8

Changing attitudes: psychoanalytic therapy of psychoses in 1950s clinical psychiatry

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In 1951, Manfred Bleuler, the director of Burghölzli, the Psychiatric University Hospital of Zurich, published a widely acclaimed, comprehensive overview of 1940s schizophrenia research in one of the most renowned German-language psychiatric journals. This paper strongly influenced the development of German-speaking psychiatry (Schneider, 1954: 873).[1] The article concludes by stating that the physical treatment methods introduced ten to fifteen years ago did not meet expectations. Meanwhile, it was clear that therapies such as fever, sleep and shock cures had purely symptomatic effects and were unsatisfactory, as they only worked temporarily or not at all. The flood of research on physical treatment methods could, therefore, not hide the 'fact that hopes have shifted … from physical treatment to psychotherapy'. For a long time, it was generally assumed that schizophrenic people could not be influenced by psychotherapy, but now this method had begun to be used to treat psychosis (Bleuler, 1951: 427–9).

The statement that hopes had shifted to psychotherapy in the treatment of psychoses may have surprised many readers of the research report. Four decades after the introduction of the concept of schizophrenia in psychiatry, the following view dominated: that schizophrenia was a biologically determined, inexorably progressing disease process, and that no conclusions about the disease could be drawn from the life history of the patients.[2] Bleuler, who, like his father Eugen, researched schizophrenia, had always advocated a

'psychotherapy of the everyday'. For psychoses, however, he had previously refused psychoanalytic treatment (Müller, 1961: 355). What had happened?

In the fall of 1949, Bleuler travelled to the USA for eight and a half months, where psychoanalysis had gained increasing influence since the end of World War II. In contrast to Europe, where analysts concentrated on the therapy of neurosis, some psychiatrists there had also begun to treat schizophrenic patients psychotherapeutically.[3] Various methods were applied. However, all approaches were based on the assumption that people with schizophrenia had been exposed to severe trauma in their early childhood. The therapy was intended to give the patients some of the love and care that their parents had denied them and thus heal them.[4]

Bleuler's experiences with analytical psychotherapy for psychoses during his research semester in the USA had not only had an impact on his overview of schizophrenia research. After returning to Switzerland in spring 1950, he submitted an application to the Rockefeller Foundation to establish a 'thorough modern postgraduate training in differentiated psychotherapy' at Burghölzli and investigate the interaction between endocrine and psychological disorders in the course of long-term psychotherapy.[5] Henceforth, Bleuler's research interests focused on psychotherapy. This had played an important role at Burghölzli in the beginning of the twentieth century, but then lost importance in the inpatient clinic (Müller, 1958: 456).[6]

When the application was approved, the hospital began to deal intensively with individual analytically oriented psychotherapy for schizophrenia in 1951. As Bleuler emphasised, the new method could not benefit many patients for the time being, but was primarily in the interest of research and teaching. The aim was to extend the initial encouraging experiences and to test them scientifically. Additionally, the new approach was incorporated into the training of psychiatrists and nursing staff.[7]

Bleuler, cautiously open to innovation, was likely the first European psychiatrist to try psychoanalytic therapy for psychoses in a state hospital after World War II. Analysing medical records, further internal clinic documents, correspondence and publications, this psychotherapeutic attempt is examined hereafter. By pursuing a cultural-historical praxeological approach, I ask how actors behave and give meaning to their behaviour. Therefore, what psychiatric

practices – in other words, patterns of perception, interpretation and action[8] – can be identified by source analysis? Answering this question, I also explore the broader sociocultural context of these patterns, both in everyday clinical practice and at the level of psychiatric discourse. Furthermore, the consequences of engaging with these methods, as well as changes in psychiatric patterns, are examined.

The last goal is not intended to postulate simple causalities for change. First, it can be assumed that in a complex institution like psychiatry, different and sometimes contradictory patterns can be identified at the same time. This holds true all the more when the focus is on everyday clinical practices. Second, the trial, as the research was called, took place in a setting that was influenced by numerous uncontrollable factors and had to adapt to the conditions of everyday life in the institution. Third, it is important to investigate whether and to what extent the new therapy had an effect on these conditions. My interest, therefore, is concentrated on the interaction processes between the new method and the relations among various groups of actors, institutional routines, the clinical setting as well as further therapeutic approaches. As I will show, the trial did not so much contribute to answering the question under investigation – to what extent schizophrenic patients can be influenced by analytical psychotherapy – as it resulted in changes in everyday clinical practice as well as at the level of psychiatric discourse.

‘Not a processing disease, but a disaster reaction’: psychoanalytic therapy for schizophrenia

In the eyes of European psychiatrists who did not see the term psychotherapy in a negative light,[9] psychotherapy had long been practised in their clinics. They defined it as milieu and occupational therapy, which was called ‘collective psychotherapy’, as well as ‘individual psychotherapy’ (Müller, 1949: 20–1). The latter included all non-somatic treatment methods that a doctor granted directly to an individual patient. For psychotherapy in the sense of long-term talk therapy in an individual setting, resources were lacking. Furthermore, it was assumed that the method was suitable only for mild mental disorders.

Psychoanalytically oriented psychotherapy for psychoses was based on completely different premises. Here, a great deal of time and effort was invested in the therapy of an individual patient. Psychoanalytic psychotherapy, analytic psychotherapy or – as it was called later – dynamic psychotherapy (or psychotherapy)[10] did not necessarily mean a talking cure on the couch in the Freudian sense. However, the approach explained the patient's illness through their biography and aimed to heal the traumas they had suffered and thus their mental disorders. This could be done in different ways, such as through speaking, whereby the patients themselves were not required to answer, or through other actions.

For the attempts at Burghölzli, the work of John N. Rosen and Marguerite Sechehaye was decisive. Bleuler had become personally acquainted with Rosen and his direct analysis approach during his stay in the USA. Sechehaye was an internationally known psychologist and psychoanalyst from Geneva with her own practice, who had developed *réalisation symbolique*, a method based on the symbolic satisfaction – realisation – of basic needs that had been denied to the patient before. She had treated a young, severely schizophrenic girl with this method for ten years and had cured her (Meier, 2015: 264). Such breakthroughs, confirmed by independent experts and discussed in professional circles, challenged the view that schizophrenia ultimately led to a 'final defect state'. Furthermore, the insight that somatic therapies did not have a specific effect increased acceptance to see 'even in schizophrenia not a processing disease but a catastrophic reaction of a person in distress and brokenness'.[11]

Once the new method had been studied at Burghölzli and applied on a trial basis to a larger number of patients, the first longer-term therapies, which are analysed below, followed in 1952. Under Sechehaye's guidance, two doctors treated three selected severely schizophrenic patients[12] according to the method of *réalisation symbolique*.[13] Two of the patients were considered chronically ill and had already been in the clinic for quite a while. Burghölzli was a university hospital with a teaching and research mandate, but unlike university clinics in other countries, it treated more than just acute cases. The doctors saw their patients daily. The duration of each meeting differed, depending on the patient's condition, the situation in the ward and their own time availability. The psychotherapeutic attempts were supported by a male and a female nurse who were

intensively involved with the individual patients – whether it was spending hours trying to feed them, getting them to draw, or taking them for a walk in the clinic park or even on an excursion.[14]

The two doctors closely exchanged information with the nursing staff about the three patients and discussed the therapeutic course with Sechehaye every fortnight.[15] In addition to the medical history, they kept a protocol on each patient, recording how they behaved during the therapy and what the nurses observed during the rest of the time. The documentation also contained the doctor's impressions and reflections, as well as short summaries of Sechehaye's feedback. According to the two doctors, they spent a total of 300, 500 and 600 hours on the three patients respectively during the therapies, which lasted between six and twelve months.[16] This meant an average of more than one and a half hours per day for each person. Compared to the time available for the other patients, this was an enormous effort. In the 1950s, one doctor at Burghölzli was responsible for an average of about thirty patients, one nurse for about three.[17]

Sechehaye, followed by two psychiatrists and psychoanalysts from nearby, introduced all the clinic's residents to psychotherapy. Volunteer doctors, with or without adequate salaries, offered to provide psychotherapy out of enthusiasm for the method. Lay people interested in psychology supported the efforts.[18] With donations, money was raised for these concerns.[19] At the end of 1952, a doctor was employed who treated several schizophrenic patients psychotherapeutically every day and supervised the therapies carried out by other staff members. In 1955, two posts for nurses engaged in psychotherapy were created. Apart from collaborating with Sechehaye, Bleuler continued to maintain contact with therapists in the USA. In the seminars and colloquia of the Zurich Institute for Medical Psychotherapy, founded in 1954, theoretical problems and individual cases were regularly lectured on and discussed (Müller, 1961: 355; Meerwein, 1965: 86–7).

Analytical psychotherapy met with great interest in clinical psychiatry outside Zurich and Switzerland. This is shown by the many enquiries Bleuler received. Patients or their relatives requested inpatient psychotherapeutic treatment at Burghölzli. Numerous foreign doctors and psychologists at the beginning of their careers came to Zurich for a traineeship to learn about the method.[20] The attempts were presented in publications and papers in various

languages and received international attention. In 1956, a new volume of a renowned German textbook on psychiatry was published, which included a contribution on analytic psychotherapy in psychoses (Benedetti, 1956). In the same year the first international symposium on the psychotherapy of schizophrenia took place in the French-speaking part of Switzerland, with papers and discussions being published afterwards (Benedetti and Müller, 1957). More followed in various other European countries. In this way, analytical psychotherapy for psychoses began to be studied in many European places, even in regions where the method was hardly used or not used at all (Bister, 1976: 750; Kulenkampff, 1985: 133; Schott and Tölle, 2006: 399–400, 465–6, 471–2).[21]

'The rose' and 'the codex': making sense of pathological behaviour

> 15 January 1952. Today first attempt to get in contact with patient. Patient, …, had spontaneously sat up in bed at Christmas while listening to a musical performance of the song 'A boy saw a little rose growing'.[22] He smiled and sang along. In the following days, it was observed that the otherwise always mute catatonic could spontaneously start to rant and rail. Appropriate to the symbolic meaning of the rose, we brought him a small red rose and gave him a poem, 'To the Rose' by Hölderlin. At first, he pushed everything aside, turned away and threw the letter down in a negativistic manner, demanded to go back into the hall, even shouted that one should go outside. The reaction was rather aggressive; he tore the rose apart when we left him alone.[23]

These are the opening words of the documentation on the psychotherapeutic treatment of Carl Schmid, one of the three patients included in the trial of Sechehaye's method of *réalisation symbolique* over a year. The delivered part of the protocol refers to the first two months of the therapy and contains twenty-eight typewritten pages. The four and a half years before psychotherapy are documented in seventeen pages of medical history. In the following, Schmid's case is used as an example to describe and analyse the therapeutic attempts. Occasionally, additional sources are consulted: the files of the other two patients who were treated in the context of the trial, as well as other hospital files and publications.

Schmid was a 30-year-old patient in the 'unruly' ward diagnosed with 'chronic schizophrenia'. At Burghölzli, he had shown 'from the beginning the picture of a severe catatonic stupor with complete mutism' and quickly developed into 'one of the most difficult patients'. He was permanently bedridden, showed no reaction to his surroundings, resisted all treatment and had to be fed by tube. The various somatic cures attempted had hardly shown any effect and had been completely abandoned after a heart defect was found.[24]

Michel Foucault described the doctor as a decoder who filters out elements from the 'noise' that the patient sends according to a certain code and links them – again using a code – to stable units of meaning (Foucault, 1999). Foucault made this comparison to explain how doctors, so to speak, created diseases. However, it also works to describe how *réalisation symbolique* proceeded. Schmid's reaction to the song 'A boy saw a little rose growing' was probably not only the reason why he was chosen for the trial, but also led to the first symbolic object the therapy began with. In the following months, the attending doctor observed the patient, looked for clues of symbols in his behaviour and deciphered them. Then, with the help of symbolic objects, she tried to 'break the patient's rigidity', to show him that someone understood him and made an effort to satisfy his present and past needs. In this way, they hoped it would be possible for him to gradually leave his own world and thus his illness, which was the only place for him where he could still exist.[25]

While the nurse tried for hours to get some food into Schmid at the beginning of the therapy, the doctor mainly talked to him, even when he showed no reaction. 'I hold', she wrote on the fourth day, 'a monologue with the patient'. After a week, Schmid managed to elicit a few words. However, the search for symbols that would enable finding a common language with him remained difficult. When Schmid repeated the expression 'iron contestation' several times, the doctor noted that it seemed to be 'a specific symbol', but got nowhere this way. She began to show the patient pictures and realised that this was a chance to start a conversation with him. Therefore, Schmid was given drawing material, hoping that he would reveal more about himself through drawings and subsequent dialogues.[26]

With psychotherapy, not only did the patient's mutism disappear but also his food refusal. Schmid accepted being nourished after

only a few days. After two weeks, he no longer had to be fed by tube, and one month later he ate on his own for the first time without having to be asked. A good two months after starting the therapy the severely underweight man had gained ten kilograms. This success was related to the fact that Schmid was now talking, which gave insight into his delusional system. The doctor and the nurse noticed that the patient believed he could not and should not eat because a 'codex' or 'earthman' lived in his mouth and went into a state of anxiety when he was forced to eat. Therefore, they repeatedly assured him 'that the mouth was empty of this codex'. The doctor also told Schmid that she knew his hallucinations were real and distressing for him. However, she and the nurse were supposed to protect him from them and to help him regain 'superiority' over the hostile forces.[27]

The patient's undesired behaviour was met with empathy. It was not simply interpreted as some symptom of illness, but explained with certain elements of his delusional system or psychoanalytical patterns of interpretation. For example, the doctor recorded in the treatment protocol that Schmid had thrown a book of poetry down the stairs. She returned it to him and explained that she knew for sure 'that he had not thrown the booklet away, that he was not responsible for it' [but the codex was]. The fact that Schmid initially spat when approached, she interpreted as his only possible defence. When he wet the bed several times, she instructed the nurses not to scold him at all and added, explaining, 'Madame Sechehaye thinks it is a sign of life, one should rather praise him for it, tell him we are glad he gives such a sign of life. Perhaps an awakening of repressed sexuality.'[28]

'I was afraid he might relapse': changing the psychiatric self

According to psychoanalytic therapy, the way in which a disorder manifested depended partially on the doctor. Therefore, the texts written in the context of such therapies were not only about the patient, but also about the therapists and their thoughts and feelings (see Meier, 2022). Once Schmid did not give a single answer for an entire hour, his doctor wrote the following day, 'I was afraid …

he might relapse. But since he continued to eat and work well and regularly, my fear calmed down.' At the same time, she stated that her goal was to show the patient that she could wait patiently until he spoke more of his own free will.[29]

Doctors who were engaged in the analytical psychotherapy of psychoses thus developed a different understanding of the mentally ill and their own work. Their psychiatric self changed: the intensive involvement with particular patients and the attempt to understand their illness on the basis of their individual life stories enabled them to perceive mentally ill people as personalities, to develop a closer relationship with them and to understand madness no longer just as something different and strange. They learned to pay attention to their own emotions, to critically reflect on their behaviour and to record such aspects. In texts, they spoke of themselves in the first person singular. The 'referent' appearing in the third person and the otherwise usual passive constructions rarely occurred. This applies to the therapy protocols and medical histories of the treated patients, as well as to published case histories of psychotherapies for psychoses. In contrast to other case studies from clinical psychiatry, such contributions usually focused on one case but discussed it in detail (see, for example, Schweich, 1953; Benedetti, 1955; Meier, 2022).

Nevertheless, it would be problematic to build up a dichotomy between the 'common' clinical psychiatry of the 1950s and the 'more humane', 'emancipative' psychoanalytic therapy of psychoses. First, in texts not written in a psychotherapeutic context, there were sometimes expressions such as 'tragic defective state',[30] in which the writing doctor let feelings shimmer through. Second, there were also limits in analytical therapy: patients who were found unsuitable for psychotherapy and not worth starting or continuing therapy because they did not meet certain conditions.[31] Thus, the approach was also characterised by clear expectations and power asymmetry. It was the doctors who explained the patients' illnesses and symptoms and knew what was good for them.

In Schmid's treatment protocol, for example, there are expressions such as 'defiance' or 'In the ward he [the patient] complies well' – formulations that were commonplace in clinical psychiatry at that time. Some entries show that the doctor reproached the patient if he spat or did not answer for a long time. She 'demanded'

certain things from him and touched him even when he was visibly uncomfortable. Various statements suggest that she perceived and treated Schmid less as an adult than as a child. Thus, she once wrote, 'The patient was very sweet in the ward today.'[32] In publications, some authors also tended to heroise their great time and human commitment.[33]

Finally, the documents from Burghölzli prove that the same doctor could observe, describe, evaluate and interpret patients' statements and behaviour differently. Depending on whether one took on the role of departmental doctor or that of psychotherapist, different expectations had to be fulfilled and different knowledge produced. However, the sources on psychoanalytic therapy for psychoses show that new patterns of perception, interpretation and action were created and learned within the framework of this approach – even in state hospitals. Or, as a representative of dynamic psychotherapy for psychoses put it in 1958: 'Whereas in the past it was a matter of course to cultivate the driest objectivity and to frown upon the personal touch in case reporting, whereas … countertransference problems were at most alluded to in publications but not called by name, today we are more careless and freer in this respect' (Müller, 1958: 461).

'An extremely pleasing improvement – but by no means a cure': the aftermath

The psychotherapeutic attempt with the three patients was completed at the end of 1952. One of the treated patients was discharged on 23 December in a 'very good condition' and started a job in January. Two weeks before, his doctor travelled with him to the future place of work and noted the following day, 'You can really say that there was nothing left to see and sense … of a schizophrenic defect, unless one is particularly trained.' In the last entry made in the medical history, he added in brackets the request to be contacted if the patient was to return to Burghölzli, even if he no longer worked there.[34] The woman chosen for the trial was also subjected to insulin cures, sleep therapies and some electric shocks during psychotherapy. Despite all these efforts, the patient, as it says in a report, 'sank more and more into the psychotic defect'. The 'special psychotherapeutic care'

was therefore stopped at the end of November 1952 'because it was too unsuccessful and too exhausting'.[35]

Carl Schmid suffered a relapse in summer 1952. He worked in the garden without supervision in July and punched a woman 'in the face with his fist on the orders of the "codex"'. In August, he attacked the nurse who was taking care of him in the course of psychotherapy on an outing and again explained this aggression with the 'codex'. However, his condition improved anew; the psychotherapy continued for a few more months, and at Christmas he gave a musical performance with his therapist. Although he relapsed a bit after the end of the intensive treatment, he continued to feel much better than before. Schmid ate on his own, spoke of his own free will and pursued activities.[36] 'An extremely pleasing improvement – but by no means a cure' was Bleuler's conclusion, and there were no doubts that the result was due to psychotherapy.[37] Thus, by considering the disappearance or alleviation of symptoms as success, a pragmatic rationale of behaviour change becomes evident even in a psychoanalytically oriented clinical context.

According to Marguerite Sechehaye, the trial proved that psychotherapy, such as *réalisation symbolique*, could also be implemented in a large state hospital if a doctor could only concentrate on this task, count on the psychological understanding of the nursing staff and 'sacrifice' himself to the patients. The fact that these conditions were difficult to fulfil was related to a fundamental problem: the financial resources. Indeed, Burghölzli lacked the funds to continue with intensive psychotherapies. When Schmid's mother asked Bleuler if it was not possible that at least the nurse would continue to take care of her son, Bleuler replied that the resources were 'simply out of reach'. Moreover, they would have to be distributed 'more or less equally'. 'I would like to give each individual patient, as was the case with your son for a long time, a large part of the working time of a doctor and a nurse alone – but you must realise yourself that this is completely impossible.'[38]

In addition to the question of resources, ethical questions arose in a state clinic: was it permissible – outside of a trial – to invest so much in the therapy of a few patients when success was uncertain, and the large majority of patients did not benefit from extensive treatment? Apart from the three intensive treatments, shorter psychotherapies were also conducted at Burghölzli in 1952. There were

several improvements and even discharges.[39] According to Bleuler, further experience confirmed the impression 'that there were no schematic theories and no individual techniques that were decisive in psychotherapy'. Instead, it was more a matter of 'the personality of the psychotherapist and the harmony of the same with the personality of the sick person'.[40] Unless it was assumed that the theoretical framework was crucial, there was no need to concentrate only on individual, analytically oriented, long-term psychotherapies. Under the given circumstances, it was therefore obvious to focus more on time- and cost-saving methods in the future.

One solution adopted at Burghölzli was to increasingly consider patients who had not been ill for long and had only recently been hospitalised. According to a catamnestic overview from 1961, of the 94 schizophrenic patients who received psychotherapeutic treatment in an individual setting between 1950 and 1958, more than half had been hospitalised for a maximum of one month before starting therapy. About two-thirds of the patients treated left the clinic afterwards, whereby a good half of them continued psychotherapy on an outpatient basis for some time after discharge.[41] The duration of therapies decreased: 55 of the 94 patients were treated for between 10 and 100 hours, 28 for between 100 and 300 hours and 11 for over 300 hours. In addition to doctors, psychologists conducted therapies as well. Most of the treatments no longer applied a specific method but followed an eclectic approach (Müller, 1961).

The other solution aimed to treat several patients together. The practice of group psychotherapy spread throughout Europe after World War II (Henckes, 2011: 174–5). At Burghölzli, the method was introduced in 1953 and expanded in the following years. The groups were composed of 'suitable patients' with different diagnoses and were led by doctors, psychologists or nurses.[42] Group and individual therapy were usually combined with somatic cures, after the introduction of psychotropic drugs increasingly with medication. As in many other places, the opinion was held that somatic treatment could facilitate psychotherapy.[43] According to the recollections of former doctors, however, even in the 1960s, psychotherapy in the inpatient clinic remained a marginal phenomenon, despite efforts to find pragmatic solutions. In view of the low headcount, it was impossible to apply the method across the board. Around 1970,

there was finally a shift to short-term psychotherapy in the sense of crisis intervention (Jenzer *et al.*, 2017: 140–2).

Therefore, what remained of psychoanalytic therapy for psychoses? Contemporary physicians emphasised mainly one point: to realise that they could also find access to seriously ill patients who had previously been assumed to be 'no longer human', and that in the course of psychotherapy, every symptom could change or even disappear. According to Bleuler, the relationship with patients and their individual fates had moved to the foreground: 'Diagnosing diseases has become subordinate to delving into personal tragedies.' He also pointed out that the procedures had 'greatly enlivened the therapeutic attitude of the clinic's doctors and nurses as a whole', and in this way benefited not only specific patients but all of them.[44]

Furthermore, from studying medical files, clinical records and professional articles, it is apparent that doctors and nurses who engaged with psychotherapy began to critically reflect on themselves, their work and the social role of psychiatry (cf. Müller, 1960; Henckes, 2011: 174). A doctor in 1956 wrote that psychiatrists often mixed social and emotional order and valued social order too highly (Ernst, 1956: 355, 365–6). Individual and common good, therefore, did not have to coincide. Doctors adopting such thoughts no longer saw themselves as unconditional guardians and defenders of the social order, but felt committed to their patients first. The focus tended to shift from abstract clinical pictures to the sick individual, from the goal of fitting patients into society and the clinical order to efforts to consider their individual needs (see, for example, Bally, 1956: 442).

Finally, the attempt with analytically oriented psychotherapy of psychoses not only brought new actors into play, but also contributed to a first differentiation of the medical clinic staff and a softening of their roles. As clinic director, Bleuler was crucial to the project because he initiated and supported it. On a practical level, however, he subsequently left the field to younger colleagues. With Marguerite Sechehaye, he engaged a woman who – as a female expert and freely practising psychologist and psychoanalyst – was, in two respects, a novelty at Burghölzli. Sechehaye was followed by other psychologists, and a new professional group entered the psychiatric hospital. In the context of intensive psychotherapies, nurses worked closely with the attending physician, took on new therapeutic tasks and later led group psychotherapies.

Analytic psychotherapy thus resulted in a fundamental, largely unintended change in psychiatric patterns of perception, interpretation and action. This change was driven by many other factors that influenced each other: the introduction of psychotropic drugs and reform efforts within psychiatry, for example, as well as sociocultural changes, such as the emergence of a new subject order that gave more weight to individuality than social adjustment (Meier, 2015: 310–5).

A final look at Carl Schmid and the second male patient included in the therapeutic attempt highlights the point that this thesis does not conceptualise change as a simple story of success or progress. Unlike his fellow patient who could leave the hospital after the trial and apparently never returned to Burghölzli, Schmid's life took a different path. When the research was completed at the end of 1952, his therapy was not continued. The worst symptoms had disappeared; the doctor and the nurse had to assume other tasks, and resources for longer-lasting intensive care were lacking. From 1953, the patient received neuroleptics. According to an entry in the medical history, his former doctor resumed psychotherapy at the beginning of 1954. Two years later, psychotherapeutic efforts by a nurse are noted. However, because any further information is missing, it can be assumed that their attempts did not last long. In 1967, Schmid was asked if he wanted to participate in group psychotherapy, but declined. The year before, he had taken up a job in the clinic library, and later he even worked outside the hospital.

Nevertheless, there were repeated phases in which Schmid refused medication, became abusive and wrote confused letters. He was obviously much better than at the beginning of the 1950s, but his condition remained too poor for discharge. Therefore, Carl Schmid remained at Burghölzli until he died in 1993 at the age of seventy-five. He had spent forty-six years in the hospital, more than half of his life. At the end, his patient record comprised four files, and the medical history had grown to 110 pages.[45] His dossier shows that in clinical psychiatry different patterns of perception, interpretation and action could run parallel, complement or even compete with each other at the same time. Apart from certain changes many practices remained static, and by no means all shifts went in the same direction.

Notes

1 For German-speaking psychiatry, the almost seventy-page article was important for several reasons: first, it was written by an internationally recognised expert in the field of schizophrenia research; second, English was not yet the international language of science, so overviews in the mother tongue were central for gaining an orientation on the state of research; third, in post-war Germany and Austria, it was difficult to gain access to publications from abroad, which is why foreign literature was received through reviews and research overviews (Meier, 2015: 85, 90–1).

2 On the transformation of the concept of schizophrenia from 1945 until the 1980s see Schmitt, 2018.

3 The first attempts to understand schizophrenic symptomatology psychoanalytically and to present it in case studies took place before World War I. In this context, Burghölzli played a central role because it was the first, and for a long time the only, European state psychiatric hospital interested in Freud's theory. After the initial enthusiasm and the departure of Carl Gustav Jung, Alphonse Mäder and Karl Abraham, however, there were no more publications on the psychoanalytical treatment of schizophrenia from Zurich. Until about 1940, the decisive factor for this subject were freely practising therapists and private sanatoria (see for example Müller, 1958; Stone, 1999: 587).

4 On the history of psychoanalytic therapy of psychoses see Hale, 1995; Vincent, 1996; Alanen *et al.*, 2009.

5 State Archives of Zurich (hereafter StAZH), Zurich, Z 99.247, Finanzierung wissenschaftlicher Arbeiten, Request by Manfred Bleuler to Rockefeller Foundation, 20 June 1950.

6 On the connection between Eugen and Manfred Bleuler's schizophrenia theory and the role of psychotherapy in psychoses at Burghölzli, see Benedetti, 1995.

7 StAZH, Z 99.253, Finanzierung wissenschaftlicher Arbeiten, Application by Manfred Bleuler to the State School Administration of Zurich, 13 June 1951.

8 Typical, widely used forms of perceiving, interpreting and acting in clinical psychiatry.

9 Clinical psychiatry in Europe seems to have been far more sceptical, not to say negative, about psychotherapy after World War II than psychiatry in the USA. That was one of the reasons why psychotherapy was introduced later in European state psychiatric institutions. However, there is not much research on this question, especially not for all European

countries. For publications on the history of post-war psychotherapy dealing with individual European countries, see for example Hutschemaekers and Oosterhuis, 2004; Neve, 2004; Roelcke, 2004; Alanen, 2009; Fussinger, 2009; Fussinger and Ohayon, 2010; Marks, 2018; as well as the contributions of Gábor Csikós, Gundula Gahlen, Henriette Voelker, Despo Kritsotaki and Katariina Parhi in Chapters 1, 3, 5, 7 and 10, which provide further literature references.

10 See, for example, Bister, 1976: 746–7. During the 1950s, psychoanalytically trained psychiatrists increasingly sought to speak of psychotherapy rather than psychoanalysis in a medical context (Fussinger, 2009: 184).

11 State Health Services of Zurich (hereafter SHSZH), 12.06.2, Heilanstalt Burghölzli, Tätigkeitsberichte von Direktor und Verwalter, Lecture by Manfred Bleuler to the Society of Physicians of Zurich, 24 January 1957, 11.

12 Manfred Bleuler himself neither did a teaching analysis nor did he conduct any psychotherapies. As far as I know, during his time as clinic director, he didn't have his own patients either.

13 StAZH, Z 99.262, Bleuler to the Board of the Jubilee Donation for the University of Zurich, 30 January 1953.

14 StAZH, Z 100.41821; Z100.45455; Z 100.46222.

15 To the general part of these meetings, which lasted for a year, all doctors and French-speaking, interested nurses at Burghölzli, the polyclinic and the child psychiatric service were invited. StAZH, Z 99.257, Wissenschaftliches, Dissertationen, Bleuler to the doctors of the polyclinic and the child psychiatric service, 30 October 1951; Bleuler to the head nurses at Burghölzli, 30 October 1951.

16 StAZH, Z 999.261, Finanzierung wissenschaftlicher Arbeiten, Reports of the two attending doctors, n.d. and 10 December 1952.

17 StAZH, DS 104.1.9, Annual reports 1950–59.

18 The lay people who offered their support were apparently from Zurich and the surrounds. In the files of one patient who received psychotherapy, for example, there is a report from a teacher who wrote about a walk with the patient. StAZH, Z 100.45455, Report of the volunteer, July 1951.

19 StAZH, DS 104.1.9, Annual reports 1950–59.

20 StAZH, Z 99.252–273, Directorial correspondence 1951–54; DS 104.1.9, Annual reports 1950–59. Unfortunately, the names of these doctors and psychologists are not listed in the annual reports. One of the doctors was Martti Siirala, and one of the psychologists was Erena Adelson.

21 The contributions appeared not only in psychoanalytic, but also in psychiatric and medical journals. A search in PubMed revealed articles on the topic of psychotherapy or psychoanalysis of schizophrenia from

the following European countries: for the years 1950–59 Austria, Belgium, Czechoslovakia, Federal Republic of Germany, France, German Democratic Republic, Great Britain, Holland, Italy, Norway, Portugal, Switzerland, Spain, USSR; for the years 1960–69 Denmark, Federal Republic of Germany, Finland, France, Great Britain, Italy, Portugal, Spain, Sweden, Switzerland, USSR, Yugoslavia. See for example Gabe and Grotjahn, 1952: 653; Gál, 1951; Schweich, 1953; Bleuler, 1954: 841; Searles, 1956; Stierlin, 1957.

22 A folksong based on the poem 'Little Rose upon the Heath' by Johann Wolfgang von Goethe.

23 StAZH, Z 100.41821, Part 2, Protocol on psychotherapeutic treatment, 1, 15 January 1952.

24 StAZH, Z 100.41821.

25 StAZH, Z 100.41821, Part 2, Protocol on psychotherapeutic treatment, 2, 19 January 1952.

26 *Ibid.*, 2 and 4, 18 and 19 January 1952.

27 *Ibid.*, 4–7, 19–27 January 1952, 19, 28 February 1952.

28 *Ibid.*, 9, 31 January and 1 February 1952, 20–1, 4 March 1952, 28, 17 March 1952. As already mentioned, only part of the psychotherapy protocol has survived. There is no statement in the existing files that attempts to make overarching sense of the therapeutic dynamics in Carl Schmid's case.

29 *Ibid.*, 22, 8 March 1952.

30 StAZH, Z 100.16072, Part 2, Protocol on psychotherapeutic treatment, 42, 3 April 1952.

31 See for example StAZH, Z 100.43763, 20, 14 November 1951; Z 100.44885, 17–18, 30 September, 14 October and 4 December 1950; Z 100.45506, 36, 4 and 26 November 1953. Cf. Henriette Voelker's contribution in Chapter 10.

32 StAZH, Z 100.441821, Part 2, Protocol on psychotherapeutic treatment, 5, 23 January 1952, 6, 24 January 1952, 9, 27 January 1952, 17 February 1952, 12, 17 February 1952, 14, 18 February 1958, 16, 22 February 1952, 18, 29 February 1952.

33 A representative of the approach also mentioned the danger of self-heroisation: Müller, 1958: 461.

34 StAZH, Z 100.46222, 19, 17 and 23 December 1952.

35 StAZH, Z 99.261, Finanzierung wissenschaftlicher Arbeiten, Report of the attending doctor, 10 December 1952.

36 StAZH, Z 100.41821, Part 1, 20–4.

37 StAZH, Z 99.262, Bleuler to the Board of the Jubilee Donation for the University of Zurich, 30 January 1953.

38 StAZH, Z 100.41821, Bleuler to the mother of the patient, 5 May 1953.

39 StAZH, Z 99.262, Bleuler to the Board of the Jubilee Donation for the University of Zurich, 30 January 1953.
40 StAZH, 12.06.2, Heilanstalt Burghölzli, Tätigkeitsberichte von Direktor und Verwalter, Lecture by Manfred Bleuler to the Society of Physicians of Zurich, 24 January 1957, 11.
41 According to Müller, the fact that many therapies were discontinued after discharge can be attributed to various reasons: the therapists changed jobs or did not find the time to continue treating patients in addition to their work at Burghölzli. Alternatively, the patients did not want to continue the therapy or lived too far away to come to the clinic for therapy (Müller, 1961: 358). As far as I know, few schizophrenic patients were treated in private practices.
42 For a published report on a psychotherapy group at Burghölzli, see Adelson, 1953. For two later examples of clinical group psychotherapy in Europe, see Chapters 1 and 10 in this volume. The group psychotherapy in the Heidelberg Psychiatric University Clinic in the 1960s and 1970s was aimed at hospitalised patients who had entered the clinic specifically for this purpose (see Chapter 3). In contrast, the Open Psychotherapeutic Centre of Athens in the 1980s provided group psychotherapy for people who did not live in the clinic. For outpatient care see Chapter 5 on the treatment of young drug users in Finland, 1969–75.
43 According to the catamnestic overview of 1961, most of the ninety-four patients included in the study received psychotropic drugs before, during or after psychotherapy. Müller, 1961: 357. See also Adelson, 1953; StAZH, DS 104.1.9, Annual report 1959, 2.
44 StAZH, Z 99.261, Wissenschaftliches, Dissertationen, Bleuler to Sechehaye, 10 December 1952; Z 99.262, Bleuler to the Board of the Jubilee Donation for the University of Zurich, 30 January 1953; StAZH, 12.06.2, Heilanstalt Burghölzli, Tätigkeitsberichte von Direktor und Verwalter, Lecture by Manfred Bleuler to the Society of Physicians of Zurich, 24 January 1957, 3 and 14. Cf. Steck, 1957: 9.
45 StAZH, Z100.41821.

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