Ana Antić, PhD, Postdoctoral fellow
Columbia University, N.Y.

УДК 616.89-08(497.1)"1941/1945"

Mental Illness under Occupation. Psychiatric Revisions of 'Normality' and 'Pathology', 1941–1945

Abstract: *The article analyzes the effect of the Second World War on the development of psychiatry in Serbia and Yugoslavia. It analyzes the war-related situations, reactions, conditions and experiences of both victims and perpetrators, noted in case files and psychiatric discussions, which may have led Yugoslav psychiatrists to re-consider their previously solid beliefs in the hereditary and constitutional nature of schizophrenia.*

Key words: Mental Illness, Second World War, Psychiatry, Yugoslavia, Schizophrenia, Neuropsihijatrijska Bolnica Laza Lazarević

In Yugoslavia, post-1945 psychiatry seemed to have undergone a truly fundamental break with the earlier professional narratives. The official explanation adhered to by the psychiatric profession was ideological: in a new socialist era, psychiatry could not possibly be exclusively organic and biological, ignorant of and uninterested in the socio-economic and cultural context. But this explanation was at best incomplete. Already during the war and well before the socialist revolution of 1945, the validity of the biological psychiatric model had undergone some serious and consequential professional re-thinking. This was obvious from psychiatric discussions, evaluations, observations and notes in mental hospital case histories; it was clear that a tremendous paradigmatic shift was about to occur when even the collaborationist regime's psychiatric project began to refer to mental pathology in decidedly psychodynamic terms. These trends were certainly reinforced by the socialist take-over at the end of the war, but they were certainly not initiated by it; in fact, much of the post-war psychodynamic thinking had roots in phenomena and figures rather removed from socialism.

Philip Nord has emphasized in his recent work the complex and mixed background of the postwar French state and followed closely its various segments' roots in the apparently radically diverse legacies of the 1930s, the resistance and Vichy[1]. In a similar vein, Yugoslavia's psychogenic psychiatry, which had its beginnings in the

[1] Nord, Philip, *France's New Deal: From the Thirties to the Postwar Era*, Princeton University Press 2010.

remarkable yet marginalized work of a group of left-wing Freudians in the 1920s and 1930s, was given a decisive boost in wartime, when hospital psychiatrists witnessed the inadequacy and breakdown of their own biomedical paradigm and searched for a new approach. In this paper, I will observe closely the wartime interactions between psychiatrists and their civilian and soldier patients, and explore the wartime origins of the new psychiatric model. I will look into the new challenges that Yugoslav psychiatry faced after 1941 and relate these novel, transformative experiences to the emergence of a dynamic and psychologically oriented postwar psychiatric interpretive/therapeutic framework. I analyze those war-related situations, reactions, conditions and experiences of both victims and perpetrators, noted in case files and psychiatric discussions, which may have led Yugoslav psychiatrists to re-consider their previously solid beliefs in the hereditary and constitutional nature of schizophrenia.

The biomedical psychiatric model tended to disregard the implications of psychological trauma and environmental circumstances, and emphasized the significance of organic and/or hereditary factors. The inability of the Belgrade hospital's psychiatrists to come to a coherent conceptualization of the issue of psychological trauma became very clear soon after the onset of the war and occupation. Still, the difficult life experiences that hospital patients ever more frequently shared with their psychiatrists after 1941 were bound to make an impact, and indeed the physicians increasingly structured their interviews and hospital case files around narratives of traumatization, partly perhaps because their own perspective was undergoing transformation, partly because both the patients and their relatives/caretakers insisted on the importance of psychological suffering with a particular vehemence. However, despite the prominence of psychological trauma as such, it remained unclear until the very end of the war what exactly its role was in the process of one's mental deterioration, and, even more importantly, how it was to be addressed and reacted to in a therapeutic context. In numerous files, although rhetorically dismissed, psychological trauma assumed the central place in conversations as well as psychiatrists' notes, and the psychiatrists demonstrated a curious confusion as to how to work it into their understanding of the diagnoses in question and their treatment.

This was particularly obvious in the case of a young female patient, diagnosed with schizophrenia, whose traumatization was powerful yet deeply misunderstood by her psychiatrist. Jelena's[2] was a case of an original trauma of truly immense proportions that received significant attention from the psychiatrist, while at the same time the patient's own pronouncements were constantly dismissed as incomprehensible and disjointed. The patient, a thirty-year old woman, was brought to the mental hospital after having spent three days alone in the same room with her dead mother who had hung herself. Her psychiatrist, Dr. Nadežda Jevtić, described Jelena as "disassoci-

[2] Archive of Serbia, fond „Neuropsihijatrijska Bolnica Laza Lazarević", G-222, F-110, file 19369. (hereinafter: AS, G-222)

ated…babbling without any sense …disoriented, foolish…" Jelena did not offer any alternative interpretations of the origins of her disease; instead she outright denied her mother's death. When asked about her family at home, she mentioned that she had a living mother, to which the psychiatrist replied: "What do you mean mother when she committed suicide?" This rather insensitive comment upset the patient to the point of leaving the interview, and the conversation was only continued when the nurse brought her back. Dr Jevtić then remarked that the patient was "'living in a regression that she [was] ten years old and that all questions [would] be answered by – Mom and Dad;" however, despite this reference to psychoanalytical interpretations, Jevtić concluded that Jelena's denial of her ordeal – the mother's death – was a proof of the trauma's insignificance, of its at best limited impact: "even though she spent three days next to her dead mother: [the patient told of the mother] "she is very well, thank you, she went to see the tailor"; the theme of the dead mother could not be pursued because the patient interpreted such questions "autistically… in the sense of hostility on the part of the environment." In the course of one of the subsequent encounters with Jelena, Jevtić noted that the patient was not able anymore to receive any external impressions; furthermore, she opined that the patient was not seriously influenced by the important events of the recent days, such as the German bombing of Belgrade in April 1941, or having spent three days alone with the dead mother, due to her "intellectual and emotional obtuseness."

Hence, absolutely no attempt was made to analyze the role of the trauma through which the patient had gone immediately before arriving to the hospital in the onset and nature of her illness. In a notable twist, the psychiatrist thus emphasized the trauma – since it could hardly be ignored – and made it the central point of reference in the narrative of the case file, but also used its supposed insignificance from the patient's point of view to stress and prove Jelena's pathology and emotional inaccessibility. Similarly, the content of the patient's pronouncements did not figure at all in the process of diagnosing and devising therapy; the patient's statements were only referred to in terms of incomprehensibility, nonsense and aimlessness. At no point did Jevtić pay more attention to explore the effects of the mother's death, or make an attempt to decipher the origins of this "regression," its potential meanings. As a result, Jelena received no therapy, either somatic or psychological, during her stay at the hospital, and died less than four months after having been admitted.

In the case file of a refugee from the Independent State of Croatia, narrated experience of a very severe war-related psychological distress caused similar confusion for the examiners trying to devise an appropriate therapy, and elicited telling commentary from the psychiatrists. The patient's[3] diagnosis, *dementia senilis*, left very little space for a discussion of non-organic sources of his mental condition and possible environmental and emotional factors affecting his deterioration. However,

[3] AS, G-222, F-111, file 19738

the patient's life experiences and his subjection to wartime persecution and finally exile were noted in rather great detail. Yet there was never any explicit attempt in the psychiatrists' remarks to relate this trauma to the patient's psychological condition: "He arrived from Sr. Kamenica in June of this year, he ran away from the Ustasha. Until that time he had been fine, but when the Ustasha came, they attacked and beat him, they also killed others…. He hadn't argued with anyone [in his village]." The psychiatrists, however, did comment upon the patient's manner of re-telling his personal history, and especially his seeming inability to narrate the escape from the Independent State of Croatia with any coherence: "In the course of a longer conversation, the patient always gives consistent information on himself, sometimes in a desultory way. For instance, he cannot retell his escape to Serbia fluently and on his own, but tells only one segment at a time and only in response to very detailed questions." This comment was meant as a criticism, a negative evaluation of the patient's mental stability and lucidity, and was interpreted as a consequence of his advanced dementia. Interestingly enough, although they noted his incoherence only in relation to the subject of his persecution by the Ustasha and becoming a refugee, the psychiatrists never suggested that the patient's inability to successfully verbalize his traumatic experience might have been an indication of the strong effect of these events on his mental condition. In other words, they never connected the verbal incoherence with the profundity of the trauma, and failed to use the patient's difficulties with retelling it to re-evaluate the importance of psychological suffering and stress for the development of his mental illness.

In a similar way, they commented critically and impatiently on the patient's reported light attitude when he talked of his difficult life after having escaped to Serbia: "When he moved to Serbia, he tells completely frivolously how he worked and lived, but when one gets into details of his life, it becomes clear that he was a vagrant and had no permanent occupation nor residence. He takes all that flippantly, and would like to leave the hospital and go to his sisters… about whom he hasn't heard anything since the beginning of the war…. He doesn't even know the name of the lady who brought him here." Again, the patient's reported "frivolity" when retelling his life as a homeless and moneyless refugee in Serbia was interpreted as a further sign of his progressive loss of touch with reality, a consequence of his organic dementia, and not as an indication of an exceptional psychological toll that such distressing experiences might have taken on him, which would make it very difficult for him to narrate them in any more coherent or realistic manner.

At the same time, however, already towards the end of 1941, a change in the structure of the patient file was beginning to take form, and it was particularly noticeable with regard to those patients who had experienced a novel, war-produced situation of distress prior to suffering psychiatric difficulties. Refugees from the Independent State of Croatia certainly belonged to this group, and their personal histories

frequently elicited a fair degree of sympathy on the part of the psychiatrists. Even in the file discussed above, despite the insensitivity towards the patient's articulation of his traumatic experiences, the interest in his personal narrative and psychological trauma was very strong, and the central part of the interview consisted precisely of the interrogation of the exact nature and possible effect of the trauma, even though the patient was diagnosed with dementia and his state thus considered a result of a neurological, organic deterioration. In the case of another inmate, Jovan[4] – a Serbian refugee from the newly independent Croatian territory as well – the hospital file included a very lengthy and detailed inquiry into his immediate past and experiences under the Croatian regime. He was questioned on these topics on several occasions, and his wife was also asked to provide in-depth descriptions of Jovan's afflictions which immediately preceded his hospitalization. Jovan was admitted in November 1941, after having spent an indefinite period of time in various towns in Serbia. He was eventually arrested by the German Command in Požarevac, in eastern Serbia, and brought to the Belgrade mental hospital.

Jovan was reportedly in an exceptionally difficult condition: he was extremely confused, often aggressive and in fear; he begged the physicians to "treat him as a human being." According to his own testimony, he was maltreated, beaten and arrested by the Germans and the Ustasha at the beginning of the war: "'I don't know what that might have been...' they wanted to make a fool out of me... tied me to a rod in the municipality building and did all kinds of things." He also mentioned that he did not know what happened to his family and material property. His wife did come to visit, and confirmed that he had been exposed to physical violence at the hands of the municipal authorities, for unknown reasons.

The patient's narrative was rather disoriented and confused; he could not give a clear account of either his experiences back home or his whereabouts after the escape to Serbia. In Jovan's case, however, the psychiatrist who conducted the interviews appeared more understanding of the connections between the patient's "state of delirium" and his past traumas, especially with regard to the patient's frequently expressed fear that someone would kill him. The psychiatrist directly related Jovan's confusion with his traumatic imprisonment prior to hospitalization. Although diagnosed with schizophrenia, Jovan was eventually released as "recovered," as he was continuously described as aware of his state and critical of his illness.

Different treatments received by two different patients diagnosed with hysteria can further testify to this process of psychiatric rethinking under the heavy impact of wartime realities. Early on in the course of the war, a very young male patient[5] was brought to the hospital, who seemed to demonstrate a textbook case of hysterical symptoms: he claimed that he had not been able to walk for the last six months, and

[4] AS, G-222, F-111, file 19908.
[5] AS, G-222, F-116, file 20499.

he complained of pains and "heaviness" in his head and chest, but no physiological cause was ever found for his difficulties. Not surprisingly, the setting of the Belgrade mental hospital proved superbly insensitive to the possibility that a psychological trauma could affect physical or neurological changes and problems; the psychiatrists in charge of this patient constantly hinted at his probable simulation and the inauthenticity of his difficulties. They remarked that, even though he "screamed and it seemed he was only thinking of himself," he was actually paying close attention what the psychiatrists wrote and said of him. Furthermore, although he did not ask for food, the examiners noted sarcastically that, when given a meal, he ate very well.

Finally, it seems that some violent practices were adopted toward the patient: when asked to move his left leg, the patient claimed he could not, after which he was "shaken" and prodded, and eventually made a small movement. Even more drastically, the psychiatrists' relationship with him at times bordered on verbal abuse. When he would not answer a question, his interviewer reportedly "threatened to send him to the military," which then prompted the patient to give "fast and thoughtful answers." Similarly, "when asked a question, he failed to respond (pretended not to have heard), but when the doctor threatened to kill him, he smiled (therefore, understood that it was a joke)." Tellingly enough, there was no mention of any form of psychological or other distress that could have caused or triggered the patient's "hysterical" reaction: the psychiatrists did not ask, and the patient or his family either did not share or their pronouncements in this respect remained unmentioned in the file. It would seem that the perceived unreliability of the patient prevented any deeper discussion on the possible psychological roots of his condition: as the patient's symptoms and complaints were never taken seriously, there was never any interest shown on the part of the psychiatrists in investigating the background of the illness.

Generally speaking, both before and in the course of the war, there were very few patients who were recognized as suffering from hysteria, a diagnosis which would be likely to spearhead at least some discussion regarding circumstances surrounding the onset of the illness, and a reflection on the connection between the psychological and the organic. In one other case, however, a patient, fourteen-year-old boy diagnosed with hysteria, received a much more sympathetic treatment, and was inquired in depth about his own psychological trauma which, as neither the patient nor his psychiatrists ever contradicted, directly caused his condition. This case history[6], created in November 1943, revealed a significantly different psychiatric approach to the issue and importance of psychological trauma. The event immediately preceding this patient's mental deterioration was a clear consequence of an extremely brutal occupation instituted in Serbia in 1941: as a part of the German army's "punitive expedition" – reprisals raid – in Kragujevac (the patient's home town in central Serbia) in the fall of 1941, the executions of over 2000 civilians of all ages and professions

[6] AS, G-222, F-116, file 20058-XI-208.

proceeded in retaliation for the Communist-led resistance attacks on German soldiers. As the patient and his parents reported, he witnessed the murder of his own younger sister by a passing German squad, while the two were playing in the courtyard of their parents' house. The immensely tragic proportions of this event – and the clear qualitative difference from any imaginable peacetime traumas – and its likely effect on someone as young as the patient, certainly shaped the psychiatrists' own evaluation, and the attention they paid to the patient's pronouncements.

The patient's description of the trauma was noted in detail, several times, and so was the patient's interpretation of the murder of his sister as the sole cause of his illness: "one [sister of his] died when she was eight in 1941, soon after the Germans' arrival, he says that the Germans shot her in the courtyard while he was playing with her and he got sick at that time. At first he lost consciousness, and then he was very upset, dragged some iron and hit it against the wall. Only after a month did he somewhat calm down. That year he could not concentrate in school..." The patient complained mainly of "seizures," physical pains and temporary problems with eyesight. In addition, "he frequently cries. 'I mourn my sister, I must mourn her.' He sees his sister all the time, and sees her suffering, the way she felt at that moment when she was killed, he would want to think about something else but he cannot, she is still in front of his eyes." The witnessing of the sister's violent death, therefore, served as the primary – and indeed only – interpretative framework for the patient's condition: he even explained his physical symptoms as a consequence of this "weakening of the nerves." Even more tellingly, the psychiatrists themselves offered no alternative opinions regarding the nature of the illness. Whenever they reported as symptoms or the patient's reactions and behavior, they refrained from commentary or any form of rhetorical distancing from the patient's own pronouncements and interpretations: as the passage quoted above demonstrated, the patient's statements were reported straightforwardly and in a matter-of-fact tone, with the assumption that they were coming from a reliable source. In the one instance of direct speech, the patient was granted his own "I" and it was clear from that as well as from the style of the surrounding text that this quotation did not serve to distance the interviewer from the interviewee's point of view but to report the patient's pronouncements as authentically as possible. This further indicated that these pronouncements were indeed taken seriously, as medically relevant, and that it appeared important to note them with the greatest accuracy.

Furthermore, it is important that "hysteria" was the diagnosis of choice, although the patient's intelligence was reportedly "deficient," he was at times unable to maintain contact and communication with other people and his examiners, he showed profound confusion, his general knowledge of even the most basic concepts was rather weak – in other cases, such symptoms often led the physicians to conclude that they were dealing with schizophrenia or some other form of grave psychosis. In this case, however,

a milder diagnosis also implied a much more optimistic prognosis for re-integration and a significantly less harsh indictment of the patient's "constitutional degeneracy." In fact, after less than three weeks, the patient was released as "recovered," described as "not exhibiting any further signs of mental disturbance."

Psychological trauma and its inaccessibility

Even before the outbreak of the war, psychiatrists at the Belgrade mental hospital used a very peculiar language to describe their schizophrenic patients. The concepts employed to try to interpret the nature of that most frequently diagnosed illness betrayed a long-lasting and profound frustration with the profession's own inability to understand the psychological processes involved. In patient case histories one encounters again and again this complex and mystifying language of inaccessibility of patients' inner lives and mental processes, which directly contradicted the above-described system of ideas attributing emptiness especially to lower-class patients. Furthermore, the hospital psychiatrists regularly established a clear distinction between schizophrenic patients' interior and exterior, between their "superficial" and "deep" layers of personality, and frequently insisted on the existence of highly complex psychological processes at work in cases of schizophrenia; these thought processes were then arguably concealed behind the external shield of schizophrenic behavior and consequently unreachable. Dr Nadežda Jevtić, for instance, often complained of this supposed internal conflict, the stark division between her patients' inner and outward personae, which always resulted in her own inability to get through to the patients' "true" individuality, to their thoughts locked up inside. This frustration was indeed understandable, especially given that, at least at the outset of the war, the biological framework went virtually unchallenged in these hospital settings, where very little time and energy was devoted to discussing or theorizing the possibility of psychogenic disorders, and no psychotherapy was ever practiced. The existence of such psychiatric discourse on schizophrenia, thus, in itself revealed some serious problems and deficiencies within the hereditary paradigm of mental illness, highlighting its unsatisfactory and reductive explanatory and therapeutic potentials.

Jevtić's notes in the case file of a particularly unresponsive female patient[7] – a maid, refugee from Slovenia – repeatedly suggested that an entire complex intellectual universe was hidden behind her "frozen" appearances: "She holds herself rather torpid, paralyzed, not that she doesn't know what to do, but that she wouldn't do anything due to fear." Furthermore, "What she is thinking about is only known to herself, nobody can get through her negativism and 'paralyzed anger.'" Jevtic recorded her own impression of the patient's "dedication to and living through something au-

[7] AS, G-222, F-110, file 19030.

tistic (whose contents are unknown to the external world)." At times, the language clearly indicated a confrontation: after eleven months of treatment, Jevtić reported, the patient was "much more collected and self-possessed, but she is still concealing something inside herself and won't admit it." She remained "Wistful, immersed in her own state," paying no attention to events and persons outside of herself.

The idea of these inaccessible internal processes was then accompanied by the assumption that the problem was in the patient's denial of her own individuality: "all her movements are as if she was running after something or somebody, compelled by some distinctive thoughts… gives the impression that, in her autistic state, she is persecuting her own personality as well." Yet, at this point the language became extremely tangled and difficult to follow – another sign of the profound confusion regarding the nature of schizophrenia and mental processes in schizophrenic patients: "depersonalization expressed in 'not wanting' to know of herself (in direct contact one gets the impression that everything that causes the patient to negate her thoughts of herself and in relation to her environment, also in her negativism she expresses identification with the surroundings)…In the state of intellectual paralysis, partly incapable of thinking, as well as incapable of understanding due to her autism, but partly also there is negativism for everything outside of herself that is being 'forced' upon her to grasp and work through." The central trait of this patient's grave and irreversible condition was thus "negativism directed against her own personality," although – as was clear from the records above – it was very difficult to understand what exactly this "negativism" entailed and how it functioned in the context of the patient's treatment.

At the same time, one regularly encountered the idea that patients were "empty," especially in the cases of people diagnosed with schizophrenia. As was frequently the case with patients of her social background – peasants – Vesna's face was depicted in the notes as "obtuse, with a torpid, empty smile;" she was, furthermore, "absolutely inaccessible," and uncooperative, frequently aggressive and mostly disobedient. These were then interpreted as signs of her internal psychological barrenness, although there still were occasional references to her being preoccupied with herself and living in her own separate world – which clearly contradicted the statements regarding her supposed emptiness. Another female inmate[8], a former clerk, was described in a strikingly similar way: as "completely inaccessible to the external world." The psychiatrist recorded that the "expression of her face betray[ed] certain dejection in obtuseness" (which implied the existence of a certain emotional or intellectual content behind or underneath this external obtuseness). Furthermore, "her gaze [signified] spiritual peregrination and inability to concentrate thoughts." The central aim established in this patient's file was for the psychiatrist to venture behind the exterior and unravel the web of thoughts and ideas affected by the illness. However, throughout the exami-

[8] AS, G-222, F-116, file 20507.

nation and treatment process, the psychiatrist kept expressing her doubts regarding whether there was any interiority to look for in the first place: "…she 'thinks' and talks, but she herself doesn't know what she thinks, what she talks about, why and for whom she reproduces all that." Although the patient was described as "completely autistic, distraught, immersed in herself, wistful…," the psychiatrist still concluded that "it [remained] unknown if she [thought] anything (if she had any thoughts) in the course of days and hours, but when encouraged to have contact, she reproduced senseless thoughts, and the more she was 'willing' to talk, the more she proved to be distraught." One note indicated the patient's "paralysis/freezing of the intellect in emptiness, and the state of obtuseness," even though the idea of emptiness – intellectual or emotional – was somewhat in contradiction to the opposition interior/exterior that the psychiatrist had been trying to establish throughout the file.

Finally, the frustration reached its culmination point: the patient was referred to as an "automaton:" "An 'automaton,' which speaks out 'thoughts' which doesn't do anything (doesn't work), which walks but it is unknown where she wants to go and what she wants – she is absolutely inaccessible." Finally, it was telling that the patient herself complained about her own treatment at the hands of the hospital's staff, and the wording of her complaint echoed Jevtić's remarks regarding the patient's similarity to automatons, machines: "She complains that they don't protect her here, but the doctors use her, a living person, as 'some object, material.'"

The conflict between these two interpretations of schizophrenia – the one based on the perception of emptiness and the other on the idea of the binary exteriority/interiority – was pronounced even more strongly in the case of Keti[9], a young housemaid, admitted in January 1941 after having attempted suicide. In Keti's case, the psychiatrists' frustration with the inaccessibility of her psychological processes and motivation was expressed most clearly, as Dr. Jevtić was repeatedly unable to convince the patient to explain her suicide attempt in any detail. As she wrote at the end of the first meeting, "as the examination, i.e. penetration into her psychic state is impossible, it will be stopped for now and postponed until and if it is possible to discover her internal developments in any direct way." Jevtic commented that the patient was in a "state of suffusion of thoughts and freezing in everything." The patient's visual and acoustic hallucinations also reassured the psychiatrists in their belief that there was indeed a complex internal psychological process at work, but one that was not yet outwardly obvious due to Keti's "freezing in negativism." At the same time, almost all words and syntagms which referred to Keti's psychological activities were regularly placed in quotation marks: "She sits with her head down, *'thoughtful*,' plucking with her fingers (senseless and stereotypical actions);" "At the end of the last month for a few days she was in a particularly '*good mood*;'" "For now, she *'explains'* the *'motive'* of her suicide attempt with a simple 'How do I know;'" "She

[9] AS, G-222, F-110, file 19352-XI-397.

touches her palm, scratches, *'ponders*,' looks around, but remains inside herself." [emphases added] During one later conversation, after Keti reportedly "unfroze" to an extent, the psychiatrist described her behavior as shy, putting that word too in quotation marks. It remained unclear what these meant exactly, but they may have been used to suggest the inauthenticity, or at least a questionable nature, of the patient's thought processes or emotions; this then indicated a degree of doubt on the part of the psychiatrists (Dr Jevtić in this case) regarding whether the patient indeed thought or felt anything, whether she truly engaged in any intellectual or emotional activity, which was certainly in contradiction with the aim outlined at the outset, to "penetrate" her psychological interiority.

This frustration, which almost regularly resulted in a poor and insensitive treatment of patients, in fact stemmed from the inability on the part of the psychiatrists to realize any meaningful contact with them, especially in the heavily organic framework of Yugoslav psychiatry which provided no conceptual or practical tools for facilitating such relationships between mental practitioners and their patients. A female schizophrenic peasant patient's file[10] reported that "only occasionally [did] she raise her head and look expressionlessly at the examiner. …asked if she is crazy, she remains absolutely indifferent, without any expression on her face….empty, obtuse, indifferent, wanders aimlessly around the ward."

The change of paradigm

In October 1942 – rather early, therefore, in the course of the war – a group of prominent psychiatrists from the Belgrade psychiatric hospital completed an elaborate evaluation of the mental condition of Spaso Lakiæ[11], a merchant and restaurant owner from Sopot, Serbia, who had been accused of murdering one of his neighbors in the days immediately following the invasion of Yugoslavia by the Axis forces in 1941. In this evaluation, which confirmed that Lakiæ should not be held accountable for the crime he had committed due to the deleterious long-term effect of his diagnosed illness – schizophrenia, the three psychiatrists formulated a possible shift in the ongoing discussions regarding the nature and origins of schizophrenia most clearly. Although the belief in the necessary constitutional degeneracy as the basis for the development of schizophrenia was maintained and upheld, the authors added that the role of environmental and psychological factors may need to be reappraised in light of the wartime experiences. After stating that, according to the then prevalent paradigm, schizophrenia could not develop solely in relation to some detrimental external events and psychological distress – regardless of the intensity of their emotional

[10] AS, G-222, F-111, file 19779.
[11] AS, G-222, F-111, 19591.

effects – but by necessity implied the existence of latent "schizoid" characteristics, the psychiatrists added noncommittally that "it [was] still uncertain whether the numerous experiences from this war and the horrors related to it would change the medical outlook on the outbreak of mental disturbances of this kind." Throughout the inter-war and wartime years, the Yugoslav psychiatrists emphasized the uncertainty of medical researchers regarding the processes – neurological, endocrynological or psychological – leading to the development of schizophrenia, but even the more psychoanalytically oriented among them always insisted on the primacy of the biological framework, viewing psychological and environmental factors as triggers and activators. Therefore, the statement from this evaluation – weak and undecided as it was – should be seen as rather revolutionary in its own context. For the first time, the psychiatric discussion of schizophrenia was explicitly opened to seriously take into consideration purely psychogenic explanations. The signaling of this new openness occurred in this particular file certainly not by accident, and analysis of the patient's profile can go some way towards understanding the circumstances of the possible shift in the paradigm.

Spaso reportedly committed his crime under what the psychiatrists as well as the justice system at the time defined as profoundly extenuating circumstances (he was initially sentenced to two, then three years of imprisonment, while the court took into account "the circumstances which had a heavy psychological effect on the indictee.") According to the evaluators and court documents, Spaso was mobilized in April 1941, after the German attack, and returned home on April 16, where he found out that his neighbor used the situation of lawlessness and breakdown of the Yugoslav army and state to "plunder state property" from the local train station. Spaso tried to prevent him and asked him to share some of the stolen goods with the local poor, after which the two engaged in a physical conflict and Spaso shot the neighbor dead with his revolver. In addition to the moral overtones – the psychiatrists clearly sided with Spaso's point of view, especially given the government-sponsored public campaign against profiteers and black marketeers of all sorts during the war – the patient's military background played a central role here.

The difficulties that he himself reported were all related to his traumatic experiences from the frontlines; furthermore, just like a number of other patients in the Belgrade hospital, Spaso saw his mental deterioration as a direct result of his wartime distress: "His head illness started ... after one particular fight and heavy bombardments. Ever since he has been feeling a pressure in his head, clutter in his ears, he feels tightening in the head and frequently cannot express what he feels. In addition to that, he often sees before his eyes everything that he lived through [in the war], all very alive and colorful, so that it makes him shiver." Later on, the patient made references to the numerous wounded and dead soldiers whom he had seen on his way home from the front; as a result, even the familiar places and areas seemed

to him "alien and distant," and he also felt some indefinite anxiety. The patient also demonstrated other symptoms that grew to be quite typical for the strained atmosphere of the German occupation: he feared that he had been accused of Communist sympathies and activities, and he occasionally claimed to have heard that his family and house were destroyed. Thus, Spaso's mental deterioration could be placed firmly within the context of the wartime brutalities – in the midst of which he found himself already in April 1914 – and occupation-related dislocations.

The change of approach was particularly noticeable in cases of those patients most directly affected by the war realities, such as members of the armed formations of different sorts. Some of these files also demonstrated how the very definition of "paranoia" as a psychiatric category could be questioned under certain conditions. Its meaning as a pathological disorder may change – or become narrower – to a very significant extent in the circumstances of a brutal and violent regime, in which the possibility of being murdered at any point and for no apparent reason was very real, and the precariousness of one's position offered more than enough rational ground for constant fear for one's own life and for feeling terrified of, quite literally, everybody.

Towards the end of the war, the very structure of the case history changed, and patient files became shorter, more concise, with psychiatric remarks more widely interspersed, and intervals between medical examinations grew longer. At the same time, however, especially in files of soldiers and others directly affected by wartime tumults, patients' pronouncements assumed the central place in narratives, and they were increasingly treated as authentic, truthful representations of their authors' mental condition and experiences – instead of being bracketed off in quotation marks or followed up by psychiatrists' dismissive comments, these narrations of psychological traumas now often constituted the chief interpretive framework for the entire cases, and were considered to be an acceptable reference in the course of establishing a diagnosis.

The psychological traumas recounted in these files were all related to wartime events and dislocations, most frequently deaths of family members, as well as expulsions and violence experienced by refugees. A refugee[12] diagnosed with schizophrenia suffered from what was termed paranoid delusions and various hallucinations; he stated that he lived in conditions of abject poverty, after having been expelled from Croatia: "The Ustasha killed my father, my mother died, one brother POW in Germany, sisters ran away somewhere, their husbands killed by the Ustasha…" The patient reportedly recovered from such a massive trauma rather quickly; after less than a month, he was evaluated as "completely considerate [of his former illness], intellectually intact, without any anomalies in mood," and released without escort

[12] AS, G-222, F-111, 20772.

as "fully recovered." Another refugee[13] from Croatia, a male peasant diagnosed with schizophrenia as well, fell ill "towards the end of the occupation," after having escaped the Ustasha terror and lived for four years in "poor and difficult circumstances," surviving aerial bombardments, constant gunfire and various other military actions. He too was deemed fully recovered at the end of his stay in the hospital. A partisan fighter[14], diagnosed with schizophrenia, described the almost unbearable living conditions that he endured ever since he had joined the resistance movement in 1941: asked if he was sad, he said that he used to be, because "there was no bread, we were completely run down, we were hungry and thirsty." Furthermore, the patient's family was obliterated in the course of the war, which he mentioned in the form of denial of his own pain over these losses: "who died, died, who survived – survived, I won't go around mourning for my mother and sister." Nevertheless, he reported hearing voices which spoke about those who had died. Although the psychiatrists noted down his difficult mental state and inability to maintain functional communication with those surrounding him, they did not discuss or mention any possible sources of his illness other than the psychological strains expressed in the patient's responses. Even in those cases in which the patient had a prior history of commitment to a mental hospital, the existence of a serious external, war-related traumatic event was at times deemed more significant for the development of the illness, especially towards the end of the war. Such illnesses then were interpreted almost solely in the light of their traumatic wartime experiences.

As the structure of the file changed, some novel practices were introduced as well. One of the most remarkable new practices was the lab-interview, a one-on-one dialogue between the psychiatrist and the patient, with open-ended questions and free-flowing conversations, in which patients' voice was allowed to stand out. According to Petter Aaslestad, lab-investigations, which appeared in West European psychiatric hospitals in the course of the 1920s but petered out by the late 1930s, were "perhaps the most unique, single feature of the genre throughout the 100-year period [1890-1990]."[15] Lab investigations were noteworthy because they presented the most systematic effort thus far to try to engage patients in a meaningful conversation and report their pronouncements as authentically and accurately as possible. In these stenographically recorded interviews, the dialogue seemed to be the goal in itself: there usually was not a pre-set direction in which the psychiatrist wanted to steer the conversation, and the questions posed to the patient were open-ended. Its purpose was to make the patient as visible as possible, and to temporarily surrender to him/her the control over the dialogue and its direction. In that sense, the psychiatrist's questions

[13] AS, G-222, F-111, 20774.

[14] AS, G-222, F-111, 20747.

[15] Aaslestad, Petter, *The Patient as Text: The Role of the Narrator in Psychiatric Notes, 1890-1990,* Abingdon: Radcliffe Medical Publishing 2010, p. 92.

were frequently not reported at all, or were put in parentheses, while the patient's speech assumed the central place. By default then, the core of lab-investigations consisted of direct speech, patients' statements recorded as authentically as possible and usually in quotation marks, at length and in great detail, in keeping with the idea that the patient should be allowed free reign in the dialogue.

Lab investigations could be seen as a highly progressive genre experiment: they implied an unprecedented degree of equality – and solidarity – between the interviewer and the interviewee, an "intellectual concordance" in Aaslestad's phrase, necessary for this kind of conversation to occur between two participants of such different statures and power levels. In other words, the usual hierarchical relationship needed by default to be sidelined if not entirely suspended for the duration of lab interviews. This potentially signified an improved position of the patient within the hospital hierarchy. If the lab investigations had the purpose of allowing the patients to freely express their viewpoints, delusions and ideas, then they certainly expressed a new spirit in the relationship between the psychiatrists and their patients, a new type of connection in which the patients' pronouncements and voices were important and relevant in themselves, and the hospital was clearly interested in listening to and recording them. Even more fascinating was the seemingly absolute dominance of the patient's voice, and the psychiatrists' willingness to allow the patient to dictate themes and take the conversation in various directions.

In the context of Yugoslav psychiatry, lab interviews only appeared in the Belgrade hospital and significantly later than in Western Europe – in 1945. The only psychiatrist who practiced lab investigations with her patients was Nadezda Jevtic, although even she quickly gave up the technique. As we saw, Jevtic's comments in her schizophrenic patients' files frequently reflected her growing frustration at the inability to establish meaningful communication with such inmates; she, furthermore, frequently played with the idea that schizophrenia merely paralyzed the patients mentally and made it difficult (or impossible) for them to express their brewing internal universe. It was thus logical that Jevtiæ would be the one to take up the technique of lab interviews; her timing was also hardly accidental, as by 1944 and 1945 the concept of schizophrenia as a biologically predetermined, hereditary disease with a highly degenerative effect on one's intellectual powers was already undermined by the profound effect of war-related environmental factors and stresses on the mental health of patients. In their original application in the 1920s, lab investigations signified a rethinking of the nature of *dementia praecox,* and the emergence of the idea that schizophrenic patients were capable of engaging in complex thought processes and intellectual activity despite their illness. In that sense, the end of the war was the most appropriate time for such an experiment in psychiatrist-patient communication to enter the Belgrade hospital as a signal of yet another round of similar rethinking. However, in Jevtiæ's case, the interviews did not seem to yield many notable results. Quite to

the contrary, they apparently confirmed Jevtiæ's doubts and further discouraged her from attempting a more humane form of communication with her patients.

The Belgrade hospital lab investigations were not quite as open-ended and freely structured as the ones described by Aaselstad in the psychiatric files of the Gaustad Psychiatric Hospital in Norway. Jevtic usually divided her interviews in several sections, such as "General data," "Orientation to place, time and persons," "General education" and "Illness." The investigations always ended with Jevtić's extensive commentary entitled "resume." Therefore, Jevtić chose to organize these conversations much more tightly than the genre required, and thereby perhaps lost some of the most important features of the exercise: in some sense, her lab investigations did not differ much from the usual questioning of patients upon admission – the section on general data asked about personal and professional biographies, "general education" tested her patients' school and experiential knowledge in a conventional way, and so did her questions regarding orientation. However, the tone of the conversation signaled that this was not an entirely conventional form of interviewing: although Jevtic most frequently relied on pre-set, schematic questions, her investigations were unique because of her willingness to follow the lead of the patients, to explore their answers in detail and at times to accept to discuss at length even those topics raised by the patients which had nothing to do with her original questions. To an extent then, in spite of their rigid structure, the interviews managed to fulfill their original purpose of creating an environment of respect and even intimacy, which in itself was a remarkable achievement given the general context of the hospital.

In some of the most instructive files, Jevtić undertook to explore her patients' delusions and hallucinations, or their interpretations of their own illness, trying to get at the roots of these complexes of ideas. This was quite progressive indeed, and implied the psychiatrist's interest in the minutiae and logical structure of the patients' internal lives; it furthermore signaled Jevtić's patience to seriously engage the "crazy ideas" proposed by her interlocutors in the investigations. At times, there were moments of solidarity between the two, when Jevtić took up the patient's interests and argued from the patient's viewpoint: "Then she talks about how she worked for some old woman for forty (?) per month (Well, that's so little!) She admits that it is, but that was three or four years ago. That woman was alone and couldn't pay her more."[16] In the same file, Jevtić made an effort to fully enter the world of the patient's delusions, asking questions as if she accepted the truthfulness of the patient's pronouncements: "Following her husband's death, as soon as she would dose off, something would grab her hand, but when she wakes up, there is nobody there (Who could that be?) I guess my husband." In this last example, although there are no quotation marks, the patient's words were reported in first-person singular, allowing her a degree of subjectivity and agency.

[16] AS, G-222, F-116, file 20104.

Frequently, Jevtić's inquiries were replaced with a question mark in parentheses, which indicated that she encouraged the patient to continue talking about the topic at hand, sometimes even when that topic did not relate to the original question asked or when the patient's statements seemed to follow no logical order and were incoherent. In a conversation with a woman who claimed that she suffered from "weak nerves" and that people looked at her "strangely," Jevtić insisted that the patient elaborate on her ideas regarding the core of her illness: "/What do you mean people looked at you strangely?/ It's been two years already that they do. /?/ They come, I sit at home working, and they tell me: that the partisans are advancing and then they don't leave, but they stand there and stare at me. It looks strange to me. And so I go out of the house to the gate, but the gates are open, and people are passing by and staring at me. It really looks strange to me, like pictures, and I wonder how it was possible that all of it used to be quite common, ordinary to me before. Then I decide to stay at home."[17] Here, the psychiatrist directly instigated the patient to share all the details of her experiences, feelings and impressions that were likely directly related to the onset of her illness, or were particularly illustrative expressions of the deterioration of her mental health. Furthermore, the patient's lengthy explanation was reported in full, without any shortenings or summaries, and as authentically as possible, in first-person singular (although with no quotation marks). What made this section of the conversation truly remarkable – and different – was Jevtić's interest in what the patient had to say, her choice to forgo editing a further proof that the patient's voice was heeded here.

Some of the most remarkable passages from lab investigations were those in which Jevtić let her questions remain unanswered or barely noticed, and instead accepted to follow the patient in whichever direction she decided to take the conversation, even when the patient spoke incoherently. In those cases, it was clear that Jevtić listened carefully and was engaged in the patient's often illogical or delusional train of thoughts, asking new questions to further the theme started by the patient and effectively surrendering control. In files like that, patients' stories emerged most poignantly and convincingly, and Jevtić managed to obtain certain very relevant information, which many patients sometimes found difficult to share. But the most important feature of such interviews was that Jevtić allowed her patients to convey and highlight those messages which they thought were central. In the case of a woman[18] who had lost her son in the course of the war, Jevtić seemed to realize early on that her questions would not always get the replies she was hoping for, and she was willing to give up on some of them. After she asked her patient about her occupation, the latter replied "gardening" but then continued talking on an unrelated subject: "he brought me over due to a nervous disease. But they gave me no medication. One night I slept

[17] AS, G-222, F-129, file 20897.
[18] AS, G-222, F-129, file 20871.

at my sister's. But Miroslav came, God forbid, and saw some saints." Jevtić chose to cooperate: "/?/ There, he says, are the saints. St. Nicholas and St. George." Instead of concluding, as was the custom in the Belgrade hospital, that "no sense was to be had from her," Jevtić noted these statements carefully. This patient was rather confused and disoriented when she was admitted, and she was reportedly not capable of giving almost any reliable information about herself and her history. Jevtić's patience in the course of the lab investigations and her willingness to listen the patient's constant digressions from the questions asked finally bore fruit, and it became clear that the patient's son Miroslav had died – a crucial piece of information for interpreting her state of mind, her mental paralysis and sorrowful disposition.

Asked if she was in a hospital, the patient began talking about Miroslav; Jevtić allowed this change of subject, prompted her with appropriate questions and found out about the circumstances of his death: "Finally we find out that her son was 22 when he died. She describes where he had glands. Allegedly he was also a partisan." More of the patient's history was discovered in the same way. When testing her general education knowledge, Jevtić asked the patient about Tito: "I only saw him on pictures." But then she continued in a different direction: "I was still working at the cemetery back then. We brought him on a cart. /Whom?/Miroslav, from the hospital. He died at home. Afterwards, one Saturday, one young girl tells me to come to their house to pray. I prefer the church. Then when there was no oil, what else was I supposed to do. Miroslav had been at the Juveniles' Home for three years, he fell ill there, started vomiting blood." At this point, Jevtić chose to interrupt the patient's free stream of thoughts which seemed to lack any solid internal logic, and asked about Stalin and Churchill. However, the patient apparently preferred to continue her story of Miroslav's death, her communication with him after his passing, the young girl who prayed in her own house on Saturdays, and Jevtić followed: "I didn't go. I pray at home, I don't need to do it under the skies. She says that one can see dead children. I saw once in my dream. And then she retells a dream in which her son told her not to cry over not going to his grave because he knows that she is weak, and he also consoled her that he wasn't hungry. I saw St George when he came with children." At this point, the engaged Jevtić again prompted the patient to elaborate further, despite the hallucinatory nature of the patient's statements: "This way it was found out that her other to children passed away as well. The youngest one was seven months. Allegedly she tripped over and the child fell and then died. The second child: a girl of thirteen died of pneumonia. This was 'many years ago,' she died during the Austrian war. She was born and died then. I don't know if she was two or three years old at the time. I have my book." At a hospital in which no psychotherapy was practiced until well after the war (and in which one psychiatrist defined psychotherapy simply as "consolation"), patients like this one could only be engaged in an exercise of this sort; labs were the only way to gain any information

regarding the patient's background, personal history and sources of illness. In that sense, Jevtić's achievement is truly significant: she managed to start and maintain a rather fruitful and meaningful communication with a patient who had thus far been consistently unresponsive throughout her stay at the observation ward and the Belgrade hospital. The lab interview had a deeply humanizing effect, and it created an intimate and supportive space in which the patient apparently overcame some of her barriers.

Lab interviews were thus important because they translated incoherent and disjointed statements into meaningful narratives, and could potentially increase the understanding and create feelings of human solidarity between patients and psychiatrists. However, in the final analysis the interviews conducted by Jevtićc did not significantly affect her pessimistic theory of mental illness (and schizophrenia in particular) as highly degenerative and paralyzing. In fact, her lab investigations apparently had the effect of confirming to her that communication with schizophrenic patients could only be rudimentary and restricted, and that a true human bond was impossible to achieve through such a therapeutic experience.

Even in the file discussed in the previous paragraph – in which there was some palpable progress, Jevtićc wrote the resume of the interview in highly pessimistic, gloomy terms, describing the patient's problems and personality as static, hopeless, timeless and therefore highly unlikely ever to change; they were marked by irreversible degeneration: "Intellectually incoherent /in her incoherence, she talks guided by some sorrow for her own personality… A flood of thoughts, but thoughts guide her instead of vice versa. Her judgment is completely damaged… Certain notions are completely excluded from her intellectual life…" Jevtić added that the patient lived under the effects of "organic depression," and experienced mental changes such as "moral depravation and destruction of the character" as a result of her illness, and concluded that the patient "leaves the impression of negativism for everything outside her personality. Damaged logical thinking, reduced to involuntary thoughts, she is an automaton affectively unattached to her children and home." In a way, then, lab dialogues served to prove the impossibility and futility of dialogue (or psychotherapy) as such, and this is exactly how Jevtić sometimes used sections of her lab investigations: as illustrations of her doubtful and negative remarks. When describing the patient's "damaged judgment," Jevtić added in parentheses: "/Her dead son walks around the neighborhood./", and when discussing the effects of the "organic depression," Jevtić supported her diagnosis with yet another summary of the patient's statements: "/dead son visits and walks in the neighborhood. son saw various saints etc./"

When utilized in this way, lab investigations acquired something of the quality of public performances of mental illness (especially hysteria) by patients, practiced in Europe in the nineteenth and early twentieth centuries. In Jevtić's resumes, patients' statements served to demonstrate to the outside readership the nature, character and

expressions of schizophrenia, rather than to enhance the psychiatrist's understanding of mental illness. The entire interview was thus redefined in these concluding sentences, so that it was primarily directed towards the external audience, meant to win the readership over to the psychiatrist's side, to prove her views right, and publicly show the impossibility of communication and the difficulty of situations with which she was dealing.

Other resumes were structured in a similar way, and none of Jevtić's lab investigations ended on a positive note. In another similar instance, Jevtić described a woman[19] as "completely autistic," and supported her claim with one of the patient's own utterances from the investigation: "/I felt I was sealed off from other people, but that was temporary…/"

Jevtiæ established control and made her voice predominant in a number of different ways throughout the investigations: through initial comments about the patient's state of mind which inevitably set the tone for the entire conversation and usually foretold the nature of the subsequent dialogue; and through her own comments and notes injected in the middle of the text, which usually referred to the patient's behavior and manner of speaking (these frequently discredited the patient's statements and ability to communicate meaningfully, pointing out, for example, that the patient was "completely lost in relating details, a logical connection barely exists. Her deliberations are the expression of the autistic."). On one occasion[20], Jevtiæ described the patient's entrance in a way which suggested the probable uselessness of the entire communication attempt before the dialogue even started: "She sits on the chair offered to her and stops fixating on her environment, looks in the 'distance,' her eyes get a completely glassy look, and in addition to all that she whispers and as if she completely forgot about herself and her environment." Predictably, then, the investigation ended with Jevtiæ's remark that "her illness is of an earlier date, no prospects for improvement, except for remissions which would only present stagnations in the course of the development of the illness." In yet another case history, communication was proclaimed an almost unmanageable and purposeless venture at the very outset: "[The patient] barely understands where she is supposed to sit. She is willing to answer questions but is actually uninterested."[21]

In her reporting of the patients' words, Jevtić resorted to multiple techniques, usually moving in one and the same file between summaries, indirect speech, pseudo-direct speech and direct speech (in first-person singular – but quite remarkably, without quotation marks). By combining these different forms, Jevtic again undermined one of the most salient features of lab investigations – the authenticity and accuracy of the patients' voice. Her choice not to use quotation marks even when giving her patients'

[19] AS, G-222, F-129, file 20897.
[20] AS, G-222, F-116, file 20104.
[21] AS, G-222, F-129, file 20838.

statements in direct speech proper, in first-person singular, created a unique situation in which it was impossible to visually distinguish between Jevtić's and the patient's voices, between her "I" and that of her patients. But quotation marks Jevtić reserved for citing those words which her patients pronounced incorrectly, thereby emphasizing their class background, linguistic incompetence and educational deficiencies, their status as laywomen in medicine. Moreover, Jevtić used quotation marks in her own comments when she referred to her patients' intellectual activities and emotional states: "At last she 'thinks' that she didn't clean here. Also she 'thinks' that this is not a hospital. But she 'thinks' that she has been here for a week already."[22] In another patient's case history, Jevtić remarked that the patient was "'melting away' in her sadness and tearless crying. She is all psychologically paralyzed in some sort of 'sorrow.'"[23] In both of these cases, quotation marks were used to express the psychiatrist's doubt regarding the authenticity of the patients' processes of thinking and feeling. Jevtić's suspicions were an integral part of the contemporary psychiatric discussion, whose active participant she was, about whether schizophrenic patients engaged in any genuine intellectual and emotional activity, whether they concealed a potentially rich intellectual life and sphere of affection beneath seemingly impenetrable layers of mental paralysis and disease. By placing those verbs in quotation marks, Jevtić suggested that she did not believe in her patients' capability to truly think or experience sadness (she even emphasized that the patient cried with no tears). Instead, she saw the patients' reactions as a pose, a theatrical gesture devoid of deeper meaning and content – artificial, inauthentic behavior – caused by the illness's degenerative effect on their intellectual and emotional capacities. Jevtic's attitude towards her patients' thought processes and feelings thus again worked to partly invalidate the lab investigations, whose main purpose was precisely to attempt to explore schizophrenic patients' internal worlds.

Ultimately, thus, in lab investigations the two voices were in theory equal, but they were at the same time distinguished from each other more clearly and rigidly than in any other form of psychiatric interaction with patients; there was no possibility for any mixing of the two linguistic zones, the very structure of this technique prevented it. For this reason, therefore, lab investigations could achieve ambiguous results, increasing the sense of understanding and solidarity in the course of interviews and medical interrogations, but also isolating the patients, making their speech stand out more starkly and bizarrely, and making their viewpoints more difficult to engage with any degree of sympathy and solidarity. In any case, Jevtić's experimentation with narrative and interrogation techniques perhaps indicated her and the hospital's need to attempt to approach their patients in a somewhat different way, and it was by no means accidental that lab interviews, which had already been practiced for several

[22] AS, G-222, F-129, file 20838.
[23] AS, G-222, F-129, file 20871.

decades in West European hospitals, only appeared in Yugoslavia in 1945/1946, when the profession's paradigm was about to undergo a rather revolutionary change as a result of both the war experiences and the vast social transformations in the country. The halting success of Jevtić's lab investigations, on the other hand, proved that this was indeed a transitional stage, one in which the existing assumptions were under interrogation yet still dominant and new theories regarding the nature and prospects of various psychiatric treatments were slowly being developed. It was not until the late 1950s and early 1960s that psychotherapy and the "talking cure" became fully integrated into Yugoslavia's psychiatric practice, after a prolonged period of political as well as professional reforms, negotiations and reconsiderations.

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In 1952, Dr. Nadežda Jevtić presented her schizophrenia-related research at a Novi Sad conference of Yugoslav neuropsychiatries. The title of her address – "Prognostic indicators when treating schizophrenia with ECTs and insulin" – clearly suggested that her focus was now on somatic therapies and rested on the assumption that schizophrenia was a biologically induced disorder with straightforward organic indicators of both recovery and stagnation. Jevtić's wartime emphasis on psychological implications of the illness and her interest in the content of her patients' delusions seemed to wane; she was instead focused on administering medication-based therapies, measuring arterial pressure, spinal fluid pressure and glycemic levels, and observing her patients' sleeping regimens. Still, the tone of her writing changed considerably: although her core therapies were purely somatic, she concluded her talk on a rather optimistic note, saying that "based on these prognostic indicators, it will not be difficult to improve one group of schizophrenic patients and re-integrate them in the economy, and to look for new successful treatment methods for the rest of the patients that would result in their healing." In the end, Jevtić expressed her hope that her research findings would help her colleagues "delve into the essential nature of schizophrenia, which would be a great success and very useful for our medical sciences."[24] In stark contrast with her pre-war and wartime notes in which she regularly referred in great detail to the impossibility of any meaningful communication with or significant improvement of the mental state of schizophrenic patients, Jevtić now spoke of cures, recovery and even complete healing; she also shared her belief that there could be other forms of therapy for schizophrenia besides the somatic treatments with which she experimented; finally, her remark regarding the need for understanding the "essence" of the illness was highly reminiscent of her previous

[24] Jevtić, Nadežda, „Prognostički indikatori pri lecenju shizofrenije elektrošokovima i insulinom", in: *III national meeting of Neuropsychiatries of Yugoslavia*, October 1952, Novi Sad; reprinted in: *Neuropsihijatrija*, 1952, p. 102

professional projects, and it also implied that her biologically based experimentation could and should be complemented with other forms of research in order to get at the core of the disease.

At first glance, the source of Jevtić's sudden optimism was not entirely clear. None of the therapies she was describing was particularly novel – they all existed and were regularly practiced since the 1930s – nor were their results, reported in Jevtić's talk, revolutionary by any stretch of the imagination. Still, she read them in a different way, suggesting that they indicated a possibility of recovery and re-integration and that they were a first step – rather than schizophrenic patients' last chance – on a long road of further research and therapeutical experimentation. But a very different psychiatric discourse was now emerging in postwar socialist Yugoslavia – one in which new paradigms could help the profession resolve some of its long-time frustrations and re-assert its mission in more convincing terms. In the context of that discourse, new opportunities and perspectives were offering themselves, and psychiatrists could now avail themselves of a chance to re-found their discipline on more respectable, socially engaged and outwardly successful grounds.

In 1949, Dr. Stjepan Betlheim argued that neurotic behavior might simply result from a "superficial psychogenic reaction, of an otherwise balanced person, to certain difficult conflicts." Betlheim in fact summarized what Yugoslav psychiatry had learnt in the war: that a psychogenic reaction to a "sudden grave trauma" could be considered normal; he, furthermore, described his observation of a young woman who grew stuporous and then depressed after having witnessed her mother's murder, but concluded that this was hardly a proof of the patient's pathological constitution, whose reactions were indeed "understandable" (given the severity of the original trauma), as well as temporary.[25]

This rejection of the view that heredity was the sole factor in the etiology of mental illness became one of the corner stones of Yugoslavia's new Marxist psychiatry.[26] In a 1949 programmatic article, the head of the Vrapèe psychiatric hospital Dr. Dezider Julius outlined some fundamental characteristics and duties of the profession in the new circumstances, and emphasized the harmful effects of the earlier "biologizing tendencies," which were both ideologically reactionary and also the reason for the pre-war psychiatry's general methodological and epistemological crisis: "We need to finally relinquish that bourgeois belief in definitively pre-constituted personalities, in an inevitable, fateful role of heredity. This perspective ignores completely important

[25] Betlheim, Ruth; Lerotić, Gordana, *Stjepan Betlhaim: Radovi, pisma, dokumenti, 1898-1970*, Zagreb 2006, p. 103

[26] The broader ideological implications of the Communist takeover for the status of psychiatry – and acceptance of psychoanalysis – in Yugoslavia are to be discussed in greater detail in the final chapter of my dissertation, *Psychiatry at war: Psychiatric culture and political ideology in Yugoslavia under the Nazi occupation*, defended at Columbia University in May 2012

effects of societal factors, and leads in the final analysis to educational nihilism and desperation. This point of view also perfectly explains the deep crisis of Western pedagogy, psychology, psychopathology and the mental hygiene movement."[27] For Julius, the ideological tenets of socialism required a radically reformed psychiatry, one in which the socio-economic conditions of human upbringing, education and personal growth were accorded their due significance instead of being sidelined in favor of purely organic considerations. As Julius noted, Marxist societies were in the business of developing a new socialist consciousness in all their citizens, and this educational task could not be accomplished without psychiatrists' careful attention to the multitude of ways in which social and historical – i.e. environmental – developments altered the human psyche and conditioned people's awareness. In other words, Julius recognized that in the postwar period as well, the fundamental character of the psychiatric profession's mission had not changed: the profession's role in molding the minds of the nation, helping the new revolutionary government to raise and nurture a new form of social consciousness and national mentality remained psychiatry's central arguments for its own social significance; the ideological content of the new nationwide mental reform was now socialist, but the purpose of psychiatrists' engagement with the society at large stayed largely the same. However, Julius's article was notable because it announced that socialist psychiatry would be much more successful in its educational role than its "bourgeois" predecessor was, precisely because it would now shed the burden of extreme biological psychiatry and come to rest on a broad set of psycho-dynamic, sociological and cultural assumptions.

[27] Julius, Dezider, „Pitanja socijalne psihopatologije", in: *Narodno zdravlje*, 6, 1949, p. 5

Резиме

Др Ана Антић

Менталне болести за време окупације.
Психијатријске ревизије „нормалности“ и „патологије“ 1941-1945.

Чланак истражује ефекте Другог светског рата на развој психијатријске теорије и праксе у Србији и Југославији. Полази од тезе да су друштвено-политички контекст и масовно насиље над цивилним становништвом у току рата и окупације имали одсудан значај за ре-дефинисање постојећих псиихјатријских категорија и за развој нових дијагноза. Такође, да су спољни, немедицински фактори генерално врло битни за развој психијатријског и медицинског знања. У чланку се анализирају промене у структури и садржају психијатријских историја болести из болнице „Лаза Лазаревић“ у Београду од 1941. до 1945, и прате стручне дискусије објављене у психијатријским публикацијама у то време. У току рата и под утицајем ратних дешавања дошло је до потпуне промене психијатријске парадигме: док је међуратна југословенска психијатрија била претежно биолошка, са соматским терапијама менталних обољења и без великог утицаја психотерапије или психоанализе, у току рата све већа пажња обраћа се на значај психолошке трауме и психолошких фактора у развоју психијатријских обољења, а психијатрија постепено постаје све више психодинамички оријентисана. Управо у време када је немачка психијатрија била све интензивније нацификована, југословенска психијатрија под немачком окупацијом пролази кроз период извесне либерализације, у коме болнички психијатри, суочени са бројним новим облицима менталних обољења, почињу да преиспитују своје ставове о нужно органским и наследним узроцима психичких болести, и предлажу да чак и најтеже форме психоза могу бити изазване трауматским доживљајима и лечене не-соматским методама. Анализа историја болести, које садрже разговоре са пацијентима (већином сељачког или радничког порекла), њихова писма, приповетке, песме и друге уметничке радове, такође пружа увид у њихов доживљај и разумевање рата, насиља, идеолошких сукоба, и омогућава писање друштвене историје рата (history from below).