

BEYOND THE CONTROL OF THE “TOTAL INSTITUTION”. THE CASE OF THE HOSPITAL FOR PATIENTS WITH EPILEPSY IN SEVLIEVO IN 1948

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Abstract

The author aims to examine the theories of the founders of medical anthropology Michel Foucault and Erving Goffman on the control and repression of the „mentally disabled people“ in psycho neurological hospitals and to trace their implementation in practice. For this purpose, a case-study is presented from the hospital for epileptics in Sevlievo at the dawn of the socialist state. A crime committed at the beginning of 1948 reveals numerous elements of the patients’ lifestyles, the actions and working methods of the hospital’s management, the intervention of representatives of the central government. For the first time, archival data from the archives of various institutions and the Ministry of Public Health and Social Care will be introduced into academic use.

Key words: total institution, control, medicalization, psychoneurological hospital

Overview. The case-study covers the extraordinary situation from the early 1948. It happened in the women’s ward in the only hospital for epileptics in Bulgaria, in the city of Sevlievo. There, eight of the “patients in full and good health staggered forward, their eyeballs bulging, popping, ocular contents leaking”.¹ The increasing number of patients with bulged eyes led to the implementation of a “cross-institutional” approach. A Red Cross plane arrived in the city from Sofia on February 6th, 1948. The sick patients were isolated, disinfection measures were enhanced , and “qualified” nurses were posted. Two of the sick patients died. Consultations were held, opinions expressed and officials from and outside the hospital were engaged d to investigate the unusual case.

¹ Централен държавен архив – ЦДА [Central state archive – CSA] fond [f]160 box [b.]9 folder [fl.] 195. p. 7

This situation shook the abilities of the institution to perform its duties “covertly” for the outside world. The case can also serve as a litmus test for theoretical ideas from various scientific disciplines related to the deep control over, including covering “deviant groups” of the population.

Methodology and goals. Several approaches are applied in the text. First, the problem approach is applied to subvert the opposing lines between “patient” – “institution”, “inner world” – “outer world”, etc. The main approach is the examination of a case study. It is devoted to investigating and detailing in depth a picture of a crisis of a short run and in a specific place – the commission of several acts harmful to the human health bringing about to murders done by patients against patients in the Psychoneurological Hospital in Sevlievo in 1948. For an accurate examination of events, it is necessary to use a third approach: the critical study of the documentary sources. The thematic content allows and requires the use, clarification and delving into the problematic context of various data from different documents. In addition to other sources, archival materials from the Ministry of Peoples’ Health and Social Care are used. This case study aims to test the practical applicability of popular ideas in the field of social sciences about the relationship between the patient and his/her body on one hand, and the institution that treats or cares for him/her, on the other.

The crimes were so exceptional that much information was accumulated and stored in the main folders of the Ministry including the patients’ records. The access to such private data is generally impossible to date. There are different reasons for that. Firstly, they are property of the medical institutions, and it depends on their decision to allow access of the researcher to them. Secondly, the legislation of the European Union doesn’t grant open access to such sensitive private data, even for research purposes. Last but not least patient files are often physically unavailable due to loss, fire, negligent storage, etc. This absence could also correspond to the fact that the archives of institutions in the psychoneurological sector are vastly incomplete. By having access to such records, the researcher could construct much richer picture of the system of psychoneurological hospitals and subjectivize the unnamed “passive bodies”.

However, many individual characteristics of the patients are elucidated from the available records including sometimes history, specificity of the character and progression of illness, and the therapies. The victims were between twenty and forty years old, suffering from epilepsy since childhood. The causes of disease were varied – pneumonia, meningitis, etc. The archives folder documenting the investigation of the case comprises six hospital records, which, logically, do not cover the history of all victims. It is necessary to bear in mind that all the patients were sharing the same room with the perpetrator.

Theoretical discourses. The theories I explore are extensively developed by two scholars, Michel Foucault and Erving Goffman, and they have conflicting or weak spots. For the purpose of this paper, the application of certain theoretical key points is envisaged.

The Canadian sociologist E. Goffman defined the notion of the “total institution”. He defines it as “a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life” (Goffman [2019] 1961: 29). The facility also introduces a program followed by all parties involved through which the “official goals of the institution are achieved”. In such institutions, it exists “binary” division between a “large, supervised group” who lives there and has limited contact with the outside world and a “small supervising group” who “often have eight-hour days and are socially integrated into the outside world” (Goffman 1961: 16–17). “Responsibility” is passed down from the supervised to the supervising group (ibid: 101–102). Goffman describes the hospitals for people with “mental disabilities” operating with “a toolkit for identity loss” through shock therapy, beatings and surgical procedures (ibid: 50).

The author classifies five different groups of total institutions, and this article will only focus on mental hospitals, which belong to the second group that “care for people who are unable to care for themselves but are capable of causing unintentional harm to society” (ibid: 33).

From the rich oeuvre of French philosopher and psychologist Michel Foucault, his ideas of the control or “supervision” of the human body are analyzed. They use different means: hierarchical supervision, normalizing sanction (disciplinary punishment) and exam. The bodies of the sick are “docile and can be subjectivized, used, transformed and improved”, i.e. “disciplined” (Foucault 1995: 136). The author claims that nothing regarding the inner “soul” or “will”, *not implemented from the institution*, overturns the validity of the theory, as seen in the examined case study. The institution, according to Foucault, must also “organize the analytic space” (ibid: 143). Similar to Goffman’s idea, the institution creates an “absolutely strict timetable, under constant supervision” (ibid: 124). Within such organized, controlled and rationalized space, there can be no room for deviation, no room for transgression.

Unlike Goffman’s working contemporary concepts, Foucault created his theory based on or in opposition to earlier eras of French history. He is a typical representative of the so called “armchair scholars”, i.e. did not conduct any practical scientific experiments in support of his theories. His works are so mixed up with data from theoretical or empirical studies of other French scientists that sometimes the reader cannot understand where the data of the primary source ends and Foucault’s (counter) data or analysis begins.

Another concept that emerged from Foucault’s “supervised bodies” is the “fleshless passive bodies”. It is developed by his contemporary follower, B. Hughes who, unfortunately, did not clarify this concept, but only put it as a subtitle in his part of a collection devoted to the impact of Foucault’s ideas (Hughes 2005). It has been used as such in other studies (see Allan, Bjørn 2016).

The **institution** that the article examines is supposed to be an example of a closed, total one subordinating and controlling its patients. Located on “Stoyan Bachvarov”

str. № 21 in Sevlievo, it was opened as an asylum for epileptic children in 1941 in the building of the former 2nd degree hospital from 1883. By 1943 it was reopened as an institution for the “mentally ill people”. It was in the city next to the displaced 2nd degree hospital. It seems that the conditions in Sevlievo were not good enough for the hospital because the archives indicate that the distance of 28 km from the nearest city, Gabrovo, was a problem.² It was the only specialized hospital for epileptics at the time in the People’s Republic of Bulgaria (PRB). It became a regular psychoneurological hospital in 1956.³

The data on the **living conditions and infrastructure** are much scarcer than those available for other psychoneurological institutions. The documents show that by 1948, the basic daily ration consisted of bread – 450 g, marmalade – 50 g, sugar – 10 g three times a week, dry fruit – 60 g, oil or lard – 10 g and 50 g of potatoes.⁴ At least once every 8 days 200 g of meat was served. The food appeared insufficient, and this was evident from the patients’ appearance who were “pale and [with] very little subcutaneous fat”.⁵ Therapeutic diets were rarely applied.⁶ By 1950, feeding was carried out in metal containers “due to the mental state of the patients” who were allowed to use only spoons.⁷

It is clear from the archival information that during the late 1940s and early 1950s there was no flushing water in the latrines, “chains to rings nailed into the floor” were used in the isolators to pacify or, more accurately, restrain the violent.⁸ There was no laboratory, so the office of the doctor-manager itself was used for examinations. The conditions of living and treatment could not meet the modern (at the relevant time) conceptions of a modern psychiatric (epilepsy) hospital.

There was a continuous shortage of qualified staff. The head of the hospital from “its opening” (1943) was Dr. Sergei Feodorov.⁹ During his time in office, a policy of reducing the qualified and increasing the support staff was implemented – with 110 patients by 1949, there were only two nurses (from four before), three servants (from seven before), but with an increase of eight (from four before) “workers”.¹⁰ This, along with the shortage of therapeutic options, was a factor in the peculiar perception of the medical staff for the inability to cure epileptic patients.

Similar to the psychoneurological hospital in Biala, “only a fraction of the staff lives in the hospital itself; the rest of the staff lives in a private accommodation

² CSA f.160 b.11 fl.149 p. 189

³ CSA f.160 b.16 fl.73. p.107

⁴ CSA f.160 b.9 fl.195. p. 57

⁵ CSA f.160 b.9 fl.195. p. 58

⁶ CSA f.160 b.11 fl.149. p.196

⁷ CSA f.160 b.11 fl.149. p.196

⁸ CSA f.160 b.11 fl.149. p.191

⁹ CSA f.160 b.11 fl.149 p. 189

¹⁰ CSA f.160 b.9 fl.195. p. 5

rented with personal funds”.¹¹ For this reason, nurses, caregivers and maids also give 24-hour on-call duty, and as some are adjacent to the patients, “are unable to use their time rationally”¹², i.e. to rest and recover. The workweek rate was approximately 59 hours, but “employees work 80–90 hours without receiving any pay”.¹³

In fact, the lives of some from the “supervisory group” became very similar to those of the controlled group. The entire system of rules, schedule, and even emergency, disciplined (Foucault) and controlled (Goffmann) not only the group of patients, but also the group of workers there. The patient in the total institution just needs to follow the order and be passive, but the supervisor must be exceptionally active in controlling, caring, curing, scheduling, systematizing, changing, developing (the institution), etc. Because of the socialist regime the worker needs also to be especially productive during the months of the so called “socialist emulation”. The realities hidden behind the grand theories show an obligation of the unprepared medical staff to cover a big swath of duties, while the patient has a sole task of not breaking the order. Such a system dooms the controlling class to obey the ineffective medicament and force treatment and the 24/7 systemic control: over the patients but also from the system. Every exam, every measure, every activity of the staff is monitored or fully documented. Moreover, the atypical situation of 1948 brought about by the “passive bodies” enlarged the pressure over the staff introducing new realities hardly regulated by the system. It led to anxiety and panic among the employees, requiring new types of and extraordinary efforts from them. Some of them even quitted jobs out of fear. The system became incapable of protecting its own staff.

Patients in the hospital were in the vast majority of cases adults with epilepsy. After 1944, the hospital admitted mainly “epileptics dangerous to others¹⁴ and homeless ones... to give shelter to at least a small proportion of the unfortunate and to secure a decent human life, and to relieve the community and their relatives from the constant dangers and unbearable burdens of their care”.¹⁵ The admissions were made only with medical papers given in advance. Since 1946, the future patients must be initially examined in a neuropsychiatric clinic, which confirms that epilepsy “is not amenable to surgery” (lobotomy?).¹⁶

Over the years the numbers increased. A revision in April 1943 shows that the hospital housed 58 patients; by 1947, they numbered 110.¹⁷ There is no data on the bed occupancy rate in this period, despite the uniqueness of the hospital.¹⁸ The

¹¹ CSA f.160 b.11 fl.149. p.198

¹² CSA f.160 b.11 fl.149. p.190

¹³ CSA f.160 b.11 fl.149. p.190.

¹⁴ In 1950 they were 75% from all. CSA f.160 b.11 fl.149. p.191

¹⁵ CSA f.160 b.11 fl.149 p. 189

¹⁶ CSA f.160 b.3 fl.180. p. 15

¹⁷ CSA f.160 b.1 fl.72. p.44; CSA f.160 b.5 fl.247. p.54

¹⁸ CSA f.160 b.9 fl.191. p.24

patients were from different ethnic backgrounds – Bulgarians, Russians, Macedonians, Jews, Turks, Pomaks, and Armenians.¹⁹ The documents do not mention any Gypsies.

Specific to the patients of this hospital, as well as of other psychoneurological institutions, is that they were part of the permanent coming “contingent”. The average stay in Sevlievo hospital amounted to between 265.9 days in 1949 and 353.1 days in 1950.²⁰ Most of the patients – 38 out of 108 – had been in the hospital for over 5 years. The annual medical report from 1950 shows “very little movement of patients and 70% stayed for 3 to 5 years and over 5 years”. Over 95% were sick for over 10 years. Only 12 were discharged for a year, 7 of them without an improvement and 1 even with deterioration; 9 died, almost all from their main diseases. The number of waiting patients almost reached the number of admitted patients – 83!²¹ Almost all of them received treatment “free of charge”, i.e. the hospital received the funds to cover their treatment from the state budget.²² There were no new admissions of children between 1 and 14 years old in 1950.²³

The case-study data shows the inadequate scope of the “exam” defined as a disciplinary factor in the control theory. For the French philosopher the examination has three functions: the exercise of power, introducing the individuality into the field of documentation, creating of a case. By the practical situation in Sevlievo, the “exam” for discharging from the hospital, did not consist of the obligatory need for improvement and successful cure. Thus, the so-called total institution fails to discipline the body, but gets rid of it by worsening its health state. This is in fact a common practice in virtually all countries with an established system of psychiatric hospitals and/or institutions for the care of “mentally retarded” children and adults (Balla, Butterfield, Zigler 1974: 530–549; Yavkin 1976: 22–28). In fact, some discharges took place due to the lack of beds and a long waiting list.

Thus, Foucault did not develop a completing fourth level of the exam: “giving (back) freedom” to the individual, closing his or her medical case and forcing him or her to get reintegrated in the society (until the next institutionalization). Such an act of the institution can be seen in the perspective of “the gift” concept by M. Mauss, in which “the gift” is a “symbol” and “power”, and its acceptance also leads to certain obligations (Mauss 2016: 69–70). Thus the “normalizing gaze” or “superimposition of the power relations and knowledge relations assumes in the examination all its visible brilliance” (Foucault 1995: 184–185) will overshadow all other functions.

The patients were characterized by changing moods in a report given by the main doctor – “highly irritable, spiteful, opinionated, quickly falling into effect, in which they can commit all sorts of crimes, including cannibalism. The same patients at

¹⁹ CSA f.160 b.11 fl.149 p. 189

²⁰ CSA f.160 b.11 fl.149. p.194, 205

²¹ CSA f.160 b.11 fl.149. p.193, 206, 207

²² CSA f.160 b.11 fl.149. p.205

²³ CSA f.160 b.11 fl.149. p.204

other times show themselves to be very meek, polite to excess etc.”²⁴ For this reason, the hospital as a total institution had to be prepared to handle a variety of patient conditions with appropriate therapy, isolation, and protection from self-harm or injury to other patients. Such measures were not only not present, but they were also not planned in any type of psychoneurological hospital.

Crimes and executioners. The case-study is covering the extraordinary situation from the early 1948. In the women’s ward, 8 of the “patients in full and good health staggered forward, their eyeballs bulging, popping, ocular contents leaking”.²⁵ A complete blood count, respiratory rate, lumbar puncture and cerebrospinal fluid (CSF) were examined, eyes got photographed, and body weight was measured.²⁶ The autopsies revealed that the cause of death was shock and the rupture of the eye was due to a hematoma in the eye that was “pressing from the back forward, while the eye muscularis and squints were pressing from the front. The eye was between two presses”.²⁷ A man died on February 7th with the same symptoms, but also “the scrotum was torn, the testicles taken out but not found anywhere.” He was not found until the following morning – the night duty simply did not notice and register the case. It turned out that he was killed by another patient with whom they were chained close together, who “took out his eyes, ripped out his testicles, which he ate, and finally strangled him by knocking his head on the floor three times”.²⁸ This second case shows that patients, who were being “disciplined” to follow the hospital order, not only didn’t follow it but also spontaneously followed the newly “fashion” constructed from bellow of eye bulging, as it would be proved below.

It was eventually revealed that the crimes were committed by one of the female patients. The perpetrator was B. K., who was 24 years old in 1948. She was admitted to Sevlievo probably at the age of 20. While committing her crimes on the victims at the time of their epileptic seizure, she was fully conscious.²⁹ What was specific about her was that from the age of 3 she had an acute inflammation of the brain and meninges with incomplete paralysis of the left limbs (left-sided hemiparesis), a deepening of the hereditary burden, and at the age of 7 had been diagnosed with epilepsy. “Mental retardation” – in the lower variant of retardation, sexuality – exacerbated, with a desire to fondle, kiss and indulge in intense masturbation.³⁰ Despite her negative traits, B. was portrayed as quiet, well-behaved towards staff and other patients, a docile but kleptomaniac. The reason for the act was not intellectual deficiency but,

²⁴ CSA f.160 b.11 fl.149 p. 257

²⁵ 2 of the sick died. Consultations are held, opinions are gathered. A Red Cross plane arrives in the city from Sofia on 6 II 1948. The sick are isolated, disinfection is increased, “qualified” nurses are posted. CSA f.160 b.9 fl.195. p. 7.

²⁶ CSA f.160 b.9 fl.195. p. 63

²⁷ CSA f.160 b.9 fl.195. p. 9

²⁸ CSA f.160 b.9 fl.195. p. 10

²⁹ CSA f.160 b.9 fl.195. p. 16

³⁰ CSA f.160 b.9 fl.195. p. 17

as the committee concluded, an exacerbation of a “peculiar morbid change of character” – “vindictiveness, cruelty, egocentrism..., self-assertion of personality”.³¹ At the same time, “the crime committed by its style requires dexterity, quick wits,... attention, cunning, i.e. a perfectly clear consciousness”.³² In fact, epilepsy does not affect the purposefulness in a person. However, the treatment, as it could be traced below, can affect the will and, in part, the active pursuit of the patient’s desires. In this case even “cured” with medicaments, the perpetrator doesn’t seem to have any problems committing the crimes. B. Hughes’s theory of the passive fleshless bodies is invalidated by this case.

The social norms implemented at the “total” institution failed to materialize as blocking mechanisms in the “mentally ill” person. Moreover, the awareness and the lack of idea of the disciplinary punishment in B. collaborating with receiving “sadistically erotic pleasures”, deepened through “the need to see the mood of the victim”³³, show that the disciplining of the “docile body” of the perpetrator just didn’t happen. When the institution cannot overcome the will, desires and actions of such a patient, it could hardly manage to change the nature of all other institutionalized adults (but maybe not a child!).

The other murder case was similar. Here, however, the killer’s desire to get out of the institution was recognized as the main motive for committing the crime. The patient’s record shows that, although epileptic (the seizures were only taking place at night), P., the perpetrator, served his military service, and completed his junior high school education with very good grades.³⁴ The man had absolutely intact intellectual capacity and “gives at the moment the impression of a completely normal person”, having no “impulsive manifestations and attractions”.³⁵ Patients’ own desires questioning the decisions of the hospital can just not exist in the sphere of the total institution and must be eradicated (as part of the “depersonalization” (Goffmann 2019 [1961]: 42–46, 76–78; Balla, Butterfield, Zigler 1974: 530) – something that cannot be carried out for years! The reasons for this (technical, financial, personnel, moral) remains unclear. Inner desires, feelings and aspirations of the institutionalized person remain intact. Such examples could be found – also by the fiction literature for example *The Star Rover* (1915) by Jack London.

Due to the lack of sufficient or successful treatment for epilepsy (not only in the “socialist” medicine), together with the perception of epilepsy as a “mental illness”, this “regular” person for society and the public order, was confined from an early childhood in the circle of social institutions. There is information in his record file concerning his attempts to leave the institution. The monthly reports show that he was restless, “believes he does not belong here”, and through another illness – car-

³¹ CSA f.160 b.9 fl.195. p. 17

³² CSA f.160 b.9 fl.195. p. 19

³³ CSA f.160 b.9 fl.195. p. 16

³⁴ CSA f.160 b.9 fl.195. p. 22

³⁵ CSA f.160 b.9 fl.195. p. 23

diovascular – attempted to get out of the hospital. Eventually he was tied up in the isolation ward despite being violent and “ready to fight”. From the time he was admitted there onwards (i.e., and at the time of the murder), his treatment was abruptly discontinued! He committed the murder while “asking for forgiveness: ‘forgive me, bai Ivan, I know it hurts you that I plucked out your eyes!’”.³⁶

After the criminal act, he was returned to the dormitory, and it was not until the next day that his “consciousness was fully restored... [but] he showed no remorse or embarrassment for the murder he had committed, of which he was reluctant to speak, but fully confessed”.³⁷ Whether he was revealed as being the killer before or after his return to the dormitory remains unclear, but this action by the institution practically endangered the lives and health of others in the dormitory. Ultimately, in the socialist social care system, a “normal” epileptic, due to the various therapies and care, became a murderer who presumably saw the crime as an opportunity to escape from the system by another one, that of justice.

The hospital management was blamed for the blinded patients and the case of murder. This could also be seen as a function of the emerging totalitarian system in Bulgaria. Managers acted at a very advanced stage of the events and denied their involvement and responsibility with the argument of “mysterious illness”.³⁸ The accusations against the management exposes, reveals and blames the individuals who normally were part of the controlling group seen as anonymous. However, this criminal case again did not affect the essence of the institution as such: it didn’t produce any change of its rules, the inner regime remained intact. This is typical of the socialist approaches in times of crisis and corruption, and it fits well to the model of “institution-orientated” institutions” (McCormick, Balla, Zigler 1975)³⁹.

In fact, whether placed in the context of socialist institutions, or of states with another politico-economic system, the loopholes in the workings of the institutions contradict the idea of Goffmanian total and Foucauldian control institutions. On the one hand, the perpetration of a crime is technically impossible, according to both theories. Running an identical program and regime, giving (voluntarily) the freedom of the patients to the institution should have blocked the possibility of committing a crime, even with the condescending factors of an epileptic seizure. The lack of “totality” and accountability in the institution and its untidy bureaucratic foundations could be followed through analysis of the daily routine and the mechanisms of the system. It could also be traced by the patient’s planning or even on a whim committing an arbitrary act contrary to the accepted rules and the lack of a countermeasures or blocking mechanism for such willfulness by the institution itself.

³⁶ CSA f.160 b.9 fl.195. p. 14

³⁷ CSA f.160 b.9 fl.195. p. 23–24

³⁸ CSA f.160 b.9 fl.195. p. 13

³⁹ For example my article about the socialist corruption is under print: Todorov, G. Corrupt practices in the carehomes for mentally disabled children and neuropsychiatric hospitals in PRB between 1940s and 1970s. in *Balkanistic Forum*, 2024.

Such lack of self-regulation was also evident from the contacts with the outside world. The lack of a quick and adequate mechanism to deal with the situation within the institution itself, led the hospital to seek help from the outside world: a committee came from Sofia by plane, established a contact with city authorities. Eventually, a representative of the Ministry of Health and social care took temporary control of the hospital. This change was a step to resolving the situation. However, the permeability of the system challenges Goffman's idea of closeness (or totality) of the institution (Goffman 2019 [1961]: 32). The rumors reached the villages away from the hospital (but not the city of Sevlievo itself), possibly through the workers from the hospital living there. It led to a widespread panic among the locals: the report by Ass. Dr. Ivan Vasilev sent from Sofia says that "there were citizens who were about to evacuate".⁴⁰ Representatives of the institution and from Sofia reassured the local authorities by holding a conference with them in the municipality.

The Victims. The record of 40-year-old **M.** presents a clinical picture of an eye problem even before the crime. The treatment was mainly done with iodine, bandages and vitamins. The epilepsy was complicated by poor memory, incoherent and rapid speech, disorientation, and overall dysfunction.⁴¹ It is unclear on the day of her death how she "in a state of complete unconsciousness was pouring into a fight, running away, refusing food, crying...".⁴² Her death, according to the hospital record, was not due to the criminal activities of **B.**, who pulled her eyes. It should be made clear that the records are mixed and in **M.**'s file, the pages attached do not correspond to the duration of her hospital stay.

L., 32, had epilepsy, "extremely limited intelligence and no information about her relatives or herself at all..." Earlier on, she was treated (it is unclear how) in the psychoneurotic hospital in Kotel. "She cannot tell whether she is in a village or a town, she is disoriented, her ideas are extremely limited". Due to this condition, impulsive manifestations were not observed.⁴³ On January, 15, 1948, it was recorded that she had a strong seizure, falling on the corner of the bed and tearing one of her eyelids, which could not be sutured because it was dirty. The eye was non-functional.⁴⁴ This occurred a month before the information about the case reached higher authorities. It should be noted that the next case involving **L.**'s eye was attributed to the epileptic seizure and not to the act of **B.** Also, the perpetrator was able to sense the rhythmicity of her victim's epileptic seizures extremely accurately.⁴⁵

T., 32, developed epilepsy at the age of 9. Later seizures with a loss of consciousness, tongue biting and convulsions, increased to one every 2–3 days. By the

⁴⁰ CSA f.160 b.9 fl.195. p. 61

⁴¹ CSA f.160 b.9 fl.195. p. 28

⁴² CSA f.160 b.9 fl.195. p. 29

⁴³ CSA f.160 b.9 fl.195. p. 31–32

⁴⁴ CSA f.160 b.9 fl.195. p. 58

⁴⁵ CSA f.160 b.9 fl.195. p. 32–33

3rd class the girl could no longer continue going to school. There were no inherited illnesses or weaknesses from the parents. She had already been treated once at the Alexandrovskaya Hospital in 1935. “Psychosomatically, she was quite stable, talkative and... chatty. Her memory is stable... Her thought activity is limited. Irritability stability in decline... Does not exhibit impulsive actions...”⁴⁶

R., 32, has also been epileptic since her primary school years. Her seizures were accompanied by a loss of consciousness, “foaming at the mouth and convulsions in the body”. Her consciousness is quite blurred, there is a poor and irregular orientation, slowed mind activity, the reasoning ability is in a severe decline, with no impulsive manifestations or sensory illusions.⁴⁷ The seizures were pure, with no “equivalents”.⁴⁸ There is no evidence from the files that equivalents were seen in the manifestation of the disease in other patients.

E., 17, was admitted in 1943 for the second time to the hospital. The first time she was discharged at the request of her parents. By the age of three she was developing normally “in every respect”. She suffered from meningitis as a child which triggered epileptic seizures: probably from the age of 10. She lives in an “intelligent family””. “Treated many times but without a result”. She had a semi-paralysis of the right arm and leg. “Her memory is quite limited, the sex drive is intense... mood changes frequent... hallucinations present. The seizures are typically... strong and prolonged. Her consciousness is very blurred afterwards... thought activity is slow.”⁴⁹ Cerebrospinal Fluid was tested for proteins (Pandy protein reaction) and globulin (Weichbrodt reaction).

The rhythm of entry in the patients’ files was established at the end of the month. In emergencies, as with eye extractions and murders, the patients’ conditions were recorded daily.

The patients’ data described here show that women with a heterogeneous course of illness, different social statuses and connections to the outside world, types and average remissions between the seizures, but on identical therapies (as will be seen in the next paragraph), most with impaired memory and cognitive abilities, were brought together in one room. The concentration of patients with the same diagnosis but with different specifications was typical of the hospital sector and was also done due to chronic shortages of places. Even with a favorable confluence of therapies for one patient, the presence of other patients around in a more severe state with equivalents and epileptic seizures would not allow or would make it difficult for the body and the “soul” to come out successfully for a longer time or faster from the spiral of disease itself.⁵⁰

⁴⁶ CSA f.160 b.9 fl.195. p. 35–36

⁴⁷ CSA f.160 b.9 fl.195. p. 43

⁴⁸ Seizures of a mental disorder (e.g. automatism, hallucinatory crises, crises of psychosensory experiences, delirious and amnesic symptoms) that do not involve loss of consciousness.

⁴⁹ CSA f.160 b.9 fl.195. p. 47

⁵⁰ For example about the closed institutions for disable children: Zamskii, H. Lev Semenovic

The Treatment can be carried out with convulsive/comatose therapies or by medication. The convulsive therapies are the Insulin Coma Therapy (ICT), the Cardiozol Shock Therapy (CST) and the Electroshock (electroconvulsive) therapy (ECT). The summarized data from the patients' records show that no such therapies were performed in Sevlievo. Only in Sofia the hospitals had electroshock machines by 1945.⁵¹ By contrast, in the doctors' meetings during the crisis, it was said that the use of ECT could lead to such eye problems.⁵² The rejection of the methods of CST and ICT took place only in the late 1950s, while ECT was appreciated as a cheap and effective alternative to expensive neuroleptics even by the 1960s.

The detailed transcripts of the records indicate the use of conventional medication. Bromides (sodium bromate, potassium bromate, etc.) and phenobarbital were used. Treatment with such drugs was "reduced to symptomatic therapy... due to the nature of the disease for which there are no causal methods of treatment".⁵³ There were no suitable isolation rooms and even "means of tranquilizing them /fixing belts/" and ICT. The majority of admitted patients came from clinics where they had received "shock therapy with very little success" (ICT or ECT remains unclear).⁵⁴ In practice, epilepsy had no effective treatment, and the only thing that could maximally be achieved was the "significant seizure resolution".⁵⁵

A **brief pharmacological review** shows the problematic nature of the symptomatic treatment with conventional medications.

The dose of **phenobarbital** determines the effect on a person's nervous system – sedative, hypnotic or narcotic. The prescription against epilepsy stipulates starting at 50 mg twice daily and increasing to a maximum of 600 mg (Mashkovskii 1977: 28). The treatment is prolonged, the cumulative stage to achieve a therapeutic (not to mention age specificity) plasma concentration is 21 days. When the desired result is achieved, the drug intake is gradually reduced. Phenobarbital possesses a long action (8–10 h) while simultaneously and rapidly reaching maximum values (1–2 h). Unlike barbitol, its derivative has a slower elimination from the body (25% pure substance). The $T_{1/2}$ ⁵⁶ at 1 week intake is between 48–144 h (R. Ovcharov gives a value of 96 h) (Ovcharov 1987: 172). With a long-term therapy, the development of mental disturbances and cognitive functions are observed. Phenobarbital is precisely the drug used by national socialists during 30s and 40s to euthanize the "mentally ill" or those declared as such in psychiatric clinics (Kranah 2006).

Vigotskii i oligofrenopedagogika. Defektologia №6, 1971. p.10, 11 []; Vigotskii, L. Sobranie socineniya soc. t.5. Moscow: Pedagogika, 1982–1985. p. 50

⁵¹ CSA f.160 b.2 fl. 138, p. 42

⁵² CSA f.160 b.9 fl.195. p. 20

⁵³ CSA f.160 b.11 fl.149. p.189, 195

⁵⁴ CSA f.160 b.11 fl.149. p.195

⁵⁵ CSA f.160 b.11 fl.149. p.195

⁵⁶ Period of half amount of the drug taken out from the patient's body

Potassium bromide allows bromine ions, which are chloride antagonists, to lower the *accelerated* tonus of central nervous system (CNS) and musculature. For this reason, the substance has anticonvulsant and sedative characteristics. Bromism⁵⁷ and general fatigue are observed within the prolonged treatment. The usual dose is 0.5-1 g 3–4 times a day, by seizures 3–5 g daily. Epilepsy was treated on a 20:10 schedule, i.e. 20 days therapy, 10 days rest (Lekarstven spravochnik 1977: 390).

Sodium bromate is used for “neurotic reactions manifested by excitement, anxiety and fearful experiences”⁵⁸, i.e. the drug is not actually directed against seizures as a symptom but as a function of the symptom causing new symptoms. Moreover, it blocks the irritation of the CNS and the psychomotor area in the cerebral cortex to such an extent “that even its direct stimulation with electric current remains without consequence” (ibid: 479). The medication should not be used for a long time as it can cause coma, depression, hallucinations, bradycardia and bromism. Like other bromides, the intake of a large amount of salt with water allows the regulation of the action of the drug and its blunting (ibid: 480).

The applied treatments met in most cases the recommended dosages of the time. In contrast, changing medications happened extremely rapidly. A good example of this was L.’s treatment. With only three epileptic seizures in November 1945, she started her treatment for the first time in two months – was sodium bromate 10% by 3 tablespoons⁵⁹ (3 times a day?) for 20 days. This dosing means that the received dosage per day was ~ 6 g by only 3 tbsps or 18 g by 9 tbsps pure sodium bromate. The seizures increased to a total of 5. At the beginning of January, 1946, the situation improved and the treatment was stopped – “communication and self-esteem good”.⁶⁰ By July 1946, with 7 seizures and in good general condition, the therapy was again changed to phenobarbital 0.05 x 3. It was continued for 4 months despite the absence of seizures, when it was replaced by the familiar potassium bromate. The duration of treatment in the following month was reduced to 10 days with, probably, 20 days rest. At the end of the year her seizures increased although her general condition was good, and for two months again it was substituted barbitol 0.1 x 3 and after that again 20 days’ sodium bromate. From May 1947 the seizures increased to 20 per month (such figures had never been recorded before), at which point potassium bromate 10% 3 tbsps (3 times a day?) was prescribed for twenty days, which had an immediate effect. In other patients such as Mila and Tsvetana, no improvement was seen by the use of the “more powerful” phenobarbital, and with R. the changes of therapies (potassium bromide for almost a whole year in a 20:10 formula) led to an increase in epileptic seizures to 17 per month.

⁵⁷ Toxication of the body with bromine and bromine-derived medicines, resulting in memory disorders, tremor, ataxia, rashes

⁵⁸ <https://static.famar.bg/documents/natrium-bromatum-sopharma-harakteristika.pdf>. Nowadays it is used only infusion form of the medicament

⁵⁹ 1 tbsps ~ 20 g liquid x 10% = 2 g.

⁶⁰ CSA f.160 b.9 fl.195. p. 32

The medications used, and the therapies prescribed in and out of Sevlievo, did not treat or target the genesis of epilepsy itself, but concentrated on treating the symptoms and seizures/equivalents. This is a symptomatic therapy. Doctors even in the 1960's with the advent and introduction of the first neuroleptics, would continue to hope for the medical treatment of epilepsy.⁶¹ Phenobarbital and potassium bromide has been imported since the beginning of the socialist regime⁶², which also suggests that the medicine was used as a cure rather than a control mechanism, because for pure control many different “analogue” approaches can be used, which will be much cheaper for the state budget and for the hospital.

The effectiveness of the therapies applied is questionable enough. While in some cases there was a reduction in equivalents or seizures, allowing a reduction or temporary discontinuation of the therapy during remission, in others the opposite happens – despite even an increase in seizures, the treatment continues. In certain cases, as with potassium bromide, it is possible to speak of a kind of anesthesia rather than a symptomatic therapy – a therapy which should give a positive development in the fight against the symptoms in the future. Whether it is appropriate to accuse the nursing staff of applying control through drugging patients to avoid more severe or even more frequent seizures, or to secure the peace for the night shift and other patients, there is no way of knowing from the available data and transcripts.

The genesis was different. The use of such “classical drugs” and formulations in socialist Bulgaria, but also in several other countries⁶³, shows the limited capacity of psychopharmacology and medicine to treat such cases. Despite Foucault's extensive theory pills and syrups do not enter as a possible factor of control over the body. Goffman also did not consider pills as capable of depersonalizing the individual. The problem, in fact, was not the institutions but the drugs. The medications themselves were synthesized with such narcotic, controlling side effects and sedative and calming main effects. None of the drugs are described as subordinating the will and body of the individual i.e. not an opiate. The effect is in a direct correlation (according to pharmacology) of the dose administered. Psychopharmacological reference books, physicians' studies and official sources cannot provide accurate, consistent and objective data on the accurate therapeutic dose. According to the sources reviewed in the article, the doses administered in Sevlievo were in most cases not narcotic but therapeutic. It is obvious, however, that they, even in such doses, failed to fulfill the basic requirements for their administration. Whether other doses were needed or administered is not known from the records. The difficulty of determin-

⁶¹ CSA f.160 b.11 fl.149. p.189, 195

⁶² For example CSA f.160 b.2 fl.159 p. 26; CSA f.160 b.2 fl.166 p. 115; CSA f.160 b.3 fl.238 p. 132

⁶³ For example in Weimar republic: Fangerau, H., Dreier-Horning, A., Hess, V., Laudien, K., Rotzoll, M. (Hrsg). *Leid und Unrecht. Kinder und Jugendliche in Behindertenhilfe und Psychiatrie der BRD und DDR 1949 bis 1990*. Köln, 2021. p 226

ing the objective therapeutic dose is a “weakness” of psychopharmacology itself, still present to this day not only because of the individuality and specificity of each individual diseased organism. To find and apply the individualized therapeutic dose requires a precise study or experimentation by the treating physician on each and every patient in the hospital. With approximately 100 patients and up to 5 medical staff (senior and mid-level), tracking each individual case in depth was a technically impossible process. An additional factor was the lack of comprehensive descriptions of the course of the disease in the patients concerned: in the hospital books, in the patient records in form No. 6, there were no space for such tracking (only anamnesis). Thus, it is not possible to argue unilaterally that the treatment provided in the hospital is a form of Foucauldian control of the system over the individual. If such claim is accepted, the genesis of control came directly from pharmacological laboratories and the authorizations for use (since the 1960s-1970s these were obtained from state institutions), as well as from the unsatisfactory economic-financial situation of the country in general and the insufficient psycho-neurological funding in particular, and far not from the social-medical institutions as such or the personnel there.

A factual case-study of the psychoneurological hospital in Sevlievo reveals some of the problematic points in the main theories on which modern anthropological and bioethical sciences are based. Goffman’s “total institution” of the second category does not appear to be in fact “total”: it admits an emergency that overturns the hierarchy, which cannot cope with and needs help from outside; leaking of information reached the city and villages; the use of psych pharmacy cannot be accounted for without significant qualifications as a depersonalizing tool. In Foucault’s conception of control, disciplinary punishment is basically a “means of correct training” but it does not apply in the emergency case of 1948; the cyclical returning of patients behind the walls of the hospital, in turn, also rejects the exam factor. Crime does not even follow punishment, and the mere presence of crime itself rejects the theory of “passive and supervised bodies”. The problem is not that the system itself may fail to carry out its discipline to its fullest extent, but that the bodies and wills of the sick are torn apart and, according to the French scholar, have no intersection within the scope of the institution. Crimes of choice – emotional or rational – present examples that refute Foucault’s idea. By all that the institution of the psychiatric hospital can be described as closed with an identical circulating contingent, but not as a total one of repression and control.

References:

Выготский, Л. 1982–1985. *Собрание сочинения*. Т. 5. Москва: Педагогика.
[Vygotzky, L. 1982–1985. *Sobranie sočinenia soc. t. 5*. Moscow: Pedagogika].

Замский, Х. 1971. Лев Семенович Выготский и олигофренопедагогика. *Дефектология* №6. [Zamskii, H. 1971. Lev Semenovič Vygotsky i oligofrenopedagogika. *Defektologia* №6] pp. 9–15.

Лекарствен справочник. 3-то изд. 1977. София: Медицина и физкултура. [Lekarstven spravochnik. 3ed. 1977. Sofia:Medicina i fizkultura].

Машковский, М. 1977. *Лекарственные средства*. 8 изд. Москва: Медицина. [Maškovskii, M. 1977. Lekarstvennye sredstva. 8ed. Moscow: Medicina].

Овчаров, Р. 1987. *Фармакология*. София: Медицина и физкултура. [Ovčarov, R. 1987. Farmakologia. Sofia: Medicina i fizkultura].

Явкин, В. 1976 Психопатоподобные состояния у потомков лиц, болевших сифилисом. *Дефектология* №3. [Yavkin, V. 1976. Psihopatopodobnie sostoyaniya u potomkov lic, bolejših sifilisom. *Defektologia* №3], 22–28.

Allan, J., Bjørn, H. 2016. Guest Editorial: Special Education and the Deviant Child in the Nordic Countries – the Impact of Foucault. *Nordic Journal of Social Research*. № 7. 1–5. https://www.researchgate.net/publication/299577154_Guest_editorial_special_education_and_the_deviant_child_in_the_Nordic_countries_-_the_impact_of_Foucault.

Balla, D., Butterfield, E., Zigler, E. 1974. Effects of Institutionalization on Retarded Children: A Longitudinal Cross-Institutional Investigation. *AJMD* 1974, vol.78, №5, 530–549.

Fangerau, H., Dreier-Horning, A., Hess, V., Laudien, K., Rotzoll, M. (Hrsg). 2021. *Leid und Unrecht. Kinder und Jugendliche in Behindertenhilfe und Psychiatrie der BRD und DDR 1949 bis 1990*. Köln.

Foucault, M. 1995. *Discipline and Punish. The Birth of the Prison*. New York: A Division of Random House.

Goffman, E. 1961. *Asylums: Essays on Social Situation of Mental Patients and Other Inmates*. Garden City: Ancor Books. Cited after the Russian translation: Гоффман, Э. 2019. Тотальные институты: очерки о социальной ситуации психически больных пациентов и прочих постояльцев закрытых учреждений. Москва: Элементарные формы. [Goffman, E. 2019. Total'nye instituty: otserki o social'noi situacii psihičeski bol'nyh pacientov i pročih postoyal'cev zakrytyh učreždenii. Moskva: Elementarnye formy].

Hughes, B. 2005. What Can a Foucauldian Theory Contribute? in: S. Tremain (Ed.) *Foucault and the Government of Disability*. Ann Arbor, MI: University of Michigan Press, 78–92.

Mauss, M. 2016. *The Gift. Expanded edition*. Chicago: Hau book.

McCormick, M., D. Balla, E. Zigler. 1975. Resident-Care Practices in Institutions for Retarded Persons: A Cross-Institutional, Cross-Cultural Study. *AJMD*, vol.80, № 1, pp. 1–17.

Online sources:

Кранах, М. 2006. Уничтожение психически больных в нацистской Германии в 1939–1945 гг. *Независимый психиатрический журнал*. №3. <http://www.npar>.

ru/journal/2006/3/killing.htm [Kranah, M. 2006 Uničtozenie psihični bolnih v nacistkoi Germanii v 1939–1945 gg. *Nezavisimyi psihiatriceskii zhurnal*. №3].

Archival sources:

Централен държавен архив – ЦДА [Central state archive – CSA] fond 160.

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