

Dorothea S. Buck-Zerchin

Seventy Years of Coercion in Psychiatric Institutions, Experienced and Witnessed¹

My name is Dorothea Buck, I am 90 years old, and a so-called historical witness. The theme of my presentation is: “Seventy Years of Coercion in the German Psychiatric System, Experienced and Witnessed.” I will start with the forced treatment and forced sterilization that was inflicted upon me 71 years ago. In 1966, Alexander Mitscherlich wrote in his book *Krankheit als Konflikt – Studien zur psychosomatischen Medizin I (Illness as a Conflict: Studies on Psychosomatic Medicine, Vol. I)* in the chapter entitled “On the Complexity of Social Influences on the Origin and Treatment of Psychoses and Neuroses” about the treatment measures: “From the days of the primitive cultures, up to present times there have always been methods of torment. On closer examination, a terrible arsenal of tortures in themselves...”

This applies also to the present-day practices of restraints and forced medication, which continue despite the fact that much more effective and helpful treatments for schizophrenia, such as Soteria and Professor Yrjö Alanen’s Need-adapted Treatment in Finland, have proven their worth for decades.

In 1936, 71 years ago, at the age of just 19, I went through the most inhumane experience of my life in a psychiatric institution. Even the experience of being buried alive during the 2nd World War was not as traumatic for me. I experienced the psychiatric system as being inhumane because nobody actually spoke with us. A person cannot be more devalued than to be considered unworthy or incapable of conversation. What made it even worse was the fact

1 Key-note speech from June 7, 2007, at the congress on “Coercive Treatment in Psychiatry: A Comprehensive Review,” run by the World Psychiatric Association in Dresden, Germany, June 6-8, 2007 (corrections by the author, translation corrections by Peter Stastny)

that this happened at the *von Bodelschwingsche Asylum Bethel* in Bielefeld, which considered itself a “Christian” institution. Bethel and its director, Pastor Fritz von Bodelschwingh, were held in high esteem and considered an embodiment of compassion in the parsonage, which was my parent’s home, and by us children as well. But I got to experience a totally different Bethel, compared to the one I had heard about from the newsletter *Bote von Bethel* (*Messenger from Bethel*).

On the light green wall opposite my bed one could read in large letters the words of Jesus: “Come unto me all you who are weary and tired and I will give you rest.” How were we to be given rest? Rest was given with buckets of cold water poured over our heads, with lengthy baths in a tub covered with canvas that bore a stiff high collar in which my neck was fixed for 23 hours, from one doctor’s rounds to the next. Rest was given with wet packs and with sedating injections of paraldehyde. A wet pack meant to be bound into cold, wet sheets so tightly that one could no longer move at all. From our body temperature, the sheets would become first warm and then hot. I would cry out in rage at this senseless restraint in these hot sheets. I just couldn’t believe that the natural way of helping in the form of conversation and occupation was being replaced by these torturous “sedative measures.” It was only natural that we got restless without occupation and diversion, without a single conversation, not even as part of the admission procedure, and from staying in bed all the time, despite being in good physical health. How were we to recognise this senseless kind of behaviour on the part of the doctors and nurses as “helpful” for us?

These methods of Emil Kraepelin, who had lived from 1856 till 1926, influenced our German psychiatry. The medical director of our *Hospital for Nervous and Mood Diseases* in Bethel, as it was then called, was one of his last students. Emil Kraepelin replaced the conversations that his predecessors, such as Wilhelm Griesinger, (1817-1868) and Carl Wilhelm Ideler (1795-1860), had kept going with their patients, with the silent observation of symptoms, the hallmark of clinical phenomenology or “nosological” psychiatry. As a result he was no longer capable of recognising his patients as fellow human beings, because that is only possible by speaking with them. The symptoms they observed took the place of the human being with his or

her experiences. Kraepelin demanded "... a ruthless intervention against hereditary degeneracy, the elimination of the psychopathic degenerate, including the use of sterilization."

Thus the director of Bethel, Pastor Fritz von Bodelschwing, demanded the sterilization two years ahead of the National Socialist Regime at the "Protestant Specialist Conference on Eugenics" held from May 18 to 20, 1931, in Treysa. He explained his position by saying that

... the destruction of the Kingdom of God in any one of its members justifies the possibility or the responsibility for its eradication to take place. Therefore I would be concerned if sterilizations were only accepted as a response to an emergency. I would prefer to see these procedures as a responsibility that conforms to the will of Christ (From the conference minutes).

A truly monstrous "Kingdom of God" that granted us only a hopeless and idle custodial existence without the right to any communication, sanctioned by the words of the Bible.

On the other hand, Dr. Carl Schneider, the medical director of Bethel from 1930 to 1933, was opposed to the sterilization law:

He considers it an error to assume that what is biologically valuable is also mentally valuable. For example, in patients with manic-depressive disorders "such a high level of social competence tends to be inherited," that it is impossible "to sterilize for purely medical reasons." Schneider's conclusion: "We know nothing about this issue, we are just drawing conclusions from experiments with animals and plants" (From the conference minutes).

Two years before the Nazis came to power, Protestant physicians and clergymen were calling for sterilization: "Those who are hereditary carriers of social(!) inferiority and need care should be prevented from procreating if possible" (From the conference minutes).

When I asked the charge nurse about the scars that my young female fellow-patients had in the middle of their lower abdomens, she explained that these were "appendectomy scars." Did they lie to us at home when they said that the appendix is located on the right side? Concealment of the fact that the operation I had been subjected to was in fact a sterilization seemed to be common practice here, even though the genetic-health law of 1933 required that

those sterilized had to be informed by the physicians about the nature of the procedure.

Even after the operation, it was not a doctor or a nurse who told me what had been done to me, but a fellow female patient. I was distraught, because people who had been forcibly sterilized were not allowed to pursue a higher education nor could they marry a non-sterilized partner. I had to abandon my chosen profession as a kindergarten teacher for which I had prepared myself such a long time. Not to mention the lifelong stigmatization as being “inferior.”

In the January 2007 edition of the *Deutsche Ärzteblatt* (a German medical journal), one finds an article about the absence of compensation for us “inferior individuals” up to the present day, which quoted a statement by Professor Werner Villinger, Bethel’s medical director from the year 1934 on, made before a German Parliamentary Committee for Restitution on April 13, 1961:

... [Dr. Villinger] claimed that by paying compensation to people sterilized under coercion they would be damaged once again: “The question arises whether this might lead to the appearance of neurotic complaints and illnesses, which would not only diminish their previous subjective wellbeing and...their capacity to be happy, but also their productive capacity?”

On the 21st of January, 1965, Pastor Fritz von Bodelschwingh’s nephew and successor, Pastor Friedrich von Bodelschwingh, argued as an expert before the Committee for Restitution in a similar manner, totally ignorant of our reality: “If one were to grant the sterilized people a right to compensation, this would cause them only unrest and considerable new suffering...”

Bethel kept on sterilizing patients long after 1945. Last year, in 2006, I received a call from someone telling me that Bethel had pressured her to be sterilized even in the 1970s. If only theologians and psychiatrists would doubt their own worth for our sake!

When some 60 asylum directors and psychiatry professors were informed for the first time about SS-Führer Viktor Brack’s “euthanasia” program in Adolf Hitler’s Berlin Chancellery in July 1939, all of them declared their willingness to cooperate in the killing of asylum patients, with the exception of Professor Gottfried Ewald from Göttingen. He explained his disapproval in detail. One single person sound in mind and soul amongst 60 professors of

psychiatry and clinic directors! Where was their conscience, their courage and their compassion, the values that account for people becoming fellow human beings?

In Berlin, at Tiergartenstreet 4, regular and senior experts pronounced death sentences simply on the basis of questionnaires that had been filled out in the asylums. In six psychiatric killing centers, those who had been sentenced to death were gassed. When Hitler responded to the protest sermon of the Catholic Bishop Clemens August von Galen in Münster on August 3rd, 1941 by ordering a stop to the gassing on the 24th of August, 1941, the asylums took over and continued the killing by medication overdoses and starvation diets. According to the latest research results submitted by the historian Professor Hans-Walter Schmuhl nearly 300,000 asylum and nursing care home patients were gassed, poisoned and starved to death. 80,000 of these came from Polish, French and Soviet institutions. Considering that our politicians, psychiatrists and theologians have since nearly completely repressed this most drastic kind of compulsory treatment in the form of killing people whose lives were considered “devoid of value,” it is mostly left up to us users and survivors of psychiatry to preserve the memory of those murdered in the name of psychiatry in our hearts.

After 1943, psychiatrists, who had turned out to be adversaries of their patients and in the period from 1939 to 1945 had proven themselves to be—in the literal sense of the term—their “mortal enemies,” continued to convey to their students and to the public nothing other than an image of deficiency regarding their patients who had been classified as “incurable.” Even on the 20th of April 1979—40 years after the beginning of the “euthanasia” program in 1939—the weekly paper *Die Zeit* ran the following headline on the front page, “A Society of Cold Hearts—In the Snake Pits of the German Psychiatric System.” The article states that “... no minority is treated as disgracefully as the mentally ill.”

The decades of backwardness of this kind of psychiatry have not been overcome despite considerable efforts in recent years. It remains devoid of conversation and uses medication even under coercion and restraint just to fight the symptoms, rather than aim for understanding.

Soteria and Professor Yrjö Alanen's Need-adapted Treatment in Finland have focused on the experiences and needs of patients for over 30 years by taking them seriously and giving immediate psychotherapy for those diagnosed with "schizophrenia" absolute priority over anti-psychotic medication. In contrast, the German Society for Psychiatry, Psychotherapy and Neurology assigns just 10 out of a total of 140 pages to the topic of psychotherapy in their draft version of *Treatment Guidelines for Schizophrenia*.

Cognitive behavioral therapy is the only form of psychotherapy they approve, but even this therapy they would only recommend when pharmacotherapy has failed. Today's German psychiatric system has fully adopted Emil Kraepelin's concept of a hereditary or genetically caused brain disease which is by definition devoid of meaning, just calling it a disorder of the brain metabolism instead.

Antipsychotic medication has existed since 1953. Since then, its immediate application has been the method of choice. A patient who is overwhelmed by his psychosis certainly wants to have his experiences taken seriously and wants to understand them. The immediate sedation with strong anti-psychotic medication cannot be taken as well-intentioned help from the patient's point of view. He or she will resist. To make the patients compliant with the medication, they will often be strapped to the bed by the waist and all four extremities restrained. At the first psychiatric world-congress in Germany after the 2nd World War, held in 1994 in Hamburg, jointly organized by Dr. Thomas Bock and our Federal Organization of (ex-)Users and Survivors of Psychiatry, the Federal Association of Relatives of the Mentally Ill, and the German Society for Social Psychiatry, the artist Jutta Jentges exhibited a large expressive painting of a person with arms and legs spread-eagled and tied to the bed with the question "Why?" She expresses the torment of being restrained even through the night. The restrained person has been furnished with a diaper, another kind of humiliating debasement. For many people who have had the agonizing experience of being restrained, it sometimes remains a life-long trauma.

During my five stays in psychiatric institutions between 1936 and 1959, this tormenting method of tying patients to bed by their hands, feet and waist, did not exist yet, and body-belts were used only rarely. Up to my 4th episode

in 1946, it was common practice to wait a few weeks to see if the psychosis would recede on its own accord, before Metrazol (Cardiazol), insulin, or electroshock were applied. In 1936, these shock treatments were not yet available either. During my last psychotic episode in 1959, I experienced for the first time, along with all of the others on the ward, an immediate injection of high dosages of anti-psychotic drugs. I considered this to be a total dictatorship which prevented us from thinking and feeling and also caused extreme physical weakness; it was deeply repulsive. I was lucky to develop a skin rash after the first two days (of injections); when pills were shoved into my mouth instead, I was able to hide them under my tongue and dump them in the toilet. Nonetheless, it took me the same amount of time as my fellow patients to be rid of the psychosis. Today, liquids are used instead of pills, to prevent behavior like mine.

In contrast, how much more helpful, respectful and competent is the *Krisenspendion* (Crisis Hostel) in Berlin, staffed in a “trialogue” manner by psychiatric survivors, family members/relatives, professionals and lay people, who work without using any kind of coercion. Here a person experiencing psychosis is taken seriously instead of being dismissed and reduced to a disturbed brain metabolism. Many people are looking for a way to understand themselves and their psychotic experiences. Whoever wants to understand their psychosis or did find a way to understand it, as I did, after five episodes at the age of 42 which enabled me to get rid of it 48 years ago, still has to find the necessary insights for this process all by themselves—even today.

For these reasons and as an attack against biological reductionist psychiatry, with its distaste for talking with patients, we started the “Psychosis Seminars” together with Dr. Thomas Bock at the Department of Psychiatry of the Hamburg University Clinic in the winter semester of 1989/90. We conceived them as an opportunity to exchange experiences between users of psychiatry, family members/relatives and professionals and called this a *Trialogue*. In this format, people who have gone through psychoses can talk freely about their deepest experiences, without having to take higher dosages of medication as would be the case in psychiatric institutions. This is way of exchanging experiences that gives equal rights for all and makes it possible to understand each other a lot better. In the 17 years of their existence, the “Psychosis

Seminars” were replicated in Switzerland and Austria, but far too few psychiatrists are taking part in them.

What is a psychosis? The problem of coercion and violence largely depends on this definition. The medical concept of a meaningless, genetically caused disorder of brain metabolism devalues the patient, ignores him as a person along with his experiences and virtually provokes his resistance.

What would happen if, instead of you—the psychiatrists—, we had the power to define psychosis? We would define it as an emergence of something that is normally unconscious, in an attempt to resolve a preceding crisis that we were not able to solve with our conscious capacities. We would also say that this was the reason for the obvious similarities between the well known schizophrenic symptoms and the stuff our night dreams are made of, since they both originate from the same source—our unconscious. For example, the emergence of symbols, thinking and acting in symbolic terms are considered symptoms of schizophrenia. Our dreams are full of symbols. Or the fact that identifications with Jesus and other personalities can often be found in schizophrenic episodes. In our dreams, we also identify ourselves with the people who appear in them, which frequently signify ourselves. And the same is true with the frequent occurrence of “ideas of reference and over-valued ideas” in schizophrenia. These can only be understood within the context of an altered experience of the world in psychosis that reveals otherwise hidden connections. The same applies to dreams. In *An Outline of Psychoanalysis*, Sigmund Freud mentioned, as regards to dreams, “... a remarkable tendency to condense, to create new entities from elements that in our waking hours we would surely have kept separate from each other.”

Consequently, the illness is based on the fact that we consider our psychotic experiences real. If we recognized them as relating to a dream level from the outset, we would not be ill. Therefore, we need to shift the contents of our psychosis to the “dream level,” which would enable us to hold on to the *meaning* of our psychosis without maintaining its objective reality. Our psychoses are often accompanied by emerging impulses and emotions, which also come from our subconscious. I always live by these impulses or by the inner, inaudible voice to prevent these impulses and feelings from getting bottled up. Some people do hear these voices. This definition of schizo-

phrenia is not debasing and invites people to deal with the contents of the psychosis and the preceding crisis, in order to understand oneself better and know how to handle oneself.

We experience and regard the emergence from the unconscious as “insertions” coming from outside ourselves. Therefore the British psychiatrist John K. Wing refers to the “experience of thought insertion” as a “central schizophrenic symptom.” It is probably this experience of thoughts inserted from the outside that provides the basis for the term “schizophrenia.” As soon as we realize that we are dealing with an emergence from our unconscious, which we experience as coming from outside ourselves because of a completely different way of thinking and imagining, which is like “being thought” rather than active thinking, then we can work towards an understanding of the psychosis and of the self. The fact that our psychoses are psychologically caused by preceding crises in our lives is known to nearly all who have had these experiences.

Many people are afraid of psychiatric institutions with their forced medication and absence of help in understanding either the psychosis or the self. From their very first contact with a patient, psychiatrists should prove themselves to be helpers and not opponents. My wish would be that the patients could—right from the start—present their disturbing experiences in group sessions, that they could talk about them, write about them, paint and draw them. I wish that they would be taken seriously with their experiences, without needing to fear unwanted psychiatric interventions. During this process, it would be very valuable to have the support of individuals who have experienced psychoses themselves and have overcome them, understood their meaning for their lives, and have been able to integrate these experiences into their regular lives.

Currently, there is a pilot project at the University Clinic Hamburg, Department of Psychiatry, called “Experienced Involvement” (EX-IN), sponsored by the European Leonardo da Vinci Program, where people who have experienced psychoses are being trained. Further details about this project can be found in the February 2007 edition of the journal *Eppendorfer* under the title *Vom Patienten zum Profi – Ein europäisches Projekt qualifiziert Psychiatrie-Erfahrene für die Hilfe anderer Betroffener (From Patient to Profes-*

sional: A European Project Qualifies (ex-)Users and Survivors of Psychiatry to Give Peer Support).

I experienced five different psychiatric hospitals from 1936 to 1959 with 23 professors of psychiatry, medical directors, senior physicians and their assistants. They all subscribed to a genetically caused, meaningless and incurable schizophrenia. As a result, I didn't experience a single conversation about the content of my psychoses or the life-crisis that led to them and certainly not about any meaningful connections. Psychiatric inpatients today still complain about this lack of dialogue.

I was encouraged by the publicist Hans Krieger who called for more considerate treatment of psychotic patients in several outspoken reviews of psychiatric and psychological literature in *Die Zeit* during the 1960s and 70s. He also had introduced us to foreign reform initiatives, such as Ronald Laing's Kingsley Hall and others. He is the one to be thanked for urging me to write about my experiences of psychosis and healing. In 1990, he edited my accounts in a book titled *Auf der Spur des Morgensterns – Psychose als Selbstfindung (On the Trail of the Morning Star: Psychosis as Self-Discovery*, currently published by Paranus [in the German language]). There you can see that I really had schizophrenia. Because according to Kraepelin a person who has recovered from schizophrenia never had schizophrenia.

How can we trust in a psychiatric system that rejects the concept of healing, because such healing would contradict the theory of a meaningless, incurable metabolic brain disorder? We older people, who have experienced psychoses have paid for this genetic-somatic dogma with forced sterilization and its consequences, and the "euthanasia" victims paid for it with their lives. Now is the time for the psychiatric system to become an empirical science based on the experiences of patients.