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Narratives of Punishment, Reward and Informal Education at the Former National Institute of Psychiatry and Neurology: A Retrospective Qualitative Study

Attila Dobai – Gergő Tósaki

Abstract
This study examines the institutional culture of the National Institute of Psychiatry and Neurology (OPNI, Lipótmező) between 1968 and 2007 within the framework of retrospective qualitative research, with particular emphasis on the mechanisms of discipline and reward. The interview-based exploration aims to uncover the narrative of institutional discipline and reward, embedded in the internal dynamics of the institute and the specificities of the career socialisation of medical and professional staff. The operation of the institution was characterised by so-called double demarginalisation affecting both patients and staff. Patients were subject to institutional control, while staff were also constrained by hierarchical structures. Physical and chemical restraints and normalised forms of verbal abuse persisted for extended periods, while psychotherapeutic and social psychiatric approaches gradually gained prominence. The research indicates that the professional hierarchy, paternalistic relationships, and symbolic boundaries between generations hindered institutional humanisation. The study highlights the duality of disciplinary practices and therapeutic intentions in psychiatric institutions, which played a decisive role in shaping professional identity. The findings may contribute to further research on historical and contemporary themes of violence in psychiatric institutional systems.
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1. Introduction

This paper examines the internal world of one of the historically significant large-scale psychiatric institutions in Hungary, OPNI, through the lens of punishment and reward. Psychiatric institutions, as classic examples of total institutions (Goffman 1961, 13), operate within closed systems where power relations, professional hierarchies, and informal norms shape both everyday practices and individual behaviour.

Within such environments, mechanisms of discipline and control coexist with therapeutic intentions, often resulting in ambiguous boundaries between care and coercion. By focusing on retrospective narratives of former employees, this study explores how institutional structures influenced interpersonal relations, professional socialisation, and the normalisation of certain practices that may deviate from formal regulations.

Against this historical background, the study examines the internal mechanisms of punishment and reward within OPNI through a retrospective qualitative design. It addresses how institutional structures shaped interpersonal relations, professional socialisation, and everyday practices of discipline and reward. The analysis is based on semi-structured interviews and supported by historical and documentary sources. This study contributes to the literature by offering a qualitative reconstruction of institutional punishment and reward mechanisms in Hungarian psychiatry, highlighting previously underexplored patterns.

1.1 Historical background of psychiatry in Hungary and the OPNI

To understand the internal structure of one of the most important institutions in the Hungarian psychiatric care system, it is necessary to briefly consider the historical context of mental health care in Hungary. This paper does not aim to provide an exhaustive overview, but a few remarks on the eventful twentieth century are essential for understanding the narrative of punishment and reward.

From the end of the nineteenth century through the 1990s, normative regulations facilitated the establishment of institutions (Lafferton 2022; Füredi – Buda 1980). In Hungary, the National Assembly of 1790–1791 was the first to consider the idea of establishing a "public asylum," though it would take several more years for this to come to fruition. In 1842, the first private asylum in Hungary opened in Budapest, thanks to József Pólya, but it admitted only wealthier patients. The primary goal of treatment was essentially isolation from society, as the treatment options were extremely limited for most of the period in question. Nevertheless, the Pólya Institute did attempt to apply modern methods by the standards of the time, primarily by providing comfortable accommodations and ensuring rest. For poorer patients, care was provided exclusively at the Narrenturm in Vienna. The Viennese court had grown dissatisfied with the fact that Hungarians were unable to care for their own patients. In 1862, the first "public asylum" opened in Nagyszeben, quite far from Hungary. OPNI finally opened its doors in 1868.

Regarding treatment options, they were limited, including bromine, belladonna extract, and chloral hydrate (Shorter 1997, 45). At the beginning of the twentieth century, the therapeutic arsenal of neurology and psychiatry in Hungary was supplemented by lobotomy, followed by the induction of insulin coma and the use of cardiazol for seizure treatment. The first treatment to induce an epileptoid seizure in the central nervous system was applied by László Meduna in Lipótmező (OPNI) in 1934. The procedure marked an important step in the development of modern psychiatric therapies.

The psychiatric ward can be understood as a site of confinement and bureaucratic control in a Weberian sense (Weber 1987). In psychiatric practice, restrictive

measures may include psychological, physical and chemical interventions, such as verbal warning, restriction of movement, isolation, and the use of medication without consent. The total institution closes itself off from the outside world, and injustices and violations of rights are legitimised through so-called justifications of cruelty (Aronson 2022, 120). The long-dominant 'hardline' therapeutic milieu was catalysed by the fact that, at the end of the nineteenth century and the beginning of the twentieth century, psychiatry still had very limited treatment options available. As Porte writes, "Treatment options were also limited. Bromine, belladonna extract, and chloral hydrate were the most common medicines, and some patients, for example, in Sibiu, were given a litre of wine a day" (Porte 2002, 102). Lukewarm baths, outdoor activities, and occupational therapy completed the treatment.

The conservatism of the old methods is illustrated by the recollections of a chief physician from the 1970s: "Those were the good old days. It was good to work back then because restless, aggressive, and insolent patients could be restrained with cold water packs, but we also had authority," says the chief physician, quoting the spirit of psychiatry in the 1960s.

In the first half of the twentieth century, the custodial approach still dominated mental health care, with patients' fundamental rights restricted and their freedom taken away as they languished in wards. Remnants of this therapeutic approach remained at the OPNI for 30–40 years after psychiatry began to move away from conservative treatment practices.

Until the mid-twentieth century, disciplinary methods were traditionally physical in nature. For decades, restless and sometimes violent patients were confined to cage beds.

> It has been described that even with today's therapeutic possibilities, mesh beds have not disappeared from mental wards. The mesh beds in the OPNI have not disappeared entirely either; they can still be found in the men's wards of the National Institute of Neurology and Psychiatry. The use of such beds still depends on the approach to treatment. This is illustrated by the fact that in 1974, one of the two mental wards that opened at the same time in a rural hospital did not need any cage beds, while the other needed eight (Füredi – Buda 1980, 1116).

Cage beds are no longer used today, but there are isolation rooms in active psychiatric wards where those who do not comply with ward rules or break the rules during leave are placed in private confinement. This practice may also occur in certain institutional settings, where so-called "isolation rooms" are created, which are simple whitewashed cells. The purpose of these rooms is to isolate patients who are difficult to manage or pose a danger to themselves or others (Bacsák 2024, 45). Recent studies suggest that chemical, physical, and psychological restraints continue to be used under regulated conditions in contemporary psychiatric practice (Steinert et al. 2022). Separation is permitted by law (Decree 60/2004).

In addition to the shortcomings of the therapeutic arsenal, it should be noted that, professionally speaking, the treatment of violent/mentally ill patients was not a preferred area for middle-level staff either. As a result, the majority of mental

health workers were unqualified, and even in the 1990s, it was rare to find an assistant nurse or general nurse with the necessary qualifications at the OPNI. In Szentgotthárd, the manager was also a middle manager and party official, and the "grand rounds" were preserved as a privilege of the caretaker and the institution's manager (Bacsák 2024, 18). Middle-ranking healthcare professionals also wielded extraordinary power in the OPNI, as without them the psychiatric ward would not have been able to function. As a result, even the chief physicians feared them. One of our interviewees, a senior physician, recalls questioning the head physician about the aggressive behaviour of the nurses, to which he replied that he could not do anything about it because, without them, the psychiatric ward would not function (Interview 6 with a senior physician).

It was common in both the mental health home environment and the OPNI for generations of mental health professionals and doctors to work within the walls of the institution, which contributed to its feudalisation. For mental health professionals who came from families with poor socioeconomic status and lacked psychological support, and who struggled with complexes, cruelty towards patients and demonstrations of power could be a means of relieving frustration.

The hierarchy can be explained by the internal functioning of the total institution. Order and discipline can only be maintained in a bureaucratic system where individual interests are subordinated – the sui generis institution absorbs the individual, and, in many cases, the institution's autocratic leader is the arbiter of interests and academic disputes. The specific (authoritarian) character of the career socialisation of doctors and professional staff is the catalyst of the process, shaping the external and internal institutional structure. Psychiatry as a scientific field is also a scene of internal power struggles (Bourdieu 2009). Rivalry between university clinics and national institutes shaped the framework for treatment and institutional capabilities, creating divisions between individual schools. Social psychiatry, the anti-psychiatry movement, and the opposition of biological psychiatry defined modern Hungarian psychiatry. The somatic approach shunned the integration of social issues, separating the sociocultural/socioeconomic aspects of psychiatric disorders from the profession.

The treatment options were expanded at the beginning of the twentieth century with frontal lobe removals and, later, electroconvulsive therapy. László Meduna first used cardiazol to treat seizures at the OPNI in January 1934 (Baran et al. 2008). The procedure resulted in significant improvement, particularly in catatonic schizophrenia, with patients' symptoms alleviated. Thanks to Meduna's results, the electroconvulsive therapy introduced by Cerletti (in which an electric current was used to induce convulsions instead of a drug-induced procedure) became part of everyday psychiatric practice (Dobai 2025). "It was a long-fetishised method, and the procedure was used routinely in many cases, with patients in certain wards being shocked at an extremely high rate" – says the chief physician interviewed for this research.

In the post-socialist period, the entire field of psychiatry was characterised by a "legal vacuum," meaning that there were no legal guarantees for investigating violations of patients' rights (Fekete 2023). In his work, Péter Hajnóczy reports

cases in which the Social Policy Department of the Executive Committee of the Budapest City Council decided on long-term institutional placement without a medical examination or justification for psychiatric referral. There are even reports of inappropriate and sometimes abusive behaviour towards patients within psychiatric institutions (Vidovszky 1995, 11–13). Kis-Vámosi also states that after his arrival in Szentgotthárd, it became apparent that several patients had not undergone any medical examination at all, and that psychotropic drugs were administered on an ad hoc basis, often on the recommendation of non-medical staff.

One of the classic means of physical restraint was the straitjacket, which continued to be used for a long time after the regime change (Vidovszky 1995, 13). With straps reinforced, it completely prevented the patient from moving freely. The ambulance service continued to use it even after the regime change. In several wards at the OPNI, dementia patients were restrained to their beds or chairs (usually with leather straps or items of clothing, such as pyjama tops or rolled-up sheets) every morning when they were taken out of their rooms.

Alongside physical violence, verbal abuse also appeared, mostly in the form of belittling remarks and harsh verbal reprimands. With the spread of second-generation antipsychotics and benzodiazepines, the range of chemical restraint tools created unlimited opportunities for so-called overdosing (often carried out by nurses without the knowledge of doctors), and doctors resorted to unjustified increases in therapeutic doses and the parallel prescription of drugs with similar indications (Pow et al. 2022).

The total institution rewarded individuals who accepted its internal rules and behaved in a conformist, servile manner (Hajnóczy – Nagy 2013). Deprivation of liberty (Fundamental Law of Hungary 2011, Article IV) is one of the most significant sanctions in psychiatry: physical confinement, psychological restraint, physical restraint, and chemical restraint are means of deprivation of liberty (Decree 60/2004, VII. 6.). Even after the regime change, it appears to be common in certain contexts in several departments to strip patients of their 'civilian' clothing, take their valuables, lock their 'outside' clothes and items not necessary during their hospital stay in bags, and make them wear hospital pyjamas. On older nightgowns, the name of the psychiatric ward was written on the patient's pyjama jacket (e.g., II/A Men's Mental Health). The confiscation of personal belongings, such as mobile phones, may occur in certain institutional settings.

There are two types of 'privileges' in psychiatry: the so-called 'walk in the park' (parkséta), also known at the OPNI, which could be used with a "Parkséta permit," a document signed by the attending physician and the head physician of the ward. At the OPNI, this meant that patients were not allowed to leave the fenced-in area of the institution and had to return to the ward after a specified time. The 'leave permit' (so-called adaptation leave) allowed hospital staff to go home for a specified period. Both 'rewards' were granted by the head physician or professor in charge of the ward, with the approval of the attending physician. During on-call hours, the nursing staff exercised the right to discipline the ward: in many cases, they decided independently on discharge, which in some cases was not medically indicated. In many cases, those undergoing treatment earned money from work therapy, which

typically paid much less than the wage for similar work. Interviews reveal that the institution of 'therapeutic money' still exists in some places. Some people receive only 3,500 HUF for the entire month.

Changes in the punishment and reward mechanisms of the Hungarian psychiatric care system parallel international developments on the continent; the characteristics of the change are fundamentally similar: a shift can be observed from overt, mechanical discipline (restraints, seclusion, "moral management") to medicalised control (shock therapy, lobotomy, and drugs) and toward regulated, last-resort coercion (Wellington 2022; Haw 1989; Ban 2007; Steinert et al. 2022). An illustration of the significant domestic changes and continental influences affecting the Hungarian psychiatric ward practices is shown in Figure 1.

The present research aimed to explore and highlight changes in the themes of violence and reward, as well as the path dependency of the internal world of the total institution. Interviewees often appeared as victims of the system; they themselves were essentially cogs in the institutional framework that had shifted toward a more modern approach.

2. Theoretical framework

The spaces for repairing the social norm system are healthcare institutions, which act as heterotopias of deviance between social layers (Foucault 2000). These are institutional systems that repair and remedy the illnesses of the masses, constituted by the intentions of medical recognition of illnesses and social consensus. In a phenomenological sense, narratives of health and illness are formed by members of society based on individual representations of reality (mental representations) and are influenced by normative and evaluative ideas (Légmán 2011). In the healthcare system, "the obligations that constitute the central rules of the institution are referred to as institutional rules" (Farkas 2023).

In this regard, it is essential to explore the general sociological and psychological characteristics of total institutions (Table 1) to observe better and understand the processes that led to the establishment, maintenance, and partial demise of large mental hospitals (Goffman 1961). The topic raises several fundamental questions: What led to the emergence of total institutional subsystems within society in the first place? What necessities create them and what makes them inhumane, exclusionary, and isolating? The total institution partially deprives its inhabitants of their free will, clothing, freedom of expression, and physical and chemical methods of restriction (Foucault 1977, Decree 60/2004, VII. 6.). The legal relationship between doctor and patient in psychiatry creates a paternalistic relationship, where patients are often treated like children and subjected to Spartan discipline (Bartha et al. 2009). A stark manifestation of asymmetry is that those receiving care (patients) in the psychiatric care system (in psychiatric homes and active psychiatric wards) are often addressed without regard to their gender or age. Epistemic injustice is particularly evident in psychiatry. In this atmosphere, personality attributes dissolve, and individuality becomes irrelevant; this represents a form of extreme

depersonalisation, where everyone is equal. In classic mental institutions, healers are often individuals experiencing moral or professional crises, whose behaviour may manifest in harmful or abusive practices.

In terms of power relations and restriction of freedom, extreme forms of psychiatric institutionalisation may show similarities to prison-like settings. In some cases, psychiatric institutions may exhibit even more restrictive characteristics, as certain forms of treatment can extend for an indefinite period, raising professional and ethical concerns (Hungarian Judiciary 2019). As Thomas Mann's novel The Magic Mountain suggests, time becomes relative in a total institution, and the end of treatment depends on the healers, which can be endless and indefinite (Mann 2015). Nevertheless, it can be said that the extremely exploitative and preservation-focused institutions outlined above are now few in number, although some still retain these characteristics. The marginalisation of people with mental illness and their expulsion from the fabric of society as abject beings already appeared during the great epidemics, and these asylums function in a similar way (Csabai – Erős 2000, 108). Of course, they did not actually provide shelter for those stranded on the outskirts of cities. Still, they served as places of actual isolation, such as TB institutes, leprosariums, sanatoriums, or prisons. The purpose of segregation is twofold: separation from society and protection of the social order; the elimination or temporary removal of those who are abnormal until the disciplinary (healing) effect of treatment takes effect (Foucault 2003). The Cancer Ward suggests that the parallel between illness and political demarginalisation, which Hajnóczy depicts in his Az elkülönítő (The Isolation Ward), can also be observed in the reality of a mental hospital (Szolzsenyicin 2015).

The culture of alienation is inevitable within the walls of a total institution: sick bodies lose their personalities, become disenfranchised, and ultimately become victims of mechanical processes, at the mercy of the machinery of the healing process. Guardianship, which completely excludes or restricts the ability to act, also contributes to the surrender of personality and the breaking of the will, further weakening free participation in social processes and making people vulnerable to the machinery of bureaucracy. The status of patient and caregiver alone determines the asymmetrical relationship that pervades the entire care system: the specificity of each process. Life in such a community is described very accurately in Sándor Szathmári's novel, Kazohinia, depicting the world of the Hinek as a model example of a dystopian society, where reason reigns supreme over emotions and emotional content cannot be expressed (Szathmári 2023).

Table 1. Based on Goffman, own ed. (Goffman 1961)

Type of institution	Relationship with residents/ patients	Personal freedom	Main function	Leaving the institution	Sanctions
Care institutions (e.g. elderly homes, psychiatric homes)	hierarchical, 'caste-based'	limited	care, survival, reintegration	rare, often restricted	physical, verbal, chemical
Hospitals / psychiatric wards	paternalistic, asymmetrical	restricted	treatment, confinement	conditional, medically regulated	restraint, isolation, medication
Prisons and detention institutions	authority-based, supervisory	highly restricted	punishment, control	after serving sentence (sometimes indefinite)	physical punishment, isolation
Military units/ camps	rank-based hierarchy	restricted	discipline, task execution	time-based	disciplinary sanctions

Szathmári's novel accurately predicts the emergence of individualised and indifferent social structures and the dangers of the decline of empathy and altruism in the postmodern world. The somewhat extreme book by Márk Horváth, which can be considered more of a dystopia than a realistic vision of the future, nevertheless, provides a shocking insight into the subject and is an essential work for understanding the social relationships of the present world (Horváth 2021).

With the disappearance and humanisation of total institutions, there is now a realistic chance that a more humane approach to illness will lead to a noticeable improvement in the situation of people with a mental health condition, but, at the same time, the empathetic, altruistic view of humanity has been thrown into crisis. Health/ illness, good/bad, normal/abnormal appear in the form of dichotomies that create their own heterotopias of deviance, with wholeness (health) as opposed to the sick (illness), i.e., non-wholeness, paradoxically creating a peripheral zone for those who do not possess the completeness of wholeness (Csabai – Erős 2000, 127).

The narrative of health culture and perfect bodies and souls permeates everyday life. Through mediatisation, we can easily create false selfies, and health discourses are also taken to extremes in the online space (Berger 2023). As a result, alongside the categories of fellow human beings and contemporaries, we now see the fake or real selfies of mediatised fellow human beings (Schutz – Luckmann 1973; Zhao 2004). Irrational behaviour is also amplified through mediatisation, and we can find numerous examples of this in contemporary life. Normality is forced – one must be balanced and beautiful, perfect; the abnormal (unreason) has no place in the centre of the social force field (Foucault 2004). One must also be comfortable dealing with personal crises; resilience is expected (Hankiss 2015, 339).

It should be noted that attitudes toward cancer patients are very similar to those toward mental illness: it is often considered a "contagious" disease in a specific psychological sense, and the patient is removed in order to maintain a healthy self-image and preserve health, since the disease reveals a possible self with which the individual does not want to identify, and therefore the inner OTHER must be rejected (Csabai – Erős 2000, 127). The total institution's themes of violence are expressed in the mentally healthy selves, i.e., the isolating attitude of healers toward patients who are considered 'infectious' agents. In everyday life, social attitudes may be altruistic, but in many more cases, they are dismissive, thus creating an invisible institution (subculture) for the mentally ill, designating their accessible positions in society, marking their place in the heterotopias of deviance, far from the centre (Bacsák 2024, 45).

3. Research questions

The study addresses the following research questions:

What interpersonal mechanisms can be identified within one of the last total institutions?

How did the career socialisation of employees take shape within the institutional environment?

How did everyday life develop in micro-communities with different professional profiles?

What themes of violence can be identified in the internal life of the OPNI?

How do former employees reflect on the community and the total institution as a 'morphological' structure?

What role did cross-generational traditions play in maintaining the rigid institutional structure?

4. Material and methods

The study applies a retrospective qualitative research design based on semi-structured interviews (Brinkmann – Kvale 2015). A total of 30 participants were included in the sample, comprising former nurses, nursing assistants, physicians, psychologists, manual workers, relatives who had worked at the OPNI between 1968 and 2007, and rehabilitated patients.

Participants were recruited through a call posted in a closed Facebook group ("We worked at OPNI") and through snowball sampling. The selection aimed to include individuals from different professional positions, including middle-level staff as well as rehabilitated patients, to capture diverse perspectives on institutional functioning.

The first author worked as a nurse at the institute between 1998 and 2002, which facilitated contextual understanding and access to participants. This positionality required continuous reflexive awareness during both data collection and

interpretation.

Data collection took place in 2024. Interviews were conducted primarily in quiet, private settings at the participants' workplaces, with one interview carried out online. All interviews were audio-recorded, transcribed, and anonymised, and the data were stored on a password-protected device accessible only to the research leader. The study was conducted with the approval of the Research Ethics Committee of the Faculty of Education and Psychology at Eötvös Loránd University (Approval No. 2022/677) and complied with GDPR requirements.

Data analysis was guided by principles derived from grounded theory methodology (Glaser and Strauss 2017). Coding and thematic analysis were carried out using the MAXQDA24 software environment, allowing for the integration of textual, visual, and audio data. The present analysis focuses on interview segments related to the themes of punishment and reward.

Interviews are anonymised and referred to by numbered identifiers throughout the text.

List of interviews

Interview 1 – nurse, Budapest, March 2024
Interview 2 – nursing director, Budapest, March 2024
Interview 3 – nurse, Budapest, 2024
Interview 4 – male nurse, Budapest, 2024
Interview 5 – former nurse, later physician, Budapest, 2024
Interview 6 – senior physician, Budapest, 2024
Interview 7 – head physician, Budapest, 2024
Interview 8 – research physician, Budapest, 2024
Interview 9 – physician, Budapest, 2024

5. Results

This section presents the main findings of the study.

5.1 Traditions spanning generations

The literature and press materials exploring the history of the OPNI, supplemented by the interviewees' accounts, provided insight into the institute's historical narrative and, through historical reconstructions, the driving forces behind its internal operations. Between 1957 and 1972, under the directorship of Béla Mária, pharmacotherapy played a key role in treatment (hibernal, lithium, bromine). At that time, there were still separate wards for men and women, in line with the structure at the time of its founding, and the institute operated as a completely closed system. The director of the institute abolished some of the doctors' residences in the 'Big House' (Nagyház), and then doctors' and nurses' residences were established on Lipótmezei Road. The separation of healing and family life was necessary to create a healthy lifestyle; the previous structure was born out of necessity, with residential units scattered throughout the entire institute. Following the introduction of the new economic mechanism, many new sectoral developments were launched. In 1969,

the Guidelines for the Development of Mental Health Care were published, stating: "By 1985, there should be 20 mental health beds for every 10,000 inhabitants and one mental health nurse for every 40,000 inhabitants" (Tariska 1984). The institute was headed by István Tariska (1972-1986), who was trained as a neurologist, certified in both neurology and psychiatry, and worked primarily as a neuropathologist, and who brought significant reinforcement to the institute's neurological profile. In the 1980s, the term 'mental ward' was replaced by 'psychiatric ward'. The period immediately preceding the regime change marked a new era for psychiatry, with developments and the entire spectrum of mental health care appearing in the life of the institute (1986–2002). From 1989, András Veér abolished closed wards (there were still closed sections within individual wards), and supported the development of a social psychiatric approach. After the regime change, it operated under the name National Institute of Psychiatry and Neurology. Under the leadership of András Veér, the institution was further liberalised and expanded with significant rehabilitation and psychotherapeutic capacities (Erőss – Veér 2002).

> Closed wards have been abolished in Hungary, at least to my knowledge. If they still exist, I condemn them. In our institute, there are only a few bunk beds left. Eight years ago, when I came to Lipótmező (OPNI), I found 15 bunk beds. Then, after a lot of effort, we removed them from the wards (Köbli 1993).

Following András Veér, Zoltán Nagy, a neurologist who had achieved significant results in the field of neurovascular diseases, became the director of the institute. He supported joint neurological and psychiatric research and considered the operation of the Tárt Kapu Gallery to be important. He announced an 'open door' ('tárt kapu') professional policy program in order to help the majority society become more familiar with the closed world of the institute (Nagy 2022). These efforts were ultimately thwarted by the closure announced in April 2007. In May 2007, the institute's management requested that the New Hungary Development Plan include the establishment of a national psychiatric institution to provide treatment, research, and education.

The interview excerpts in the next section clearly show how the OPNI's traditions have been passed down and shaped over generations, so the quotes will not be repeated here.

5.2 Interpersonal mechanisms and career socialisation

This section examines interpersonal dynamics and career socialisation within the OPNI based on interview data. Generations of families worked at the institute, with most positions being offered to acquaintances and friends. This created a close-knit internal community, which strongly influenced interpersonal relations and career socialisation. The following excerpt illustrates this dynamic:

Open recruitment was extremely rare, which meant that internal relationships and micro-communities functioned like families. Young people were typically enthusiastic and found the OPNI to be an inclusive and accepting community:

Well, it was a commune… No, they weren't colleagues, they were more like family members. Well, obviously, I stood out from the crowd. And […] my friend and I went there together. We were both cult members at the age of eighteen. (Interview 1, nurse)

However, in line with the hierarchical, closed structure, accepting new employees was sometimes difficult, and mistrust arose towards 'outsiders':

My supervisor nurse, who said he knew me from the inspection and liked me very much, would have preferred someone else from the institute, someone else who was better suited to the job… (Interview 2, nursing director)

The professional community was diverse. Basically, the structural organisation of work communities was determined by a hierarchical system based on professional qualifications and positions:

This 'white-collar world' was heterogeneous, and the nurses were also very diverse, from many different places; our head nurse became head nurse from the kitchen, she didn't even have the right qualifications, but at the same time, there were others who were more professionally suited to the job, so it was a very mixed team. (Interview 3, nurse)

The following recollection clearly illustrates the controlling and norm-setting role of the head physician in the micro-community of one of the departments:

Well, you're a little crazy too […] You got the impression that all your colleagues had their own little quirks. So, for example, the chief physician, if he were having one of those days, would take the whole staff out for a walk after rounds and walk around really fast. She was a very fit woman and walked incredibly fast, and she galloped ahead, and there was this concrete section that ran outside Lipót, and then we galloped along it (Interview 4, male nurse).

The internal hierarchy of the institute was dominant throughout, and the transition between the different 'castes' caused difficulties for colleagues in liminal situations who were still in training, with group membership causing internal dilemmas:

…then the conflict between nurses and doctors was even more pronounced. As a university student, I was more aware of this because I was torn between the two, wondering where I belonged. It was a separate 'caste' or 'clan,' the nurses and the graduates, but primarily, of course, the doctors (Interview 5, former nurse, later physician).

At the end of the 1970s, the institute began a slow, barely noticeable liberation from its former conservative approach. Psychologists appeared on the scene, and Ferenc Mérei and his students worked tirelessly to gain recognition for the legiti-

macy of psychodiagnostic tests. This laid the foundation for meaningful therapeutic and relational work with patients and the introduction of a psychotherapeutic approach.

…in fact, it became a world of freedom for them. In other words, in contrast to confinement, a world of freedom appears. The patients are nice; they are already there, so it is possible to establish a good relationship with them, etc. So, it's living psychology. Here you can do something with people, and I ended up with [Ferenc] Mérei in his lab, but the truth is that it's tiny, like half of this. It was such a tiny little hole, the Psychodiagnostic Laboratory.

Psychologists were gradually present throughout the entire institute, and working conditions for psychologists were created in every department – it was an educational/teaching environment where the approach was instilled through modern practical work.

[Ferenc] Mérei came over from Lipót and held training sessions for the large group. So that's how I stumbled into this very fast-paced little life. And that really just confirmed that yes, this is what interests me. (Interview 5, former nurse, later physician).

One of the main characteristics of the institute was that it functioned as a knowledge hub, where experts in various fields shared their practical knowledge in close collaboration. Paradoxically, it was the totalisation of the institution that ensured professional coherence between the different schools.

5.3 Themes of violence in the OPNI

The periods covered in the interviews span from 1967 to 2007, encompassing a significant period of socialism and the renaissance period of regime change. The career socialisation of resident doctors and specialist staff involved learning practical skills (in somatic medicine as well as psychiatry, since most of them involved biological or chemical interventions), internalising the often extreme system of group norms, but above all accepting them (Table 2).

Table 2. Methods of abuse in psychiatry

Physical abuse	**Chemical abuse**	**Verbal abuse**
cage bed/ tying up	unnecessary overdose of medications	informal address
sexual assault	administering a painful injection for the purpose of causing pain	obscenity
beating	narcotic penalty injection	shouting at

The following interview excerpt contributes to understanding the harshness of the practice, faithfully reflecting the attitude of an entire era in the OPNI, the harsh manifestation of physical aggression:

That was what the nurse wanted and said. I go into the 14-bed ward, and there sits a 17-year-old schizophrenic kid in a state of delirium, a schizophrenic in the early stages. I can still see his face. He's sitting on a chair, and he's a big guy. I can't say anything else about it. […] He slaps the kid so hard that he has to lift him back onto the chair with his other hand. And then I was standing behind him like this… well, I reached halfway up his back, so I had to pat his back, and then he looked back. 'Well, you had to come in right now,' that was the answer. And when I went to see the [head physician], I told him that I couldn't take it anymore, and he said, 'XYZ, without these nurses, the psychiatric ward would collapse.' And I got to the point where I was going to leave, leave it all behind, go away, become a district doctor, whatever.… (Interview 6, female head physician).

Electroconvulsive therapy (ECT) was routinely used, with young doctors learning the technique from their elders, and regular ECT therapy was part of their daily work.

There were times when I did 15 or 20 ECTs in the morning after my shift. And we did it like this… well, at the […] Hospital, they taught us how to do it. Because there, you know, the Hungarian wink Marshall method of anaesthesia, relaxation – everyone who was a soldier learned it there. And we went there and did the daily electroshock; well, it was described as highly distressing and comparable to depictions in popular culture, such as One Flew Over the Cuckoo's Nest, the film with Jack Nicholson. It was really something; they would grab the patient by the ten fingers, drag him in and zap. Meanwhile, a good few, eight of them, held him down everywhere so that his spine wouldn't break, but that epileptic seizure was still an epileptic seizure, you know. And then it turned out that the reason for this was that once a colleague's patient died after electroshock, probably due to polianaesthesia (over-anaesthesia) … (Interview 7, head physician in psychiatry).

Although the use of mesh beds was professionally unjustified, it persisted until the 1990s, partly out of tradition, illustrating the slowly forming ideological framework of the total institution:

The cage bed was unacceptable to me from the very beginning. Besides, I don't think it even served its purpose because the confused old woman was able to untangle the ropes. I saw it with my own eyes: she somehow broke the fishing net and stuck her head through it and almost suffocated. In 1999, I met Erzsébet Blaha in the hallway: 'Visit me, since I'm meeting you face to face, in the institute's last hospital bed' (Interview 8, head physician in psychiatry).

Other means of restricting freedom were also used to restrain restless patients. The use of restraint straps was widespread, and many former OPNI employees kept them after retirement (Figure 4). Occasionally, sheets or pyjamas were used to make "ropes" to replace the straps.

While patients often saw the institute as a symbol of suffering, torment, and helplessness (especially before the regime change), the following section shows that the staff was positively influenced by the environment and sociophysical spaces of the OPNI.

> And I lived relatively close by, so for me, Lipót as a whole, with its entire subculture, its large park, its tennis courts, and even the swimming pool that was there at the beginning, represented a separate living space and experience for me (Interview 9, research physician).

6. Conclusion

The retrospective research was useful in learning about the decades-long development of the largest institution of twentieth-century Hungarian psychiatry. The interviews helped reveal the dual nature of a total institution, the diversity of human and professional relationships behind the disciplinary and corrective machinery. The mechanisms of discipline, reward, and demarginalisation emerged, contrasting with the humane characteristics of the institution's socialisation processes. The internal normalising structures of a total institution may create conditions for abuse. Power, hierarchy, and ideologically based decision-making fundamentally determined the functioning of the institution. The medical and professional communities were absorbed into the institution and were almost prisoners of its peculiarities: they were both its operators and its victims. A double demarginalisation can be observed in psychiatric institutions, which also significantly influences the patterns of group cohesion within the healthcare professional community.

The research highlighted the mechanisms of total institutional socialisation and interpersonal mechanisms, which also shed light on the specific nature of psychiatry within medicine. The biological approach, combined with social psychiatry and psychotherapeutic methods, could provide fertile ground for the integrative care of psychiatric patients (Harangozó – Perczel 1998). However, the interview excerpts revealed structural and interpersonal barriers that led to misguided treatment at the institution under study. The professional 'caste' system and the symbolic boundaries between generations, which are often inherited, slowed down and hindered the effective functioning of the institution in accordance with the principles of contemporary psychiatry. Professional advancement was often aided not only by competence but also by loyalty and acceptance of (outdated) prevailing principles. However, the emergence of professional, innovative islands such as Mérei's psychological laboratory or Péter Halász's Comprehensive Epilepsy Centre at the OPNI cannot be ignored. The duality prevailing in the institute is well illustrated by the rigid, outdated professional guidelines and the aforementioned innovations, as

well as the continuous liberalisation of the generational approach.

The primary goal of the research was to explore the themes of violence within the OPNI. During the life interviews we conducted, we encountered severe forms of abuse only sporadically; the methods of discipline were much more sophisticated than expected in institutional practice. It is assumed that behind the facts we learned, there may be latent patterns of violence: this may have a somewhat distorting effect on the research, which is the most significant limitation of our work. Few reported physical abuse, but physical violence, restriction of freedom, and the non-therapeutic use of therapeutic tools (ECT), primarily for discipline and restraint, occurred. Although current guidelines did not allow certain methods, such as the use of net beds, we observed that the example mentioned remained a routine procedure without any professional justification. We know from other analyses that verbal abuse was part of everyday life at the institution, which we only observed sporadically in the interviews. There may be several reasons for this. It is likely that, in addition to physical and chemical discipline, this form of abuse seemed insignificant to the staff. Furthermore, profanity, shouting, and swearing directed at patients may have been part of everyday life, and thus became normalised. The staff had to make professional and moral compromises in order to perform their duties within the institution, so it is not only the patients who can be considered the sole victims of the structure, but also the professionals themselves.

Due to the limitations of our work, we are unable to shed light on the current situation of psychiatry in Hungary. Still, it lays the foundation for further research in the future. Our research can serve as a particularly useful basis for understanding the structural problems of the segmented, integrated psychiatric care system. Furthermore, it is also justified to examine the changes in the themes of violence under a magnifying glass. In recent decades, significant changes and tightening have been implemented in the treatment methods used in the psychiatric system. Human and patient rights issues have come to the fore, but deviations from the guidelines can be assumed. It is urgent to explore the current problems and difficulties in the field of psychiatric care, as other systemic difficulties in the integrated system place a fundamental burden on health and social care staff.

One limitation of this study is the retrospective nature of the interviews, which may involve selective memory and underreporting of certain forms of institutional violence.

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