary in the 1950s. From the end of the 1940s, academic discourse was characterised by the communist political line of implementing Pavlovian theory in the sciences. In 1897, the Russian physiologist Ivan Petrovich Pavlov had demonstrated the effect of reinforcement and aversion in modifying animal behaviour. His views were warmly welcomed in Marxist-Leninist scientific circles, which saw these experiments as proof of the human ability to change. His teachings were widely adopted in Soviet science and made binding on other socialist states as part of the Pavlov campaign in the 1950s (Leuenberger, 2007). In psychiatry, especially in the first half of the 1950s, a biologicistic perspective based on the stimulus-response pattern, conditioned reflexes, and the theory of higher neural activity prevailed.

In 1956, Hungary witnessed a popular uprising. The revolutionaries demanded democratic changes, but the movement was violently

repressed with Soviet support. The new government under János Kádár was aware of the lack of popular support and assumed political apathy to be the key to staying in power (Feinberg, 2021: 109–10). This political context also had repercussions for the scientific field. In the psy-sciences, the Pavlovian approach became less and less dominant after 1956. As psychiatric practices could differ from academic discourse, this case study will examine the relevance of Pavlovianism to treatment practice in Lipótmező in the second half of the 1950s, by focusing on electrotherapy and hypnotherapy as treatment methods.

### Muted people, politicised science

The period from the boy's birth to his silencing (1944–50) was a turbulent phase in Hungarian history. Several doctors had fallen victim to the devastations of World War II and the Holocaust. One of them was Pál Ranschburg (1870–1945), a pioneer of Hungarian child psychiatry and a former student of Wilhelm Wundt, who starved to death during the siege of Budapest. The post-war period did not bring balanced democratic development for the country, which belonged to the Soviet-dominated zone. Communist rule became increasingly manifest and in 1949 they seized all political power. Their ambitious social project was characterised by a high level of voluntarism and utopian salvationism (Bottoni, 2017; Kovács, 2014). Communist theorists believed that creating a new society would free people from alienation. However, this utopian objective had to be adapted to economic and political realities over time (Janos, 1996).

The boy's family was deeply affected by the events of these years as the 'maternal grandfather became epileptic due to war injuries ... and the father has been feeling ill since the war' (OPNI, 0161–004053.335). The accelerated industrialisation of the post-war years offered industrial work for unskilled labourers like the family father. He started to work as a mine-labourer in Tatabánya, a larger industrial town 250 km from their home village near the Romanian border. His average salary only allowed the family of six to live in poverty. By the time of their move to the border, the boy was mute as in 1950 'a great shock caused him a nervous breakdown and

from that time he was in complete lethargy and talked to no one' (OPNI, 0161–004053.335). The circumstances that caused his silence only became clear to his doctor in the course of his treatment in Budapest.

The year 1950 also opened an important chapter in the life of doctor Blanka Lóránd. She was offered a position as head physician in the newly founded child psychiatry ward in Lipótmező. Regarding her career, this offer was reasonable in terms of both political and scientific standards. She had received her diploma in 1916, nearly twenty years after the first female physician's Swiss diploma had been naturalised in Hungary. When she started to work, associations focusing on child psychiatry were already operating. The *Gyógy-pedagógiai és Pszichológiai Magyar Királyi Laboratórium* (Hungarian Royal Laboratory of Psychology and Special Education) was founded by Pál Ranschburg in 1899. Despite constant struggles with financial issues, this institution contributed significantly to child psychopathology research. From 1932, Lóránd worked as a neurologist at the Research Institute of Child Psychology, a successor of Ranschburg's institute that examined questions of child psychotherapy in a positivist manner. She conducted neuropsychiatric research inspired by the Viennese Pözl school and focused on aphasia and the pathology of speech development. She also developed criteria for differential diagnosis in mentally disabled people (Vetró, 1999).

Her scientific views and neuropsychiatric framework fitted in well with Pavlovian theory, which became binding in psychiatry in the socialist states under the influence of the Soviet Union after 1945. Pavlovian doctrines were not necessarily ideology-driven, but they easily met the expectations of communist policymakers after their seizure of power. They articulated views on human functioning that were in line with Stalinist expectations in social planning. In contrast, psychoanalytic associations were dissolved partly because their concept of irrational motives threatened the project of fully conscious social engineering (Frosh, 2019; Lászlófi, 2019).<sup>3</sup> Instead, reductionist versions of Pavlovian reflexology flourished. Pavlov soon became the cultic representative of 'authentically' Soviet science that promised the explanation and cure of mental problems by conditioning (Doboş, 2015).

Since it was not possible that Pavlovian scientists could be trained in masses in a short period, scientific policy had to rely on those

who had worked within a similar theoretical framework before. This particularly applied to representatives of the ‘organic school’ with a biological orientation, which followed the Wundtian tradition of experimental psychology. They mainly investigated basic elementary psychic processes with the methodology of the natural sciences and excluded philosophical approaches. Concentrating solely on the organs, these experts could not be blamed for psychologization (Laine-Frigren, 2016: 44–52). Blanka Lóránd belonged to this tradition: her scientific status based on her publications on neuropsychiatric disorders in the late 1930s and her neurological approach fitted in well with the Pavlovian framework.

For Lóránd, Lipótmező was an attractive workplace. Her job at the Research Institute of Child Psychology had ended. The institution had been subordinated to the Hungarian Academy of Sciences as communist health policy favoured specialist centres. State control of people working in the same field was an important element of social and economic planning, which can be seen in the cases of the nationalisation of industrial companies, collectivisation of agriculture (Kovács, 2014) and centralisation of health care. Following this concept, the prestigious institution of Lipótmező became the centre of psychiatry.

Since its foundation in 1868 as ‘Buda Asylum’, this hospital had remained the largest psychiatric institute and received constant support from post-war governments. Public servant status was given to the formerly freelance psychiatric professionals (Bakonyi, 1984; Szokolszky, 2016; Kovai, 2019) and there was a significant expansion of staff. From 14 doctors in the pre-war period, their number grew to 43 in 1952 and 70 in 1958. The number of nurses increased from 150 to 282, and in the late 1950s, 5 special education teachers were hired. Material improvement was visible as well. Nevertheless, it was noticeable in Lipótmező that psychiatry as a whole remained an underfinanced sector within the healthcare system. The fact that Lipótmező was commonly led by powerful political lobbyists, whose connections could have more weight in decision-making than the patients’ actual needs, did not help (Kovai, 2015). The general scientific spirit of the place facilitated it becoming a central institution. Although there had been some important psychoanalytic initiatives before,<sup>4</sup> the dominant approach in Lipótmező was organic and thus easily harmonised with Pavlovian principles. This applied to Lóránd,

too: in 1955, she was celebrated as a physician who brilliantly used Pavlovian nervism in the assessment and cure of childhood mental diseases (Gegesi Kiss, 1955).

The establishment of child psychiatry followed European specialisation trends. István Tariska (1915–89) was the director of Lipótmező and the former head of the Health Protection Department of the Ministry of Health. In 1950, he visited Maudsley Hospital in London, where insulin and electroshock therapy dominated the therapeutic design (Varga, 1964). Eventually, Tariska decided to ‘make something similar’ in Hungary (Ferenczy, 2014). At first glance it might be surprising that a communist country imported know-how from capitalist Great Britain. However, there were striking therapeutic similarities. The head of the psychology department at Maudsley, Hans Eysenck, preferred suggestion and conditioning over psychoanalysis. Although he had some critical remarks on Marxism (Eysenck, 1954), the ideological gap between Western behaviourism and Pavlovism did not hinder knowledge transfer.

In Hungary, the field of child psychiatry had received little scientific attention until then: even the first post-war comprehensive psychiatry textbook paid little attention to childhood mental problems. Only ten out of seven hundred pages discussed this scientific subfield, and they drew attention to the importance of the specialisation (Nyíró, 1962: 655). However, it was to be a long time before child psychiatry was established as an independent subdiscipline in Hungary. A qualifying exam for child psychiatrists was only introduced in 1965 (Herczeg, 1993; Vetró, 1999). The high workload of those working in this field and organisational difficulties hindered child psychiatry in becoming an independent discipline. Members of the Lipótmező ward staff in the 1950s were not necessarily trained psychiatrists or paediatricians.<sup>5</sup>

The department had complex and divergent tasks. In 1961, the following was written about the first decade: ‘The 50-bed child psychiatry department, established in 1950, has already greatly facilitated the widening of the healing, research, and prevention work carried out in the field of mental and nerve diseases in childhood’ (Fekete, 1961: 60). This assessment of the situation was optimistic as it was rather a beginning than an expansion of child psychiatric work in Hungary. Beside the limited possibilities of the district clinics in Budapest, Lipótmező was the only place to treat mentally

ill children. Furthermore, this remained the only institute where wards were operating. Only in 1960 was another ward for child psychiatry, with fourteen beds, established at the Clinic of Neuropsychiatry of the Medical University in Szeged in southern Hungary.

The limitations of child psychiatry provision are visible in the boy's medical history. After his nervous breakdown in 1950 the family sought support at the Institute for the Deaf and Dumb in Szeged as well as the Centre of Special Education in Budapest. Finally, in another hospital, the boy was diagnosed with epilepsy. He showed symptoms of this disorder, such as grimacing, but they disappeared when he turned eight. The only treatment for his persistent muteness was to prescribe tranquilisers. Even though he did not speak, the boy was integrated into the school community. The school community accepted him, and the teacher replaced oral exams with written ones. The medical history of 1957 reads:

He is open, he reads novels and does his homework. Based on his written performance he could finish three classes, but the teachers constantly suggested special education for him. He received tranquilizers that reduced his stress, but he did not start speaking. He used his left hand, which was tied down. He did not get food if he used the left hand, so for now, left-handedness is not a problem.

Only when the boy had not spoken to anyone except his mother for eight years did he receive explicit child psychiatric treatment. In 1957, he came to Lipótmező where Blanka Lóránd became his doctor. Because of his response to environmental harm, a psychological trauma, with passive resistance, he seemed to be an ideal case for research and treatment by an expert who followed Pavlovian principles.

### **Diagnostic methods for elective mutism**

Lóránd herself pointed out in her study on infantile mutism that the differential diagnosis of mutism was difficult. On the one hand, the child's silence, passivity, and oppositional defiance could mask mental disability. On the other hand, contact opportunities were rare because most children had not yet acquired literacy. These problems appear in the boy's medical history before his treatment

in Lipótmező due to uncertainties over adequate diagnosis and treatment. So, Lóránd recommended caution in the diagnosis and treatment of mutism: ‘The prognosis without any longitudinal observations is insecure since the modern diagnostic tools – e.g. electroencephalographic or the arsenal of psychological tests – can often fail ... During the child’s development constant surprises, both positives and negatives might occur’ (Lóránd, 1961: 16).

In a way, Lóránd’s circumspect sentences contradicted the prevailing optimism, especially in regard to Pavlovian-inspired psychiatry in the early 1950s. This can partly be explained by the fact that the Pavlovian approach lost some of its scientific dominance at the end of the 1950s. The aforementioned psychiatry textbook by Gyula Nyírő shows more permissive attitudes towards the non-Pavlovian approaches, including psychoanalysis: ‘Psychoanalysis taught the neurologist that they must listen to their patient ... Some diagnostic significance of the analytical method cannot be denied, but it has no healing importance’ (Nyírő, 1962: 329).

At the same time, the fact that child psychiatry had been using psychoanalytical methods in diagnostics long before this official acceptance certainly had an effect. While psychodiagnostics ceased in adult wards in the 1950s, they persisted in child psychiatry. However, these had the flaw that with the elimination of psychological training and psychoanalytic workshops, interpretations of projective tests like the Rorschach or Thematic Apperception Test showed great variance. Children were commonly tested by neurologists, who were untrained in the method and produced less reliable interpretations. Psychologists in the institute were in marginal positions and were listed under the term ‘other professions’.

The fact that psychoanalytic diagnostic methods were not taboo in Lipótmező was related to the specific structure of this institution, which could modify political power. As the historian of the institute, Melinda Kovai, points out, this was a place of ‘strong professional solidarity, an inner hierarchy tainted with patriarchalism, and a very heterogeneous milieu, both institutionally and professionally’ (Kovai, 2015: 130). Because the hospital was not linked to university education, it could apply a wide range of diagnostic methods, and these were less determined by ideological influences than in university clinics. Moreover, it is likely that projective methods were a better fit with the play and free-associative games of childhood. Finally,



methodological eclecticism was also promoted by the fact that child psychiatry was still emerging. The practice was characterised by a small team of specialists and, as in this case, they typically (but not exclusively) had a neurological focus (Brunecker, 1968; Szakács and Bagdy, 1993).

However, in her case study of the boy in the context of her 1961 study, Lóránd does not reflect this eclecticism in terms of diagnostics: ‘In a left-handed child who had a neurological illness and was violently accustomed to right-handedness, great scare caused hysterical mutism. The fixation of infantile reaction mode – fear of strangers – resulted in elective mutism’ (Lóránd, 1961: 18).

In her summary, Lóránd stressed three circumstances that characterised the case. Highlighted here were firstly his former left-handedness, then his writing skills that made the patient contactable, and finally that the patient experienced stormy panic reactions during the treatment. These viewpoints prioritised biological and situational features and paid relatively little attention to social factors. Lóránd’s study briefly referred to the mental health history of the family (epilepsy of the grandfather and stomach complaints of the father) but left several details unelaborated. It mentioned that the mother was neurotic and ‘was hospitalized after the burn injuries of her daughter’ (Lóránd, 1961: 17–18). Only the health report reveals that these burn injuries led to the death of the 14-year-old girl. It is also noted here that five other siblings – including four twins – died shortly after their birth.

It is noticeable that in the case of the adolescent boy, views of the organic school continued to dominate the diagnostic work. This also applies to Lóránd’s study in general: divergent diagnostics cannot be detected in the central hospital. In the case study of the boy, however, the eclecticism mentioned is evident in the therapies.

### Electroshock treatment in child psychiatry

Lóránd suggested the following design for the treatment of elective mutism in her 1961 study. First sedatives and drugs with euphoric effects (caffeine, codeine) should reduce the child’s anxiety caused by the new environment. If the child became calm, electroconvulsive therapy and psychotherapy should be used. It is worth noting that

in Lóránd's study the politically optimistic premise that socialism would prevent mental disorders<sup>6</sup> was replaced by the optimistic premise that medication would remedy the mental disorder.

The subsequent therapy was electroshock treatment, which was administered without anaesthesia and was primarily intended to have a behavioural therapeutic effect. Here, too, Hungary relied on Western European experiences. The first reports on applying electroconvulsive therapy to children were published in 1941, on the Bristol City and County Mental Hospital, and in 1942, on the Hôpital des Enfants-Malades in Paris. The application in children appears to have been carried out not with awareness, but rather with indifference to the patients' age. In Paris, electroshock therapy was typically used to treat childhood schizophrenia – only one Parisian boy was diagnosed with elective mutism (Shorter, 2013). The first Hungarian reports, which also date from the 1940s, reveal the same pattern (Angyal and Juba, 1943). For example, Pál Ranschburg reported in 1943 on his experiences with the outpatient treatment of 'intelligent' schizophrenic patients aged 17 to 65 (Ranschburg, 1943). Later, electroconvulsive therapy became widespread in Europe and the United States in the treatment of tic, melancholia, and other mental disorders. Its popularity declined notably with the raise of pharmacotherapies and the critique of Swedish child psychiatrist Anna-Lisa Anell in the second half of the twentieth century (Shorter, 2013).

Although it was not Soviet science that brought electroshock treatment to Hungary, it was undoubtedly a good fit with the Pavlovian ideas on conditioning. Electric shocks could be applied in a behavioural manner, in which undesirable behaviours were to be eliminated by repeated unpleasant stimuli (Davison, 2021). This aversive approach combined healing with punishment, and was, as already mentioned, commonly used in the Maudsley Hospital in 1950, which inspired Tariska in organising the Hungarian child psychiatry ward.

Lóránd reported in her 1961 study on the electrotherapy of a 7-year-old girl and a pair of siblings from 1954. No neurological abnormality was identified behind the elective mutism of the 8- and 10-year-old boys: initially, the staff tried glutamic acid therapy in vain. The older boy became attached to one of the nurses and wrote about his motivation to help her. However, he displayed panic

reactions to all interventions and only accepted electrotherapy after watching his brother's treatment. The 1959 follow-up showed that a partial cure had been achieved. There were no complaints about his behaviour as he was working in the fields, but he spoke only to the cemetery watchman, apart from his family (Lóránd, 1961).

Although the behavioural use of electroshock had declined somewhat with the spread of drugs, the institute's documentation shows that it remained the standard therapy for children with elective mutism in later years. In 1960, a 7-year-old boy was treated for anxiety and feelings of inferiority. His muteness was explained by inappropriate coddling which made starting school traumatic. According to the institute's diary, his initial dysphoria turned into euphoria after treatments with tranquillisers and electric shocks.

Lóránd found that electric shocks were effective in treating mutism. This is even more surprising since, in her summary study, she writes that the child's development might present the doctor with constant surprises, both positive and negative. Based on pre-war German literature, she stated that those affected by mutism were generally 'anxious, gentle, good-natured, affectionate children who have great difficulty in adapting to new surroundings and become mute in all such situations' (Lóránd, 1961: 16). It is noticeable that despite this description, she nevertheless advocated aversive methods that increased anxiety. One reason for this was certainly that Lóránd was convinced of the empirical results. She writes in her summary that in seven of sixteen cases presented, a persistent cure was achieved.

The boy's first treatment started in April 1957. Lóránd noted:

We experimented with electrotherapy after the unsuccessful tries with different stimuli. The test caused panic reactions, he was retreating and crying. I tried to calm him, promising that we will give him time to talk without any pressure. I believe he can do it. Regarding that different types of treatment increased his stress and hindered speaking (except for Glutarec which medication cannot be continued due to shortages) ... We try to involve him in written communication. He answers shortly, but when we are asking about his muteness, he gives no answer, puts the pencil down, and keeps his eyes forward. (OPNI, 0161-004053.335)

A few days later, changes in his medication (Actedron) affected his behaviour positively. The medical history reads: 'He is very vivid and motile, sometimes he is truly vicious [later corrected to aggressive],

he hits other kids, plays violently but speaks no word' (OPNI, 0161-004053.335).

This short extract from his health report gives an insight into the state of Hungarian pharmacology. Glutarec (glutamic acid hydrochloride) was authorised in 1953 for use in the treatment of various degrees of oligophrenia, acquired degenerative brain lesions, schizophrenia, and the melancholic form of psychopathy. Upon his discharge, the boy was prescribed Andaxin, a Meprobamate-based drug. In a 1971 study, this drug is recommended in cases of conflict reaction, psychoneurotic or pre-electroshock fear (Siftár, 1971: 50, 62–3). Among the drugs prescribed to the boy was Actedron, an amphetamine derivative that was widely used before World War II to increase mental or physical performance (Ujváry, 2000). Although this chapter does not focus on changes in medication, it is worth mentioning that the growing effectiveness of drugs remarkably influenced the use of beds within Lipótmező. The shift from long to short-term hospitalisation and outpatient care changed the role of the healthcare staff and their way of exercising power (Foucault, 1999). Interestingly, the danger of a relapse and the emergence of a 'revolving door system' was very precisely recognised by clinicians in the cases of mutism and prevention was attempted. Lóránd pointed out: 'In cases where, despite our advice, the child was taken early, we did not succeed ... Recovery is complete if there is no relapse in a foreign and unfavourable environment after leaving the hospital – but in most cases, it is necessary to get the help of an understanding parent and educator to achieve permanent asymptomatic relief' (Lóránd, 1961: 26).

Drugs and electric shocks did not help the boy in 1957. Three days later, on 11 July 1957, at the conference of doctors, a hypno-therapeutic plan was accepted and conducted by Blanka Lóránd herself. She summarised in her study: 'Regarding the total failure of previous therapeutical attempts, we turn to hypnotherapy, putting ourselves in the role of the mother and trying to talk to him' (Lóránd, 1961: 18).

### The potential of hypnosis

At first reading, this kind of therapy may seem surprising, as it represents a shift from so-called active therapies (drugs, electroshock

treatment) to psychotherapy. At the time active therapies were considered to be not only calming, but curing (Nyírő, 1962: 315). To which tradition can hypnotherapy in this case be linked – to a Pavlovian framework of stimulus–response patterns or to a legacy of depth psychology treatment approaches? Was the use of hypnotherapy in Lipótmező a sign of the renaissance of alternatives to Pavlovism?

The beginnings of Hungarian hypnosis research reach far back. Pál Ranschburg was the first researcher, who made hypnosis scientifically accepted in 1900 by separating it from animal magnetism. At the same time psychoanalyst Sándor Ferenczi (1873–1933) held more spiritualistic views and gave depth psychology hypnosis a place in everyday medical practice. Hypnosis had been spreading in Hungary since 1945. For ideological reasons, these approaches were labelled bourgeois and therefore suspicious in the 1950s. The recurrent narrative on hypnosis in socialist Hungary is that authors who promoted depth psychology hypnosis generally met with disbelieving or even hostile attitudes in the professional community. As a first assessment of this development from the early 1960s emphasises, scientific examination of the field had been intensified to meet this critique of its ideological roots: ‘Hypnosis research and hypnosis therapy show a great boom after World War II. This renaissance of hypnosis is characterised by increased scientific demand and exact experiments, which slowly dispel any existing aversion, scepticism, and mystification in connection with this valuable method of psychotherapy and research’ (Koronkai, 1964).

In any case, active alert hypnosis was still labelled as a mystical phenomenon in the mid-1970s (Gyimesi, 2018). It is worth noting that, while depth psychology hypnotherapy was being restricted ideologically in Hungary, the method lost popularity in the Western world as well. In the late 1950s, hypnotherapy did not belong to the most up-to-date or popular methods. Adult hypnosis attracted some attention in the treatment of war shock. The renaissance of child hypnosis did not start until the 1960s when major systematic research began. Wide use of the method took place only in the 1970s, accompanied by conferences, workshops and teaching sessions in self-hypnosis for children (Kohen and Olness, 2011).

However, suggestive hypnosis fulfilled the requirements of Pavlovian reflexology (Gyimesi, 2019) differently from depth psychology

hypnosis, according to Freud. In this framework, fear and calmness were understood as neuro-physiologically opposing processes, and hypnosis could be used to weaken the link between stimulus and anxiety. Giving suggestions in hypnotic induction increased the occurrence of positive responses and made the patient react more strongly to the next suggestion. In other words, while electroshock therapy could be described as aversive conditioning, suggestive hypnosis involved the extinction and replacement of existing reflexes.

In communist countries, reflexology made the use of hypnosis possible. Although Pavlov underlined the importance of aversive therapies, his colleague Vladimir Bekhterev (1857–1927) explored suggestion and hypnosis as adjunct techniques (Davison, 2021). For Hungarian psychiatrists, traditionally the reference point had been Germany and, in the socialist era, the German Democratic Republic was set as positive role model for psychotherapy (Laine-Frigren, 2016). In 1959 and 1960, two highly recognised representatives of Hungarian clinical child psychology went abroad to study up-to-date practices of child psychiatry within the Eastern bloc. The reports on their visit to Leipzig (Hirsch, 1960) and to Leningrad (Liebermann, 1961) revealed that hypnotherapy and suggestion were widely used in other socialist countries, too. A year later, Lucy Liebermann discussed the presentation of Ernst Kretschmer in Vienna. He supported the combination of autogenic training, medication, hypnotherapy and psychotherapy to retune the whole personality (Liebermann, 1962). In 1962, neuroscientist Ferenc Völgyesi published *Az orvosi hipnózis* (Medical hypnosis). Völgyesi showed a certain talent in political self-promotion: he dedicated one chapter in his book to the hypnotherapeutic experiences of Engels with a 12-year-old boy (Völgyesi, 1962: 130). Mixing Pavlovian theories with political slogans could satisfy political trends (Gyimesi, 2018).

At Lipótmező, hypnotherapy had been used in several cases already a few years after the end of the war. However, it is not clear from the treatment histories in which exact ways the hypnotherapies were carried out. Examples from the adult ward include the treatment of alcoholism or obsessive-compulsive neuroses. For example, in 1952, a 16-year-old boy was hypnotised by Blanka Lóránd. Although he had been stuttering since he was four, it had become a serious problem only a year before his admission. His parents always asked him to speak slowly and this sometimes led to arguing and nagging.

The mother often cried in the presence of the patient, who would reply that it made things worse. When the boy was treated with hypnotherapy his condition improved in a week. The treatment history does not include any other methods (OPNI, 0161–007175 424).

This case appears rather atypical as hypnosis was generally only used after unsuccessful treatment attempts with drugs or electrotherapy. Lóránd described sixteen cases in her 1961 study on infantile mutism, but she used this method only once. The typical design for treatment was to start with medication, and if it failed, electrotherapy was used. If that did not work either, they tried hypnosis, like in this case.

The fact that Lóránd described the hypnotherapy performed on the adolescent boy of our case history in 1957 is a distinct feature. And it is very clear from the description that she did not only work with suggestion here, but also aimed at processing the trauma:

In hypnophase, we will give him the instruction that he is at home with the parents (we call him the name used by his mother), and slowly we substitute us with the role of the mother (Your mother is sitting next to you, cling to her ... etc). We must remind him of the trauma and we will talk to him when he becomes alert. The first time he was uneasy, he started fidgeting. The second occasion was slightly more successful as he indicated with his eyes that he wants to recover and become like the other children. Although he was motivated for the treatment on the third occasion, he remained mute. The therapy that was of great expectations failed because of the mother's arrival. She told them that she will give birth soon and needed every help including the boy. The child was really happy to see his mother, he told her in tears that he was homesick even though everybody is so nice here except the kids who are making fun of his dumbness.

What is striking about the description is that in the attempted hypnosis, the therapist places herself in the role of the mother and works towards processing the trauma by with the help of the parental relationship with the child. This work with the therapeutic relationship is an indicator for the use of depth psychology therapy approaches. Thus, they were not rejected but integrated into the treatment. The case shows that psychiatrists had scope for eclectic practice beyond the political dogma in the case of hypnotherapy.

What is also remarkable is the doctors' acceptance of the boy's discharge in the middle of the therapy. This shows the level of

parental agency. Therapies or observation stays in Lipótmező were interrupted only rarely until 1960. In these cases, the parents, generally described as ‘worried’, assuming overprotective attitudes, appeared a few days after their children’s hospitalisation and, ‘despite the counsel’ or ‘notice’ of the doctors, took them home. The final report of the boy from 1957 registered no changes in his status and suggested a cure with the anxiolytic Andaxin to reduce his anxiety.

### The therapeutic design in 1959–60

In November 1959, the boy returned to Lipótmező. In the two years after his interrupted therapy, he remained mute and became unable to continue his studies. He left school and started to work as an unskilled labourer in masonry. The following is written about the new admission in his medical history: ‘There was still no complaint about his behaviour, he was loved by his colleagues, but he talked to no one except for his mother. He said that he desired to be healthy again.’

This time too, written communication was supported by the psychiatrists, and it turned out to be more effective. Some of his answers were preserved in his medical documentation:

[What would you like to be?] Miner to cut coal for the Motherland.  
I will finish elementary school.

Do you have a speech disorder? No.

*Who mocks you?* Lajos and Pászti, every evening. They hide under my bed and draw it. They are calling me deaf and dumb.

Do you agree to shock therapy? I dare, but only once.

*Which nurse do you love the most?* Nurse Kati.

The boy’s medical file contains a detailed diary of his previous treatment in 1957 and a description of the treatment this time in 1959–60. One might expect the therapeutic process to be continued where it was interrupted, but it was not. The same order of therapeutic approaches was followed as during his first stay. This time too, an attempt was made to treat him with electroshock therapy, which was unsuccessful again. When the boy was taken to the central



office ‘he got slower with every step we were nearer to the room. He stopped dead in his tracks and started to protest furiously when he sees the machine. What are you afraid of? He gives written answers: the electro-shock.’ In her study, Lóránd recalled the incident as follows: ‘He came obediently to the doctor, but on seeing the Pantostat he turned pale, began to tremble, and then produced a stormy panic reaction, and tried to escape. When he was relieved, he seemed to be very ashamed of his cowardice. We are reintroducing hypnotherapy’ (Lóránd, 1961: 18).

The next day the doctors decided to continue the treatment with hypnotherapy: ‘He reacts well: he whispers his name in hypnosis and answers questions with a few words.’

On 6 January 1960, ‘he gets bromide before the treatment, and he has to fixate for a long time before the hypnosis could start. He talks more, he even uses sentences, but he is still whispering.’ For the following day, it is described that a posthypnotic suggestion took place in which he was instructed to answer the questions of a nurse. On 8 January, ‘he explosively starts talking loudly, he says his name, suddenly he raises his hands, squeezes the fingers and the rest becomes easier. There is a boy in the department who stutters. We suggested him as a friend. They play board games and have a cigarette in the office of the special education teacher.’ Nevertheless, his peer relationship was burdened with conflicts. In December, he wrote: ‘Cili spit on me and Aunt Zsuzsa told me to slap her. I don’t. Remember. Clearly. I want to go home at Christmas. My soap has been stolen.’

Suggestion helped him to talk with ever more nurses and doctors, but he hardly spoke to children except for his friend. His peers revealed that they thought ‘he only pretends that he cannot speak. That is why we tickled him.’ He beat a smaller kid for allegedly taking his cigarettes. At the same time, he showed a growing interest in girls.

His therapy stopped in the middle of January 1960 due to the illness of his doctor Lóránd. During these days he kept talking but only to ‘the old acquaintances’. The therapeutic breakthrough happened on 18 January under hypnosis: ‘We asked him to talk to us about his puppy being shot. We have asked him about this before but in the unconscious phase he could only say the name of the dog.’

According to the parents' narrative, 'when he was six, a dog by his side was shot and then he fainted. He was unconscious for only a few seconds, he turned pale but had no convulsions. After his awakening, he remained silent and only after half a year started to talk to his parents in a very low voice and only if there was no one else present.' The boy's handwritten version of the story was also preserved in the medical file: 'The dog was called Bodri. And this dog was very naughty. A border patrol came. I stood beside the dog. The soldier was drunk. He shot the dog and I got frightened.'

During hypnotherapy on 18 January 1960, the boy explained that he and the dog were the same age, and he liked the animal very much for being his perpetual playfellow. A drunken border guard shot the dog for barking at him. The first shot reached the dog's neck which made the animal flee to a barn. When it came out of the building, the guard shot it again. He had to watch while the dog died. He felt sorrow and the scene returned in his dreams. The medical file reads: 'He could not remember how he stopped speaking, but he remembers clearly that he was really scared because of strangers, and he could not formulate words ... He wants to study, finish school and become a carpenter.'

On the same day, the boy left the institute in 'cured' status. Throughout the description, it is clear that the 1959–60 treatment was aimed at coming to terms with the trauma, in addition to utilising suggestion. The fact that he was able to talk about the traumatising events was seen as crucial for his healing.

Two weeks later, the mother wrote a letter to the institute, addressing Blanka Lóránd:

Dear Department Chairman, please!

I inform the dear Department Chairman that the results of my son are very good. He speaks openly, I can send him to the shop. There is not a single error in his speech. He started the fourth class that he would finish this year and he would continue his studies at night school. He has had a part-time job since the first of February. His only trouble is his great anxiety. We ask him politely to hold back himself. He wants everything the way he likes. So, I humbly ask the dear Department Chairman to send us medicine that would help. To stop his anxiety. Please send us the recipe for the medicine you prescribed so we can order it from the local doctor. My dear Department Chair, we would like to thank you for your nice, conscientious knowledge and healing.

We will not keep him closed. The *Népszabadság* newspaper likes to promote this beautiful science. My son used to say that everybody was so nice to him as his mum and dad. We kiss your hands with love. My son also sends his greetings to everybody, to the dear Department Chairman, and to the kind nurses, too. Please, dear Department Chairman, answer us regarding medicine and everything. With love.

The letter not only registers the improvements, but also reveals that the cure was not as complete as the documentation suggested.

### Conclusion

Some important biographical elements of the boy coincide with crucial years in the history of Hungarian psychiatry. His elective mutism emerged in 1950, one of the darkest years of Hungarian Stalinism, characterised by political arbitrariness, economic hardship and, in relation to psychiatry, by the doctrinal suppression of certain psychological and psychiatric trends. Although this is not, of course, a causal relationship, the boy's microhistory in some ways illustrates the macrohistory of Hungarian society. The boy's mutism and trauma were related to an encounter with a member of the armed forces. Such encounters were frequent for civilians between 1944 and 1960 during the deportations, the Stalinist terror, the crushing of the 1956 revolution and the collectivisation of agriculture. The silencing of the boy can also be paralleled in a figurative sense to the suppression of the voices of representatives of the 'bourgeois' traditions in science.

The present case study investigated practices in child psychiatry before the medical specialisation of this field came about in 1965. The study revealed that the effective functioning of the institution was hindered by financial obstacles, drug shortages and the low number of doctors. Once, the therapy had to be interrupted for a week when the doctor got sick. Effective operation depended on the individual's capacities and efforts.

The case shows a certain dichotomy: while diagnostic practices followed the tradition of the organic approach, the choice of therapeutic methods was eclectic (drugs, electroshock treatment, hypnosis). In the pathogenesis, the forced right-handedness of the child was considered more important to be taken into account than environmental aspects. The psycho-trauma in early childhood was mentioned, but his doctors paid little attention to social factors that

aggravated the patient's condition, like moving, financial hardship of the family, death of relatives or the mother's institutional treatment. Iatrogenic effects were not discussed either: from today's perspective, the boy's encounters with electroshock therapy can be regarded as re-traumatisation.

As shown in the chapter, a certain eclecticism can be detected in the therapeutic design. The hypnotherapy carried out was a psychotherapeutic method and had a different quality from the electroshock therapy. Nevertheless, the contrast between the methods was limited by the fact that suggestive hypnosis was not considered taboo but conformed to a large extent to Pavlovian reflexology. In this respect, the therapies carried out on the boy (medication, electroshock treatment, hypnotherapy) were in line with Pavlovian doctrine. And although the boy reacted with fear to electroshock therapy, and hypnotherapy proved effective in the boy's case, it is striking that the same sequence of therapies – medication, electroshock, hypnotherapy – was maintained in both the 1957 and the 1960 treatments.

However, the detailed description of the hypnosis carried out clearly shows that Lóránd did not limit herself to positive reinforcement through suggestion, but also aimed at working through the trauma and at utilising the therapeutic relationship for the curative process. This openness to depth psychology approaches reveals the individual scope of the doctor in hypnotherapy and corresponds to the observation on the therapeutic practice at Lipótmező that the professionals here were open to anything that was deemed useful (Laine-Frigren, 2016).

In addition, the boy's treatment took place in a period characterised by changes regarding the ideological influence on scientific work. The early term in office of President János Kádár since 1956 saw Pavlovism increasingly lose its binding force and influence in research, while international trends gained in importance. This became visible, for example, in the increasing acceptance of psychoanalysis in theoretical writings.

Even though Lóránd presented the boy's case as a successful healing story in her 1961 study, her therapeutic work was not addressed in Hungarian hypnosis history. Based on her professional merits, colleagues insisted that she be awarded a doctorate after her retirement in 1967, but the request was rejected. Not least because of the lack of academic embeddedness, the therapeutic work taking

place in Lipótmező became a forgotten chapter in the history of Hungarian hypnotherapies (Gyimesi, 2018).

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### Notes

- 1 The documentation of the National Institute of Neurology and Psychiatry (OPNI) is preserved in the Országos Kórházi Főigazgatóság (National Directorate General for Hospitals), Budapest. In further references to this collection, the abbreviation OPNI is used. In particular, the case dealt with in this chapter can be found under number 0161-004053.335. Citations in the following pages, when not differently specified, are taken from this file.
- 2 Also published in German (Lóránd, 1960).
- 3 The decline in scientific status and popularity of Freudian psychoanalysis was a worldwide post-war phenomenon (Micale, 2014), but their repression in the Eastern bloc brought psychoanalysis into the political arena.
- 4 Director István Hollós (1872–1957) promoted ‘humanistic’ psychiatry and believed in the effectiveness of open-door care (Szokolszky, 2016).
- 5 This is demonstrated by the example of Lenke Rugonfaly. She was the daughter of a high-ranking military officer and after acquiring her diploma in 1940 she worked as an ophthalmologist. However, in 1951 she can be found among the staff members of the Men’s Department in Lipótmező (*Orvosi Hetilap*, 1951).
- 6 This optimism was based on three assumptions. First, it was assumed that Soviet science was superior to others in understanding and curing diseases. Second, mental diseases provoked by external factors (syphilis, alcohol) were expected to be covered by an effective prevention programme. Third, neuroses and anxiety were understood as results of the repressive conditions in capitalism. Therefore, the development of socialism would diminish these disorders.

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