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Writing patients: group psychotherapy and reform efforts in 1970s GDR university psychiatry

Henriette Voelker

In 1974, a psychotherapy patient at the Charité psychiatric hospital in East Berlin wrote to his therapists: 'I am not fully occupied, i.e., the activity does not satisfy me. However, I use my free time for conversations and pleasant talks with my fellow patients. In general, I do not like the laxity. The daily schedule is carried out much too casually. Many things would have to be organised more tightly.'[1] Another patient reported: 'Afternoon: Club afternoon (organised by us, worked out because there was a lot of laughter). Lots of good-looking therapists in the afternoon in the corridor! It's great that they showed themselves from a very natural side (no need for a supervisor's facial expression).'[2]

These excerpts are taken from medical records, in which patients documented their stay in a psychotherapeutic ward themselves. In the evening, these patients were expected to note what concerned them during the day. They handed over their writings via a postbox next to the therapists' office by the following day. The therapists read and stored the reports. Sometimes the addressees changed, suggesting monthly reading shifts. The writing practice was part of the therapeutic concept of what was termed dynamic group psychotherapy, which was introduced at the psychiatric hospital of the Charité in the early 1970s. The reports' therapeutic aim was to encourage patients' self-reflection and understanding of transference phenomena in the group. This therapeutic method was developed especially for the treatment of neurotic disorders and was one of

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the main methods for inpatient psychotherapeutic treatment in the German Democratic Republic (GDR) from the 1970s.[3]

The daily reports as material artefacts of this practice were bundled in the medical records and are preserved in the Historical Psychiatric Archive of the Charité (HPAC). Their scope ranges from a sentence to several pages a day. Some bundles had only a few, others up to several hundred pages. One hundred and forty-eight such medical records from this group psychotherapeutic ward have been analysed, covering a time span from the introduction of the method in 1974 to the end of the current archival holdings in 1978.[4] The sources allow patient voices to come to the fore and are a rare finding in patient history, which, since Porter's call, has sustainedly faced a source problem inherent to psychiatry (Porter, 1985). Usually, psychiatrists wrote about their patients, but in the case of the present practice the relationship was reversed – even if the patients wrote the reports for the psychiatrists and the reports were read with a medical eye. The particularity of this practice lies in the fact that patients were its main actors and took over a task that otherwise lay in the psychiatrists' sphere of competence.

From a praxeological perspective, daily reporting had a variety of diagnostic, therapeutic, social and political-ideological implications that are worth exploring. The quotes above suggest changes in the traditional hierarchy of the therapist–patient relationships in such departments. Here, the reports will serve to examine reformist efforts, namely the introduction of the 'therapeutic community' concept, and their limitations in the context of group psychotherapy in a psychiatric university hospital in the GDR.[5] It should be mentioned that the East Berlin university clinic was the most prestigious medical institution in the German Democratic Republic, but it was not among the leading places for the development of psychiatric reforms (see, for example, Steinberg, 2014). The chapter will discuss the ambivalent effects of daily reporting as a writing practice and the reciprocal effects it had on local reform efforts. The daily reports will exemplify that even rather mundane psychiatric practices could have contradictory impacts on the implementation of larger structural agendas.

Daily reporting was a reflexive practice, as the patients as authors referred to themselves when writing. Yet the practice as such reflected on the social fabric and therapeutic space of the ward in two other ways. As a primary effect, it could trigger a conscious moment of

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reflection on the therapists' own actions in terms of evaluation and thereby impact on the social setting. Here, the analysed material offers only limited insights: while the patients wrote daily, the therapists only rarely documented their reactions to the writing in the medical files and did not publish about this practice either. Moreover, underlining and annotations in the sources can be assigned to the group of therapists but rarely to individuals, so that the therapists appear as a rather amorphous group. The focus of the present analysis will thus lie on the secondary reflexive effects of the writing practice. The chapter takes as a premise that practices can reverberate on the social fabric of the institution in a manner which did not correspond to or could even counteract the original motivation to act. Secondary effects of the present writing practice could thus be unintended repercussions for the therapist–patient relationships.

Group psychotherapy, therapeutic communities and psychiatric reforms in the GDR

The dissemination of psychotherapeutic approaches was among the reformist demands to improve psychiatric care in the GDR in the 1960s and 1970s. The first psychotherapeutic wards had been established in university hospitals in the 1950s, for example in Leipzig and East Berlin. Increasingly, from the 1970s, specialised departments for psychotherapy were introduced in several psychiatric district hospitals as well. According to an inventory from 1990, there were 35 such psychotherapeutic departments or institutions with about 760 beds at the end of the GDR (Dührssen *et al.*, 1990: 155). Considerable differences in material and personnel conditions as well as in the number of beds must be assumed. Due to the slow improvement in outpatient care structures, such facilities took over a significant share of all psychotherapeutic treatments provided. From the 1970s, there was a trend towards group psychotherapies in the GDR, which has been described for capitalist countries (Elberfeld, 2019), but also for other socialist countries such as Yugoslavia (Savelli, 2018). A variety of these facilities used the dynamic group psychotherapy developed by Kurt Höck (1920–2008) at the House of Health, the GDR's largest polyclinic.[6] In 1964, he established an

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associated hospital for neurotic disorders in East Berlin for inpatient group psychotherapy. On Höck's initiative, a training programme was set up. Consequently, a substantial number of therapists adapted the method and thereby established psychodynamic approaches in their facilities. Among them was Helmut Kulawik (1941–93), head of the psychotherapy department at the Charité since 1973.[7]

Höck developed the method from the 1960s. The term 'dynamic' ambiguously stands for group dynamics and psychodynamic therapy. As a student of Harald Schultz-Hencke (1892–1953), Höck was strongly influenced by his 'neopsychoanalysis', which had turned away from traditional Freudianism. However, psychoanalysis had been taboo since the Pavlov campaign of the mid-1950s, and the term 'psychodynamic' also served to cover this theoretical backdrop.

According to Höck, psychodynamic processes would improve the integration and harmony of the patients' personalities (Höck and König, 1976). The knowledge that others might have similar fates would relieve and liberate them from isolation. The therapeutic group allowed one to test and correct one's own behaviour. Moreover, participants could simultaneously project affects onto different group members. Dynamic group psychotherapy was based on the theory of group dynamics and foresaw five phases of group interaction: warm-up, dependency, activation, toppling process and work phase. Therapists were to provoke these by reserved behaviour. Serving as a projection screen for patients' expectations, they should not encourage, confirm, or provide any psychoeducation, dictate topics, or guide the group. The frustration of such expectations should enforce interaction among the patients. Uncertainty about authority and emotionality should arise. Eventually, a new ranking structure and a field of tension would emerge as a foundation for the therapeutic process. A central element of this method was to deny authoritarian guidance and support empowerment – which in turn, could lead to pressures of expectation and adaptation. Because the toppling process could be interpreted as a metaphor for the overthrow of the socialist social system, the therapeutic concept gave rise to debates about its political implications among psychotherapists after reunification (Leuenberger, 2001).

At the behest of the therapists, patients submitted handwritten reports on non-uniform paper. As this routine was part of dynamic group psychotherapy, it was also practised in the hospital for neurotic

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disorders of the House of Health (Hess, 2011b) and in an unknown number of other inpatient and outpatient institutions, such as a Magdeburg polyclinic (Weise, 2011). According to all the evidence so far, this writing practice was not subject to research in the GDR.[8] Höck's colleague, Czech clinical psychologist Stanislav Kratochvíl (born 1932), described a similar technique, with the term 'diary', in a therapeutic community for neurosis therapy in Kroměříž, Ceskoslovenská socialistická republika (CSSR). He highlighted a therapeutic and an administrative function, which can be assumed for the Charité as well: 'The function of the diary is to inventory one's own thoughts and at the same time everyday communication between the patient and the staff who reads through the diaries during the morning shift' (Kratochvíl, 1976: 225).

When dynamic group psychotherapy was introduced at the Charité in 1974, voices were raised in the GDR calling for social psychiatric reforms based on the concept of the 'therapeutic community' according to British social psychiatrist Maxwell Jones (1907–90). The first reform agenda, called the Rodewisch Proposition (1963), is considered to be the epitome of social psychiatric reform attempts in the GDR and has received wide scholarly attention (e.g. Schmiedebach *et al.*, 2000; Hanrath, 2002; Hennings, 2015). Nevertheless, it is associated with the notion that the reforms of the 1960s 'got stuck' (see Richter, 2001). Material, financial and personnel shortages, inhibitions from the professional society and university psychiatry, as well as the political unwillingness of crucial officials of the Socialist Unity Party to implement the reforms, hindered their progress (Kumbier and Haack, 2018: 247). In the 1970s, reform-oriented psychiatrists ventured a new attempt. A 'turn to the inside' (Hanrath, 2002: 438–47; Balz and Klöppel, 2015) marked the developments, which culminated in a second reform agenda, called the Brandenburg Proposition (1974). It no longer sought to expand outpatient, community-based care structures. Instead, the new agenda aimed at turning large asylums, which were seen as places of safekeeping and social seclusion, into institutions with a therapeutic agenda. In the same respect, the internal order should be restructured and traditional hierarchies flattened by the installation of therapeutic communities.

How these therapeutic communities should be put into practice remained a matter of negotiation: Jones's concept was ideologically controversial and should be adapted to socialism – not least to

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demarcate it from the West German anti-psychiatric movement (Thom, 1976). Although the relationship between political interference and self-censorship could not yet be further elaborated, it can be stated that professional and political discussions resulted in an adaptation of the Brandenburg Proposition to 'socio-political goals and their principles of collective education' (Kumbier and Haack, 2017: 434).[9] In 1976, an adjusted version was published (Schirmer *et al.*, 1976). This agenda no longer criticised societal conditions but held the psychiatric institutions themselves responsible for deficiencies. A debate had been ignited around the compatibility of the concept with socialism and the understanding of authority and democracy in socialist societies.[10] Yet the demands to transform mental hospitals into therapeutic institutions remained. It is still an open question how these endeavours influenced the large psychiatric hospitals and how the practical implementation consequently differed from Jones's concept.

The psychotherapeutic hospital for neurotic disorders in East Berlin, founded by Kurt Höck in 1964, was later referred to as a therapeutic community (Hess, 2011b: 373). Two years after the opening, Höck hosted an international symposium on dynamic group psychotherapy in East Berlin. It was a rare opportunity for East German therapists to get in touch with Western colleagues after the construction of the wall. With his contribution to this conference, Maxwell Jones popularised the therapeutic community among group psychotherapists in the GDR (Jones, 1967).

At the 1966 symposium, he complained that neither 'organic and descriptive psychiatrists' nor the 'psychoanalytic school' had 'so far given sufficient attention to the world of patients in the asylum or hospital' (Jones, 1967: 187). A vague concept of social psychiatry would be sufficient for the sake of its flexibility, but it demanded that psychiatry 'devotes increasing attention to the patient's social environment' (Jones, 1967: 189). In this sense, Jones sought to maximise patient involvement, give patients the role of therapists and use the authority of the therapeutic staff only when needed. This 'patient accountability' was not only to concern the organisation of ward life. For example, staff and patients were to decide together on dismissals or transfers to other wards. This should counteract the lack of trust and build self-esteem and independence. The 'mainstay

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for any therapeutic community' should be 'daily ward or community meetings with all patients and all staff … followed by a staff meeting of 30 to 60 minutes … where the interactions between staff and patients can be discussed during community meetings'. These meetings should be similar to the working mechanisms of group treatment, and thus be conducive to the therapeutic process: 'The manifest and latent content, the unconsciousness and the ego-defence are gradually understood in a similar way to small groups' (Jones, 1967: 191). Subsequently, Höck emphasised for psychotherapeutic departments: 'the structure, the workflow, the entire atmosphere of the clinic differs substantially from the usual hospital environment' (Höck and König, 1976: 154). Psychotherapists from the GDR, Poland and CSSR further developed the combination of group psychotherapy and therapeutic communities during the 1970s (Geyer, 2011a: 248). Moreover, in 1978, the curriculum for the newly introduced medical specialisation in psychotherapy included references to the therapeutic community (Akademie für Ärztliche Fortbildung, 1978: 201–6). Professional discussions on this combination were continued at the second international symposium on group psychotherapy in 1982 (Hess, 2011a: 277). Eventually, psychotherapists from other institutions and psychotherapeutic orientations also retrospectively stated that, since the 1970s, they had increasingly applied the basic principles of the therapeutic community – even though some faced considerable resistance from other staff members (Maaz, 2011; Misselwitz, 2011).

Even though the concepts could function without one another, structural overlaps between the therapeutic community and dynamic group psychotherapy seem to consist in the rejection of authoritarian guidance and the empowerment of patients, accompanied by a participatory ward life. The patient's position in the hospital setting and the therapeutic process should be enhanced. It appears that in addition to the Brandenburg Proposition, group psychotherapy contributed to the dissemination of the basic ideas of the therapeutic community. In the case of the Charité, an employee publicly referred to the psychotherapy department of the university hospital as a 'therapeutic community' on GDR television.[11] The following examples will help to assess the extent to which the implementation corresponded with Jones's visions.

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Ward life through the lens of daily reports

Dynamic group psychotherapy was developed exclusively for certain forms of neurotic disorders. During the period of study, this diagnosis was an exclusion criterion for psychotherapeutic treatment at the Charité. Moreover, quantitative evaluation of the sample of psychotherapy patients at the Charité by social structure reveals additional admission criteria. The files document the stay of adults, who were predominantly between 25 and 50 years old, as one aim of the therapy was reintegration into employment. In the socialist society, the social imperative to work endorsed this tendency. In principle, the treatment was open to all genders and in the sample, seventy-four patients each were registered as male and female. Typically, the patients spent two to three months in the ward – in rare cases up to half a year. Longer stays did not occur, as the length of therapy was inherently limited. The Charité was partly involved in local healthcare structures but could accept patients from other parts of the GDR who were deemed suitable. About half of the patients were resident in East Berlin, while the remaining people came from other districts of the GDR. Typically, the patients were referred to the Charité after unsuccessful treatment attempts elsewhere.

Pre-treatment with medication was particularly frequent, mainly with the newly emerged benzodiazepines or barbiturates. Sometimes the patients had learned autogenic training in earlier outpatient treatment, an autosuggestive relaxation method developed by German psychiatrist J. H. Schultz (1884–1970).[12] Only a small minority had previously been treated with other psychotherapeutic measures. Often, patients had been suffering from their symptoms for years and additionally accepted long waiting times for inpatient treatment in Berlin.

The therapists at the Charité had to select their patients based on a small number of beds. The sample shows a significant accumulation of people with a high level of education or academic training and of people whose profession involved textual work. One possible explanation would be that therapists expected better treatment results from patients with high therapeutic motivation and strong reflexive abilities. A more precise analysis proves difficult, as the reasons for admission were rarely made explicit and no records of rejected

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patients were archived. During reunification, a social psychiatrist from Leipzig criticised that admission to psychotherapy had been reserved for socially privileged patients (Weise, 1990: 291). This criticism of social inequality in the provision of mental healthcare connects to a discourse that had been going on since the first half of the twentieth century. Even though the sample includes counter-examples, the preponderance of people with elevated social status and education can hardly be denied. It is conceivable that the requirements of self-reflective writing reinforced therapists to favour patients with higher levels of education and conversely to exclude others, given the limited number of psychotherapy beds.

Shortly after admission, the patients began to write. Often, the bundles of writing began with a schematic breakdown into therapeutic and non-therapeutic activities. As the group discussions proceeded, social matters on the ward, as well as reflections on one's own challenges and those of others, became prevalent. In the following, some excerpts will help to approach the organisation of the daily routine in the ward.

One began with a list, which gives insight into the therapeutic spectrum: 'Morning: Psychodrama, playing table tennis, shopping done. Afternoon: Taking a stroll around town with my visitors. Evening: Handicrafts and reading.'[13] Shortly afterwards this patient added: 'I went swimming early in the morning. (I very much missed the sporting activities during my home leave.) In the morning I wanted to buy tablecloths for the common room of ward 5, which I unfortunately did not succeed in despite many efforts. Since the music therapy was cancelled, I could occupy myself with handicrafts until the club afternoon.'[14]

Sport was one of the core activities during the patients' stays. Most took part in groups for so-called foot, swing and cardio gymnastics. The standard programme included ball sports such as volleyball, badminton and table tennis, some swam or went bowling. Physical activity had been anchored in the psychotherapy department by former hospital director Karl Leonhard as part of his individual therapy in the late 1950s. He believed this would provide patients with distraction, conditioning and an understanding of their own physical capacities. On the downside, patients could find themselves confronted with the expectation that they had to appear sporty. Another continuity was the ideal of permanent occupation – for

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example, with handicrafts. Walks or department store visits could function as confrontation techniques. The occasional work therapy placement had also persisted since Leonhard's tenure. For instance, patients worked on an hourly basis in the archives, on the children's ward or at the reception of the polyclinic. Psychopharmaceuticals were continuously rejected on this ward in the 1970s, which an analysis of the respective medical records confirms. In terms of the group therapeutic programme, the patients listed autogenic training, music therapy, psychodrama, communicative movement therapy,[15] creative therapy and group discussions. Most of these methods were newly introduced in the 1970s and their experimental status becomes apparent for instance in patients' statements about organisational difficulties. Furthermore, the daily reports give insight into different evaluations of therapy components. One patient criticised a lack of effectiveness: 'The psychodrama disappointed me. Maybe I just expected more or too much of it, but I had the impression that not even the central person for whom all the plays were performed could be given helpful hints.'[16] Some evaluations seemed more positive: 'The communicative movement therapy was a bit unusual for me and the others, but I enjoyed it very much. The miracle [Wunder] that we created together in the creative therapy would not be very well received, but we laughed heartily, and I think we have certainly come a bit closer again.'[17]

As in the following case, it can be observed from some medical histories that the therapists evaluated the success of the therapy measures with the help of the daily reports: '3 March, cf. daily report from the weekend! Important insights adequately processed in the group discussion. Although influences of childhood were already pointed out by me in the individual discussion – by far no such resonance there!'[18]

Moreover, the daily reports often partially or completely replaced the medical histories. Even if this observation can hardly be quantified, it can be stated that patients took over the therapists' role in the documentation to a certain degree. As a result, there are only a few entries by therapists on the patients' writings. It is noticeable that they mainly commented on positive evaluations by patients. One patient observed the positive effect of music therapy in which music was listened to together: 'Supported by Händel in the music therapy and what I felt was a relaxed and constructive collaboration in the

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psychodrama, my optimism lasted throughout the day.'[19] Through such descriptions, the therapists perceived and documented how the therapies affected their patients: 'In music therapy, pat. regains "upper water": through the music (in the "react[ive] Music therapy") he felt encouraged, cf. the daily report.'[20]

Besides these evaluative functions, the daily reports were intended to have a therapeutic effect. Often, the reports were explicitly mentioned in a therapy plan at the end of the anamnesis.[21] The therapeutic effect of writing was, among other aspects, to foster self-reflection and help uncover unconscious conflicts. Some patients actively reflected on the therapeutic effects of writing. A woman highlighted the functionality of daily reports as an inventory: 'Writing a report means thinking about yourself and the day that has passed. I do nothing more than think about myself. Capturing thoughts and writing them down means bringing order to things.'[22]

In the following example, a patient purposefully developed the writing so that she could use it as an immediate reflection on the different therapies during the day:

> I think I have found a better method, or any method at all, to cope with my problem. I continuously write down insights, experiences, and situations throughout the day. The written form is for me, next to psychodrama and discussion groups, the most important method of dealing with my problem consciously, namely in that way and not as a daily report, which I usually only wrote in the evening.[23]

Most of the daily reports dealt with the authors themselves. When referring to others, the reports could illustrate certain expectations regarding their therapeutic motivation – on the part of the therapists, but also on the part of fellow patients: 'In my opinion, the group discussion "exposed" [another patient]. Now, I have the impression that she shuns all activity and personal responsibility, sees the guilt in others and feels sorry for herself (pouts to the point of inner defiance). At the moment, I see no will for change in her.'[24]

Patients were exposed to a variety of expectations and pressures on their behaviour and emotional lives. It was a fundamental part of the therapeutic concept of dynamic group psychotherapy to stand up to authority and imposed expectations. It repeatedly becomes clear, though, that such revolt was only wanted within a quite narrow therapeutic framework. Scepticism about the therapy,

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low motivation or refusal to write could be seen as problematic behaviour. For example, one patient did not want to write honestly about her feelings. She wrote on the top of an otherwise blank A4 page in small letters and thereby underlined her statement with the material appearance of the report: 'I ask you to spare me the daily reports. Firstly, I am not able to rationalise my thoughts and experiences so that I can write them down; secondly, you would spare me a probable lie.'[25]

She wrote several more reports expressing her aversion. Less than two weeks later, she was discharged from the clinic and took up her professional occupation again. In cases like this, no evidence of coercive disciplinary measures was found as a reaction to the reports or the general refusal, but there were indications that therapists repeatedly asked patients to write or to engage more in therapy. Patients' judgements about their fellow patients, like the one above, indicate possible social consequences in terms of social interaction on the ward. These, in turn, are scarcely constructible from the files.

It seems conceivable that close cohabitation may have increased the pressure to adapt one's own behaviour. The patients lived together in narrow rooms with four to six beds. The still image of a public TV documentary below shows that, at least for external presentation, value was placed on an appealing room design with pictures, plants and bedside lamps. However, the patients only had a small bedside table for their personal belongings. In addition, the beds were placed close together and hardly allowed for any privacy (see Figure 10.1).

Self-organised group activities dominated the patients' spare time. During 'colourful patient afternoons', they were supposed to practice lectures or music-making in front of others. Dance events and joint singing were a mostly popular pastime. Moreover, the patients were asked to put together a cultural programme, which could include visits to museums, theatres or sights. For instance, one report was entitled 'Weekend plan – ward 5', and gave an account of two visits to the cinema, one to the opera, one to a museum as well as an excursion to an outer Berlin district within three days.[26] The emphasis therapists seem to have placed on cultural activities provides some insight into normative ideas about the behaviour of patients. To some extent it may even reflect the impact of ideological ideals of an all-round educated socialist personality – even if this mission was rejected in Höcks's conceptual writings (Höck and König, 1976).

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Figure 10.1 Still image from a public TV documentary, showing autogenic training in a patients' dormitory at the psychotherapy department of the Charité. Source: DRA, DRAB-H, 004167, 'Neurosen – Krank durch Überforderung?', DEFA, 9 March 1976.

While many patients enjoyed such excursions, some writers perceived collective ventures as a burden. Given the abundance of group activities, they addressed the pressure of expectation to integrate into the patient collective. Some notes from therapists clearly confirm such pressure, as in the case of the following entry in a medical record: 'Pat. shirks going to the cinema with the group.'[27] Under this impression, many dealt with tensions between privacy and group life in their reports:

> Three of us … were at the State Opera. Like the last time I went to the opera, my eyes fell shut with tiredness. I was not receptive at all. Both times I had gone with them so as not to isolate myself. Since I never sleep well anyway, and since I don't know beforehand whether I will be able to take a nap, I am even more tired the following day in such cases, which does not exactly improve my mood. Therefore, I consider this involuntary 'subordination' as pointless. The price I had to pay again is too high.[28]

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Later, the same person added: 'I miss a quiet place where I can be alone from time to time, undisturbed.'[29] In the same respect others justified themselves when they had separated from the group. The therapeutic benefits expected from group treatment could turn into the opposite for patients if they craved privacy. In this regard, the pressure to adapt was occasionally perceived to be coercive.

The two wards of the psychotherapeutic department were located in a side wing of the psychiatric department of the Charité,[30] and thus spatially separated from other psychiatric and neurological wards. Consequently, the authors were mainly in contact with other psychotherapy patients. The patients of both wards were involved in the organisation of everyday life. As they were partly self-sufficient, patients cleaned their rooms, went shopping, prepared meals and did the dishes in kitchen duties. How community should be organised could be perceived as a political question. This participatory concept could be interpreted as a sign of democratisation, but some evolving conflicts point towards frictional notions of social and societal organisation in a broader sense among patients:

> By the way, [a fellow patient] wanted to suggest to the patient council to shift the breakfast from 7.30 to 7 o'clock (which would have spoken for him). But he did not do it. … regarding the discussion about the kitchen duties, I was disappointed by the dishonesty in the patient council. The fact is: a) the patients of ward 4 sometimes start breakfast at 7.20 a.m. and are therefore finished sooner; b) the patients of ward 5 sometimes get the bucket trolley too late (because they do not get up in time), which may increase the time difference between the two wards; c) the claim that all patients always come to breakfast on time is untrue.
>
> I wish this complex matter to be completely clarified. My question is: Am I the victim of a primary neurotic maldevelopment? Are these conflicts typical for certain neuroses or is this specifically my problem? Does an already emerging anti-authoritarian society of egoists cast its shadow here? And if so, is it better for me to 'float with this current'?[31]

Until his release, he remained critical of the form of organisation: 'My thoughts and feelings circle around the discharge. I don't like the dawdling that has occurred in the hospital. It is time to lead an "orderly life" again.'[32]

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As in the case of therapies, the patients could raise criticism also in relation to self-organised ward life, but it often remains vague as to what extent it was heard. Moreover, this patient implied a political dimension by suggesting that the community in the ward deviated too much from societal standards of the authoritarian ruled GDR, perhaps also approaching Western models too closely. His statement shows how differently patients reacted to the efforts to reorganise ward life. Among therapists and patients alike, the status of authority in the context of reform attempts and dynamic group psychotherapy seems to have been controversial.

In isolated cases, the patients' political attitudes are recognisable from their daily reports, but political debates seemingly rarely took place. To prevent betrayals, therapists of the same methods in other institutions asked their patients to focus on the here and now in group sessions and to leave political issues aside. It is likely that the same policy was followed at the Charité. From the patients' point of view, too, surveillance by state security had to be feared and presumably prefiltered their writings.

In addition, the author above referred to committees that resembled political bodies and were designed to enable patients to participate in organisational issues, represent their interests and resolve conflicts. A so-called 'patient council' was held once a week. It was composed of elected representatives from the patient dormitories and had an elected chairperson. The 'general assembly', in turn, was attended by all patients.[33] The combination of therapeutic components seems to have been non-negotiable, but when it came to cohabitation issues, patients could raise topics of concern and contribute to their solution. Details on these gatherings were rarely included in the reports. It still becomes apparent that not all patients were satisfied with these solutions or the way they were found.

The institution aimed to guarantee orderly social interaction and the course of therapy by a set of house rules. The precise wording has not been preserved. From the medical records it appears that curfews in the evening with open doors during the rest of the day and a ban on taking medication were central. In case of violations, the therapists issued admonishments or implied disciplinary measures. When a patient took medication on her own and lost consciousness, the medical history read:

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Determination:

1) Pat. gave up all medication in the presence of Dr. … + nurse … (Dormutil, Caffeine, Gelonida, Titretta Supp, Obridan, Regulax).
2) Pat. informs the chairman of the pat. council until the departmental meeting.
3) Urine check on Friday.[34]

On the one hand, this is an example of how such patient committees could be incorporated in the execution of disciplinary measures. The patients' council was supposed to have a monitoring function here and the case should be negotiated in the patients' assembly. In this way, the patients were urged to control and discipline one another. On the other hand, the patient's reaction shows how strongly such social pressure could affect those concerned: 'Tomorrow, I will be lined up against the wall in the patients' assembly to be shot. I don't think I can endure it.'[35]

In the case of repetition, therapists threatened exclusion from psychotherapy, seemingly without consulting the other patients. Disciplinary measures which had not been jointly agreed upon with the patient community were also used in other conflicts. When a patient did not agree to her transfer to another dormitory, an argument arose. The medical history read: 'A short time later, the patient demonstratively wanted to leave the ward. Consultation with Dr. Seidel: no exeat!'[36]

This note emphasises that the therapists were still able to take away patients' freedoms as a disciplinary means, even though the ward was organised as a therapeutic community. In this example, the patient's protest was not perceived as legitimate criticism, but was instead interpreted as a negative behavioural trait. The following complaint emphasises that the hierarchy between the clinical professional groups and patients persisted and provided further potential for conflict: 'Again, I was "kicked out" by nurse … Her harassing manner causes me to need more instead of less time, to her disadvantage. It is unacceptable that she wants to close the ward before 4 p.m. while I treat my nail fungus …, especially since Dr. … did not give us a time limit in response to our explicit question (witnesses: [two fellow patients]).'[37]

Despite these conflicts and the continued hierarchical positioning of therapists and patients, the latter often used the daily reports

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to give strong voice to their opinions. Due to the nature of the sources, it is hardly possible to assess the weight of their statements for conflict resolution. How such disputes were dealt with is rarely documented. In this respect, the daily reports served as a medium for complaints, not as a space for resolution. Where therapists attached importance to the patients' problems, solutions were sought through direct verbal exchange or in one of the patient committees.

At the same time, however, it should be emphasised that the liberties granted to the patients were high compared to other departments of the psychiatric hospital of the Charité and that, overall, the patients' statements in this regard were mostly positive. Patients were allowed to receive visitors or leave the hospital grounds during the day – for example, to meet family or acquaintances in East Berlin. In so-called 'stress test leaves' on weekends, the treated were to keep up or re-establish a connection to their social environment. It seems that this strategy also had to compensate for inadequate outpatient aftercare in other districts of the GDR (see, for example, Rose, 2005: 137–8). Patients who lived close by could continue their treatment as day patients. Yet patients had to ask for permission for weekend leaves and longer time out in the evening and the decision was made by the institution. Open doors can be seen as an expression of reformist efforts, even though institutionally imposed rules were still enforced hierarchically, and violations were sanctioned. To conclude, the following observation of a patient highlights pronounced differences to other psychiatric wards: 'Since I was here on the ward, my reservations about the inner thought-and-rumour-knot "mental hospital" had pretty much faded into the background. Now it's all back again. Not on our ward, but we are close to other departments where there is more going on between nursing staff and patients than the absent doctor could dream of.'[38] The patient was able to overcome her reservations about a psychiatric clinic in the setting of the psychotherapy. She did not specify her experience of visiting other wards. However, they made a strong negative impression on her and made her draw a contrast between the psychiatric and psychotherapeutic wards. Despite all the ambivalences, the psychotherapeutic ward seemed more advanced to this patient in a reformist sense.

The lens of the daily reports allowed for some spotlights on the group psychotherapy ward of the psychiatric hospital of the Charité

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in the mid-1970s. This perspective revealed attempts to reorganise social ward life. The establishment of a therapeutic community in a psychiatric hospital in the GDR required renegotiation of the status of authority and participatory decision-making on psychotherapeutic wards. The therapeutic community, as envisaged in Jones's model, was generated by the subordination of clinical hierarchy to consensus-oriented decision-making based on democratically controlled bodies. At the same time, however, some patients' complaints demonstrate that concessions were made to maintaining institutional authority, which could not and should not be overcome by the emancipation process envisaged by the group psychotherapy. In view of the debates on the Brandenburg Proposition, this may also suggest adaptations to the authoritarian societal system.[39]

Moreover, the concept had to be adapted to personnel and material circumstances. As the Charité was a university hospital, it can be assumed that the latter were exceptionally good compared to other institutions in the GDR (Janssen, 2012). In the present case, hierarchical structures eroded, but were not dissolved to the extent envisaged by Jones. Moreover, the reformist efforts were tied to the department and hardly transferred to non-psychotherapeutic psychiatric spaces, as broad implementation according to the Brandenburg Proposition would have required. This kind of 'islandisation' can also be observed in other attempts to establish therapeutic communities in sociotherapy wards (Falk and Hauer, 2007: 248). Among others, such attempts and the reservation of other professionals are known from Brandenburg-Görden and Berlin-Buch (Eichhorn and Busch, 1979; Späte and Otto, 2011).

Ambivalent effects of daily reporting as a practice

Unlike what Kratochvìl's explanations might suggest, the daily reports were no 'diaries', as the patients directly addressed their therapists. Thus, it was a hybrid form of writing that combined self-analysis and interpersonal communication. The fact that both were demanded simultaneously appeared to some patients as an intrusion into a private process – they refused. Others responded with technical descriptions of daily routines, while for those with a trusting relationship to the therapists, daily reports could become an appreciated

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means of expression and a helpful, if not central, therapeutic tool. Based on these different perceptions, our focus turns to the various implications that the practice had for social life on the ward.

Writing at first appears as a reformist practice and blended into the general therapeutic concept. The daily reports materially reflect a diversified psychotherapeutic spectrum. Due to its self-reflexive nature, the practice had a therapeutic effect itself, as several patients made use of it to uncover their unconscious mental conflicts. Moreover, the daily reports offered an additional means of communication. In this way, they promoted the flow of information and stand for an enhancement of the patient perspective in the therapists' perception. This means of communication had the potential to foster participatory organisation of the ward as well. Requests for private consultations were frequent and allowed for exchange in addition to the group sessions, when accepted. In some cases, therapists sought individual talks because of patients' writings, especially concerning suicide risks. Furthermore, the daily reports strengthened patients' voices in the documentation about themselves. Storing the daily reports in the patient records filed a 'second voice' next to the institutional one and enhanced the patients' subjective perception of their stay in the hospital. In this respect, patients even took over the responsibilities of therapists, when their reports replaced the journal in the medical files.

In addition, the patients' daily reports offered a means of evaluation for their treatment. Reading offered the therapists a moment of conscious reflection on their patients' assessments of the therapeutic effects and critiques. Thus, the reception was conductive to therapeutic ambitions, but the effect on their individual reformist endeavours can only be estimated. What can be substantiated, for the most part, are confirmatory perceptions of positive therapeutic or organisational effects. From the present sources, the impact criticism had on the therapists remains largely an open question. It is especially difficult to deduce whether protest was seen as therapeutic progress in terms of critique towards authorities, or whether the therapists took it into consideration as such, and either dismissed or ignored it, or adapted their behaviour or the respective circumstances. Still, the reports allowed patients to address the staff with questions, comments and sometimes sharp criticism concerning psychotherapy and everyday organisation. The writing practice thus strengthened

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the patients' capacity for action – a concern that the therapeutic community pursued as well.

However, this scope remained in distinct dependence on the therapists as representatives of the institution. This circumstance hints at some downsides that run counter to reformist ideas. First and foremost, the practice performed a hierarchy between therapists and patients in a way, which opposed the erosion of traditional hospital structures. Writing only took place in one direction, as therapists did not write back, but continuously requested the patients to write. Instead, they accumulated knowledge from each individual's written communication. In turn, the patients faced a certain kind of social control, as they did not know what their fellows wrote, and could not respond to it, even if it concerned them. It remained up to the therapists to decide when they considered the concerns important enough to respond. The hierarchical distribution of roles between therapists and patients remained and ultimately the writing practice repulsed attempts at its erosion.

Additionally, patients' testimonies were not free from institutional constraints. Their writing was subject to expectations in terms of commitment and therapy motivation, as well as assimilation into the group and predetermined hospital structures. There was pressure to appear sporty, hardworking and willing to reintegrate into work life. These values were considered therapeutically beneficial, but they also depict – whether intended or not – societal ideals of socialism in the therapeutic context. It seems reasonable to assume that patients were subject to these structures and that their statements were shaped accordingly. Personal testimonies are widely considered 'impressively unfree' and it seems conceivable that, in this case too, the patients made repressive mechanisms of the institution operative through writing (Osten, 2010: 8). Meanwhile, frequency, tone and the extent of criticism in some reports suggest a relative openness and seem to challenge the structural determinacy of patient perspectives to some extent. After all, this dilemma depicts one of the therapy itself: it aimed at emancipation from authoritarian structures, but ultimately remained bound to the institutional and societal context.

Apart from this, it seems plausible that the writing practice indirectly affected the choice of patients among those with neurosis diagnoses. The small number of psychotherapy beds were noticeably more likely to be given to people with a higher school education

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or even academic qualification. As an integral part of therapy, this practice may have intensified the notion that higher education was necessary for psychotherapy. In the final account, this observation remains an assumption, as the sample also contains a few examples to the contrary. Finally, daily reporting may have hampered the transfer of the therapeutic concept to other psychiatric wards and institutions. Staff capacities might have been a limiting factor, as reading and processing the reports required time and a close supervisory relationship. Perhaps the practice contributed in small part to the fact that this psychotherapy remained out of reach for most psychiatric patients. Instead, the psychotherapy of neurotic disorders was further differentiated and bridges to the rest of psychiatry remained scarce.

The polyphony of patient opinions shows that the examined reform attempts were still in the making. They were subject to ideological and social negotiation not only on the part of therapists, but also of several patients. A similarly ambiguous picture emerges when looking at the implications of daily reporting as a practice. In an almost contradictory way, it strengthened the voices of patients in everyday life and in the medical documentation, while limiting them to an inferior role in the institutional system. Daily reporting can be seen as an expression of reformist endeavours, as it facilitated the expression of criticism and placed attention on patients' perceptions. If one considers secondary reflections of the practice on the social fabric, a more ambivalent picture emerges: daily reporting upheld the performance of hierarchy and thus eventually limited attempts at its erosion. Finally, the practice may serve as an allegory for the challenges of psychiatric reform projects in the context of socialist society.

Notes

1 Historisches Psychiatriearchiv der Charité [Historical Psychiatric Archive of the Charité] (henceforth HPAC), Berlin, 557/74M, Daily report from 6 January 1974.
2 HPAC, 449/74M, Daily report from 11 December 1974.
3 For a broad compilation of contemporary testimonies on the development of psychotherapy see Geyer (2011b).

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4 The quotations of patients' speech in this article are used to express the polyphony of patient opinions and voices. To protect the patients' identities, this article does not include names or information on living conditions and renounces coherent case histories. From 1978, other patients from the second psychotherapeutic department with an individual therapy focus wrote as well. These twenty-six files were supplementarily included in the analysis. At the time of the research, the medical records of the 1980s had not yet been transferred from the clinic to the Historical Psychiatric Archives. These files will first be made accessible to researchers in 2022.
5 The concept of a 'therapeutic community' is also significant for Chapters 1, 2 and 5.
6 See Malich, 2019 for an outline of Höck's career.
7 The psychotherapy department was founded by Karl Leonhard (1904–88) in 1959 in order to put his Individual Therapy for Neuroses into practice.
8 Interviews with two psychotherapists working in the GDR revealed that the interviewees were not aware of any research based on the daily reports or on their use in therapy. Moreover, volumes from the 1970s and 1980s of the only psychiatric journal in the GDR, 'Psychiatrie, Neurologie und medizinische Psychologie', were examined.
9 The criticism of medical historian and philosopher Achim Thom had a decisive influence on the reformulation. He considered the psychodynamic understanding of illness and the individual psychological view of groups to be incompatible with Marxist ideas of society and the individual. Under socialism, a 'therapeutic community' could only be a 'rehabilitation collective' with an educational mission in the sense of forming socialist personalities, Kumbier and Haack (2018), referring to Thom (1974).
10 For example, disciplinary aspects of therapies were rejected in the first version, but in 1976 they were considered necessary, as was the maintenance of institutional authority (Kumbier and Haack, 2017: 439).
11 Deutsches Rundfunkarchiv [German broadcasting archive] (henceforth DRA), Potsdam, DRAB-H, 004167, 'Neurosen – Krank durch Überforderung?', DEFA, 9 March 1976.
12 Suggestive methods were widespread in the GDR as well as in other Eastern bloc countries, cf. Marks, 2018.
13 HPAC, 577/74F, Daily report from 12 December 1974.
14 HPAC, 577/74F, Daily report from 9 January 1975.
15 A group and self-awareness method developed at the Leipzig University Psychiatric Clinic (Kohler and Wilda-Kiesel, 1972)
16 HPAC, 319/78F, Daily report from 21 June 1978.
17 HPAC, 502/78F, Daily report from 14 September 1978.

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18 HPAC, 14/75M, Therapist's entry in the medical history from 3 March 1975.
19 HPAC, 339/78M, Daily report from 16 August 1978.
20 HPAC, 339/78M, Therapist's entry in the medical history from 16 August 1978.
21 E.g. in the case of HPAC, 499/76M.
22 HPAC, 179/77F, Daily report from 28 June 1977.
23 HPAC, 228/77F, Daily report from 9 June 1977.
24 HPAC, 391/76M, Daily report from 14 September 1976.
25 HPAC, 356/74F, Daily report from 4 November 1974.
26 HPAC, 477/77F, Daily report from 2 October 1977.
27 HPAC, 514/78M, Therapist's entry in the medical history from 2 February 1979.
28 HPAC, 557/74M, Daily report from 30 January 1975.
29 HPAC, 557/74M, Daily report from 13 March 1975.
30 Dynamic group psychotherapy and individual therapy respectively were practised there, but there were interferences in terms of therapeutic components. Prospective patients were distributed according to diagnoses.
31 HPAC, 557/74M, Daily report from 18 April 1975.
32 HPAC, 557/74M, Daily report from 8 and 9 May 1975.
33 On the general assembly as therapeutic practice see Chapter 2.
34 HPAC, 121/77F, Therapist's entry in the medical history from 16 March 1977.
35 HPAC, 121/77F, Daily report from 16 March 1977.
36 HPAC, 414/78F, Therapist's entry in the medical history from 3 October 1978.
37 HPAC, 557/74M, Daily report from 15 and 16 May 1975.
38 HPAC, 420/76F, Daily report from 11 August 1976.
39 Nevertheless, some therapeutic communities in the United States were criticised by European practitioners for maintaining authoritarian patterns and the leadership of a charismatic leader (Ottenberg 1982: 171). In this respect, the gradient in authority may not be explained by the East–West divide alone.

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