

G. E. SUKHAREVA'S PLACE IN THE HISTORY OF AUTISM
RESEARCH: CONTEXT, RECEPTION, TRANSLATION

BY

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Abstract

Grunya Efimovna Sukhareva was a Soviet child psychiatrist and neurologist who described an autism-like condition closely resembling Asperger's syndrome about 20 years before Hans Asperger and Leo Kanner published their descriptions of autistic psychopathy and early infantile autism, first naming it schizoid psychopathy (1925), later renaming it autistic psychopathy (1959). While autistic-like syndromes were repeatedly described independently in many countries in the first half of the 20th century, Sukhareva seems to have been the only person to give a detailed description of the syndrome's presentation in girls and its sex differences. Considered the founder of child psychiatry in Russia, she is little known elsewhere, despite a significant portion of her work being written in German. Awareness of Sukhareva and her work has been slowly making its way into autistic history, largely as a result of the 1996 publication of Sula Wolff's translation of the 1926 case studies on schizoid psychopathy in boys, but the large majority of her work remains untranslated from German and/or Russian and inaccessible to many people. Her 1927 paper of case studies on girls, describing sex differences similar to those being described now, are virtually unknown even in German texts.

Including the translation of Sukhareva's German-language paper on schizoid psychopathy in girls, summaries of her Russian-language texts on the syndrome, and what is hoped is a comprehensive bibliography of her published work, this thesis seeks to place Sukhareva's work and its reception within the wider context of research into autistic-like syndromes in Anglo-European medical literature, and to understand the impact of domestic and international politics of the 20th century on child psychiatry and the international exchange of scientific knowledge. The thesis also corrects misinformation found in some recent popular histories of autism.

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Introduction

So there's this tiny kid, right, and he's nearly two but he doesn't talk. His parents try everything to get him to talk but he never does. They get him tested but he's not deaf, it's just a big mystery. No one knows why he won't talk. He turns two, doesn't talk. Turns three, still doesn't talk. He turns four and then one morning he goes, "Mum, the toast is burnt." Everyone is shocked. "You could talk this whole time?" they say. "How come you didn't talk before?"

"There was no reason to," he says.

joke heard when I was in primary school

The joke is not funny. As a child, I often didn't understand jokes or laugh at them, but I recognised their social potential. I had a prodigious memory for jokes and could keep children up all night telling them. I learned to distinguish good jokes from bad by the reactions they generated. This one is a bad joke. As an adult, I can explain it. The humour is meant to be that the trivial matter of burnt toast is such a catastrophe to the mute child that this, and not all previous entreaties and methods employed by parents and doctors, causes him to speak. The humour is also that clearly nothing else of any significance has happened in the child's life so far. He has led such an uneventful life that burnt toast is worth breaking his years of stubborn mutism. The joke never succeeded, but its main point of failure was that other children found the premise implausible. "He doesn't speak until he's *four*?" they would say. "And then he only speaks because the toast is burnt?" and "I don't get it." and "But if he could speak, then why didn't he?" and "Why didn't he just say he didn't want to talk?" and "I've never heard of such a thing. You can speak when you're *four*."

They had never heard of such a thing because it was the 1980s and children with speech delays were not in regular schools or even kindergartens. As an adult, the only thing I now find implausible is that the child explains his mutism. Sure, he would comment on the toast, but after that, he'd more likely just go back to not speaking¹. And there's no

¹ A similar anecdote appears in Leo Kanner's 1949 paper "Problems of nosology and psychodynamics in early infantile autism" in which a mute 5-year-old boy one day gets a prune stuck to the roof of his mouth and in his distress requests its removal before resuming his former muteness (*Childhood Psychosis* 53).

humour in it for me now because I find it *too* plausible. Didn't speak till he was four? But I know autists who didn't speak till they were six. It's no longer a joke, it's a nothing story like "One day a woman walked to the dairy and bought a litre of milk." So what. And it never answers the question, did the child lack the ability to speak or was he choosing not to?

The idea for this project came while reading Steve Silberman's *NeuroTribes*, in which Silberman mentions the language barrier hampering his research and the great cost and hassle of paying private translators to translate German texts and correspondence. Lack of literacy in German certainly is a big barrier to anyone attempting to write about Hans Asperger or follow Leo Kanner's references, and yet to my great astonishment, not only have people given histories of autism without access to key works (Roy Richard Grinker's *Unstrange Minds*, Adam Feinstein's *A History of Autism*), but people are still attempting them now (*In a Different Key* by Jon Donovan and Caren Zucker, the aforementioned *NeuroTribes*). Almost every self-help book for parents, spouses, therapists or autists includes the customary 'history' derived from all the other books, recycling the same slim pickings of information and cementing the notion that the history of autism is complete and contains no further stories that can be told.

Realising that the majority of Asperger's work has never been translated into English, and seeing many people in autistic communities online bemoan their own lack of German and the stark absence of English translations of writing by the man whose name provides the root for 'aspie', a word many people adopt as an intrinsic aspect of their identity, I saw in 2015 that there was a gap here people were asking to have filled and proposed my PhD as a translation of Asperger's work.

But Silberman had also briefly mentioned in passing a Soviet psychiatrist and neurologist who had published widely in German called G. E. Sukhareva, little known in the Anglophone world yet considered the founder of child psychiatry among Slavs. I began looking into her work from curiosity and from this Sukhareva emerged as the more interesting topic for me, especially when I discovered that an important paper of hers had never been mentioned in the English literature on her.

The 'discovery' of Sukhareva's work is usually credited to Sula Wolff, who published a translation of Sukhareva's 1926 German-language paper studying schizoid psychopathy

in adolescent boys under the title “The first account of the syndrome Asperger described?” in 1996. In investigating this paper, I found that it was merely part 1 of a two-part study on schizoid psychopathy and that part 2 contained adolescent girls and a discussion of sex differences. My project then became to translate this unacknowledged paper and make information about Sukhareva available in English. I came into this project assuming her work had been overlooked due to sexism, Russophobia and academic rivalry², probably influenced by the tone of *NeuroTribes*. I found that while Russophobia was certainly very present at a governmental level in the USA, not all medical professionals felt the same way and Sukhareva was not unheard of by any of the serious psychiatrists. Her work on schizophrenia and oligophrenia (intellectual disability) was well-known and she was in contact with key researchers in the United States and Europe, including Leo Kanner. The overlooking of her work on schizoid psychopathy, later renamed autistic psychopathy (Asperger’s syndrome) is perhaps a fault we can attribute to child psychiatrists active between the 1950s and 1980s. It is also true that there was far more gender equality in psychiatry in the USSR than the USA. But it may be that this work was ignored due to redundancy: much of it was in Russian, and what wasn’t, was being said by others. It may be that it was ignored because it did not align well with the then conceptualisation of the syndromes as affecting largely boys. It may be that it was ignored due to fashion; researchers in the USA were more interested in childhood schizophrenia and severe forms of autism than milder presentations. It may be that it was ignored because people had not read it and information exchange and translation was far more difficult then. That said, the ‘moral’ is possibly that there is never a first and that, while any search for moral outrage will always succeed, the search for a true first in anything is a vain enterprise. That Sukhareva appears in English language research articles well before Sula Wolff’s ‘discovery’ does not make her less interesting. Indeed, it further highlights the importance of her work and lack of biographies about her in English. The fraught political tensions of the 1950s reinforce the extraordinariness of the citations she received and the dedication to the international exchange of scientific information that the majority of researchers had. Lack of attention to her work was bemoaned by Italian neuropsychiatrists Annio Posar and Paola Visconti in a letter to *Journal of Pediatric Neurosciences* in 2017. “I’m working on it,” I wanted to say. Sukhareva can indeed be

² In a 2018 article for *Spectrum*, also reprinted in *Scientific American*, Lina Zeldovich takes the indignation and outrage even further, claiming that Sukhareva was ignored due to anti-Semitism. If history is now written by the common online consensus, I have little hope that such speculative dramas as those disseminated by Silberman and Zeldovich will not end up established as fact.

considered an early³ pioneer of autism research and is well deserving of recognition outside Russia and further study for this reason alone, but schizoid/autistic psychopathy constitutes only a small portion of her life's work and contributions to child psychiatry.

Why Sula Wolff either ignored or was unaware of part two of Sukhareva's case studies will remain an unsolved mystery as Wolff is now deceased. The first (1926) of Sukhareva's schizoid psychopathy papers contains case studies of the syndrome in boys, the second (1927) those of the syndrome in girls. Her third (1930) paper on the topic appeared solely in Russian and documents the life course of the schizoid psychopath individual and the prognosis. Her 1959 textbook includes a chapter on the syndrome and renames it autistic psychopathy. Not only did Sukhareva document a collection of behaviours that closely resembles the autistic psychopathy documented by Hans Asperger 20 years later, she also documented the syndrome as it appears in both boys and girls and made notes on what she perceived to be the sex differences in the manifestation of the syndrome. This to me is the most interesting aspect of her work in this area, given that a. for many years researchers were confident Asperger's syndrome appears rarely in girls if at all⁴ and b. there are still no separate diagnostic criteria for girls and women. The disparity in the number of boys and girls diagnosed with autism spectrum disorders is well-known and has been reported variously over the years as 10:1, 4:1 and 2:1, the ratio diminishing with both the passage of time and the *DSM's* subsummation of Asperger's syndrome into the more encompassing autism spectrum disorder in 2013 (the more disabling form of autism often referred to as Kanner's autism has often been reported as occurring equally in boys and girls). There is currently debate between geneticists who hypothesise that the biological makeup of females or female hormones may offer a fetus protection against autism (Jacquemont et al. 2014), and those who take the more sociological approach pointing out that diagnostic criteria may be biased towards boys. While having certainty of the veracity of either of these hypotheses would not necessarily invalidate the other, this second perspective has resulted in increased calls from researchers (Bargiela et al. 2016; Shefcyk 2015) and the affected community (Pellicano et al. 2014) for the development of a female autistic phenotype, although whether those calling for a distinction between

³ It is difficult to ascribe superlatives to any of the researchers appearing in this thesis and my own superlatives should also be read with scepticism.

⁴ Rainier Vedder wrote in 1962, "de patiënten zijn uitsluitend jongens." (146) [the patients are solely boys.] In 1960, Hans Asperger was confident that autistic traits in girls, at least in his country, were nearly always the result of organic brain disease (63).

male and female, boys and girls, feel the difference that needs to be clarified is primarily one of biological sex or of socialised gender is seldom clear.

Over the last decade or so, researchers and laypeople have been redescribing the sex differences Sukhareva described back in 1927, again in 1930 and again in 1959, and, for all anyone describing them knows, these descriptions are wholly new 21st century accomplishments. However, they are mistaken!

This study aimed to answer the question, “Did people lack the ability to speak of Sukhareva or were they choosing not to?” The answer is unsatisfactorily “Neither!” and also “Both!” However, I hope the study can provide a context of the wider research into autistic-like syndromes in Anglo-European medical literature into which Sukhareva’s work might be placed, create some understanding of the impact of domestic and international politics of the 20th century on child psychiatry and the international exchange of scientific knowledge, correct misinformation found in some recent popular histories of autism, furnish the Anglolexic world with a greater understanding of Sukhareva’s work and her place in autism research, and make one of her papers accessible to a wider audience. This last aim has been further achieved with the translation’s recent publication in *European Child & Adolescent Psychiatry*.

Overview

Before getting started, I’ll briefly discuss what autism might be. Chapter 1 contains current *DSM* and *ICD* diagnostic criteria. While not accepted by all, these manuals are globally the most widely used and as such exert the most powerful normative influence. The chapter is intended to summarise current understandings of autism as a point of comparison for the various ASD-like conditions described in the historical sources discussed in subsequent chapters.

Moving on to the main body of the thesis, my literature review aims to lay out the history of autism research, a central element of the context in which Sukhareva’s work ought to be viewed. The chapter moves progressively from a wider-angle view of matters of general relevance to a narrower focus on matter pertaining directly to Sukhareva and this study. I look firstly at standard sources in the history of autism research, then cover some non-standard or overlooked texts before moving on to the

history of the history of autism research. Finally, I look at sources informing Sukhareva's work, specifically, researchers she referenced, with commentary on the prevalence of their ideas in the period.

Chapter 3 is my translation of Sukhareva's 1927 paper "Die Besonderheiten der schizoiden Psychopathien bei den Mädchen." This is the first English version of a paper that by rights should change the common understanding of the history of autism research, as the topics it addresses are ones which researchers in the English-speaking world have become interested in only in very recent decades. This translation is intended to complete the begun by Sula Wolff with her 1996 translation into English of Sukhareva's 1926 paper on schizoid psychopathy in boys. I have not retranslated this paper ("Die schizoiden Psychopathien im Kindesalter"); however, it is included in the appendix for consideration by those interested in a more complete picture. I did translate a co-authored paper from 1925 called "Materialien zur Erforschung und der Korrelationen zwischen den Typen der Begabung und der Konstitution", which includes case studies of several children with schizoid psychopathy, some of the individuals reappearing in the papers of 1926 and 1927, but this has been omitted for want of space.

In my notes on the text in Chapter 4, I give some background to the paper, talking about several key concepts that occur in it, as well as its place in Sukhareva's work as a whole and its relation to other important descriptions of autism spectrum disorders, specifically Kanner's autism. This chapter then provides notes on the translation process, outlining my translation philosophy with respect to this project and detailing some translation problems and solutions. These notes also give an overview of translations of Sukhareva's work into other languages. As a measure of its diffusion, this section contributes to my depiction of the international reception of her work.

Chapter 5 summarises Sukhareva's two Russian publications on schizoid psychopathy. These give some insight into the evolution of her work on schizoid psychopathy over the subsequent decades and give a more complete impression of the clinical picture of schizoid psychopathy as understood by Sukhareva.

Chapter 6 provides a meagre biography. This was created with the assistance of Richard Millington who translated many Russian articles for me. I have devoted a substantial section of the biography to the events that have become known as the Pavlovian

Sessions, which have been left out of previous biographical accounts, even though they played a crucial role in shaping both Sukhareva's work and the environment in which she conducted it. I am further indebted to Benjamin Zajicek who kindly made his photos and scans of several of Sukhareva's textbooks and articles available to me. I endeavoured to compile a complete bibliography of Sukhareva's published work including translations, but it is incomplete.

The Reception History in Chapter 7 enters into more of the political aspects of this story. In contrast to the previous chapter, this chapter is concerned with developments on the western side of the Iron Curtain, how the political environment there affected the reception of the work of Sukhareva and Soviet doctors more generally in the English-speaking world, and how this contributed to lack of proper recognition.

In the conclusion, I provide my thoughts on completion of this project.

A timeline precedes the bibliography. It is hoped the timeline will be of useful reference in the reading of this text.

The appendix contains work authored by others: two of Sukhareva's German papers and a translation of the Soviet child psychiatric classification system Sukhareva developed.

The various components that make up this thesis combine a wide-ranging account of the scientific and political background to Sukhareva's research into schizoid psychopathy, close consideration of her work itself both at specific moments and over the course of her career, and an overview of its reception in Russia and especially internationally. Together these elements should provide the basis for a more accurate and informed assessment of her importance to the history of ASD research than has previously been possible.

Methodology

While this is really history of medicine, this project consists of elements that traverse several disciplines including translation, Russian, German, Dutch, history and psychiatry. The sources informing Sukhareva are primarily in German, while those contemporary with her are in German and Russian with a smattering of French and Italian. Those immediately persequent to Sukhareva (from the 1940s to roughly the 60s)

are largely in English with scattered German and Dutch, and German influence. English becomes more dominant from here on. The translation draws on practical skills from my experience in commercial translation with a more foreignising, literal approach taken than is customary in commercial work. Concurrent with my enrolment in this degree, I also undertook and completed a Certificate of Proficiency in Medical Terminology which complemented my undergraduate study of Latin. For the work in German, Dutch and English, both contemporary and historical, I have drawn on my own language skills and made intensive use of dictionaries like *Oxford English Dictionary*, *Concise Oxford English Dictionary* and *Duden* as well as historical and historiographical dictionaries.

The work on Sukhareva's biography, reception history and historical context involves research into largely German, Russian, and English sources (a few other languages appear but are not the focus), using these sources to create historical narratives in English⁵. While one of my goals during this study was to increase my Russian skills to a working reading knowledge, this did not transpire. For the Russian sources, I used a combination of human translation and OCR with machine translation – already far superior in 2018 to machine translation in 2015. I was incredibly fortunate to have a graduate of VUW's no longer extant Russian programme still on staff at Victoria as Senior Lecturer in German. I mention this in support of language programmes in universities. Dr Richard Millington's knowledge of Russian and Italian and his familiarity with my project was crucial to the success and completion of this thesis and I owe him a lot.

I have an enormous advantage over earlier researchers as I not only have access to huge databases and catalogues, the searching of which takes no more than a few minutes from anywhere with internet access, but I now also have access to hundreds of historical books scanned en masse and digitally archived, along with easily searchable plain text versions generated by OCR. The hunt for instances of a single word across multiple volumes is reduced from days' labour to 15 minutes. It is important to remember this any time we are tempted to criticise previous authors for not mentioning one writer or another or for not giving due credit.

⁵ During the writing of this thesis, Benjamin Zajicek contributed some of Sukhareva's story to the English literature in his 2018 paper "Soviet psychiatry and the origins of the sluggish schizophrenia concept, 1912-1936".

I also have an advantage over current researchers writing in English because of my language skills. Doctors historically read several languages and the acquisition of further languages was formerly an essential component of any university education. Anglophone doctors of the 1930s and 40s still had some familiarity with German, but current first language English speakers are usually monolingual. This is rarely seen as problematic and nor perhaps is it, as machine translation increases in aptitude and fluency daily. Yet I may indeed criticise modern researchers who did not bother to use Google Translate for Sukhareva's Russian Wikipedia page or Google Scholar to see a bibliography of her work. On the other hand, if they had done so, where would this thesis be?

Perhaps, too, I am advantaged to have an autism spectrum disorder myself. I think not and would happily swap the abilities to write a thesis and focus on minutiae for hours at a time for the abilities to get and hold a job, form sustained and meaningful relationships, exchange emotional support with humans, have children, achieve the life milestones of others my age, be a real boy, etc., etc., but we cannot all have what we want. Perhaps you would rather not be examining this thesis, but it is (probably) too late to back out now! We will instead think about the things we can do. One of those might be giving more recognition to women in science. Is this truly meaningful? Eventually, humans will evolve into something else. Earth's sun will extinguish. The universe is expanding and whether the expansion is finite or infinite hardly affects anyone ever likely to read this. But like the person throwing washed up starfish back into the ocean in Loren Eiseley's variously mutilated "The Star Thrower", the action, while making no difference to starfish overall, makes a difference to a single one. Perhaps recognising this one woman in science will be meaningful to one potential scientist. But it is not truly significant, no. Yet if we will not ingest cyanide and take our leave of existence, we must pass time somehow. And so onwards!

1 What is Autism?

The perspective this thesis seeks to develop is a historical one. As understandings are always historically contingent, it is essential to look at what is now understood by ‘autism’ and ‘Asperger’s syndrome’. Although the current state of the field is complex and confusing enough, it is good to see where it stands before grappling with the complexities and confusions of earlier times upon which our current confusion was built.

The question this chapter is concerned with has no fewer answers today than it has had in the past. “What is autism?” has no such clear answer as, “How many atoms of hydrogen are in a molecule of water?” This is partly because, unlike with, say, molecular chemistry which has had the means to determine ratios of chemical composition for far longer than medicine has had fMRI, medicine does not yet know very much about neurology or psychiatry. It has only recently become possible to study the brains of living people. Autoimmunology seems implicated in psychiatric illness and neurodevelopmental disorders but this field is even newer. When the pathogenesis of a psychiatric disorder becomes known, the disorder moves out of psychiatry into another specialisation such as endocrinology. If medicine had all the answers about the origins and processes of all mental illness, psychiatry might well cease to exist.

Currently, autism spectrum disorders are syndromes, collections of symptoms that keep reappearing without a clear aetiology or pathogenesis, but are likely attributable to a combination of heredity and environmental factors during fetal development. ‘Autism’ is not one thing but many unknown things, some of which will hopefully become known as research progresses. Now considered neurodevelopmental disorders, ASDs fall into the specialisations of psychiatry, paediatrics, and neurology.

So far, diagnosis of autism is solely clinical, based on self-reporting from the patient or caregiver, and observation by the diagnosing practitioner. Aside from the inherent and obvious flaws of diagnosis via subjective impression interfered with by the desired outcome of the patient or caregiver, even aspects of medicine that are “testable”, such as blood, are still not as clear cut as the number of hydrogen atoms in a water molecule.

Different labs use different reference ranges. Different practitioners have different ideas on when symptoms move from subclinical to clinical, and different patients have different impressions about how their lives are impacted. Psychiatry is often perceived by laypeople as the flakiest branch of medicine, subjective and as open to interpretation as the humanities, but subjectivity is not any more specific to psychiatry than to any other specialisation.

This leads us to the next reason this question is so difficult to answer, which is itself another question, and again, not specific to psychiatry: to define what is abnormal, deviant, divergent or pathological, must we not first define what is normal? And is normal not a fluid idea changing across time periods, regions and cultures? And if these things *are* definable, where is the line between pathology and normality? Eugen Bleuler's chapter "Die Grenzen des Irreseins"/"The borderlines of insanity" in *Lehrbuch der Psychiatrie/Textbook of Psychiatry* is a particularly memorable and still relevant discussion of this, while Sukhareva's supervisor M. O. Gurevich writes this in 1927: "Sehr verbreitet ist die Überzeugung, daß die Psychopathien, als Variationen sehr komplizierter psychischer Erscheinungen, außerordentlich zahlreich sein müssen; gewöhnlich spricht man von einer unendlichen Anzahl von Grenzzuständen – Übergangsformen zwischen den Zuständen der Gesundheit und der Krankheit⁶." (458). This is a problem that has plagued psychiatry, psychology, pedagogy, sociology and the general public and popular culture for years. The problem is repeated throughout the autism-related texts I read for this project, often in the form of, "If all these people are x, then isn't everyone in the world x?"

And where do identity politics come into all this? What about all the people online who are "self-diagnosed, peer-confirmed"? What about diagnosed autists who insist autism is misinterpreted and must be redefined according to their definitions? What is the purpose of definition? Is it for self-validation and affirmation, is it for insurance purposes and extra school funding, is it so that better therapeutic tools can be constructed, is it so that contraindicated treatments are not dispensed, is it a tool of oppression or marginalisation, is it means of exclusion and inclusion? All of these.

⁶ [There is a widespread conviction that, as variations of very complex psychic manifestations, psychopathies must be extremely numerous; we generally speak of an infinite number of borderline states – transitional forms between the states of health and illness.]

But what autism is can't be answered in a way that satisfies all the various needs of doctors, therapists, teachers, politicians, relatives and autists, and this thesis cannot provide all possible definitions. However, we *can* answer the questions, "How is autism currently defined by the American Psychiatric Association?" and, "How is autism currently defined by the World Health Organisation?", so let us do that instead.

From the APA's *DSM-5*:

Autism Spectrum Disorder

Diagnostic Criteria

299.00 (F84.0)

1. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by all of the following, currently or by history (examples are illustrative, not exhaustive; see text):
 1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
 2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
 3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Specify current severity:

- **Severity is based on social communication impairments and restricted, repetitive patterns of behavior** (see Table).
2. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):
 1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity:

- **Severity is based on social communication impairments and restricted, repetitive patterns of behavior** (see Table).

3. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).
4. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
5. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder.

Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

Specify if:

- **With or without accompanying intellectual impairment**
- **With or without accompanying language impairment**
- **Associated with a known medical or genetic condition or environmental factor**

- **Associated with another neurodevelopmental, mental, or behavioral disorder**
- **With catatonia** (refer to the criteria for catatonia associated with another mental disorder, pp. 119–120, for definition)

Table: Severity levels for autism spectrum disorder

Severity level	Social communication	Restricted, repetitive behaviors
Level 3 “Requiring very substantial support”	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches.	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 “Requiring substantial support”	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and who has markedly odd nonverbal communication.	Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 “Requiring support”	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

	<p>decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to-and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.</p>	
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The *DSM-5* does not mention psychosis, but it does mention catatonia, often historically seen as a form psychosis can take.

From the WHO's *ICD-10*, version 2016:

Pervasive developmental disorders

A group of disorders characterized by qualitative abnormalities in reciprocal social interactions and in patterns of communication, and by a restricted, stereotyped, repetitive repertoire of interests and activities. These qualitative abnormalities are a pervasive feature of the individual's functioning in all situations.

Use additional code, if desired, to identify any associated medical condition and mental retardation.

F84.0 Childhood autism

A type of pervasive developmental disorder that is defined by: (a) the presence of abnormal or impaired development that is manifest before the age of three years, and (b) the characteristic type of abnormal functioning in all the three areas of psychopathology: reciprocal social interaction, communication, and restricted, stereotyped, repetitive behaviour. In addition to these specific diagnostic features, a range of other nonspecific problems are common, such as phobias, sleeping and eating disturbances, temper tantrums, and (self-directed) aggression.

Autistic disorder

Infantile:

- autism
- psychosis

Kanner syndrome

Excl.: autistic psychopathy (F84.5)

F84.1 Atypical autism

A type of pervasive developmental disorder that differs from childhood autism either in age of onset or in failing to fulfil all three sets of diagnostic criteria. This subcategory should be used when there is abnormal and impaired development

that is present only after age three years, and a lack of sufficient demonstrable abnormalities in one or two of the three areas of psychopathology required for the diagnosis of autism (namely, reciprocal social interactions, communication, and restricted, stereotyped, repetitive behaviour) in spite of characteristic abnormalities in the other area(s). Atypical autism arises most often in profoundly retarded individuals and in individuals with a severe specific developmental disorder of receptive language.

Atypical childhood psychosis

Mental retardation with autistic features

Use additional code (F70-F79), if desired, to identify mental retardation.

F84.2 Rett syndrome

A condition, so far found only in girls, in which apparently normal early development is followed by partial or complete loss of speech and of skills in locomotion and use of hands, together with deceleration in head growth, usually with an onset between seven and 24 months of age. Loss of purposive hand movements, hand-wringing stereotypies, and hyperventilation are characteristic. Social and play development are arrested but social interest tends to be maintained. Trunk ataxia and apraxia start to develop by age four years and choreoathetoid movements frequently follow. Severe mental retardation almost invariably results.

F84.3 Other childhood disintegrative disorder

A type of pervasive developmental disorder that is defined by a period of entirely normal development before the onset of the disorder, followed by a definite loss of previously acquired skills in several areas of development over the course of a few months. Typically, this is accompanied by a general loss of interest in the environment, by stereotyped, repetitive motor mannerisms, and by autistic-like abnormalities in social interaction and communication. In some cases the disorder can be shown to be due to some associated encephalopathy but the diagnosis should be made on the behavioural features.

Dementia infantilis

Disintegrative psychosis

Heller syndrome

Symbiotic psychosis

Use additional code, if desired, to identify any associated neurological condition.

Excl.: Rett syndrome (F84.2)

F84.4 Overactive disorder associated with mental retardation and stereotyped movements

An ill-defined disorder of uncertain nosological validity. The category is designed to include a group of children with severe mental retardation (IQ below 35) who show major problems in hyperactivity and in attention, as well as stereotyped behaviours. They tend not to benefit from stimulant drugs (unlike those with an IQ

in the normal range) and may exhibit a severe dysphoric reaction (sometimes with psychomotor retardation) when given stimulants. In adolescence, the overactivity tends to be replaced by underactivity (a pattern that is not usual in hyperkinetic children with normal intelligence). This syndrome is also often associated with a variety of developmental delays, either specific or global. The extent to which the behavioural pattern is a function of low IQ or of organic brain damage is not known.

F84.5 Asperger syndrome

A disorder of uncertain nosological validity, characterized by the same type of qualitative abnormalities of reciprocal social interaction that typify autism, together with a restricted, stereotyped, repetitive repertoire of interests and activities. It differs from autism primarily in the fact that there is no general delay or retardation in language or in cognitive development. This disorder is often associated with marked clumsiness. There is a strong tendency for the abnormalities to persist into adolescence and adult life. Psychotic episodes occasionally occur in early adult life.

Autistic psychopathy

Schizoid disorder of childhood

F84.8 Other pervasive developmental disorders

F84.9 Pervasive developmental disorder, unspecified

These (2016-2018) definitions of autism are the most dominant and widely used worldwide. Notice that Asperger's syndrome (autism without verbal delays or intellectual impairment) is at present a disorder of uncertain nosological validity for the *ICD*. It is expected that Asperger's syndrome will be folded into autism in *ICD-11* as happened in the *DSM*. Notice also the sentence, "Psychotic episodes occasionally occur in early adult life", and bear this in mind as we review the history and the schizophrenia-or-not debates. It is also important to understand that, despite people using "broad autism phenotype" to refer to the higher level of autistic-like traits seen in the family members of autists than in the general population, and others writing about "invisible autisms" in a way that blurs all boundaries between health and pathology to a point where descriptions become meaningless, reminding me very much of the sluggish schizophrenias of the Soviet Union, and despite some corners of the neurodiversity movement wanting autism demedicalised as happened with homosexuality, in the *DSM-5*, **any autism spectrum disorder necessarily involves "clinically significant impairment"**. This will be the position taken by most doctors of medicine. To those corners of the neurodiversity movement who want autism demedicalised, I would say

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that any autism without clinically significant impairment is *already demedicalised*. Also in *DSM-5*, with Asperger's syndrome now subsumed into "autism spectrum disorders", differences are considered in terms of the level of support the individual needs. If no support is needed, impairment cannot be considered clinically significant. That said, we can also here be reminded that disability is not static and that an individual may have clinically significant impairment at some points of their life while having subclinical impairment at others. Many more definitions of autism, definitions which are period-bound, area-bound and individual-bound, follow in the literature review.

In this thesis, I will use autism spectrum disorders (ASDs) to mean all conditions in that category. I will use Kanner's autism, Kanner's syndrome or classic autism to mean an ASD with intellectual and verbal impairment that remains disabling throughout an individual's life and rarely ventures into the subclinical. I will use Asperger's syndrome or Asperger's autism to mean autism without intellectual impairment or verbal delays, a more precarious autism that is often disabling but has more integrative possibilities and more frequent periods of subclinical impairment. I will use Asperger's-like or Kanner's-like to refer to conditions that resemble Kanner's or Asperger's autism. Leo Kanner uses early infantile autism. Hans Asperger uses autistic psychopathy. G. E. Sukhareva initially uses schizoid psychopathy but later autistic psychopathy.

I did not investigate the history of Rett syndrome, technically no longer a syndrome as the pathogenesis is now known, but I have touched on childhood disintegrative disorder (Heller syndrome).

As we move into the history of ASDs, remember that not everything described maps directly onto modern diagnostic categories, and that to read any of these historical works, whether it is G. E. Sukhareva describing schizoid psychopathy in the 1920s followed by autistic psychopathy in 1959, Eugen Bleuler describing autistic thinking in the 1910s or Martin W. Barr describing echolalia accompanied by prodigious memory in the 1890s, and then exclaim, "Ah ha! A clear description of autism!" or "What a frightfully misunderstood concept of autism!" will always be anachronistic to some degree (and I do exclaim all of these things). Additionally, precisely where the lines

between normal and abnormal, function and dysfunction are drawn is always contingent on who is doing the drawing⁷.

⁷ E.g. Do young Māori boys have ADHD requiring intense medication by white doctors or are their struggles symptomatic of systemic injustice and the trauma of colonisation?
<https://www.stuff.co.nz/national/102115864/In-narrative-therapy-M-ori-creation-stories-are-being-used-to-heal>

2 Literature Review

New discoveries are period-bound rather than area-bound; they often emerge at the same time in different geographic sections.

D. Arn. van Kreveken, 1971

The aim of this chapter to outline the field of research into which Sukhareva wrote, the field into which I have written, and the existing work Sukhareva built on. As Sukhareva has frequently been omitted from the history of research into autism spectrum disorders, this has been done in order to better understand that history into which she can be inserted. It contains four sections. The first section looks at what I have termed “standard sources in the history of autism research”. These are the sources which are well-known and frequently cited and credited. The second section, Non-Standard Sources in the History of Autism Research, looks at other researchers who were carrying out good and interesting work but who, like Sukhareva, are frequently omitted or forgotten about. In several cases, these authors are even more neglected than Sukhareva. Next, given that a substantial portion of this thesis is itself a history of research into autism spectrum disorders, I hope a wide-ranging and very thorough one, there is a section on other histories of autism written in English – I have called this “The Anglalexix History of the History of Autism”. This outlines the field into which I am writing. The fourth and final section of the literature review looks at sources that informed Sukhareva’s work. This is given in order to understand the foundation Sukhareva’s work on schizoid psychopathy was built upon and how her work came to be what it was in terms of substance and where it was in terms of time.

Standard Sources in the History of Autism Research

Traditional First Credit: Asperger, Wing, Kanner, Bleuler

Self-help books, memoirs, biographies and other books on Asperger’s syndrome (Autism Spectrum Disorder Level 1 in the *DSM-5* of 2013) for a lay audience are usually written by authors whose expert status derives from personal experience. While they are not known for research rigour, fastidious fact-checking⁸, bibliographies, or

⁸ A 2009 book claims that “Asperger Syndrome has been recognised for about the last 60 years or so” (Boyd 18). That is technically correct, but only in the geographical section of central Europe, and those who did recognise it didn’t exactly agree on what it was, although they still don’t, so maybe that’s okay.

citations (nor are they expected to be), any work giving a single paragraph history of Asperger's syndrome will mention the Viennese paediatrician Hans Asperger (1906-1980). It may even go so far as to mention his 1943/1944⁹ paper "Die ‚Autistischen Psychopathen‘ im Kindersalter". Although Asperger never applied his name to the syndrome, rather calling it 'autistic psychopathy', it is this paper that led Lorna Wing to write her 1981 paper "Asperger's syndrome: a clinical picture". English-language books going into more detail on the background to Asperger's syndrome will certainly mention Lorna Wing (e.g. Stillman 1-3), as it was her paper which is claimed to have introduced Hans Asperger to the Anglophone world. Leo Kanner, however, is usually credited as the 'founder' of autism with either his 1943 paper "Autistic disturbances of affective contact" or his 1949 paper "Problems of nosology and psychodynamics in early childhood autism" mentioned. Sometimes a nod is given to Eugen Bleuler, whose 1911 text *Dementia Praecox oder Gruppe der Schizophrenien* contained the neologism "autistisch" to describe the schizophrenic trait of withdrawing from society and receding into an inner world, a partial but not complete loss of contact with reality, which he then termed "schizophrenic autismus" (Bleuler 1913, 874), using that mixture of English and German in an address given at the opening of the Henry Phipps Psychiatric Clinic in Johns Hopkins Hospital in Baltimore in April 1913.

Footnotes: Autism, Auto-Erotism, Introversion

The English translation of *Dementia Praecox* contains the footnote:

Autism nearly coincides with what Freud has termed auto-erotism. Since, however, for this author the concepts of libido and erotism are so much broader than for other schools of thought, his term cannot very well be used here without giving rise to many misunderstandings. (63)

In *The Theory of Schizophrenic Negativism* of 1912, which I have likewise only seen in translation, Bleuler's footnote is less tentative:

By autistic I understand practically what Freud (not however Havelock Ellis) means by autoerotism. I think it well, however, to avoid the latter expression, as it is misunderstood by all those not very familiar with Freud's writing. (19)

⁹ The paper was received in 1943 but published in 1944. Books may refer to either or both dates.

In “Das autistische Denken” (1912) in *Jahrbuch für psychoanalytische und psychopathologische Forschung*, edited by Bleuler and Sigmund Freud, yet another footnote reports:

Zu einem ziemlich großen Teil deckt sich der Autismus mit dem Jungschen Begriff der Introversion, womit das Nachinnenwenden der Libido bezeichnet wird, die sich normaliter ihre Objekte in der Realität suchen sollte. Autistische Strebungen können sich indes auch nach außen richten; so, wenn ein schizophrener Weltverbesserer die Gesellschaft umgestalten will und überhaupt beständig nach außen wirksam zu sein strebt, wenn das kleine Mädchen ein Stück Holz in ein Kind umphantasiert, wenn man Objekte beseelt, oder wenn man sich aus einer Kraft oder einer abstrakten Vorstellung einen Gott schafft. (1)

The 1916 *Jahrbuch* contains a paper by Carl Jung, whose doctoral thesis was supervised by Bleuler, called “Kritik über E. Bleuler: Zur Theorie des schizophrenen Negativismus”, written in response to Bleuler’s 1912 book. Within this, Jung lays out his then-understanding of Bleuler’s theories:

Bleuler stellt folgende Ursachen des Negativismus zusammen:

- a) Das autistische Zurückziehen des Patienten auf seine Phantasien —.
- b) Das Bestehen einer Lebenswunde (Komplex), die vor Berührung geschützt werden muß.

[...]

Ad. a. Das „autistische Zurückziehen“ auf die Phantasien ¹⁾ ist dasselbe, was ich früher als das augenfällige Überwuchern der Komplexphantasien bezeichnet habe. Die Verstärkung der Komplexposition ist identisch mit der Widerstandserhöhung.

Ad. b. Die Lebenswunde ist der Komplex, der natürlich in jedem Falle von Schizophrenie vorhanden ist und immer notwendigerweise auch die Phänomene des Autismus oder Autoerotismus mitführt, denn Komplex und unwillkürliche Egozentrität sind untrennbare Reziprozitäten. Punkt a und b sind daher eigentlich identisch. (472)

Jung’s footnote 1 reads: “Autismus (Bleuler) = Autoerotismus (Freud). Ich habe mir dafür schon seit längerer Zeit den Begriff der Introversion zurecht gemacht.” (472) The equation of Bleuler’s autism, Freud’s autoeroticism and Jung’s introversion seems curious today when the modern meanings of these terms are quite removed from each

other, yet both Asperger's and Sukhareva's work is built on this foundation. The paper immediately succeeding Jung's in the annual is Bleuler's response, a portion of which is excerpted below. Here he partly disagrees with Jung's interpretation of autistic withdrawal and elaborates on the *Lebenswunde*, describing what 21st century psychologists would probably refer to as a trauma reaction with triggers.

Das „autistische Zurückziehen“ ist mir allerdings nicht identisch mit dem „Überwuchern der Komplexphantasien“; letzteres kann vorkommen ohne das erstere, z. B. bei paranoiden Weltverbesserern, die dann auch nicht negativistisch werden. Aber sei dem wie ihm wolle, nachdem der Autismus einmal besteht, wird er zu einer direkten Quelle des ablehnenden Verhaltens.

Für mich ist auch die Lebenswunde nicht identisch mit der Abschließung, sondern die letztere ist die Folge derselben¹). Nun kann die Berührung der Lebenswunde im speziellen Falle direkt vermieden werden, weil sie schmerzhaft ist, oder sie kann zu einer allgemeinen Ablehnung der äußeren Einflüsse führen, wodurch oft erst sekundär negativistisches Verhalten bedingt wird, und zwar auch Reizen gegenüber, die an sich die Lebenswunde nicht tangieren. (476)

To my great interest, Bleuler's footnote 1 contains a description more akin to autism as it is thought of today: "Umgekehrt besteht die Tendenz zur Abschließung oft schon in der Kindheit, bevor man von einer Lebenswunde im gewöhnlichen Sinne reden kann."^{10, 11} This is not something Bleuler is known for, but it demonstrates that the traits more closely analysed by Sukhareva, Asperger and Kanner were by no means unobserved prior. Although Jung was popular enough, even famous, in the Anglophone world that this critique of Bleuler appeared in C. E. Long's translations *Collected Papers on Analytical Psychology* as early as 1917, autism and introversion parted ways in both English and German¹². In "Das autistische Denken", Bleuler's description of autistic thinking is the opposite of the cold, emotionless, excessively literal rationality popular culture typically portrays men with Asperger's syndrome as possessing. For

¹⁰ [Conversely, the tendency for closing-off often appears even in childhood, before one can speak of a life wound in the usual sense.]

¹¹ C.f. Kretschmer, "We sometimes find schizoids who look just as if they had already been through a schizophrenic psychosis before they were born, from infancy they are as weak in intelligence, and as obstinate, odd, hostile, and untractable as the majority of schizoids become later when they have a severe psychosis behind them." (*Physique and Character*, trans. Sprott, p. 153-154)

¹² However, ASD-like disorders have been compared to introversion in many texts over the years. Sukhareva contrasted schizoid psychopaths with 'normal' introverted children in 1925. Asperger saw a similarity between introversion and *autistische Psychopathie* in both 1944 and 1952: "Ist doch 'Introversion' nichts anderes als eine Einengung auf das eigene Selbst (Autismus), eine Einschränkung der Beziehungen zur Umwelt." (1944, p. 136)

Bleuler, autistic thinking includes the imagination of children playing games, the creativity of adults painting and telling stories, all religious belief, as well as all forms of illogic and fallaciousness, from the general public's irrational fear and stigmatisation of the mentally ill to the confirmation biases and cherry-picking of doctors¹³. It leads to both great art and war. It is anything that diverges from reality to even the slightest degree. Returning to the passage from Bleuler's response, one symptom, described as schizophrenic, negativistic reactions to *Reize* unrelated to a *Lebenswunde*, resembles a symptom now included for ASDs. Peculiar responses to particular stimuli, involving either avoidance behaviour with strong reactions when unable to avoid the antagonising stimulus or stimulus-seeking behaviour, are now listed among the *DSM*'s diagnostic criteria¹⁴ but were not included prior to 2013. It is no surprise that there was and still is¹⁵ confusion, speculation and discussion about possible overlaps with schizophrenia. Bleuler says, "Begriffe treten füreinander ein, weil sie irgend eine, oft nebensächliche Komponente gemeinsam haben; so kommt es zu einer konfusen Symbolbildung."¹⁶ ("Das autistische Denken" 11)

Introducing Leo Kanner (1894-1981) and Early Infantile Autism



Leo Kanner in 1963.
JHU Sheridan Libraries/Getty Images

We return to Leo Kanner in the 1940s. Like Asperger, Kanner was from Habsburg Austria-Hungary. Born in 1894, he came from Klekotów¹⁷, a Yiddish-speaking village on the Austro-Hungarian/Russian border in

¹³ "Die laienhaften Ansichten über die Irrenanstalten sind geradezu autistische, dem Gruseln vor den Geisteskrankheiten und dem Eingesperrtsein und ähnlichen Affekten entsprechend. Sogar in der Wissenschaft ist das, was man gern glaubt, bald bewiesen, und Gegen Gründe dazu werden leicht ignoriert." (5)

¹⁴ See criterion 2.4 in chapter 1, commonly referred to outside of the *DSM* as sensory sensitivity or sensory processing difficulties.

¹⁵ E.g. Carrie Bearden of UCLA's Department of Psychology in an opinion piece for *Spectrum*, October 2016.

¹⁶ [Terms stand in for each other because they share a component, often a secondary one, giving rise to a confused construction of symbols.]

¹⁷ Today known under its Ukrainian spelling Klekotiv/Клекотів.

what is today Ukraine¹⁸, but was educated almost entirely in Berlin, his family sending him there when he was around 12. He studied medicine in Berlin, was conscripted into the Austro-Hungarian army during World War I, attained Prussian citizenship after the war and his graduation in December 1919, and then emigrated to the United States in 1924 with his wife and daughter; his timing fortunate, as he was Jewish (Neumärker). At Johns Hopkins Hospital in Baltimore, Maryland, he founded the Children's Psychiatric Service and conducted the work he is famous for. "Autistic disturbances of affective contact" appeared in *Nervous Child* in 1943. Like Hans Asperger's paper, this is a collection of case studies. His next paper "Early infantile autism", appearing in *Journal of Pediatrics* in 1944, is a heavily abridged version of the first, the 11 case studies reduced to two.

Michael Rutter calls Kanner's naming unfortunate:

To begin with, there was the unfortunate choice of name (that is "autism"), which immediately led to confusion with Bleuler's use of the same term to refer to the active withdrawal into fantasy shown by schizophrenic patients (Bleuler, 1911/1950). This was confusing (see Bosch, 1970; Wing, 1976) because, first, it suggested a withdrawal from relationships, whereas Kanner had actually described a failure to develop relationships; second, it implied a rich fantasy life, whereas Kanner's observations suggested a lack of imagination; and third, it postulated a link with schizophrenia as evident in adults. This last confusion was further compounded by a tendency among child psychiatrists to use childhood schizophrenia, autism, and child psychosis as interchangeable diagnoses (Laufer & Gair, 1969). (139)

Kanner says he referred to it as such for want of a better term, but it is this term that has remained.

Kanner wrote many more papers throughout his life in which his understanding of early infantile autism developed, was expanded upon and revised, and in which he engaged in discussion on the topic with the wider medical community. He became the founding editor of *Journal of Autism and Childhood Schizophrenia* in 1971. Several of his previously published papers ranging from 1943 to 1968 were collected into the volume

¹⁸ He briefly attended the same school as Joseph Roth, a German-language gymnasium in Brody. Born the same year, they were presumably in the same class.

Child Psychosis: Initial Studies and New Insights in 1973, along with new work from the early 1970s, including a follow-up study of the children from his initial case studies. 1944's "Early infantile autism" does not appear in this book, most likely to spare the reader the repetition. Kanner's other notable work is *Child Psychiatry*, although this was first published in 1930 before he began his observations of autism¹⁹. In "Notes on the follow-up studies of autistic children", first published in 1955, an example is given of a child whose outcome was favourable and who became a meteorologist and composer, marrying and having a child. This case, Robert F., sounds much more like someone with Asperger's syndrome than "classic autism". Kanner's other patients largely remained in state care for the rest of their lives, many of them non-verbal, with only a few able to attend school. One other child, Jay S., also resembles Asperger's syndrome. He had a very high IQ, became exceptionally good at mathematics and ended up going to an accelerated school, spending his spare time collecting maps and postage stamps. This may perhaps be where the overlap or spectrum comes in, but these two cases are notable outliers among the others. Of the 19 non-speaking children Kanner studied, all but one "can hardly be distinguished from markedly feeble-minded persons." (CP 88) "Of the 23 speaking children, not less than 13 have achieved sufficient emergence to function in a more or less schizoid fashion at home and in school, while 10 are now clearly psychotic." (ibid.) The prognosis for Kanner's patients was overall much worse than for Hans Asperger's and G. E. Sukhareva's.

Kanner today is sometimes praised and sometimes condemned. In Steve Silberman's bestselling 2015 book *NeuroTribes*, Kanner is utterly vilified. Having read all Kanner's papers on autism, I do not find him particularly out of place for his time, nor his case studies especially cold-hearted or his overall manner any different to that of Hans Asperger²⁰, or at least, these men are similar in the way they come across in their writing. The few sentences used to lend support to the vituperation he is given in *NeuroTribes* are taken out of context.

¹⁹ The 1955 edition of *Child Psychiatry* appears in Sukhareva's reference list in volume 2 of her clinical lectures (1959); the 1962 edition appears in the reference list for the 1974 edition of her clinical lectures.

²⁰ During writing, in promotion of the forthcoming *Asperger's Children: the Origins of Autism in Nazi Vienna*, a piece by Edith Sheffer appeared in *New York Times* roundly condemning Asperger and requesting the complete abandonment of the eponym. After a brief moment of heroism, Asperger is now the villain.

Bruno Bettelheim (1903-1990)

But Kanner's words²¹ did give rise to Bruno Bettelheim²²'s 1967 English-language book *The Empty Fortress*. Some of these words have been excerpted, wholly without context again!, in footnote 21 but are all from papers in Bettelheim's bibliography. *The Empty Fortress* is heavily influenced by Freudian psychoanalysis, with Bettelheim even criticising the European author Gerhard Bosch for his failure to incorporate it into his methods (433). This is the book that directly blames mothers for their children's autism and compares autistic children to the inmates of the World War II concentration camps where Bettelheim himself had been a prisoner. I do not wish to delve further into Bettelheim's biography or questions of whether he was an abusive pathological liar and anti-Semitic Jew or someone who merely misrepresented his credentials and favoured corporal punishment, as that is tangential, but these matters were investigated by the *Chicago Tribune* (Bettelheim being the director of a therapeutic school under the University of Chicago) after his death in 1990, and several biographies have been written. Whatever may be said of him, his literature review in the "Etiology and Treatment" chapter of *The Empty Fortress* is thorough, if confused. It includes researchers who described similar cases prior to Kanner as far back as 1799 (not Victor of Aveyron, mentioned elsewhere in the book as being of 1799 also), although the

²¹ In 1943: "One other fact stands out prominently. In the whole group, there are very few really warmhearted fathers and mothers. For the most part, the parents, grandparents, and collaterals are persons strongly preoccupied with abstractions of a scientific, literary, or artistic nature, and limited in genuine interest in people. Even some of the happiest marriages are rather cold and formal affairs. Three of the marriages were dismal failures. The question arises whether or to what extent this fact has contributed to the condition of the children. The children's aloneness from the beginning of life makes it difficult to attribute the whole picture exclusively to the type of the early parental relations with our patients." (CP 42)

However, in 1949, 50 children later, he becomes less clear: "Maternal lack of genuine warmth is often conspicuous in the first visit to the clinic." (CP 57) and speaking again of the parents, "These people, who themselves had been reared sternly in emotional refrigerators, have found at an early age that they could gain approval only through unconditional surrender to standards of perfection." (CP 58) "Yet the parents did not know what to do with the children when they had them. They lacked the warmth which the babies needed." (CP 60) And of the children: "They were neatly kept in refrigerators which did not defrost. Their withdrawal seems to be an act of turning away from such a situation to seek comfort in solitude." (CP 61) but he concludes the 1949 paper by questioning, "Further, do not the personalities of the parents indicate that there are milder degrees of detachment and obsessiveness which enable a person to function and even gain a certain type of success in a nonpsychotic existence? These are highly important questions which await much further thought and study." (CP 62)

In 1954, he continues the musing but reaches no further firm conclusions, thinking that there may be elements of both nature and nurture: "The parents themselves have escaped the psychotic proportions of their offspring's aloneness and sterile obsessiveness. It is possible to speak of them as successfully autistic adults. One is, therefore, led to think of a familial trend toward detached, obsessive, mechanical living. At the same time, it should not be forgotten that the emotional refrigeration which the children experience from such parents cannot but be a highly pathogenic element in the patients' early personality development, superimposed powerfully on whatever predisposition has come from inheritance. These provocative findings warrant further research and classification." (CP 75)

²² Born 1903 in Vienna, Austria-Hungary, interned at the Dachau and Buchenwald concentration camps, died 1990 in Maryland, United States.

source cited for the 1799 case is a secondary one, Vaillant, who in turn has applied a psychoanalytical interpretation to John Haslam's unremarkable description of a boy with intellectual disability²³. While Kanner's choice of words is most certainly responsible for the phrase 'refrigerator mother', Bettelheim's book, more than anything Kanner wrote, is more usually considered the true origin of the false refrigerator mother theory²⁴. Bettelheim spends several pages taking Kanner to task for his insistence on an organic or hereditary aetiology rather than a psychogenic one. Bettelheim considers the organic aetiology position "defeatist", as there can be no cure for an inborn condition, he claims bizarrely, whereas adopting a psychogenic hypothesis would lead one to the optimistic viewpoint that autism is treatable. (405)²⁵ For Bettelheim, a scientific approach is uncaring and objectifies the patient. There is some validity to such an opinion, and Kanner made a similar criticism in his address to mothers²⁶, but I have no time or patience for people who dismiss science or turn to pseudosciences as a result.

²³ The case study of the child W.H. can be found at 188-197 in Haslam's 1809 book *Observations on Madness and Melancholy*. Other than the child continuing to speak in the third person at 13, I see no striking similarities with any conventional descriptions of autism and no indications whatsoever of schizophrenia or what Vaillant calls the "'splitting' of affect" or any equivalence with descriptions by Bleuler. W.H.'s employment of the third person is accounted for by his linguistic skill not having progressed much beyond early childhood. A more likely candidate for an ASD seems to me the adult of Case XXXII found at 159-163. If so, then of the Asperger's variety. Vaillant's paper tries to have an "Ah ha! Stigler's law!" moment but this paper is fatuous.

²⁴ Bettelheim writes, "That is, so much is made in the literature of the attitudes of the mother as a causative factor in infantile autism. Throughout this book I state my belief that the precipitating factor in infantile autism is the parent's wish that his child should not exist." (125) Here, what was for Kanner speculation and a call for further research becomes established fact for Bettelheim. Although he gives references for many of his claims, Bettelheim does not give one here. He could likely have cited J. Louise Despert but does not. Kanner scientifically considered all possible angles, and his observations of the parents drew him to conclude, as Asperger did, that hereditary genetic factors were involved in autism (CP 42-43, 45) and that the parents might simply be autistic adults (CP 62, 75), examples of what the children could grow up to be. From a purely linguistic perspective, it is curious to note that while Bettelheim is talking about mothers, when the subject becomes the gender neutral 'parent', he applies the masculine pronoun.

²⁵ In 1969, Gerhard Bosch treats this respectfully, saying, "Like Bettelheim (1967), we were unable to convince ourselves that early infantile autism is in all cases a static condition, following on after a completed process, or that it necessarily strives towards increasing disintegration of the personality, to the extent that any personality has been formed. There is certainly a chance for therapy, even if in 75% of the cases the effect unfortunately does not last and the condition ultimately freezes as an autistic defect." (Bosch 1970, p. 129) This understanding is in line with currently popular thinking that 'early intervention' is essential and best, or, more importantly and slightly harder to understand in practice, that degrees of ability and disability are variable and can change according to circumstance or period of life (e.g. Tantam 4, 90).

²⁶ "Libelling Labels" (102-111), *In Defense of Mothers*

Leo Kanner: Actually Quite Nice

In 1941, prior to his work on autism, a monograph of Kanner's was published in the form of a charming book with illustrations, aimed at a general audience and called *In Defense of Mothers: How to Bring Up Children in Spite of the More Zealous Psychologists*. It is an encouraging, mostly sympathetic, and generally reassuring book, probably still relevant today. On the first few pages, we find:

People go around with knowing looks and, whenever a child does not come up to their standards of perfection, they growl in a chorus, '*Cherchez la mère!*' Mothers are told everywhere by every Tom, Dick and Harry that, no matter what happens, they are the culprits. (3-4)

This is precisely the type of rhetoric Bettelheim and Despert later perpetrated and then perpetuated, and which the book sets out to combat, somewhat presciently as Bettelheim's book had not yet been written. As this book was also reprinted in 1950 (the quote is from the second edition, now in the public domain and digitised by Google), we might reasonably assume Kanner remained as sympathetic and caring for the rest of his career as he showed himself to be in 1941, and indeed, his criticism of the *Cherchez la mère* approach to aetiology reappears in his paper "The children haven't read those books" of 1969 (5) alongside a solid condemnation of Freudian child analysis (4). Kanner died in 1981. Occasionally, parenting books mention Bruno Bettelheim in the course of refuting historical ideas about autism in an effort to reassure the reader that, these days, their child's autism is not their fault.

Juliette Louise Despert (1892-1982) and Childhood Schizophrenia

J. L. Despert worked on childhood schizophrenia in New York around the same time as Kanner. Her name is more familiar for its appearance in lists of references at the end of work by other people than for the work it is attached to. In "Problems of Nosology and Psychodynamics", first published in 1949, Kanner reports receiving two letters from Despert, one which includes, "It cannot be accidentally that the symptoms described by you have an almost word-for-word similarity with the symptoms which I, for instance,



CHAPTER I

An Open Letter to Contemporary Mothers

FIRST of all, allow me to extend to you the sympathy of one to whom thousands of you have come with various worries, anxieties and bafflements. Some there were who smilingly and tranquilly sought advice or reassurance. Some came with heavy hearts, craving an opportunity to unload their burdens, to have someone straighten an upset apple cart. Some came in frantic despair. Some sat guiltily on the corners of their chairs, awaiting hammer blows of

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*From In Defense of Mothers
Hathi Trust/Google*

have described regarding the language-sign and language function, the fear of noise, the compulsive acts, the need for things to be the same, etc.” (CP 54) As Kanner then goes on, in response to Despert, to address the research on childhood schizophrenia carried out by “Ssucharewa” and “Greblskaja-Albatz” (using the German transliterations), I assume the symptoms Despert reports having already described were those in her 1938 paper “Schizophrenia in Children”, for which the only references are the two papers by Sukhareva and Grebelskaya-Albatz²⁷ that Kanner cites throughout his work and which become established citations in English texts on childhood schizophrenia²⁸.

In *NeuroTribes*, Silberman refers to the same exchange (194) but takes his information from a secondary source (492), and while he quotes the 1938 “Childhood Schizophrenia” paper directly, he cites a different paper of Despert’s as the reference in his chapter notes (492), the 1942 “Prophylactic Aspect of Schizophrenia in Childhood” (the same child does appear in both papers). I don’t think the second paper is relevant to Kanner and Despert’s public conversation. Kanner agrees with Despert that the children he has described with early infantile autism may be indistinguishable from Despert’s “insidious onset of childhood schizophrenia” cases or cases described by Sukhareva in 1932 and Grebelskaya-Albatz in 1934 (“langsam verlaufende kindliche Schizophrenien”²⁹), but he doesn’t himself think his cases *are* schizophrenia.

Despert uses ‘autistic’ and ‘autism’ a lot in her work and is clear about what these mean:

Autistic thinking, originally described by Bleuler as a characteristic of schizophrenics, is associated with a loss of contact with the external world of reality, whatever determining relation there may be between the two. The child’s phantasies, on the contrary, do not contribute toward separating himself from the external reality world, and Bleuler himself, in referring to the child’s “autistic thinking,” sought to differentiate it from the schizophrenic’s autistic thinking when he stated in a later writing (2, p. 886), “The child accustoms himself by his phantasies to the situations of his future life.” But even to describe child thinking as “autistic” is not in accordance with the facts, since the

²⁷ Despert’s paper uses three different spellings of Sukhareva’s name, one of them, bizarrely, being Sussecherewa, with the latter error corrected in the book of her collected papers but the first two spellings remaining.

²⁸ Even in places as far afield as Japan. Kiyoshi Makita cited these in 1966 and 1973.

²⁹ [slowly progressing childhood schizophrenia] Note that this is *not* the schizoid psychopathy which Wolff later speculates to be Asperger’s Syndrome.

concept of autism implies belief in the projections, delusions and hallucinations.

(*SC:CP 32*)

And “autistic thinking is, on common agreement, contrasted with logical and realistic thinking” (*SC:CP 33*). Her definitions are provided here for future reference when we look at Hans Asperger. For Despert, autism verges on psychosis, if it is not already there.

Despert, Ribble and Mothering

Despert’s work is not widely read today, perhaps for good reason. Her 1951 paper “Some considerations relating to the genesis of autistic behavior in children” and Margaret Ribble’s appended “Discussion” of the same is largely nonsensical according to today’s understanding of the causes of schizophrenia. There is a focus on psychoanalysing the patients’ and their relatives’ behaviour for symbolism and hidden sexual implications they themselves are oblivious to. The paper and discussion are almost entirely mother-blaming, ignoring any role in parenting fathers might play or any contribution a husband might make to the mental health of a wife. Despert’s 1968 book *Schizophrenia in Children: Collected Papers* likewise frequently attributes children’s psychoses to attitudes of their mothers, including the “rejection” by one mother who had neither planned nor wanted a pregnancy but was nevertheless a devoted parent. The 1938 “Schizophrenia in Children”, both the original paper and the revised version in her book, suggests that the children of “Hebrew” parents may be more psychotic than those of other ethnic backgrounds, pointing to a matriarchal family structure as the cause. While these ideas correspond to the prevalent thinking of the time, such conjecture is bewildering. I struggle to understand how Despert and Ribble, two educated doctors, themselves women who must surely have believed in women’s intelligence and their capacity for careers outside the home, at least for their own circumstances, could be so condemnatory of other educated women applying their intelligence to child-rearing or succumbing to the expected career of housewifery and motherhood with anything less (or more) than moderated enthusiasm. The 1971 obituary for Ribble in the *New York Times* possibly contains a hint of derision or dismissal:

She held that our highly impersonal civilization has insidiously damaged woman’s instinctual nature” [sic] and warned that the natural impulses of art infant cannot be

summarily dammed up or snuffed out when their expression becomes inconvenient for adults.

What infants need is more of the old-fashioned “mothering,” she maintained, adding that the rocking chair and the cradle should never have been discarded.

Compare Despert and Ribble’s approach to Kanner’s. In *In Defense of Mothers*, he praises a woman who hires a housekeeper and returns to work, thus solving her problem of feeling trapped by housewifery after a successful career as an accountant (30-31). Despite this, Kanner shows great professional respect for Despert. Not only does he reference her in many papers in *Childhood Psychosis: Initial Studies and New Insights*, he also wrote a glowing foreword to her 1968 book *Schizophrenia in Children: Collected Papers*, in which he asserts that this collection will be of “unquestionable benefit to the historian”, praises her “scientific honesty” and says:

What impresses one more than anything else is the persistent emphasis on factual data, on the absence of dogmatism, on a truly scientific study of perceived phenomena and their correlations; all this is presented with full consideration of the work of others and, where this is indicated, with gracious, good-natured criticism of confused and confusing theories. Dr. Despert has no axes to grind.

Regardless of what I may think of Despert and her colleagues, it is clear Kanner was not trying to quash the work of others in his field in order to take full credit and fame for the discovery of autism as portrayed by Silberman. I see no reason to believe that “Kanner was also likely put off by Despert’s style of clinical interpretation, which seemed designed to fit her patients into prefabricated pigeonholes” (174) or that Despert’s approach “wasn’t very helpful for man striving to establish child psychiatry as a rigorously empirical field of medicine” (174), given that he really did find her work rigorously empirical and later, as an editor, published papers by Despert in *Journal of Autism and Childhood Schizophrenia*. It is also difficult to determine that Despert’s “case descriptions were muddled by her assumptions that her patients were hallucinating and suffering from the initial stages of adult psychosis” (180) without having been there. The children Despert studied, both in her 1938 book *Emotional Problems in Children* and in the *Childhood Schizophrenia* papers, do sound markedly more disturbed than the children in Kanner’s papers on early infantile autism, and

Despert provides the reader with reasonably clear demarcations between the imaginings of normal children in the course of play and children with more serious problems.

Hans Asperger (1906-1980) and Autistic Psychopaths

Leaving the English-language work on autism of the 1940s, 50s and 60s to cross over to Europe, we come back to Hans Asperger, a paediatrician who completed his habilitation in 1943 in Nazi-occupied Vienna. His habilitation thesis was “Die ‚Autistischen Psychopathen‘ im Kindersalter”, published in 1944. Asperger continued working with and writing about children long after the war, publishing many clinical textbooks, and was well-known in Europe.

I have the fifth (1968 non-revised) edition of *Heilpädagogik: Einführung in die Psychopathologie des Kindes für Ärzte, Lehrer, Psychologen, Richter und Fürsorgerinnen*, first published in 1952, at which time Asperger was the *O. Ö. Professor für Kinderheilkunde*³⁰ and on the directorial board of the Children’s Hospital at Vienna University. This book contains a chapter on ‘autistic psychopaths’, with many notable points. It includes a paragraph of discussion about the similarities or dissimilarities with types proposed by earlier researchers. The similar types listed are Ernst Kretschmer’s schizothyme, E. R. Jaensch’s disintegrated type, and Carl Jung’s introverted thinking type; the typologies of Kurt Schneider and August Homburger are mentioned for their absence of anything resembling an autistic psychopath. These comparisons to Kretschmer’s schizothyme and/or schizoid and to Jung’s introvert are made by authors again and again. There is a paragraph of discussion about Kanner’s early infantile autism. Here Asperger writes that early infantile autism “sich aber, wie wir glauben, deutlich von den in diesem Kapitel beschriebenen Fällen trennen läßt, wenn auch viele Gemeinsamkeiten in zahlreichen Wesenszügen zu finden sind.”³¹ (204-205) He covers both the refrigerator mother theory and the spectrum approach, although without referring to them as such:

Während Kanner selbst zunächst annahm, die Ursache dieses schrecklichen Zustandes sei der Mangel an mütterlicher Zärtlichkeit und Gefühlswärme, was die Kinder in ihre

³⁰ Professor in Paediatrics. O. Ö. (ober öffentliche) is an Austrian academic position, with the O denoting head professor and the Ö denoting one who is employed by or affiliated with a government-funded institute as opposed to a private institute.

³¹ [...that although many similarities can be seen in numerous traits, we believe early infantile autism is significantly differentiated from the cases described in this chapter.]

Vereinsamung hineintreibe, ihre sozialen Beziehungen störe, rücken in der Gegenwart er selbst und viele andere Beschreiber von diesem rein milieutheoretischen Standpunkt ab und meinen, daß es sich da nicht um ein einheitliches Krankheitsbild, sondern um recht verschiedenartig verursachte Störungen handelt: echte schizophrene Verläufe, Folgezustände nach organischen Hirnstörungen [...] und vielleicht tatsächlich vor allem exogen verursachte, „neurotische“ Entwicklungsstörungen. (205)

In 1952, well before Rimland and Bettelheim, Asperger reports a moving away within the field of psychiatry from poor parenting as a cause. The “verschiedenartig verursachte Störungen”, different conditions with different causes, is still the thinking on autism today. Asperger considers his autistic psychopathy distinct from Kanner’s autism for two reasons, firstly that the children in Kanner’s case studies seemed far more severely affected than his, affected to a degree Asperger thought verged on psychosis (recall Despert), whereas his children were able to lead a normal life, somewhat socially integrated if noticeably eccentric, and secondly, he believed the origins of autistic psychopathy were largely genetic, reporting similar cases to his children found throughout their ancestries.

The Extreme Variant of Masculine Character

There are two other items worth noting in this chapter of *Heilpädagogik*. The first is the appearance of the Extreme Male Brain theory, attributed these days to Simon Baron-Cohen (1958-) who developed it presumably independently³² as well as the associated empathising-systemising theory. Baron-Cohen does not appear to be aware of Asperger’s paragraphs reproduced below, even though the theory was later referenced in English by van Krevelen. Given that Asperger explicitly calls it “eine Extremvariante des männlichen Charakters, der männlichen Intelligenz”, I found it strange that I had not seen anyone point this out before, although I have since seen reference to it by Francesca Happé³³. At the time of writing, February 2017, the EMB theory is receiving much scorn and ire from women identifying as autistic online. The second noteworthy item is the strong interest in the lack of girls among this group.

³² I assume independently as a 2011 paper listing Baron-Cohen as a co-author (most likely to raise the profile of the paper) says the theory was “first proposed in 1997”, although it gives the source as Baron-Cohen’s 2003 book.

³³ “Simon Baron-Cohen, inspired by Hans Asperger’s 1944 comment that autism might be seen as ‘an extreme form of maleness,’ has built a theory around fetal testosterone exposure and an ‘extreme male brain’ in autism that processes systems well but social information poorly.” (2015)

Betrachten wir unsere autistischen Kinder in Hinblick auf ihr *Geschlecht*, so stehen wir vor der zunächst erstaunlichen Tatsache, daß es fast ausschließlich Knaben sind. Wir fanden wohl bei Mädchen Kontaktstörungen, die in manchen Zügen an die autistischen Psychopathen gemahnten, wir fanden schizophrenie-ähnliche Bilder, ferner Mädchen, bei denen man Enzephalitis als Ursache eines derartigen Zustandes annehmen mußte, wir fanden aber bei unserem eigenen Material bei Kindern weiblichen Geschlechts kein voll ausgeprägtes Bild, wie es im bisherigen geschildert ist. Handelt es sich da um eine geschlechtsgebundene oder zumindest geschlechtsbegrenzte Vererbung? Es ist etwas von der Art.

Der autistische Psychopath ist eine Extremvariante des männlichen Charakters, der männlichen Intelligenz. Schon innerhalb der normalen Variationsbreite finden sich typische Unterschiede zwischen Knaben- und Mädchenintelligenz: die Mädchen sind im allgemeinen die besseren Lerner, ihnen liegt das Konkrete, das Anschauliche, das Praktische, das saubere, eifrige Arbeiten nach gegebenen Vorbildern, dagegen den Knaben mehr das Logische, die Fähigkeit zur Abstraktion, das präzise Denken und Formulieren, das eigenständige Forschen; wo Mädchen dieses letztere auch können, handelt es sich meist um ins Maskuline gehende Typen. (Das ist auch der Grund, warum im allgemeinen Knaben bei den höheren Altersstufen der Binet-Prüfung, aber auch bei manchen anderen Testmethoden besser abschneiden als die Mädchen; die recht einseitig logisch-abstrakten Anforderungen, welche die Binet-Tests etwa von der Altersstufe zehn Jahre an stellen, sind eben den Knaben viel mehr gemäß!) Beim autistischen Psychopathen ist dieses Verhalten ins Extreme gesteigert. Die Abstraktion – die ja überhaupt mehr dem männlichen Denken liegt, während das Weib mehr fühlt, sicher in ihren Instinkten beruht – ist so weit fortgeschritten, daß die Beziehungen zum Konkreten, zu den Dingen und den Menschen, weitgehend eingeschränkt sind; die Anpassung an die Forderungen der Umwelt, die ja vorwiegend über die Instinktsfunktionen geht, ist nur in sehr herabgesetztem Maße erreicht.

Während wir, wie schon gesagt, kein Mädchen gefunden haben, bei dem das Bild dieser Psychopathie voll ausgeprägt zu finden gewesen wäre, sind uns mehrere Mütter autistischer Kinder begegnet, die selber in ihrem Verhalten ausgesprochen autistisch waren. Wir können uns das nur so erklären, daß bei Mädchen diese Wesenszüge erst nach der Pubertät in der charakteristischen Ausprägung auftreten.
(198-199)

The section quoted could easily be a German explanation of Baron-Cohen's E-S theory, yet it is from 1952 not 2003. The book continues on to the quite astonishing claim that there are many more truly autistic women, that is, women showing the traits of autistic

psychopathy to the same degree as men, in the United States than in Europe and that this can be attributed not just to the greater advancement of modern civilisation there (Asperger writes earlier that autistic psychopathy belongs to the intellectual and artistic circles of society and is entirely absent from farming communities) and an intellectual ‘hypertrophy’ that accompanies progressive city life, but also to the circumstance that *Gleichberechtigung* (equal rights, given in scare quotes in Asperger’s text) has taken a much stronger hold in the United States than it has in Europe (at the time) and *Gleichberechtigung*’s consequent “Maskulinisierung der Frau”. This aetiological hypothesis is very reminiscent of Margaret Ribble.

Sensory Sensitivity

Another interesting point in the *Heilpädagogik* chapter is the paragraph describing what we now call ‘sensory sensitivity’. Asperger describes hyper- and hyposensitivity to taste, touch and noise but not light (were flashing lights less ubiquitous in the 1950s? Quite possibly). Noise sensitivity is mentioned in his 1944 paper, but not tactile sensitivity or food difficulties. Sensory sensitivity did not enter the diagnostic criteria for ASDs until *DSM-5*³⁴ and then only because it was so insisted upon by autists. Psychiatrists earlier than Asperger wrote about the symptom of *Hyperästhesie*.

Psychopathy

A 1919 definition says that by psychopathy or psychopathic constitution, a doctor refers to cases situated on the boundary between mental illness and mental health (Scholz and Gregor 124).

Asperger’s 1944 paper contains a lexically interesting parenthetical point. Concern with the use of psychopath in 1944 was not due to association with homicidal maniacs but with mental deficiency: “das Wort ‚Psychopathie‘ wird von *Schröder* abgelehnt, weil man daraus schließen könnte, ein Psychopath sei ein Halb- oder Viertelnarr, was weder in Bezug auf das Zustandsbild noch auch in erbbiologischem Sinn zutrefte”.³⁵

Such detraction from the word provoked Eugen Kahn at Yale University to pen this bit of psychopathy apologism in 1949:

³⁴ See criterion 2.4 in chapter 1.

³⁵ [Schröder declined to use the word ‘psychopathy’ because one might then assume a psychopath to be a half- or quarter-idiot, which is inaccurate both in respect to the clinical picture as well as in the hereditary-biological sense.]

Der Begriff der Psychopathie ist jetzt einige sechzig Jahre alt. Er mag gelegentlich ein wenig angegraut ausgesehen haben, aber er zeigt keine Spuren von Altersschwäche. Seine Frische und Resistenzfähigkeit hat sich nicht nur in immer neuen Bearbeitungen erwiesen, sondern ist auch immer wieder zutage getreten in den manchmal recht temperamentvoll Versuchen, ihm als einem überlebten und undynamischen Popanz den Garaus zu machen. Nur eine auf untrüglichen Beobachtungen aufgebaute Formulierung konnte dem guten bzw. bösen Willen von Freunden bzw. Widersachern erfolgreich überstehen. Die Psychopathie hat keine *apologia pro sua vita* nötig. Sie bedarf auch keiner Wiederbelebungsversuche, da sie durchaus lebensfähig ist. (242)

Asperger sees no need to justify his use of the word but he does explicitly distinguish autistic psychopathy from autistic schizophrenia and also says, “Es handelt sich dabei aber nicht um im Zentrum der Persönlichkeit gestörte, also nicht um psychotische, sondern nur um mehr oder weniger abartige, psychopathische Kinder,”³⁶ going on to say that once you know what you’re looking for, seeing this type of child becomes a fairly common occurrence. This is a frequently reiterated claim.

Already a Fad Diagnosis

From Dirk Arnold van Krevelen in 1958 on autism (“Zur Problematik des Autismus”):

Ich setze voraus: Die Diagnose des Autismus droht eine Modediagnose zu werden, was mich um so mehr beunruhigt als man das Wort öfter aus dem Munde medizinischer Laien hören muß. Denn die Diagnose des Autismus hat große Konsequenzen, sie führt Maßnahmen herbei, unter denen ein Vorschlag zur Behandlung, die gar nicht ohne Schaden sind, wenn auch nicht für die jungen Patienten selbst, so doch für die Eltern. Die Diagnostizierung des Autismus bedeutet eine Gefahr. (87)

Is this the autism of Kanner? Yes, but it is also a general autism now existing independently of Kanner. Later in the article, van Krevelen unpacks Asperger’s autism³⁷ and mentions the blurring of the two:

³⁶ [We are not talking about a disorder in the core of the personality, that is, not psychotic children, just more or less deviant, psychopathic ones] O, the woes of non-contemporary translation!

³⁷ He also mentions that he has observed Asperger’s children in person. I believe this was a visit to Asperger’s clinic.

Ich habe die Erfahrung gemacht, dass das durch *Asperger* beschriebene Bild dem frühkindlichen Autismus Kanners für gleich erachtet worden ist – ein unzulässiger Fehler. (89)

Unbeknown to van Krevelen, many of the features he attributes to Asperger's autism are the same that Sukhareva attributed to schizoid psychopathy in 1930. Kanner read "Zur Problematik des Autismus" and concurred with van Krevelen's warning:

This sort of attitude has led in some quarters to a dilution of the concept of early infantile autism, and the diagnosis has been made much too prodigiously. If one adheres to the essential criteria, autism is a rare disease. (110)

[...] Any idiotic or imbecile child who shows oddities of behavior is then promptly classed as autistic and thought to be the victim of an emotional block, with the expectation that psychotherapy will somehow bring about an ameliorative change in the course of the child's development. This procedure has recently assumed the proportions of a habit in the United States and, as *van Krevelen* has pointed out, also in Europe. (111)

And Reinier Vedder also held this opinion in 1962 regarding the two autisms:

Some paediatric psychiatrists called Kanner and Asperger have used the word 'autism' to signify a certain type of deviant children in whom a relational disturbance with the external world comes to the fore as a dominant symptom of the clinical picture.

Thus the American psychiatrist Kanner described 'early infantile autism' in 1943 and the Austrian Asperger 'autistic psychopaths' in 1949.

Since then, the literature on the 'autistic child' has broadened considerably and as often happens, the more texts appear, the more imprecise the picture becomes and the greater the linguistic confusion surrounding the term. The result has been that, as van Krevelen correctly observed, 'autism' has become a fad diagnosis and every child who shows a serious disturbance in their contact with the external world is labelled an autistic child³⁸. (135-136)

³⁸ "Enkele kinderpsychiaters, met name Kanner en Asperger, hebben het woord 'autisme' gebruikt om daarmee een bepaald type afwijkende kinderen aan te duiden, bij wie ook een relatiestoornis met de buitenwereld als een op de voorgrond tredend verschijnsel het ziektebeeld beheerst. Zo beschreef de Amerikaanse psychiater Kanner in 1943 het 'early infantile autism' en de Oostenrijker Asperger in 1949 de 'autistische psychopaten'.

Nadien heft zich de literatuur over het 'autistische kind' aanzienlijk uitgebreid en zoals het zo dikwijls gaat, hoe meer geschriften er verschijnen, des te onduidelijker wordt het beeld en des te groter wordt de spraakverwarring rondom het begrip. Het gevolg is geweest dat, zoals Van Krevelen terecht heeft

But fad diagnoses are no fad! In 1941, prior to his work on early infantile autism, Kanner had written:

Whether or not your child has been labelled as neurotic, he surely is at least a 'problem child'. That does not upset you nearly so much. It is fashionable nowadays to have problem children. They are a prolific topic of parlor conversation, as good as the weather, the war, the latest scandal, and the servant question. They are always good for some delightful cartoon in *The New Yorker* or in *Esquire*. (108)

And in 1809, John Haslam's opening words for *Observations on Madness and Melancholy* were, "The alarming increase of Insanity [...]". (v)

1958: the Deutsche Vereinigung für Jugendpsychiatrie's Conference on Autism

Autism was the theme of the Deutsche Vereinigung für Jugendpsychiatrie's fifth annual conference held in Marburg an der Lahn over 29 and 30 July, 1958. The report was compiled by Hermann Stutte and published in *Zentralblatt für die gesamte Neurologie und Psychiatrie*, 1958/59. During the conference A. Friedemann opened up a discussion around the question, "Sollen wir Kinder als ‚autistische Psychopathen‘ (H. Asperger) und als ‚autistic children‘ (L. Kanner) bezeichnen?" The conference continued on the similarities and differences between Bleuler's schizophrenic autism, Kanner's early infantile autism and Asperger's autistic psychopathy, with only a few topics unrelated to autism. Presenting on autism were Werner Villinger, Hans Asperger ("Autistisches Verhalten im Kindesalter" – this paper published later in 1960), Dirk Arnold van Krevelen, Jürg Zutt, Franz Gunther Ritter von Stockert, Gerhard Bosch ("Bemerkungen zur Selbst- und Weltgestaltung bei autistischen Kindern"), M. Vogl ("Autistische Durchgangsstadien bei Neurosen"), H. Leuner ("Über die Affektdynamik bei autistischem Verhalten"), H. Harbauer ("Zur Abgrenzung autistischen Verhaltens"), Hermann Stutte, H. Göppert, R. Ganal ("Autistisches Verhalten bei jugendlichen Schizophrenen"), R. Lempp ("Zur Ursache der Kontaktstörung bei Jugendlichen") and Lenore Zumpe ("Selbstmordhandlungen bei kontaktgestörten Kindern und Jugendlichen").

geconstateerd ‚autisme‘ een modediagnose is geworden en ieder kind, dat een ernstige stoornis in het contact met de buitenwereld vertoont als een autistisch kind wordt bestempeld." (136)

There was much discussion of terminology during this conference, including the degree to which autistic personalities could be separated from schizoid ones and whether ‘psychopathy’ was a useful descriptor³⁹. Asperger made the odd remark (in keeping with his printed remarks in general but many of his ideas are a little odd) that while boys were by far the most common autistic psychopaths in “our” country, epidemiology was not the same in countries to the west⁴⁰ where emotional disorders were commonly found among women⁴¹, and then stated that his condition was clearly neither schizophrenia nor the early infantile autism of Leo Kanner, Kanner’s condition seeming indeed to belong more to the schizophrenias⁴². Concluding the discussion led by Friedemann, Asperger was urged to come up with a more suitable term:

So möchten wir den Vorschlag zu Erwägung stellen, den Begriff des ‚autistischen Psychopaths‘ sowie auch den des ‚autistic child‘ nicht einfach gefährlich umzumünzen, sondern zu ersetzen. Wir würden stattdessen von egozentrischen Fehlhaltungen des Erlebens und Benehmens bei Schizoiden sprechen. Wenn Asperger, dem wir bereits so viel verdanken, seine Terminologie durch eine bessere ersetzen könnte, so werden wir ihm ganz besonders verpflichtet sein. (14-15)

Addressing Asperger directly, van Krevelen introduced three points of difference between the two autisms:

Ich will nur einige differentialdiagnostische Fakten hervorheben: 1. Die autistische Psychopathie manifestiert sich im Kleinkindalter und tritt sehr deutlich zutage beim Schulanfänger. Der „frühkindliche Autismus“ Kanners offenbart sich schon während der ersten Lebenswochen; er repräsentiert eben eine zentrale Störung. – 2. Sie haben als charakteristisches Merkmal hervorgehoben, dass der autistische Psychopath im allgemeinen früher spricht, als er geht. Er ist motorisch ungeschickt, die Sprache

³⁹ “Wir wissen gerade aus den Berichten Villingers und Stuttes, dass man mit dem Psychopathiebegriff im Jugendalter nicht vorsichtig genug umgehen kann. Gewichtige Stimmen warnen, vor dem 20. Lebensjahre eine solche Diagnose zu stellen.” (14) “Und wenn Asperger von ‚autistischer Psychopathie‘ spricht, so hat der umstrittene Begriff der Psychopathie bei ihm den wertnegativen Akzent verloren. Er will damit zum Ausdruck bringen, dass es sich beim Autismus um eine anlagemäßige Verhaltensweise handelt, die sich auch in der Familie nachweisen läßt. Das ist sicher richtig. Der Begriff der Psychopathie birgt aber doch die Gefahr, dass man die autistischen Symptome zu statisch sieht.” (19)

⁴⁰ I gather from *Heilpädagogik* and his 1960 paper based on the conference presentation that by “countries to the West”, he means the USA.

⁴¹ “In unserem Lande überwiegen weit die Knaben (nicht so in westlichen Ländern, wo thymische, emotionale Störungen auch beim weiblichen Geschlecht viel häufiger sind).” (14)

⁴² “Der Zustand ist, auch was die Prognose betrifft, eindeutig von der Schizophrenie abzugrenzen, desgleichen auch vom ‚early infantile autism‘ L. Kanners (der wohl zum Kreis der Sch. gezählt werden muß).” (14)

entwickelt sich früh. Bei den Patienten Kanners ist die Sprachentwicklung verzögert. Manchmal kommt die Sprache überhaupt nicht zur Entwicklung, die Patienten bleiben mutistisch. Die Motorik des Kannerschen Patienten ist jedoch auffallend gut, die Kinder manipulieren treffsicher mit Objekten. Einerseits also eine frühe Sprachentwicklung mit schlechter Motorik, andererseits eine verzögerte oder nicht zustandekommende Sprache mit relativ guter Motorik. – 3. Was die eigentliche Intelligenz anbelangt, so haben Sie gesprochen über die Probleme der „autistischen“ Patienten und über ihr „schöpferisches Erleben“. Die Patienten Kanners kennen keine Probleme, sie sind dazu nicht imstande – eben ihrer zentralen Störung wegen. (15)

Hilariously, van Krevelen's proposed solution *for avoiding eponyms* was to replace autistic psychopathy with schizoid psychopathy, unwittingly returning to the term used by Sukhareva in the 1920s, a term she would discard in favour of autistic psychopathy the following year.

Wenn somit die Autisten Kanners und Aspergers in essentiellen Zügen voneinander verschieden sind, muß man entweder immer den Autornamen hinzufügen oder, um die entstandenen Mißverständnisse zu beseitigen, eine bessere Lösung suchen. Wenn wir uns darüber einig sind, dass die von Ihnen beschriebenen Patienten eine Sonderart des Charakters darstellen, einen abwegigen Persönlichkeitstypus, muß ich Sie fragen, ob Sie es als einen Nachteil betrachten würden wenn wir in der uns schon geläufigen Terminologie hier vom ‚schizoiden Psychopathen‘ sprechen würden. [...] Der Begriff ‚autistisch‘, wie Sie ihn gebrauchen, umfasst so viel. Darum richte ich die Frage an Sie: „Wie würden Sie den ‚autistischen Psychopathen‘ charakterisieren, wenn Sie sich vom Autismus abstrahieren würden (vorausgesetzt, dass dies Ihnen möglich wäre?“ Mit anderen Wörtern: „Welche Eigenschaft des autistischen Psychopathen würden Sie außer den eigentlichen autistischen Zügen in den Vordergrund rücken?“ Denn darauf kommt es an, wenn man die Notwendigkeit einsieht, die Bezeichnung zu ändern. (15-16)

Johann Zutt felt the psychiatrists should not be too quick to categorise such children among either the autistics or schizoids and suggested “Begegnungsscheue” as a replacement term, pointing out that children with Asperger's syndrome were not afraid of going out into the world like shy (schüchterne) children, but rather had a problem with encounters or interactions, trouble with eye contact and body language, causing them to be seen as inaccessible. Zutt also suggested anorexia could be the female counterpart:

Auch die Beziehungen und Unterschiede zu den „Magersüchtigen“ sind zu bedenken. Interessant ist das Überwiegen der Knaben bei den Autisten, der Mädchen bei den Magersüchtigen. (16)

Villinger seemed to adopt van Krevelen's suggestion immediately: "Wir sind dankbar für die ausgezeichnete Schilderung Aspergers, die die Schizothymie und schizoide Psychopathie so ungewöhnlich anschaulich machte [...]" and wanted to hold a symposium to clarify things once and for all. "Es muß vermieden werden, dass mit demselben Fachausdruck zwei verschiedene Krankheitsbilder belegt werden, da sonst leicht Verwirrung entsteht." (16).

Overall, the attendees agreed that Kanner's autism and Asperger's autism were not the same (Stutte alone wished to stress the similarities between the two, feeling differences could be accounted for by variance in intelligence, sex, development phase, sociological and pedagogical influences (19)), and that Asperger's autism appeared solely or predominantly in boys⁴³, although many attendees also spoke of female patients, both child and adult.

Van Krevelen summarised everyone's definitions:

Der Begriff ‚Autismus‘ wird offensichtlich in unterschiedlichen Bedeutungen gebracht, dass man oft nicht weiß, was jeweils damit gemeint ist. Der Terminus ‚Autismus‘ stammt von Babel⁴⁴ her. Es gibt nach der heutigen Diskussion schon 4 Arten von Autismus: 1. jenen im Sinne Bleulers als ein Symptom der Schizophrenie, 2. den Autismus Kanners als die Schizophrenie selber in ihrer ursprünglichen Form, 3. den Autismus Aspergers als ein Sondercharakter und schließlich 4. der im Sinne von Frau Vogl als eine uns alle bedrohende Eigenschaft. Aber ich kann Ihnen versichern, Frau Vogl: „Ihr Autismus ist nicht der meinige.“ (18)

⁴³ H. Harbauer: "Es handelte sich nur um Knaben." (18) In Asperger's 1960 paper "Autistisches Verhalten im Kindesalter", he writes that children with the classical presentation of the autistic way of being are almost solely male and that they have nearly always been able to attribute autistic traits in girls to the consequences of organic brain disorders. Here he also mentions that he himself has visited the USA, has seen there "classically autistic girls" and has been informed by his Usonian colleagues that there is no great difference in sex distribution in the United States (63).

⁴⁴ In 1971, G. Nissen called it an almost Babylonian language confusion: "Seitdem 1943/44 Asperger und Kanner unabhängig voneinander ihre Beobachtungen über scheinbar in sich geschlossene Syndrome mitteilten [...] ist [...] eine babylonische Sprachwirrung über die diagnostische und nosologische Zuordnung kindlich-autistischer Syndrome entstanden." (36)

The conference ended with Villinger asserting that, “Zwischen dem Kannerschen Autismus und den Aspergerschen autistischen Kindern und Jugendlichen bestehe aber einstweilen eine nosologisch nicht überbrückbare Kluft, die nicht wegzudiskutieren sei.⁴⁵”

The Two Autisms Side by Side

The discussion now begun, European child psychiatrists engaged in autistic psychopathy versus early infantile autism debates throughout the 1960s. By the time Lorna Wing called the attention of the English-speaking world to Asperger’s work in 1981, the English-speaking world was about 20 years behind.

Thus in 1960, we find Asperger’s paper “Autistisches Verhalten im Kindesalter”, the paper presented at the 1958 conference. Asperger looks at his and Kanner’s syndromes and the differences between the Usonian and European conceptions of autism, attributing the differences not just to understanding, definition, interpretation (54, 64-65), the difficulty in communicating across countries and languages and the post-war period (54), but also to fundamental social, cultural and environmental differences in the populations (63). The same year we see Hermann Stutte recording the two syndromes as well-established diagnoses within a classification system⁴⁶ that makes up the “Kinder- und Jugendpsychiatrie” chapter of Benda et al.’s *Klinische Psychiatrie*. Here Asperger’s autism appears as “Die Autistischen” in a list of 13 childhood psychopathies, which in turn are under “Konstitutionell bedingte psychische Störungen”:

Als Sondervariante schizoider Temperamentsveranlagung hat Asperger (1, 3) die autistische Psychopathie herausgestellt und in überaus plastischer Weise beschrieben. Eigenartig leerer Blick, Bizarrerien in Sprache, Gestik und Gewohnheiten, abseitige Interessen, Hypertrophie ganz umschriebener intellektueller Fähigkeiten bei gänzlicher Insuffizienz gegenüber allen praktischen Daseinsanforderungen, weitgehende Kontaktunfähigkeit (personen- und sachbezogene!) und vielfältige Absonderlichkeiten auch im Trieb- und Gefühlsbereich sind die Hauptmerkmale dieser angeblich stets erblichen, vorwiegend bei Jungen auftretenden Charakterabnormität, die über alle Entwicklungsphasen hinweg bis ins Erwachsenenleben eine bemerkenswerte Konstanz zeigt.

⁴⁵ [For now, a nosologically unbridgeable gulf exists between Kanner’s autism and Asperger’s autistic children and adolescents that cannot be discussed away.]

⁴⁶ Incidentally, not unlike the classification system developed by Sukhareva.

Um die differentialdiagnose Abgrenzung der autistischen Psychopathie (ASPERGER) von dem Kannerschen frühkindlichen Autismus, von frühschizophrenen Bildern und von anderen Formen schizoider Charakterabnormität sind lebhafte Diskussionen entstanden [vgl. VAN KREVELEN (6) und die Berichte über den 5. Kongreß der Deutschen Vereinigung für Jugendpsychiatrie im Zbl. Neurol. 148, 12 (1958) und FRIEDEMANN (2)].

Autistisches Verhalten im Kindesalter ist offensichtlich ein polyvalentes Syndrom. Die Sonderstellung der autistischen Psychopathie im Sinne von ASPERGER – als einer anlagemäßigen Charakterabartigkeit – erscheint ebenso begründet wie jene des von KANNER beschriebenen frühkindlichen Autismus (s. dort), der sich bei aller Ähnlichkeit im Phänotypischen doch nach Heredität, Manifestation und Verlauf von ersterem unterscheidet. Über die Möglichkeiten und natürlich auch die (enggesteckten) Grenzen einer heilpädagogischen Behandlung der autistischen Psychopathie hat ASPERGER beachtenswerte Ausführungen gemacht. (1010-1011)

Autistic behaviour in childhood is here yet again a heterogeneous (“polyvalent”) syndrome, Asperger’s autism is again a character variant that persists throughout the life of the individual, and we see the two syndromes described as similar, different, and valid. Describing treatment, he mentions that, “In erster Linie ist jedoch die Behandlung von Charakterabartigkeiten nicht Sache der Psychotherapie im engeren Sinne, sondern eine heilpädagogische Aufgabe.” (1011) Again, this corresponds to current thinking on ASDs, but is unaligned with Usonian thinking of the same period, then heavily focussed on Freudian psychoanalysis. And finally, we see reference to the debate on the differences between autistic psychopathy and early infantile autism that had already taken place.

The section “Frühkindlicher Autismus” found among the “Endogene Psychosen” is much longer. But we find here more notes on differentiation:

Das im ganzen seltene und nosologisch noch sehr umstrittene Krankheitsbild (KANNER sah in 19 Jahren 150 Fälle) wird heute sehr häufig – wie VAN KREVELEN meint: zu oft – diagnostiziert. Wir sahen in den vergangenen 10 Jahren bei einem Jahresdurchgang von rund 500 stationären und ambulanten Fällen (außer den schizophrenen) 23 Kinder mit „autistischem Verhalten“ als Leitsymptom. Davon glauben wir aber doch nur 10 dem „Frühkindlichen Autismus Kanner“ zuordnen zu können, 3 gehörten zu den autistischen Psychopathen (ASPERGER), und 10 war der Autismus Begleitsymptom des Schwachsinn oder einer Encephalopathie. (1019)

I am not certain, but it sounds as though Stutte is excluding children with intellectual disability from a diagnosis of Kanner's autism. There is also a mention of the parental behaviour aetiology hypothesis with an implied rejection and the inclusion of Kanner among those rejecting the hypothesis:

Andere führen diese Zustände zurück auf einen „emotionalen Block“ in der ersten Lebenszeit, hervorgerufen durch gemüthafte Vernachlässigung von seiten der Mutter, durch das pedantische Naturell des Vaters oder durch die (oft, aber keineswegs regelmäßig) in diesen Familien praktizierte, stark rationalisierte und reglementierte Form der Versorgung und erzieherischen Betreuung des Kindes. Aber auch diese Hypothese ist von KANNER, EISENBERG, VAN KREVELEN, FRIEDEMANN u.a. mit guten Gründen in Frage gestellt worden. (1019)

He again mentions that outwardly, the picture of Asperger's autistic psychopathy has much in common with Kanner's early infantile autism, referring the reader again to the "comprehensive discussion on the status of autism" from the 1958 conference.

Sukhareva's Description Presented as Synonymous with Asperger's

In 1961, Walter Spiel compared not just Asperger's and Kanner's autisms with each other but also Sukhareva's. *Die endogenen Psychosen des Kindes- und Jugendalters* contains the headings "Der frühkindliche Autismus (Kanner)", "Die autistische Psychopathie (Asperger)" and "Andere schizoid und ‚präschizophrene‘ Zustände". There is, unavoidably, much discussion of terminology.

BRADLEY UND BOWEN sowie CAPON meinten, dass es sich bei der Prägung des Begriffes des frühkindlichen Autismus um eine Ausweitung des Kraepelinschen Begriffes handelt, und VAN KREVELEN sagt, dass der Autismus bei BLEULER, E., ein Symptom der Schizophrenie ist, während es bei KANNER zur Schizophrenie selbst wurde. (94)

The heterogeneity of Kanner's autism is very present:

Da schließlich und endlich auch die Progredienz wegfällt, KANNER UND EISENBERG haben das Stationärbleiben der Fälle in einer katamnesticen Nachuntersuchung selbst nachgewiesen, scheint uns die Annahme berechtigt,

die auch VAN KREVELEN andeutet, dass es sich bei den Kannerschen Fällen um ein poliätiologisches Syndrom handelt [...]. (94)

The schizoid/autistic psychopathy problem is, however, too difficult to immediately address:

Bevor in die Diskussion eingegangen werden kann, inwieweit diese autistische Psychopathie Aspergers eine gewisse Selbständigkeit beanspruchen kann, bzw. inwieweit sie in die Gruppe der schizoiden Psychopathen überhaupt eingereiht werden können oder inwieweit dieses Syndrom psychogenetisch auflösbar ist [...] (95-96)

When Spiel returns to the problem⁴⁷, he first lays out reasons Kanner's autism should be suspected as a differential diagnosis for autistic psychopathy and the differences: Kanner's autism is noticeable from the very beginning, while the traits of Asperger's are noticeable early on. Autistic psychopaths have motor skill deficits and good intellect, often with above average language abilities, while Kanner's autists have the opposite. The autistic psychopath has a rich inner life and creative perspective, the Kanner's autist supposedly does not (96-98). Compare these traits with those listed by van Krevelen at the 1958 conference and by Sukhareva in 1930 (see "Summaries" in this thesis).

Zur großen Gruppe der schizoiden Zustandsbilder besteht praktisch keine Abgrenzung, was ja auch gar nicht möglich ist, da beide Beschreibungen dieselben Typen meinen. STUTTE und STOCKERT sagen ja direkt, dass ASPERGER eine Sonderform des schizoiden Charakters beschrieben habe. (98)

Spiel leaves the question open in a way that acknowledges the vastness of Kretschmer's schizoid personality type (which I will return to when I talk about sources informing Sukhareva's work):

Die letzte Frage, ob die Heraushebung der Gruppe der autistischen Psychopathen aus der viel größeren Gruppe der schizoiden Psychopathen tatsächlich gerechtfertigt ist, muß noch offen bleiben.

SSUCHAREWA beschreibt den schizoiden Psychopathen ganz ähnlich wie ASPERGER den autistischen: Es bestehe ein eigenartiger Typus des Denkens, eine

⁴⁷ Spiel's later (presented in 1964, published in 1966) paper, "Zur Problematik sogenannter schizoid-autistischer Zustandsbilder", mentions not Kanner, Asperger or Sukhareva!

Neigung zum Abstrahieren und Schematisieren, eine autistische Gefühlseinstellung, eine Oberflächlichkeit der Gefühle und Neigung zum Automatismus und zu Zwangszuständen, und ganz besonders wird noch auf die motorische Ungeschicklichkeit hingewiesen. (99)

With Sukhareva's papers on schizoid psychopathy so rarely cited at this time, it is extremely interesting to find Sukhareva under autistic psychopathy and not in the following section on "other schizoid and preschizophrenic conditions". Is Walter Spiel in 1961 then the first to make the connection between Sukhareva's schizoid psychopathy and Asperger's autistic psychopathy? Did van Krevelen preempt this with his desire to rename autistic psychopathy schizoid psychopathy in 1958? Did Sukhareva make the connection herself in her textbook of 1959 when she renamed schizoid psychopathy autistic psychopathy? Perhaps Spiel is the first to explicitly connect the two. Sukhareva cites this work of Spiel's in her 1974 abridged lectures, so was clearly aware that the connection existed. We might also infer that the connection was approved of. Van Krevelen read Spiel's text, citing it in 1962 ("Autismus infantum"), so van Krevelen also should have read Sukhareva's schizoid psychopathy papers yet does not appear to have.

Formal Attempts at Differentiation: Reinier Vedder (1907-2000) in 1962

The obscure R. Vedder is possibly the first person to have formally compared and contrasted the autisms described by Asperger and Kanner and to have attempted to establish differentiating criteria⁴⁸. Vedder also mentions another writer, Kamp, who discussed the two forms, saying he does not agree with him. Vedder's criteria first appear in the second edition (1962) of a slim book called *Kinderen met leer- en gedragsmoeilijkheden* [Children with Learning and Behavioural Difficulties], a book with a pedagogical focus.

⁴⁸ With so many falsely attributed 'firsts', it is worth viewing any 'first' claim with scepticism, including those made by me, and as we have just seen, his work here presented was merely adding to a very involved discussion taking place in Europe at the time.

<i>Kanner</i>	<i>Asperger</i>
1. de contactstoornis is kort na de geboorte te constateren.	de contactstoornis treedt aan de dag op 2 à 3 jarige leeftijd.
2. de patiënten zijn zowel jongens als meisjes.	de patiënten zijn uitsluitend jongens.
3. er is een ernstig intelligentie-defect.	er is een goede of zelfs zeer goede intelligentie.
4. de sociale prognose is slecht.	de sociale prognose is redelijk goed.
5. geen ogencontact (de ander bestaat niet).	kortdurend ogencontact (de ander wordt ontweken).
6. de spraak is geen communicatiemiddel.	de spraak is wel communicatiemiddel.
7. geen heimweereacties.	sterke heimweereacties.
8. bijzondere vorm van zwakzinnigheid.	extreme karaktervariant.

Vedder's 1962 differentiation (146-147)

Note point 2, that Kanner's autism affects both boys and girls but Asperger's autism affects only boys, and points 3 and 8, that there is serious intellectual impairment in Kanner's autism, while intelligence is good or even very good in Asperger's autism, that Kanner's autism is a particular kind of intellectual disability but Asperger's autism is an extreme character variant. In the explanatory notes on these points, Vedder admits he has seen girls presenting with the clinical picture of Asperger's autism but believes these are cases of encephalitis, a claim also made by Asperger two years earlier⁴⁹. Vedder cannot be considered a standard source for the purposes of this literature review, but his work is good and I will return to him along with other overlooked characters later.

Dirk Arnold van Krevelen (1909-1979) and Cats

D. Arn. van Krevelen's work, covering Asperger's and Kanner's autisms extensively, was published in English, German, Dutch and French in a wide range of journals. As one of the most prominent researchers of autistic conditions in Europe of the 20th

⁴⁹ "Autistische Züge bei Mädchen konnten wir fast immer als Folge organischer Hirnstörungen erklären." ("Autistisches Verhalten im Kindesalter" 63)

century, he is more recognised than Vedder but still rather overlooked in the Anglosphere.⁵⁰ Van Krevelen wrote on autism from 1952 into the 1970s and Leo Kanner, reading van Krevelen in English, Dutch and German, engaged with van Krevelen's work in 1954⁵¹, 1955⁵² and 1958⁵³ and, as editor of *Journal of Autism and Childhood Schizophrenia*, published or even commissioned it. In 1962, the same year as the second edition of Vedder's book, van Krevelen published two papers, one in the *Japanese Journal of Child Psychiatry* called "Autismus infantum and the autistic personality. Two clinical syndromes" reported as coming from the University of Leiden, the second co-authored with Christine Kuipers and called "The psychopathology of autistic psychopathy" from the Paedologische Kliniek Curium at Oegstgeest. Both papers are comprehensive comparative discussions of Kanner's and Asperger's autisms in English. Van Krevelen makes many references to Vedder, but Vedder rarely published outside the language of Dutch, so access to his work was limited. In the paper published in Japan, van Krevelen writes that he aims:

[...] to present a schematic survey in order to elucidate the difference between both conditions. Such a scheme has been set up by Vedder in the Netherlands. I will make use of his table completed by a few features that to my mind emphasize the differences in symptomatology and etiology. (143)

⁵⁰ Silberman does not mention van Krevelen at all.

⁵¹ "There has been justified puzzlement about the nosological position of the autistic illness. Van Krevelen (1952a, 1952b) saw in it an 'oligophrenia with concomitant emotional defects.'" (CP 71)

⁵² "Additional observations were made and reported by Despert, Mahler, Rank, Weil, Murphy and others in this country, Cappon in Canada, Creak in England, Stern and Schachter in France, and van Krevelen in Holland." (CP 78) "Similar divergencies exist also with regard to nosology. Van Krevelen argues that early infantile autism represents an 'oligophrenia with affective defect.'" (CP 79)

⁵³ "Autistic children were described and discussed in the United States by *Despert, Mahler, Weil, Rank, Ritvo* and *Provence*, and others, in Canada by *Cappon*, in England by *Creak* and *Norman*, in France by *Stern* and *Schachter*, in Holland by *van Krevelen* and *Grewel*." ("The specificity of early infantile autism" 109) "*Van Krevelen, Grewel, Stern, and Schachter* suggest that for the time being the placement of the condition in any definite category should be avoided or at least held in abeyance and that it should best be regarded, at least temporarily, as a syndrome *sui generis*." (109)

Early infantile autism	Autistic psychopathy
1 disturbance is obvious shortly after birth, at all events in the first year of life	1 peculiarities come to light in the second or third year of life and are clearly manifest in the first school years
2 patients walk earlier than they speak	2 speak earlier than they walk
3 disturbance occurs in both sexes	3 the peculiarity is an extreme variation of the male character
4 cognitive defect	4 lack of intuition
5 social prognosis is poor	5 social prognosis is fair
6 speech has no communicative function	6 speech is used as a means of communication
7 there is no eye contact : the others do not exist	7 there is a cursory eye contact : the others are evaded
8 if the patient is hospitalized no signs of homesickness	8 homesickness is manifest (homesickness of cats?)
9 the intellectual endowment is poor	9 good general and special abilities
10 disturbance	10 peculiarity

Van Krevelen's 1962 differentiation based on Vedder's (143-144)

Van Krevelen's scheme is mostly a translation of Vedder's, but there are some changes, notably the presence or absence of speech delays. For Vedder's point 2 "de patiënten zijn uitsluitend jongens" [the patients are solely boys], van Krevelen returns to Asperger's work, writing "the peculiarity is an extreme variation of the male character", still predating Baron-Cohen. That girls are excluded from autistic psychopathy is not explicit and can only be inferred from the corresponding point in the early infantile autism column: "disturbance occurs in both sexes".

And we cannot go past the homesickness of cats! Although Vedder's table refers only to "sterke heimweereacties" [strong homesickness reaction] with no cats, the homesickness of cats is a direct borrowing from Vedder. However, it is no preponderance to pet ownership. Vedder explains:

[...] in the autists admitted to his hospital, Asperger saw serious homesickness that lasted longer than in normal children. The question of course is whether the homesickness is the result of a strong emotional connection to their parents or whether it comes from a longing for the old, familiar surroundings. This last seems more

probable to me so that we have here more to do with a “homesickness of cats” than a “homesickness of dogs”.⁵⁴ (139)

And here is van Krevelen and Kuiper’s interpretation of Vedder accompanied by a sort of refutation, which seems odd, considering van Krevelen was the one who added it to the table in the first place:

It is said (*Vedder*) that autistic psychopaths do not know real homesickness. According to this author, the nostalgia of the patients is a “homesickness of cats”, not a “homesickness of dogs”. The meaning is obvious, no attachment to any person would be at the root of the patient’s grief. The anxiousness to return refers to the old familiar surroundings, to the equipment of the home rather than to the persons who live in it. *Asperger*, however, states that he has been confronted with desperate separation reactions. We can confirm his findings from our own experience. From this, it may be concluded, that there is no disturbance of attachment, no contact disorder in a narrower sense. Moreover, there are many examples that prove that deep attachments to people and animals can come into existence. What separates the child from other human beings is his lack of intuition. This means the disorder is not rooted in deep areas of the mind, it depends on a deficiency of highest personality strata. (25)

But perhaps this is why van Krevelen removed the trait from the 1971 table.

Gerhard Bosch (1918-2011) in 1962

Gerhard Bosch was a teaching doctor of neurology and psychiatry at the psychiatric hospital in Frankfurt am Main in 1962 when his book *Der frühkindliche Autismus: eine klinische und phänomenologisch-anthropologische Untersuchung am Leitfaden der Sprache* was published. This version of the book briefly covers the differences between Asperger’s and Kanner’s conceptions of childhood autism in the introduction, but his comprehensive comparison is not found here. Worth mentioning, though, is his use of the word ‘schizoid’ (bolding below is mine), the word Sukhareva first employs:

⁵⁴ “[...] zag Asperger bij de autisten, die hij in zijn kliniek opnam, ernstige heimweeacties optreden, die langer duurden dan bij normale kinderen. De vraag is natuurlijk of dit heimwee gevolg is van een sterke gevoelsband met de ouders of dat het voortkomt uit een verlangen naar de oude, vertrouwde omgeving. Dit laatste lijkt mij het meest waarschijnlijk, zodat ik aanneem dat wij hier meer met een „kattenheimwee“ dan met een „hondenheimwee“ te maken hebben.”

ASPERGER hingegen spricht von „autistischen Psychopathen im Kindesalter“ und hat typologisch eine Sondergruppe abnormer, psychopathischer Kinder herausgearbeitet, zu der er sowohl solche mit schwersten Beziehungsmängeln als auch solche mit geringeren Schwierigkeiten der Kontaktaufnahme rechnet. Trotz einiger weitgehend identischer Fälle, die man vielleicht als „Kernfälle“ bezeichnen könnte, ist dadurch das Krankengut der beiden Autoren sehr unterschiedlich geworden. Eine große Gruppe autistischer Kinder ohne Sprachentwicklung, die KANNER in seinen frühkindlichen Autismus mit hineingenommen hat, fehlt bei ASPERGER ganz, während dessen Fälle mit leichteren Beziehungsschwierigkeiten, **die man bisher wohl eher als introvertierte oder schizoide bezeichnet hätte**, von KANNER kaum seinem Syndrom zugeordnet würden.

(2)

During *DSM-IV* when Asperger's syndrome and autism were distinct diagnoses, presence or absence of speech delays became the main point of differentiation. This distinction is observed by Bosch in 1962. When the English translation of *Der frühkindliche Autismus* appeared in 1970, Bosch was a professor of paediatric psychiatry at the University of Düsseldorf and the director of the Rhineland juvenile psychiatric hospital. Translated by Derek and Inge Jordan, *Infantile Autism* contains an appendix not present in the German and dated 1969, as well as a preface explaining the introduction of this appendix and a foreword by Bruno Bettelheim. The appendix is no brief matter, adding an extra seven chapters. The chapter of interest is "Differences Between the Asperger and Kanner Syndromes". This was written in German and translated by the Jordans, but the German Bosch wrote has not been published. The translation is now a primary rather than a secondary source.

In the introduction to my book (1962) I discussed the differences between these two syndromes, but I also pointed out where they overlapped. In the meantime various researchers, in particular van Krevelen, have made more detailed attempts to outline the differences between the syndromes, and even Asperger has revised his initial standpoint that his cases and those of Kanner are on the whole identical. Since these syndromes have in the meantime found their way into the European literature and textbooks on the subject and since they have also proved practical for everyday clinical purposes, I will discuss them here. (126-127)

Van Krevelen (1962) has contrasted the following differences:

Early infantile autism

1. Disturbance is obvious shortly after birth, at all events in the first year of life.
2. Patients walk earlier than they speak.
3. Disturbance occurs in both sexes.
4. Cognitive defect.
5. Social prognosis is poor.
6. Speech has no communicative function.
7. There is no eye contact: the others do not exist.
8. If the patient is hospitalized no signs of homesickness.

Autistic psychopathy

1. Peculiarities come to light in the second or third year of life and are clearly manifest in the first school years.
2. Speak earlier than they walk.
3. The peculiarity is an extreme variation of the male character.
4. Lack of intuition.
5. Social prognosis is fair.
6. Speech is used as a means of communication.
7. There is a cursory eye contact: the others are evaded.
8. Homesickness is manifest (homesickness of cats?).

Van Krevelen in Bosch (1970). Did Bosch miss the next pages of van Krevelen's article?

Bosch credits van Krevelen's 1962 paper with establishing the criteria, even though van Krevelen stated he borrowed it from Vedder. Presumably Vedder is "various researchers". The passage just quoted also suggests that, even more than a fad diagnosis, Asperger's syndrome was, if not as early as 1960 with Stutte's chapter, then by 1969 at the latest, a well-established nosological entity. In 1958, van Krevelen had written on Kanner's autism that, "Heutzutage ist die Diagnose Autismus gar nicht so selten und es gibt nur wenige kinderpsychiatrische Kliniken, wo man nicht einen oder mehrere ‚Autisten‘ antreffen kann." (87) And in 1962, Vedder had, also in relation to Kanner's autism, written:

In 1943, the American psychiatrist Leo Kanner described a clinical picture in young children which he named "early infantile autism". In 1952, the first European case matching Kanner's description was published by the Dutch psychiatrist Van Krevelen and since then this author has devoted many publications to the topic. Once Kanner's illness had gained more recognition both in America and Europe, descriptions by other authors of this deviant type of child followed. At present the literature on the syndrome is already very comprehensive and the term "autistic child" has even crossed over into lay circles⁵⁵. (141)

⁵⁵ "In 1943 beschreef de Amerikaanse psychiater Leo Kanner een ziektebeeld bij jonge kinderen, dat hij de naam gaf van ‚early infantile autism‘. In 1952 werd het eerste geval in Europa, dat overeenkwam met de

Bosch's English book is also important for its heavy use of references and quotes from Asperger's work as yet untranslated into English⁵⁶. Bosch discusses the work Asperger continued to produce on this topic after "Die ‚Autistischen Psychopathen‘ im Kindersalter", quoting work from the 1960s and following Asperger's own changing views and engagement with Kanner's work. Bosch's interpretation of Asperger's writing presages the current neurodiversity movement: "He believes that behaving 'autistically' is quite a general possible feature of human existence."

Bosch's final remarks in this chapter discuss the ever-unsolved problem of taxonomy and anticipate the debate that reappeared a good 40 years later during the preparation for *DSM-5*, or which has perhaps been ongoing since autism's inception:

In summary, it can be said that the delineation between the two syndromes made by Asperger and van Krevelen is valuable for the purpose of arranging the material, for the clinical understanding of the cases, for the therapy and for the prognosis. Doubt still remains whether the difference between the two syndromes is fundamental or only one of degree, and whether a fundamental disturbance of a similar type is present here. [...] Asperger's syndrome involves the risk that the concept of autism will be extended to people who are slightly afraid of personal contact, who are unsure of themselves, schizoid and abnormal, and that the concept will thus be watered down and generalized in a dubious way. The Kanner syndrome, on the other hand, involves the risk that much more retarded cases of oligophrenia with autistic traits would be included, in particular with the non-verbal early infantile autists, and that this area might become a hotch-potch of cases of very different etiology and severity. It might perhaps after all be a promising task for the future to make a clear etiological and symptomatological distinction between non-verbal and verbal autists. Finally, from our experience, it is to be assumed that there is an intermediate realm between the two syndromes which cannot easily and clearly be ascribed to this or that side, particularly if one also considers the course the condition takes. (129-130)

beschrijving van Kanner, door de Nederlandse psychiater Van Krevelen gepubliceerd en nadien heeft deze auteur nog menige publikatie aan dit onderwerp gewijd. Toen de ziekte van Kanner zowel in Amerika als in Europa bekendheid had gekregen volgden ook van andere auteurs beschrijvingen van dit type afwijkende kinderen en op het ogenblik bestaat er al een vrij omvangrijke literatuur over dit syndroom en is de term ‚autistisch kind‘ ook tot in lekenkringen doorgedrongen.” (141)

⁵⁶ A sentence I partially quoted earlier and translated in footnote 10 is given as "One can designate as [‘]autistic[’] behavioural disturbances of very different genesis – disturbances which can very readily, and indeed must be, differentiated but which in their overall character and in subtle details are very similar." (128)

The symptomatological distinction between non-verbal and verbal autists was made, but the conditions remained syndromic. Perhaps this is why the distinction was then unmade. It has been proposed⁵⁷ that Asperger's syndrome may be hereditary or endogenic and Kanner's syndrome may be caused by environmental factors, an exogenesis, but there is little clarity, and 'autism' is indeed a hotch-potch of cases.

1965

Still another German paper discusses Kanner's and Asperger's autisms in 1965: “,Autistisches Verhalten‘ im Kindesalter und seine Ursachen” by H. P. Gross and H. Schlange. This paper presents the Usonian/European child psychiatry divide on the topic of autism as one of schizophrenia/not-schizophrenia (344) and provides two cases studies, one of each form of autism. The paper also has an English summary.

Van Krevelen in 1971

Vedder's table appears again with some revisions in van Krevelen's 1971 paper “Early Infantile Autism and Autistic Psychopathy” in the first issue of *Journal of Autism and Childhood Schizophrenia*, edited by Leo Kanner.

⁵⁷ Even by Vedder as early as 1962, although for Vedder the evidence lies in the skewed sex ratio: “Het autisme van Kanner betreft zowel jongens als meisjes, hetgeen wijst in de richting van een exogene ontstaanswijze, terwijl bij dat van Asperger de endogene oorzaak duidelijk is (heredititeit).” [The autism of Kanner affects both boys and girls, which points towards an exogenous origin, while in the autism of Asperger, the endogenous cause is clear (heredity).] (147-148)

Early Infantile Autism

Autistic Psychopathy

1. Manifestation age: first month of life.	1. Manifestation age: third year of life or later.
2. Child walks earlier than he speaks; speech is retarded or absent.	2. Child walks late, speaks earlier.
3. Language does not attain the function of communication.	3. Language aims at communication but remains "one-way traffic."
4. Eye contact: other people do not exist.	4. Eye contact: other people are evaded.
5. The child lives in a world of his own.	5. The child lives in our world in his own way.
6. Social prognosis is poor.	6. Social prognosis is rather good.
7. A psychotic process.	7. A personality trait.

Van Krevelen's 1971 revision

We have sadly bid the cats farewell, and also the extreme variation of male character. Is the addition of "a psychotic process", harkening back to childhood schizophrenia, for the benefit of Usonians? Theories on autism go back and forth on the schizophrenia connection. Van Krevelen notes that:

Kanner's publications are well known internationally. I doubt sincerely whether this can be said about Asperger's work. This might create – and has in fact sometimes created – the impression that Asperger's autistic psychopathy refers to analogous cases described by Kanner. The two clinical pictures differ considerably. Both Kanner and Asperger are masters of descriptive art, hence much depends on the thoroughness of the reader to become aware of the points of difference. (83)

This paper contains an anecdote about a man in his 30s with Asperger's autism, interesting as the descriptions in the literature so far are usually of children. The man had sought out van Krevelen for advice on making friends and getting women to like him. A cursory glance at the Love & Dating forum on WrongPlanet shows incessant requests for such advice. Van Krevelen also points to a possible connection between the two autisms, while still believing they are separate, in that he gives an example of a family who had one child with Asperger's type and one with Kanner's.

1971 was a popular year for autism differentiation. Gerhardt Nissen and Klaus Hartmann both separately published German differentiations of Kanner's, Asperger's, Heller's and Kramer-Pollnow's syndromes, while Kanner's journal printed English-language summaries of their work. Nissen included a chart where we see his "Autismusfaktor" closely resembling *DSM 5*'s autism spectrum disorder⁵⁸.

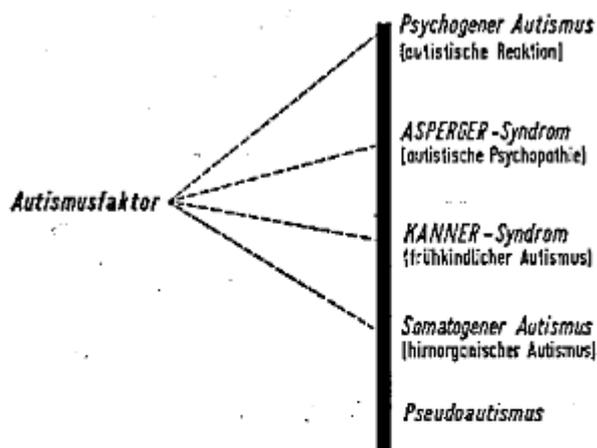


Abb. 1. Den autistischen Syndromen liegt wahrscheinlich ein *erbgenetischer Autismusfaktor* verschieden starker Ausprägung zugrunde. Dieser kann 1. unter starker Milieubelastung aus der Latenz heraustreten und zum *Psychogenen Autismus* führen, mit zunehmender Penetranz, 2. in einem *Asperger-Syndrom* bzw. 3. in einem *Kanner-Syndrom* sich manifestieren oder 4. durch *hirnorganische Schädigungen* als *Somatogener Autismus* in Erscheinung treten. Der „*Pseudoautismus*“ ist eine direkte Störungs- und Schädigungsfolge schwerer Schwachsinns- und Demenzzustände oder partieller Werkzeugstörungen (V.Stockert) und unabhängig von genetischen Voraussetzungen

Gerhardt Nissen's conception of autism, 1971

Autistic Psychopathy Becomes Asperger's Syndrome

Recapping the first paragraph of this review, in 1981, the British psychiatrist Lorna Wing (1928-2014 (Watts)) had a paper published in *Psychological Medicine* called "Asperger's syndrome: a clinical account", looking at Asperger's 1944 habilitation thesis. Although Wing's paper was published after Asperger's death, Adam Feinstein reports that Wing met Asperger in England in the late 1970s, where they discussed his syndrome and Kanner's over a cup of tea, with Asperger maintaining them to be distinct conditions and Wing arguing for a spectrum concept. (10) Wing is often credited with coining 'Asperger syndrome', despite its English appearances in *Infantile Autism* in 1964 (Bernard Rimland (1928-2006)), in the new appendix to the 1970 English translation (also called *Infantile Autism*) of Bosch's 1963 book, and in van Krevelen's

⁵⁸ Nissen published another version of this scheme in 1980.

papers of the 1960s and early 70s. Crediting Wing with the popularisation of the term is more accurate⁵⁹. Yet although the term already had some currency, Wing still made a conscious decision, shown below. ‘Autistic psychopathy’ had been perfectly⁶⁰ reasonable in German and English in 1943, but by 1981, ‘psychopathy’ was loaded with negative connotations.

The name he chose for this pattern was *autistic psychopathy*, using the latter word in the technical sense of an abnormality of personality. This has led to misunderstanding because of the popular tendency to equate psychopathy with sociopathic behaviour. For this reason, the neutral term *Asperger’s syndrome* is to be preferred and will be used here. (115)

As continued testament to the heavy influence of English-language research, *autistische Psychopathie* is now known as ‘Asperger-Syndrom’ in German with the *autistische Psychopathen* identifying as ‘Aspergers-Autisten’. Asperger’s syndrome, well-known in Europe, and its similarities and differences with Kanner’s syndrome, had been discussed heavily in English by van Krevelen and Bosch (the latter in translation but well-cited in English at this time) in the 1960s and 70s, as well as by Wing herself and Sula Wolff. It is not clear why Wing’s 1981 report on Asperger’s thesis became so well-known or why her paper catapulted his work into Anglophone fame.

The abstract for van Krevelen’s 1971 paper, published by Kanner, shows he was attempting to do precisely what Wing achieved:

Early infantile autism and autistic psychopathy were first reported within the span of 1 year (1943-1944). While the former (Kanner’s syndrome) has become the widely known focus of intensive investigation, the latter (Asperger’s syndrome) did not receive the attention it deserves. Often the two conditions mistakenly have been thought to be identical. This paper tries (a) to assign to autistic psychopathy a definite place in psychiatric nosology and (b) to delineate sharply the differences between the essential characteristics of it and of early infantile autism. The author (who was the first European child psychiatrist to publish a case of early infantile autism) reports briefly a

⁵⁹ Melmed and Cubells put this nicely: “[...] the monograph was not widely known or appreciated in the English world until Lorna Wing called attention to it [...]”. (1498-1499)

⁶⁰ With a few detractors!

case of his own observation – the occurrence of Kanner’s and Asperger’s syndrome in one each of two members of the same family.

Sula Wolff acknowledges this in her 2004 paper “The history of autism”: “Although van Krevelen and others attempted to put Asperger’s work on the map, it was not until Lorna Wing’s seminal paper of 1981, that Asperger’s syndrome as we now know it was born.” (204)

Introducing Autistic Psychopaths to English

As a result of Lorna Wing’s report, Asperger’s “Die ‚Autistischen Psychopathen‘ im Kindersalter” was partially, with the omission of the initial literature review and discussion of typologies and terminology, translated into English and annotated by Uta Frith (1941-) and is included, accompanied by a biographical article on Asperger, in the 1991 book *Autism and Asperger Syndrome*, which Frith edited. However, there was also an earlier paper “Das psychisch abnorme Kind” in *Wiener Klinische Wochenschrift* in 1938. This was originally a lecture given at Vienna University, where Asperger later taught, remaining there for twenty years until his death. This paper appears to be the beginning of the work that became his habilitation thesis. In recent years, this paper has been heavily cited online, but my library was unable to acquire it and I am not convinced many people have seen it. This paper is not mentioned by van Krevelen, Wing, Wolff or Frith, nor does Asperger mention it as his first description of autistic psychopathy – the year he gives is always 1944. Tony Attwood quotes from the 1938 paper in *The Complete Guide to Asperger’s Syndrome* (13). The paper is also covered in Adam Feinstein’s history (10-11).

Sula Wolff (1923-2009): Loners and Schizoids

About the same time that Lorna Wing had been working with Asperger’s ideas, Sula Wolff was working on a 20-year longitudinal study of what she had been publicly referring to as ‘schizoid personality disorder’ since at least 1980. This was not the same as the schizoid personality disorder defined in the DSM today, which she explains in a 1991 paper:

The term ‘schizoid personality disorder’ was initially applied because the children matched descriptions of this diagnosis in the adult psychiatric literature of the time (Wolff & Chick, 1980). Asperger’s work had not yet appeared in the English literature,

and DSM-III (American Psychiatric Association, 1980) and DSM-III-R (American Psychiatric Association, 1987) definitions of schizoid and schizotypal personality disorders were not yet available. (615)

She also mentions here that the term was “applied by the author some 25 years ago” but does not say where. This would put her first use of it in the 1960s. The culmination of her work was *Loners: The Life Path of Unusual Children*, appearing in 1995. She had spent over 30 years on the study, necessitating an introductory chapter, parts of which read more like a disclaimer:

It will become clear that the boundaries of the condition with which this book is concerned are not yet well defined and that it is uncertain whether we are dealing with one or a number of syndromes. What is more, the condition (or conditions) has been described by a bewildering variety of terms (Wolff, 1991b). Even more confusing is the fact that the definition and meaning of some of these terms have changed over the years. It is one of the aims of this book to contribute towards a clarification of the syndrome to which we initially applied the label of schizoid personality disorder in childhood (Wolff and Chick, 1980; Wolff, 1984). This label will be used throughout much of this book, although towards the end, and as a result of evaluating the extensive literature on the topic, the term schizoid/Asperger disorder will be recommended. (14)

The chapter discusses the modern understanding of schizoid personality disorder, which Wolff felt to be restrictive, *DSM-IV* and *ICD-10* and their replacement of the earlier broad category of schizoid with the new broad-category ‘schizotype’ (broken down into components, the words mean exactly the same thing). Despite the several pages of discussion on the terminology and justification for her own use of schizoid personality disorder with the statement, “This use of the term for adults is not idiosyncratic” (17), I do find her use of it somewhat idiosyncratic, more for her persistence with a definition that was no longer current than for any lack of persuasion in her argument. Language changes even when it shouldn’t, and contractions are witnessed in academic writing these days, quite heedless of all instruction to the contrary. However, it could also be argued that Wolff rightly continued with this term to maintain consistency across her body of work. Sukhareva did not take this strategy.

The initial chapter of Wolff’s book concludes with:

It will be clear how much doubt there currently is about how to explain and categorize the conditions exemplified by the children described in this book. We shall return to the debate about the nature of these conditions and what the best name for them might be in Chapter Ten. Meanwhile, we shall use the term ‘schizoid’ for the children we describe, on the understanding that this term is used broadly, to include schizotypal disorder, and that affected children were like the children Ssucharewa (1926) and Asperger (1944) had discovered, and overlap with the more seriously handicapped groups studied by other workers. These include the children and adults Wing (1981), Tantam (1991), Gillberg (1989) and Szatmari *et al.* (1989a) have reported on under the name ‘Asperger’s Syndrome’, and the children described by Cohen *et al.* (1986) and by van der Gaag (1993) as having multiplex developmental disorders. (29)

Sula Wolff had come to the UK in 1933 with her family as an eight-year-old German-Jewish refugee. The majority, if not all, of her schooling must therefore have been in English. She studied medicine at Oxford and became a prominent child psychiatrist in Edinburgh (Graham). Just after *Loners*, she released a small paper called “The first account of the syndrome Asperger described? Translation of a paper entitled ‘Die schizoiden Psychopathien im Kindesalter’”. This was indeed a translation of the said paper (Sukhareva’s first paper on schizoid psychopathy published in 1926 and featuring case studies of boys) but the specific translation errors made indicate Wolff was not a regular reader of traditional German literature and more likely had only a colloquial understanding of the language from her home. However, since globally, few people in the 1990s were interested in research written in German in the 1920s, even in Germany, this probably didn’t matter (the original has since been digitised but is paywalled). Possibly Wolff translated the title as “Schizoid personality disorders of childhood” rather than “Schizoid psychopathies in childhood” to align this work with her own, but it is more likely that in 1996, precisely as with ‘psychopathy’ in 1943, ‘personality disorder’ was not the stigmatised label it is today, and was a respectable one, as neutral as ‘syndrome’. Frith does not shy away from psychopathy in her translation of Asperger’s paper but her annotation comments, “This term could have been translated as autistic personality disorder or else autism to bring it into line with current terminology.” (37) Wolff discusses Asperger, Wing and Frith in *Loners*, making free use of Frith’s translation ‘autistic psychopathy’, but expresses scepticism of Frith’s suggestion that the autistic psychopathy of childhood Asperger talks about could ever be known as autism. Remembering that the -oid suffix designates “not the thing but *like* the thing”, *schizoid*, meaning not schizophrenia but like it, arises from the same

observations that led both Asperger and Kanner to borrow Bleuler's word for a symptom of schizophrenia, *Autismus*, and, despite its more negative associations today, is etymologically no less apt⁶¹.

Introducing Sukhareva to the Anglophone History of Autism

And thus with Sula Wolff's translation, the Soviet psychiatrist and neurologist G. E. Sukhareva's "Die schizoiden Psychopathien im Kindesalter", first published in 1926 in *Monatsschrift für Psychiatrie und Neurologie*, was pushed into the awareness of Anglophone writers of autism history.

⁶¹ Unless we venture further back to the Greek at which point it *is* less apt!

Non-Standard Sources in the History of Autism Research

I have now covered the famous people and the people who have covered the famous people. However, it is also worth mentioning a few lesser knowns. Many of these are well known to psychiatrists and specialists in the field, but they are largely absent from the popular discourse.

Tantam Now, Heller and de Sanctis in 1908

Digby Tantam has been working on Asperger's syndrome and ASDs since the 1980s, having been introduced to them by the Wings (John and Lorna) before Lorna Wing's paper so popularised 'Asperger's syndrome'. A quick terminology recap and a brief comment on research trends by Tantam in 1988:

Bleuler introduced the term 'autism' (Bleuler 1911) for one of these [fundamental disturbances of schizophrenia], and the term 'schizoid' for individuals who had a large measure of autism. Both new terms have been taken up by later psychiatrists and applied, confusingly, to a number of apparently different groups of disordered and socially isolated individuals. 'Autism' was applied by Kanner (1943) to children with what has now come to be regarded as the developmental disorder of 'early childhood autism' or 'infantile autism'. It was also applied by Asperger (1944) to children with a disorder similar to that described by Kanner, but this disorder has been variously called 'autistic personality disorder' (Van Krevelen, 1971; Asperger, 1979), 'schizoid psychopathy' (Mnukhin & Isaev, 1975) and 'schizoid personality disorder' (Wolff Barlow, 1979; Wolff & Chick, 1980).

Descriptions of Asperger's syndrome (e.g. Wing, 1981*a*) are quite different from psychodynamically influenced descriptions of 'schizoid' individuals (Fairbairn, 1952) and from the non-analytic descriptions of schizoid personality that have followed on from Kretschmer's pioneering work on the subject (Kretschmer, 1925). Comparison of issues of *Index Medicus* in the 1950s and contemporary issues suggests that interest in schizoid personality has been replaced by interest in borderline and schizotypal personality, but the same problems of eccentricity and social isolation lie behind these terms, too [...]. (777)

Here we see Sukhareva's schizoid psychopathy appearing as a synonym for Asperger syndrome via Mnukhin and Isaev – two Russians who published an English language

paper which, among other things, informed readers that in Russia Asperger syndrome was known as “schizoid or autistic psychopathy”.

In the introduction to Tantam’s 2012 book *Autism Spectrum Disorders Through the Life Span*, he mentions two much earlier researchers, the (again!) Viennese paediatrician Theodor Heller (1869-1938) and the Italian psychiatrist and psychologist Sante de Sanctis (1862-1935). These researchers are not usually given credit in the cursory credits found in introductions (although they are given credit in histories of schizophrenia or childhood psychosis) but are sometimes mentioned in more in-depth discussions of the history as researchers tangential to the history of autism. Both of these researchers described schizophrenia-like syndromes in children in 1908, with Heller referring to a Latin “dementia infantilis” and de Sanctis referring to both a Latin “dementia praecocissima” in 1906 and then a “dementia praecocissima catatonica” or a German “Katatonie des früheren Kindesalters” in 1908, followed by an Italian “sindrome aparetico-afasica tardiva” in 1916. In “Asperger’s Syndrome: a clinical account” (1981), Wing mentions both (123). Previously, in 1979, Wing, along with Gould, had conducted “an epidemiological study of all mentally or physically handicapped children in one area of London in an attempt to identify all those with autism or autistic-like conditions, whatever their level of intelligence” (123). Wing then introduces the triad of impairments still used in autism spectrum diagnoses today. She writes:

When all children with this cluster of impairments were examined, it was found that a very few resembled the description given by Asperger and some had typical Kanner’s autism. A number could, tentatively, be classified as having syndromes described by authors such as De Sanctis (1906, 1908), Earl (1934), Heller (see Hulse, 1954) and Mahler (1952), although the definitions given by these writers were not precise enough for identification. (123)

According to Wing, Heller and de Sanctis gave vague descriptions of syndromes that were neither Asperger’s nor Kanner’s. However, in his introduction in 2012, Tantam considered them similar enough to still be relevant:

Nor did either Asperger or Kanner appear to know of previous descriptions of similar disorders, such as the ‘dementia infantilis’ described by De Sanctis and Heller. Their

cases had a more organic flavour and might be likely to be diagnosed today as having another related disorder, disintegrative disorder. De Sanctis and Heller both considered that these conditions were related to the dementia praecox that had been described by Kraepelin, hence their term ‘dementia infantilis’. Dementia praecox was the basis for Bleuler’s description of the group of schizophrenias. Case reports similar to those of De Sanctis and Heller continued to be published after Bleuler’s terminology was widely accepted, but now under the name of ‘childhood schizophrenia’. (1)

In 1949, Sukhareva cautioned against mistaking children with Heller’s syndrome for childhood schizophrenics, presenting such a case study as an example of misdiagnosis. Here too, she was years ahead of Anglophone researchers.

Heller’s Syndrome

The year after Tantam’s book came out, a translation of Heller’s “Über Dementia Infantilis: Verblödungsprozess im Kindesalter” was published in the paper “Revisiting regression in autism: Heller’s dementia infantilis” (Westphal et al., 2013) with the abstract reporting that “Dementia infantilis is most closely related to the modern diagnosis childhood disintegrative disorder.” At the time that paper was published, preparations for *DSM-5* were underway and a call for descriptions of CDD, a condition in which children who have been developing normally experience a sudden and dramatic loss of skills, was put out with a view to subsuming CDD, like Asperger’s syndrome, into autism spectrum disorders. Heller’s work was translated in response to this call. In their discussion, the translators write:

...Heller is describing the triad of impairments that currently define autism, many years before Kanner or Asperger wrote on the topic. Heller describes social withdrawal, *stereotypisch* behaviours, and language loss. But Heller did not use the term autism, nor did he emphasize the fact that these characteristics seem to travel together. (271)

But they follow this up with, “It is clear that the natural history of CDD, or *dementia infantilis*, differs dramatically from the onset pattern of other ASDs.” Their concluding sentence, “Without a diagnostic descriptor to identify the children as a justification and a focus [of further research efforts], a descriptor that had survived 100 years of diagnostic vagaries virtually unchanged, clinicians will be less likely to bring the unusual, late-regressing children whom they see to the attention of researchers.” (271) seems to be a protest statement against the proposed subsummation. However, the

proposed changes did indeed take place, and childhood disintegrative disorder is at present considered a regressive form of autism.

One of the key difficulties I see in the study of historical medical cases also arises in reading Heller's descriptions, namely, that other aetiologically and/or pathogenically distinct conditions causing similar symptoms may be more easily distinguishable now but were not necessarily looked for, known, treatable, testable or diagnosable at the time the case studies were recorded. Other relevant symptoms that could have pointed modern diagnosticians to other illnesses may have been considered irrelevant and therefore omitted. For example, Heller's second case subject, K.W., is recorded as having a goitre. We will see this problem again when I look at Ernst Kretschmer. It is therefore difficult to say with certainty that the descriptor has indeed survived 100 years of diagnostic vagaries virtually unchanged as stated by Westphal et al. *ICD-10* lists "Other childhood disintegrative disorder" under the Pervasive Developmental Disorders, where Asperger syndrome, childhood autism, and atypical autism (or pervasive developmental disorder not otherwise specified) are also to be found. Synonyms given here for other childhood disintegrative disorder are dementia infantilis, disintegrative psychosis, Heller syndrome, and symbiotic psychosis. Heller is not usually included in books on autism because childhood disintegrative disorder is not usually included in books on autism. Since *DSM-5*, that may begin to change, but I also expect that at some point causes of CDD will be found, as happened with Rett syndrome.

Sukhareva talks about Heller's syndrome in a chapter on differential diagnoses for childhood schizophrenia in volume 1 of [Clinical Lectures on Child Psychiatry]⁶². The 1940 and 1955 sections on dementia infantilis, a "group of childhood diseases of the central nervous system"⁶³ are not quite identical but fairly similar. Sukhareva opens by stating that it is easy to misdiagnose children of a young age and that we can assume most children diagnosed as severely schizophrenic with rapid speech disintegration are in fact suffering from "unidentified infectious cerebral disease" or some other type of organic disease, somehow distinct from schizophrenia⁶⁴. In the 1955 edition, Sukhareva

⁶² *Клинические лекции по психиатрии детского возраста*, pp. 223-224 in 1940 ed.; pp. 390-392 in 1955 ed.

⁶³ "группа заболеваний центральной нервной системы у детей"

⁶⁴ "нераспознанные инфекционные мозговые заболевания или органические заболевания головного мозга"

provides an example of a six-year-old girl who was initially thought to have schizophrenia but who, on closer examination, showed no “schizophrenic splitting”⁶⁵ and no “true autism”⁶⁶. The patient had seizures before her arrival and gastrointestinal symptoms during her two-month stay terminated by her death. The symptoms are assumed to be the result of organic brain disease caused by a head injury. As a result, a diagnosis of dementia infantilis was given and Sukhareva here refers to Heller’s 1908 paper. Sukhareva is clear that this is *not* childhood schizophrenia or oligophrenia (intellectual disability) accompanied by psychoses. There is also no chance this can be one of the constitutional psychopathies (among them schizoid psychopathy) which appear in volume 2 of the lectures. Sukhareva then mentions that Kraepelin files this under childhood schizophrenia and that Sante de Sanctis⁶⁷ described a very similar disease in 1916, calling it phrenasthenia. I am now accustomed to seeing Heller paired with de Sanctis, but not for this paper! In Sukhareva’s classification system, which tries to group according to hypothesised aetiology, pathogenesis and prognosis rather than according to behavioural or symptomatological commonalities, Heller’s syndrome exists but it exists nowhere near the autisms.

De Sanctis’s Syndromes

The children de Sanctis describes in his German paper “Dementia praecocissima catatonica oder Katatonie des früheren Kindesalters?” do not have regression. They sound rather like the children described by Sukhareva in the papers on schizoid psychopathy that are the central topic of this thesis. The vocabulary used by de Sanctis and Sukhareva is similar with de Sanctis listing, “gute Wahrnehmungsfähigkeit und gutes Gedächtnis, jedoch sehr bewegliche Aufmerksamkeit, geringe oder fehlende höhere Gedankensbildung, ferner schwere Störungen der Willenstätigkeit, des Benehmens und des Charakters, so Negativismus, Neigung zum Rhythmus, Suggestibilität, Impulsivität⁶⁸” (9) as traits of dementia praecocissima and commenting that the children do not easily fit into the then current descriptors of conditions. Sukhareva was familiar with de Sanctis’s 1916 paper, but I did not find a mention of the 1908 paper, and Sukhareva draws no connection between de Sanctis’s work and

⁶⁵ “шизофреническое расщепление”

⁶⁶ “настоящий аутизм”

⁶⁷ Misspelt Санкте де Сантис (Sancte de Santis) in 1940 and partially corrected to Санкте де Санктис (Sancte de Sanctis) in 1955.

⁶⁸ [good perception skills and good memory, however very erratic attention, slight or absent formation of ideas, as well as serious disruptions in activity of the will, in behaviour and in character, thus negativism, tendency to rhythm, suggestibility, impulsivity]

schizoid psychopathy herself. I do not believe she was fluent in Italian. Baumann and Vedder's 1936 paper "Zur Frage der infantilen Schizophrenie" does not mention Sukhareva's 1932 paper on childhood schizophrenia but does point out, referring to another Italian psychiatrist, G. Corberi, that Heller's dementia infantilis has very little in common with de Sanctis's dementia praecocissima catatonica, calling the two "wesentlich verschieden".

In "Dementia praecocissima catatonica oder Katatonie des früheren Kindesalters?", de Sanctis stresses that his children could not be considered to have dementia praecox (schizophrenia) and that his terming their complex of symptoms "dementia praecocissima" is due to the similarities in symptoms rather than a shared aetiology or prognosis. He considered his term more of a temporary placeholder until a better one could be found. Sukhareva's opinion of Heller's syndrome as a group of diseases, pointing also to A. I. Vinokurova who does not believe dementia infantilis is a "nosological unit"⁶⁹ but rather something awaiting further differentiation, may be in line with de Sanctis's thinking here, or de Sanctis may have simply felt his term inadequate, as Kanner felt about early infantile autism. De Sanctis's German paper on childhood catatonia, from which the above list of dementia praecocissima traits is taken, is but one case study, that of a small girl who witnessed her mother run over by a tram and was subsequently raised in an orphanage. This paper is essentially a discussion of conditions the child does *not* have and whether catatonia can exist in isolation from schizophrenia (de Sanctis believes it can, adherents to the Emil Kraepelin school of psychiatry believe it cannot) with the condition the child does have remaining largely a mystery. Towards the end, he makes an interesting philosophical point about medicine:

Diese Erkrankung mag nun ihre Benennung verdienen oder nicht; unzweifelhaft aber besteht sie. Bevor eine Krankheit benannt wird, müßte ihre Pathogenese festgestellt werden; wie oft geht aber die Klinik der pathologischen Anatomie voran! (12)

That would be nice but since it is not an ideal world, we use the word 'syndrome'. However, it is good to be reminded again that syndromes are (strictly speaking) collections of signs and symptoms that are frequently seen together with either the aetiology or pathogenesis unknown. This is also again a reminder that despite the

⁶⁹ "нозологическое единство"

merging of many conditions into ASDs under the *DSM-5*, we may one day, if such pathogeneses become known, be able to separate some disorders out again, and perhaps rename them more accurately. Perhaps any psychiatric descriptor should be considered “nur eine vorläufige” à la de Sanctis (“Dementia praecocissima catatonica” 9), who would clearly have been in favour of the Sukhareva method of classification.

“Sopra una sindrome della frenastenia cerebropatica postnatale: ‘Sindrome aparetico-afasica tardiva’”, de Sanctis’s only work published in 1916, is the one Sukhareva mentions, calling the syndrome *frensastenia* and equating it with Heller’s. The Russians have seriously misunderstood or misremembered the terminology, as phrenasthenia is the Italian equivalent of oligophrenia – the word then being used as an umbrella term for various types of intellectual disability – and not a new discovery of its own. The new discovery is tardive aparetic-aphasic syndrome with this triad of criteria: 1. the absence of “true” paralysis (limbs and face) with the loss of previously acquired language skills, 2. unrest and instability: epileptoidism in some cases and convulsive epilepsy in others, usually occurring at a later stage, 3. insufficient intelligence for their age⁷⁰. (2-3) The sudden, dramatic and irreversible loss of skill occurs between ages 1-3. While *frenastenia* is misused, Sukhareva is still right in finding this a far better match for Heller’s dementia infantilis than de Sanctis’s other syndrome dementia praecocissima, which we see frequently paired with dementia infantilis perhaps more for their similarity in names. PubMed has several records for papers on infantile aparetic-aphasic syndrome, but all are in Italian, indicating that this syndrome probably did not take hold anywhere else. Laura Fiasconaro notes in a dictionary entry on de Sanctis that his 1925 book *La neuropsichiatria infantile*, having “una grande risonanza”, was translated into Russian. The 1916 paper is neither included nor referenced in the 1925 book and neither is the syndrome so we can rule that translation out as the source of the misunderstanding around *frenastenia*. This syndrome does receive a paragraph in R. A. Q. Lay’s 1938 paper “Schizophrenia-like psychoses in young children”, between a paragraph on dementia praecocissima and a paragraph on dementia infantilis.

That some researchers have linked Heller’s dementia infantilis and de Sanctis’s dementia praecocissima together, that some consider these forms of autism, that some

⁷⁰ 1) assenza di fatti paralitici (paralisi delle membra e della faccia), ma perdita progressiva del linguaggio cominciato già a svilupparsi: 2) irrequietezza e instabilità: in taluni casi epilettoidismo e in altri perfino epilessia convulsiva, che sopravviene, per regola in secondo tempo: 3) intelligenza insufficiente per lo più di alto grado.

have considered them forms of schizophrenia, that others found Heller's dementia infantilis more similar to de Sanctis's tardive aparetic aphasia shows again that we cannot consider anyone's claims of equivalency for these brief written descriptions of patients seen in past years definitive fact. No one is posting filmed footage of their patients around the world, a few are taking photographs, and everyone is relying on written descriptions.

De Sanctis is another early researcher deserving of further Anglophone credit and his papers of translation. As the Russians consider Sukhareva the founder of child psychoneurology, so do the Italians consider de Sanctis the founder of child neuropsychiatry. The Italians have the antecedent claim.

Echolalia with Intellectual Disability in the 1800s: Martin W. Barr (1860-1938), Moritz Heinrich Romberg (1795-1873), Adolf Kussmaul (1822-1902)

Tantam also mentions an English language paper from as far back as 1898 called "Some notes on echolalia with the report of an extraordinary case." Martin W. Barr was the Chief Physician at the Pennsylvania Training School for Feeble-Minded Children. Barr's paper first expresses frustration that "the literature of this subject is most meagre, the search for information most discouraging" and points to Moritz Romberg as the first employer of the term. The relevant passage by Romberg is found under "Psychische Krämpfe" in the second volume of *Lehrbuch der Nervenkrankheiten der Menschen* in 1851⁷¹:

Die nachahmenden articulirenden Bewegungen in Krankheiten sind bisher noch nicht Gegenstand der Untersuchung gewesen. Eine merkwürdige Erscheinung, welche ich das Echo nennen möchte, hat sich mir mehreremal in verschiedenartigen Krankheitszuständen des Gehirns dargeboten. Der Kranke wiederholt monoton die von einer Person in seiner Nähe gesprochenen Worte und Sätze, ohne eine angeregte Aufmerksamkeit zu bezeugen, und überhaupt ohne einen Begriff damit zu verbinden.

(313)

After an example of *Hirnerweichung* which Barr calls cerebral softening, Romberg gives an example of a child with intellectual disability: "Bei einem elfjährigen Fatuus ist

⁷¹ I have not seen the second volume of the first edition of 1840 and 1846.

diese Nachäffung in der tönenden Mimik sehr auffallend.”⁷² (313) In Edward Sieveking’s 1853 translation the relevant sentence is given erroneously: “I am acquainted with an idiot of 11 years, who in this way mimics music in a remarkable manner.” (vol. II, 181) In the 1857 third edition, Romberg provides further examples of echolalia (655-656). These appear to be temporary conditions and are attributed to fever, doses of morphine and other anaesthetising substances or illness. These are unlikely to be related to autism, but the 11-year-old’s echolalia may well have been and comes across as an outlier among the examples listed in the third edition.

Returning to Barr’s paper, Barr relates making enquiries with his colleagues at other institutes for examples of echolalia but being given very few instances, with one colleague even asserting that “echolalia is not found among the feeble-minded”. However, the phenomenon of echolalia in conjunction with intellectual disability had also been documented by Adolf Kussmaul at this point in his 1877 book on speech disorders (bolding mine):

Nach Vernichtung der Willenssprache bleibt (bei nicht ataktischen) Aphatischen oft das Vermögen, vorgesagte Wörter nachzusprechen, obwohl sie dieselben Wörter freiwillig nicht hervorbringen können. Sie sind nicht im Stande, die Wortbilder durch Vorstellungen in die Erinnerung zu bringen, dagegen hat die Articulation nicht gelitten. Durch das Vorsagen werden ihnen die acustischen Bilder der Wörter, die von innen her nicht mehr erzeugt werden, von aussen zugeführt und damit die reflectorische Auslösung der entsprechenden Lautbewegungen ermöglicht. **Dasselbe geschieht bei der Echosprache geistesschwacher Personen mit demselben triebartigen Zwang, der das Kind bestimmt, Begriffenes und Unbegriffenes nachzusprechen.** (57)

It is not clear whether Barr read German. He used ‘cerebral softening’ where Sieveking used ‘softening of the brain’, but if Barr had read Sieveking’s translation of Romberg, Romberg would certainly have been misunderstood. As always, the search for the ‘first’ discoverer is elusive.

The extraordinary case Barr reports on is a 22-year-old man called Kirtie M. Mansfield. The description is virtually identical to what one could expect to find in textbooks on classic autism with intellectual disability today. Mansfield has epilepsy, a common co-

⁷² [This imitation with sonic mimicry is very striking in an 11-year-old with intellectual disability.]

morbidity in classic autism but less common in Asperger's syndrome. His parents and relatives are described as having "no trace of nervous or mental disease". He speaks of himself in the third person. He is unable to read and write but his memory is phenomenal ("phenominal"), remembering the names of people he has not seen for years, as is his echolalia: he is able to repeat all the words of a song after hearing it once and will repeat sentences spoken in other languages with perfect intonation. He also performs echopraxia although this word does not appear in the text. Dr William G. Spiller adds his opinion on the case, calling it "a symptom-complex resembling that of transcortical motor aphasia". Interest in examining Mansfield's brain when he dies is expressed. Today, the Usonian organisation Autism BrainNet solicits, accepts and administers voluntarily donated brains and brain tissue of deceased diagnosed autists and their relatives in order to further neurological research into autism. Barr's case study strikes me as a very typical description of the autism often thought of as classic and sometimes referred to as Kanner's autism, yet who knows but that he did not have some other condition such as FG syndrome, as Kim Peek is now thought to have had. Barr wrote no similar case studies. As an alienist and director of an institute for the intellectually disabled, Barr was largely concerned with more general social issues and this paper on echolalia is a side note in his corpus.

T. P. Simson in 1929

For the opening issue of *Journal of Autism and Childhood Schizophrenia* in 1971, the editor Leo Kanner published a series of abstracts from Soviet medical journals. He himself wrote the abstract for V. M. Bashina and G. N. Pivovarova's paper on the history of autism-like syndromes. Kanner writes:

Much is made of a 1929 treatise by T. P. Simson on *Neuropathy, Psychopathy and Reactive Conditions in Childhood*. In a chapter entitled Autistic Children, a syndrome was described which indeed had much in common with early infantile autism and was said to "constitute a reason for including such children in the group of schizoid psychopaths." But, aside from the semantic nebulosity shared to this day by many people everywhere, it must be conceded that Simson's chapter can be seen as one of the precursors of later, more concise delineations. ("Abstracts" 110)

Unfortunately, I found this only towards the end of this project and have not been able to acquire Simson's work. Bashina and Pivovarova attribute the 'first' description to

Simson – Sukhareva is mentioned in their paper but not for her work on schizoid psychopathy. In her own work on schizoid psychopathy, Sukhareva does not mention Simson's work on autistic children until 1959.

Moritz Tramer (1882-1963) in Switzerland in the 1930s

Moritz Tramer was born to a Jewish family in Ostrava, a Polish city now in Czechia but in 1882 part of the Austro-Hungarian Empire, but his adult life was lived in Switzerland where he is considered a Swiss psychiatrist⁷³. His first doctorate was in maths. He then studied medicine and went into child and adolescent psychiatry. His wife Franziska Baumgarten was a well-known psychologist. Tramer founded *Zeitschrift für Kinderpsychiatrie*, later known by its Latin title *Acta Paedopsychiatrica*, and edited this journal until his death in 1963, at which point D. Arn. van Krevelen assumed editorship. Documentation of Sukhareva's work appears many times in this journal from a report on a Russian conference in the journal's second issue, citations by authors writing in English and German over the years, praise of her work in English in the 60s to papers she actually authored. Tramer also documented echolalia but invented the term 'phonographism', a very cute but technologically dated word. Ordered over a year ago, at conclusion of this thesis, Tramer's book containing phonographism has still not yet arrived at my library.

Echolalia and phonographism were both used by Despert in a 1941 paper "Thinking and motility disorder in a schizophrenic child", seemingly synonymously. Interestingly, this is another description of a child who was developing normally and then suddenly regressed accompanied by the sleepiness and vomiting usually indicative of a head injury. The child was also found to have spina bifida occulta⁷⁴. The paper contains, "Echolalia was marked." (528) and, "'Phonographismus' is evidenced to a marked degree." (531) Note that Despert uses the German suffix. Neither phonographism nor phonographismus appear in the *OED*. The second recorded English use of echolalia is

⁷³ He is an entry in *Historisches Lexikon der Schweiz* and his papers are held by the Burgerbibliothek of Berne.

⁷⁴ Despert did not find the physiological symptoms significant writing: "Etiological factors are not wanting in this case. These are the same factors which were found to be present in a previous study of schizophrenic children [...]" She attributed the child's illness to "marked familial tainting as seen in the social attitudes of the paternal grandparents" (we were previously informed they were more interested in Communism than in their family), again, to the fact that the pregnancy was unwanted as the family was in poor financial circumstances at the time, to parenting ineptitude on the part of the mother, and to the mother's relationship with her own father. "Organic genesis has been ruled out."

found in William James's *The Principles of Psychology*, but here it is used in relation to the language acquisition process occurring within normal child development.

Tramer was also the 'first'⁷⁵ person to talk about elective mutism (*elektiver Mutismus*), now usually referred to as selective mutism, one of the many optional add-ons for ASDs. Tramer is thus more likely to appear in histories of speech and language disorders.

Tramer's book *Lehrbuch der allgemeinen Kinderpsychiatrie (einschließlich der allgemeinen Psychiatrie der Pubertät und Adoleszenz)* was another very popular clinical textbook aimed at both fellow doctors and psychologists and pedagogues, going into several editions. The third edition, one used by Sukhareva, was published in 1949. She also used an edition from 1964.

Schneersohn in Israel in 1952

Yehoshua Fischel Schneersohn (ca. 1885/88-1958) was born into a rabbinical family in Kamianets-Podilskyi⁷⁶, then under the Russian Empire, today in Ukraine. He was both a doctor of medicine (working in paediatrics) and an author of Yiddish novels. From 1908 to 1913, he studied medicine in Berlin. At some point in the 1930s, Schneersohn moved to Mandate Palestine where he ran a clinic for neurotic children. From Tel Aviv, he sent Tramer's journal a study of 64 children, only 16 of whom were girls, who were socially isolated and had consequently (in his view) withdrawn into compulsive reading. His study was based on observations conducted there between 1937 and 1951. His report on this study was published in 1952 in three parts as "Die Lesesucht bei Kindern". The description of compulsive reading behaviours is very close to descriptions of hyperlexia today, yet Schneersohn's approach is enthusiastically Pavlovian. While it is likely the children had any number of disorders ranging from trauma-induced behaviours to neurodevelopmental conditions like ASDs and ADHD to others like OCD and Tourette's, Schneersohn saw all such symptoms as caused by their reading behaviour.

He provides one case study of an 11-year-old boy whose compulsive reading results in frequent truancy. When at school, he does not participate, nor does he ever do

⁷⁵ Prior to Tramer, Adolf Kussmaul talked about *aphasia voluntaria* and other writers had written of *Sprachverweigerung*.

⁷⁶ Кам'янець-Подільський in Ukrainian, Kamieniec Podolski in Polish, Camenița in Romanian, Каменец-Подольский in Russian, קאַמענעץ-פּאָדאָלסק in Yiddish and Kamanets Podolskij in German.

homework. Despite his “Talent im Lernen”, he remains behind in school. He can read the same book many times over, and will often wake in the middle of the night to read. Schneersohn’s aim with all the children seen at his clinic (or in its attached remedial afterschool youth club) has been to reduce this “übertriebene Lesen” so lacking in discriminatory selection. The children are gourmands when they should be gourmets. Although he wrote books on the importance of play, Schneersohn was critical of escapism. Acknowledging that humans require play to restore their strength for the *Existenzkampf*, he did not believe we can escape this struggle altogether and nor should we attempt to. Obviously, it is good if the children were able to participate in school and have friends, which Schneersohn claimed to have achieved for many of them, but it is sad to hear him talk of recidivism as if reading is a crime.

Schneersohn’s focus on the ability to integrate into the life of the collective is similar to that of Soviet psychiatrists, which we will see again in the chapters covering political conditions. His devotion to I. P. Pavlov and environmental conditioning is something we would only expect a Soviet psychiatrist to be doing, and even then, only after the Pavlovian sessions of 1950-51. That a psychiatrist in Tel Aviv would be concerned with social integration is unsurprising⁷⁷ – Israel was founded by Marxists and the collectivist *kibbutzim* were widespread and thriving in 1952. That a psychiatrist in Tel Aviv would voluntarily comply with the academic standards enforced on Soviet child psychiatrists by the communist party is rather more unusual.

Psychiatric or psychologic texts (the boundary then being somewhat slimmer than now), by Schneersohn were published in English, German, Yiddish, French, Polish, German and Russian. He was a frequent contributor to Tramer’s *Zeitschrift für Kinderpsychiatrie/Acta Paedopsychiatrica* and was possibly on the editorial board in the 1940s⁷⁸.

Robinson and Vitale in the USA in 1954

Over in the USA, J. Franklin Robinson and Louis J. Vitale, both medical doctors at the Children’s Service Center of Wyoming Valley in Pennsylvania, published three sample

⁷⁷ Or anywhere, indeed, social conformity is just as crucial to life in a capitalist society but the insistence on it is less overt and more insidious. Explicitly, a capitalist society may be seen to prize individualism but this is no more true than it is in a communist society which is explicitly seen to value civic contribution.

⁷⁸ Another Israeli, H. M. Marburg, was on the journal’s advisory board during the 1960s.

case studies (while having seen many more children with this clinical picture than three) in 1954 called “Children with circumscribed interest patterns”. The children were all socially ostracised and therefore isolated boys of above average intelligence who read avidly. One was interested in chemistry and corporate finance, the next in public transport (with a vast knowledge of trolley routes and a ticket collection), maps and calendars, and the last was interested in space and astronomy and was pedantic about terminology. All three had difficulty engaging with other people when not related to their interests. This paper compares them to Kanner’s early infantile autism children, saying that they are similar but not the same. Particularly, these children are more emotionally engaged with people than those with Kanner’s syndrome and “reveal flashes of good emotional reactive capacity” (761). Again, the children have no language impairments and are of normal or above average intelligence. They know an enormous quantity of facts and information which contributes to their social difficulties with peers. They lack conversational initiation but wax verbose on their “favoured themes”. The syndrome becomes noticeable between the ages of 8 and 11 when failures to integrate socially become more obvious and of concern to parents but usually to teachers. The parents, being somewhat odd themselves, tend to consider their child normal until the oddness is called attention to by others. The children become more anxious and fearful as they grow older and experience more social rejection and frustrated when thwarted in pursuit of their circumscribed interests. Robinson and Vitale’s report is followed in the journal with a discussion of their work by Leo Kanner. Kanner here agrees that their syndrome is similar yet different to early infantile autism and he directs the reader to Schneersohn’s study of reading-addicted children, writing also that Robinson and Vitale’s work is of immense importance. Van Krevelen also read this report, equating Robinson and Vitale’s syndrome with Asperger’s autistic psychopathy in 1962 (“Autismus infantum” 142).

Reinier Vedder in the Netherlands

R. Vedder, of homesickness of cats fame, was a psychiatrist who made some prescient remarks in the 1960s, but he wrote almost solely in Dutch, which is rather a less-read scientific language than German, and so exists undercited. It has also been very difficult to find out any biographical information about him even in Dutch writings; however, it is clear that his interest in unusual children and the symptomatically overlapping pictures of childhood schizophrenia and autism as a general subject goes back a long way. He was born in 1907 in Amsterdam and married Johanna Scheeres in 1932. In

1936 he worked at the Amsterdam Pedological Institute, co-authoring a paper with C. Baumann that appears in German in *Zeitschrift für die gesamte Neurologie und Psychiatrie*, the journal which published Sukhareva and S.V. Osipova's paper on giftedness and constitution in 1926 and the two reports by E.A. Osipova and Sukhareva on oligophrenia in 1928. He and Jan Waterink also published a French-language paper on cases and treatment of "thymogenic" (resulting from emotional causes) mutism in young children⁷⁹ in Tramer's *Zeitschrift für Kinderpsychiatrie* the same year. "Zur Frage der infantilen Schizophrenie" is two case studies showing the emergence of autistic withdrawal and mutism in two boys much older than the children described by de Sanctis and Heller. These children are school-aged when they withdraw into themselves. The first is 4 and a half at the time of the study. He gradually speaks less and less, and gives strangers the impression of intellectual disability, although his mental faculties are proven to be intact. He ceases to express any attachment towards his parents, but shows no signs of psychosis or hallucinations. When he does speak his speech is correct. Even this early paper of Baumann and Vedder's, prior to Asperger, prior to Kanner's early infantile autism, is asking and answering:

Hat sich hier also ein Autismus im *Bleulerschen* Sinne entwickelt? Dafür spricht allerdings vieles! Tatsächlich fällt es uns immer wieder auf, daß der Patient absolut ein eigenes geistiges Innenleben führen muß. [...] Der Patient nimmt zwar in sich auf, selbst aber ist er meistens verschlossen und verarbeitet den verschiedenen Geistesinhalt ohne daß man bei oberflächlicher Betrachtung den Eindruck gewinnt, daß sich überhaupt psychische Prozesse in ihm abspielen. (703)

The second child in this paper also withdraws and becomes selectively mute. He is 11 at the time of the study and was developing normally until 7. This boy shares similarities with a child mentioned in Sukhareva's clinical lectures, one who was initially diagnosed with schizoid psychopathy but later, as an adult, confirmed to be schizophrenic. Baumann and Vedder's second child does not become affectively mute, instead showing ambivalent emotions. He also at times creates a rich fantasy world and seems to also have something like absence seizures:

⁷⁹ "Quelques cas de mutismus thymogénique chez des enfants très jeunes et leur traitement." *Zeitschrift für Kinderpsychiatrie*. 3.4 (1936): 101-112.

Auch hat der Patient mitunter Zeiten, in denen er vollständig in sich gekehrt und mutistisch ist. Es ist dann kaum möglich, mit ihm Kontakt zu bekommen. Schon sein Gesichtsausdruck weist dann darauf hin, daß er sich ganz in seine eigene Seelenwelt zurückgezogen hat. (706)

Baumann and Vedder confess that both cases present diagnostic difficulties, as did similar cases for other clinicians in the past. They point to Wilhelm Lange's 1933 descriptions of cases which presented great diagnostic difficulties only a few years earlier. These are also worth noting for their high likelihood of being a Kanner's-style autism.

Lange's cases had neither congenital nor acquired intellectual disability and fell somewhere between Heller's dementia infantilis and a hyperkinetic illness. Lange reported on children with echolalia, loss of contact with their surroundings, stereotyped play and behaviour, motor unrest and states of agitation, children others could not seem to make contact with. His children parroted heard phrases or sang songs by way of answer, sometimes seeming not to hear at all, only to be heard repeating lines to themselves alone later. The children took no notice of their parents' comings and goings at the clinic. Hilde K. had an unaffected identical twin sister. She had periods where she screamed and scratched herself till she bled, reducing in frequency over time. She smeared and ate faeces but eventually became cleaner. She looked at books and newspapers but spent equal time on pages with pictures and pages with solid blocks of text. Horst G. stacked toys repetitively and refused unfamiliar food. Lange provides many other case studies of children with other illnesses for the purposes of differentiation and comparison. All forms of encephalitis were ruled out, as was dementia infantilis – there was no sudden regression. These children had developed oddly from the start.

Children with elective mutism, normal intelligence and no psychosis are described by many clinicians throughout the 20th century.

In 1938, Vedder published the sympathetically titled book *Waarom niet als andere Kinderen?* (*het achterlijke kind; het "schijn-achterlijke" kind; het nerveuze kind; het psychopatische kind*) [Why Not Like Other Children? (the retarded child; the "pseudo-

retarded” child; the nervous child, the psychopathic child]⁸⁰. In 1939, he completed his doctoral thesis, writing on the abilities of children with oligophrenia to copy geometric shapes. He authored several psychiatric books, some with a more clinical focus and others aimed at a more general audience. The one of most interest to me is *Kinderen met leer- en gedragsmoeilijkheden* [Children with Learning and Behavioural Difficulties]. This book informs it was written from Haarlem. Vedder reportedly worked at St. Elisabeth Gasthuis. It is a slim easy read, intended for both pedagogues and clinicians. The first edition of 1958 contains no mention of Asperger, Kanner, or autism, although there are subsections on “Het psychopathische kind” and “Het gepsychopathiseerde kind” in chapter 9 “Stoornissen van de aanpassing” (disturbances of adjustment or of fitting in). From the second edition (1962), a new chapter 10 is inserted – “Stoornissen van het contact” (disturbances of contact) whose headed sections I here translate: “The term autism”, “The autistic psychopaths of Asperger”, “The early infantile autism of Kanner”, “Causes of autism”, “A comparison between the autists of Kanner and those of Asperger”, “The life of the Kanner’s autist” and lastly “Therapeutic and pedagogical considerations”.

What I appreciate about Vedder’s writing is the way he poses the differences found in schizophrenics (included in his discussion of the etymology of autism) and autists compared to the general population. The differences are presented not as much simple failure or deficits on their part as they are equally failures or deficits on the part of society. It is the “us” (non-schizophrenics and non-autists) who finds it hard to understand, comprehend, empathise with and relate to schizophrenics and autists, not the schizophrenics and autists who are lacking in understanding, comprehension, empathy or relational skills. It is not that the actions of schizophrenics or autists are inherently nonsensical or incomprehensible but that the “we” (*wij*), i.e. those readers who are not schizophrenic or autistic, cannot comprehend the motivations behind them. This phrasing removes the blame from the patients and reinforces the oft-forgotten reality that communication is two-way and not just dependent on the skill or lack of skill on the part of the person with autism. Vedder uses “solisten” [soloists] (Vedder’s quotes) to refer to the children with Asperger’s syndrome, much like Sula Wolff’s “loners”. Many of the things Vedder writes could come straight from a Tony Attwood

⁸⁰ This book was published in Indonesian translation thirty years later in 1968, by which time it was out of date. Indonesia achieved independence in 1945 after Japanese occupation during WWII ended but the influence of Dutch education and Dutch as a European language continues today.

book today. He talks about their difficulties in school at different ages but also states that the prognosis, including the social prognosis, is later not so bad and that their skills and niche areas of expertise can make them useful employees in places like libraries or archives. In his discussion of Kanner's autism, Vedder talks about the echolalia referred to by Kanner as well as the word used by Tramer in the 1930s – phonographism. In “Causes of autism”, Vedder covers the refrigerator parent theory, first looking at Kanner's descriptions of educated, cold, formal parents before moving on to “anderen” [others] who blame mothers more specifically. He is highly critical of the “moedervergoding” [mother worship] (Vedder's quotes) which he says exerts a strong influence on child psychiatry in the United States. Mother worship leads to mother-blaming, even so far as blaming parents to their faces, which can be catastrophic for a marriage. He writes that various authors in the Netherlands have warned against the theory that a mother is responsible for her child's autism. He also rejects Asperger's notion that being an only child has anything to do with it, roundly refuting all psychogenic theories then prevalent.

Like Bosch, Vedder compared Asperger's autism to the schizoid type:

With the Asperger's autist, the disturbance is indeed serious, but certainly not as fundamental as with the Kanner's autist. I readily align myself with Asperger's position that the autistic psychopath is an extreme character variant, one related to the schizothymes and schizoids of Kretschmer and the introverted thinking type of Jung. But I do not agree with this author when he says that the type he has described has “weitgehende Übereinstimmung” with the type described by Kanner⁸¹. (150)

As already stated, most of Vedder's work is in Dutch (and the German and French papers of 1936 may have been written by his co-authors), but there is also a 1967 English-language paper in *Acta Paedopsychiatria*, another journal that published work by Sukhareva. This paper is “Openness and closeness [sic] in the schizophrenic and autistic child”. *Acta* may have published more of Vedder's work, but this defunct journal has many accessibility issues. Further editions of *Kinderen met leer- en*

⁸¹ “Bij de autist van Asperger is de stoornis wel ernstig, maar zeker niet zo fundamenteel als bij die van Kanner. Ik sluit mij gaarne aan bij de opvatting van Asperger, dat de autistische psychopaat een extreme karaktervariant is, die verwantschap heeft met de schizothymen en schizoïden van Kretschmer en het geïntroverteerde denktype van Jung. Maar ik ben niet met deze auteur eens, wanneer hij meent dat het door hem beschreven type ,weitgehende Übereinstimmung‘ heeft met dat van Kanner.” (150)

gedragsmoeilijkheden were published in 1969 and 1983. I have not seen these. Vedder died in 2000 in Schiedam.

The Anglologic History of the History of Autism

The major works on the history of autism have been Adam Feinstein's *A History of Autism* (2010) from the UK, and from the USA, *New York Times* bestseller and winner of the Samuel Johnson Award, Steve Silberman's *NeuroTribes* (2015), followed by *In a Different Key* (2016) from John Donvan and Caren Zucker. To my mind, Feinstein's book is the only serious one. The latter two, while certainly taking the side of autistic people and their supporters, are sensationalist and seek out drama where little drama exists. Silberman is a journalist and his book attempts to paint early researchers in the starkly black and white colours of hero-versus-villain. This may be representative of his cultural background and the Usonian style of storytelling that comes across as jarring melodrama to me, a New Zealander, and it may be his journalistic training or a combination of both. Half memoir about his daughter, anthropologist Roy Richard Grinker's book *Unstrange Minds* is also half information on ASDs more generally, giving history and background. It is worth mentioning for its small coverage of ASDs in three non-European countries, South Korea, South Africa and India. The dominance of Usonian and British authorship on ASDs and ASD history, as well as the prestige afforded such work by writers in other countries, has consequences, one of them being that work written in English about German research is now more well-known and cited in German than the original German research itself. The first four authors mentioned were limited by language barriers in the research they were able to achieve. I do not include Roy Richard Grinker's book as a major work on the history of autism as I feel the intent of his book was slightly different.

Brief histories also appear in journals, but, although perfectly readable, academic journals are inaccessible to most people unaffiliated with an institution and the articles are much less known. Leo Kanner's many editorials on the history of his field and early infantile autism are among these, and V. M. Bashina and G. N. Pivovarova's 1970 Russian paper "Синдром аутизма у детей", arguing, like myself, that the syndrome has been repeatedly independently described, is even less accessible. Lorna Wing's "The history of ideas on autism" was published in *autism* in 1997. Wing's history begins with Brother Juniper from the legends associated with St Francis of Assisi as the earliest 'idea'. She also writes:

It is interesting that, out of all the workers writing in this field, Kanner and Asperger are the only ones whose names have become generally well known throughout the world.

Kanner was the first to have his work widely recognized. Asperger achieved his status in the English language literature much later than Kanner, though his work was known earlier in mainland Europe. (15-16)

She posits that, “The reason why Kanner’s and Asperger’s papers continued to capture interest, while other early workers tended to fade into obscurity, is probably because both described the children they saw in such vivid detail.” (16) But if that is so, one wonders why the case studies of Despert, Sukhareva and Wolff did not capture similar interest. “The history of autism” by Sula Wolff was published in *ECAP* in 2004. Berend Verhoeff’s “Autism in flux: a history of the concept from Leo Kanner to *DSM-5*” is my favourite paper on autism history and an excellent literature review despite his omission of Sukhareva. Here is an excerpt:

Books on the history of autism are not as numerous as autism novels, parent guides, autobiographies and textbooks. Of the small number of histories that are available, there is a wide variety of depth and specific focus of historical attention. Some recent histories of autism have as their object the pioneers in research, treatment and care (Feinstein, 2010), the role of parents and parent organizations (Silverman, 2011), or the social and cultural conditions that made autism possible (Eyal et al., 2010; Nadesan, 2005). However, most histories of autism have been written by autism researchers and experts – or ‘practitioner-historians’ – often as an introductory first chapter to the topic in text- and handbooks, or as a short introduction in review articles or empirical studies. A common denominator of these latter histories is that they approach their main object – autism – as a static, decontextualized ‘thing’, discoverable by science. Moreover, these histories present a more or less chronological, linear and progressive development towards an ‘inevitable’ current understanding of autism, while mentioning the myths, mistakes, struggles and scientifically unsound convictions of earlier darker periods. (443-444)

Since that paper appeared in 2013, two books by non-practitioner-historians (Silberman, Donvan and Zucker) were added to the histories of autism in English bringing the total of books to approximately 3. The histories Verhoeff mentions are journal articles. Both of the recent books continue the tradition of linear development towards an ‘inevitable’ understanding. Verhoeff terms this a positivist history. As well as positivist, Silberman’s book is also what Verhoeff terms essentialist, as is Wing’s paper on ideas, myths and legends. Verhoeff’s two types are closely related. Positivist histories find the

common thread in all stories leading progressively towards more accurate ‘truth’; essentialist histories rewrite the past, finding examples of autism in eras when autism was not defined. Both histories rely on the conviction that the current ‘autism’ is a true and real one, one which has always existed and will always exist. Not merely an excellent literature review, Verhoeff’s paper is a caution against believing that what is presently accepted as truth is the only truth, a truth which will always remain truth, and against the anachronism of reading everything historically written about autism under the assumption that this is exactly the same thing currently thought of as autism.

2015’s *Encyclopedia of Autism Spectrum Disorders* includes an entry “Russia and autism”, where Moscow researcher Alexander Sorokin provides a paragraph of historical background. Here autism within Russia begins with Sukhareva and Simson.

Not strictly Anglolexic but worth mentioning, given it was summarised in English by Leo Kanner for *JACS*, is Klaus Hartmann’s history in his 1971 paper. Kanner’s and Asperger’s syndromes feature as dementia processes in Hartmann’s table below. This history differs to the one presented in this thesis, with Berkhan and Kelp, whom I did not look at, credited as ‘first’ describers. Sukhareva does not appear here, despite Spiel’s *Die endogenen Psychosen des Kindes- und Jugendalters* listed in the references. Hartmann comments that his history is not the same as Spiel’s.

Tabelle 1. Zur Geschichte der Konzeption der Frühschizophrenien

Erste Beschreibung von kindlichen Demenzprozessen:

1862 Berkhan.

1875 Kelp.

Konzeption und Differenzierung der endogenen Demenzprozesse:

1871 Hecker: Konzeption der Hebephrenie.

1874 Kahlbaum: Konzeption der Katatonie.

1893 Kraepelin: Konzeption der Dementia praecox.

1911 Eugen Bleuler: Konzeption der Schizophrenien.

Weitere Beschreibung von kindlichen Demenzprozessen u.ä. Zuständen:

1890 Charpentier: Démences précoces simples des enfants normaux^a.

1905 De Sanctis: Dementia praecocissima^a.

1908 Heller: Dementia infantilis^b.

1932 Kramer und Pollnow: Hyperkinetisches Syndrom^b.

1943 Asperger: Autistische Psychopathie^b.

1943 Kanner: Frühkindlicher Autismus^b.

^a Umfaßten noch Demenzprozesse bekannter und unbekannter Ätiologie.

^b Vielfach als schizoforme Sonderformen bzw. Grenzzustände konzipiert.

Klaus Hartmann’s history of childhood schizophrenic syndromes, 1971

Sources that Informed Sukhareva's Work

Having covered where Sukhareva might fit into the wider history of autism as it is told in English today, I now move to her position in her own time, before today's concept of autism existed. This means going back to the 19th century to review Sukhareva's sources.

The first is Emil Kraepelin (1856-1926). To go back further than him would be to embark on a history of psychiatry and well beyond my scope. Kraepelin is often credited with producing the 'first' psychiatric classification system, one which led to both the Western *DSM* and Sukhareva's system. I will here cover all editions of his textbook. Kraepelin is needed to understand the foundation early child psychiatrists were working from, but the most important sources for the papers I translated were Ernst Kretschmer (1888-1964) and Gottfried Ewald (1888-1963) (with almost the same lifespan). The Russian version of Sukhareva's case studies on schizoid psychopathy in boys is not identical to the German and includes a comprehensive literature review with much discussion of Kretschmer's *Körperbau und Charakter* and its reception. It also contains a full bibliography (the German does not). "Materialien zur Erforschung der Korrelationen zwischen den Typen der Begabung und der Konstitution" (1925), the paper featuring schizoid psychopathy but omitted from this thesis for space, uses an adaptation of a formula from Ewald's *Temperament und Charakter* (1924). Using a formula published only the year before demonstrates that the clinicians at Sukhareva's hospital were very up to date. Given that M. O. Gurevich is consistently referred to in the headings of all the German papers as the director of the Moscow Psychoneurological Children's Hospital, and that Sukhareva and her colleagues always thank Gurevich warmly for his supervision in closing, I believe it is important to look at Sukhareva's direct supervisor. Like Sukhareva and her colleagues, Gurevich was well-published in German, but is not as famous in Russia today as Sukhareva. Throughout this section, I will discuss the terms 'schizoid' and Kraepelin's *Verschrobene*, suggested by Sukhareva as the closest match for her schizoid psychopaths.

Emil Kraepelin (1856-1926)

The first in Kraepelin's series of psychiatric textbooks was *Compendium der Psychiatrie Zum Gebrauche für Studierende und Aerzte*⁸². This was published in 1883. In

⁸² This spelling is no longer standard German.

1887, *Psychiatrie. Ein kurzes Lehrbuch für Studierende und Aerzte* appeared as the “2., gänzlich umgearbeitete Auflage” of the first with 540 pages. In 1889, the “3., vielfach umgearbeitete Auflage” came out with 584 pages, with the same title as the second edition. This title continues until edition five. In 1891, a Russian translation of Kraepelin’s textbook was published in Saint Petersburg⁸³. In 1893, the “4. vollständig umgearbeitete Auflage” of 702 pages appeared: four editions, appearing at two-year intervals. After a longer gap, the fifth and again “vollständig umgearbeitete Auflage” appeared in 1896, achieving 825 pages! The second, third, fourth, fifth and sixth editions have been digitised and are viewable online. From the 5th edition onwards, the textbook ceases to be a “kurzes Lehrbuch” and becomes simply a *Lehrbuch*, over time, a very, very long one. Another Russian translation came out in 1898, of the 5th edition. What can be made of this? Why were Russians seemingly more interested in psychiatry than English-speakers? Was it assumed that a doctor with a sound Western education naturally spoke European languages including German? Was there no need for a translation? Or was psychiatry not yet popular? The sixth “vollständig umgearbeitete Auflage” appeared in 1899, finally in two volumes, the first volume, “Allgemeine Psychiatrie”, coming in at just 362 pages and the second, “Klinische Psychiatrie”, at 607. “Allgemeine Psychiatrie” covers exogenous and endogenous madness, with exogenic factors being physical (e.g. diabetes, Graves’ disease, syphilis, pregnancy, heart and lung problems) and psychological (e.g. war, imprisonment, over-exertion), and endogenic factors being, confusingly, things that might predispose one to madness such as age, sex, profession, socioeconomic background, living circumstances, or heredity, development disorders, nurture. It then covers the presentation of madness, the course, starting point and duration of madness, its recognition, and various treatment methods, including a range of what are today illegal class A drugs, physical therapy, psychotherapy, and treatment within an asylum. “Klinische Psychiatrie” goes into more depth on specific ailments, including thyroid dysfunction, alcoholism, intellectual impairment, epilepsy, hysteria, paranoia, schizophrenia and, appearing for the first time in the sixth edition, 70 pages on manic-depressive insanity.

In 1902, A. Ross Diefendorf published the first edition of *Clinical Psychiatry A Text-Book for Students and Physicians*. This is not strictly a translation by Diefendorf’s own admission. Diefendorf’s first edition, based on Kraepelin’s sixth, was not available to

⁸³ As both the 2nd and 3rd editions bear the same title, it is not clear to me which edition the translation was based on, and I have not seen a copy.

me, but the second edition in 1923 says on the title page “Abstracted and adapted from the seventh German edition of Kraepelin’s ‘Lehrbuch der Psychiatrie’”. The first paragraph of “Preface to the First Edition” follows:

The motive for this work was to make the teachings of Kraepelin in psychiatry accessible to American medical students and general practitioners, and, at the same time, to provide a full, but concise, text-book, not only for the writer’s own classes in psychiatry in the Medical Department of Yale University, but as well for other American teachers who follow Kraepelin’s views. Urged by the rapidly increasing interest in Professor Kraepelin’s teaching during the past five years in this country and the constantly growing number of his disciples, it was the writer’s first intention to publish a complete translation of the sixth edition of Kraepelin’s “Lehrbuch der Psychiatrie.” It was feared, however, that a full translation would be too large to best subserve the function of a text-book, and would have rendered impossible the adaptation of the Kraepelin psychiatry to our peculiar American needs. (v)

This foreword gives the impression that Kraepelin’s work was very novel, perhaps even radical, and that people in the USA needed time to come around to the taxonomic way of thinking, unlike the Russians, who were early adopters of the new approaches coming out of German countries.

Diefendorf’s work did not stay current for long because volume 1 of Kraepelin’s 7th “vielfach umgearbeitete” edition was released in 1903, and volume 2 in 1904. Volume 2 was the first edition to include “psychopathische Persönlichkeiten” with these personalities further broken down into various types. After the longest publication pause for this textbook, the last edition published in Kraepelin’s lifetime appeared in four volumes from 1909 to 1915. Numbering 676 pages, volume 1 alone is devoted to general psychiatry, with the remaining three volumes on clinical psychiatry. This approach of releasing volumes of a single book over several years is the one taken for Sukhareva’s clinical lectures, which likewise functioned as a classification system. Released in 1910, volume 2 has 666 pages. As volumes 2-4 comprise part two, “Klinische Psychiatrie”, 1913’s volume 3 of edition 8 begins its page count where volume 2 left off, ending at 1395 pages.

Volume 4, A Plea to Librarians, and *die Verschrobenen*

The Victoria University library is bizarrely in possession of only the first three volumes,

donated as part of a collection by Sir Thomas Hunter in memory of his wife. I find it difficult to believe Hunter owned an incomplete set and I personally believe the library to have lost volume 4, although given that it was published in 1915, it is also possible World War I interfered with its acquisition in the allied countries. This is mentioned as a point in need of further research by any librarians or Hunter collection scholars the reader might happen to be or come across. Volume 4, the only one of interest to me, contains Kraepelin's final seven psychopathic personalities, although if he had lived longer, they may well not have been final. This edition is the only one with "die Verschrobenen", the type Sukhareva and Osipova call the most similar to schizoid psychopaths ("Materialien" 490), and is therefore the edition Sukhareva was working from, at least around 1925-27. This volume is available online.

Kraepelin had begun working on the 9th edition with Johannes Lange when he unexpectedly died of pneumonia as a complication of influenza in October 1926 (*Lebenserinnerungen XIII*). Lange completed the work and the 9th edition came out in 1927 with Kraepelin and Lange as co-authors. This edition comes too late to have been used as reference material by Sukhareva for the papers I translated.

My supervisor Professor Bart Ellenbroek once referred to Kraepelin in passing as "psychiatry's accountant". While I highly doubt this phrase was Ellenbroek's own invention, I was unable to find another source for it. As one might imagine given the number of editions and volumes of *Psychiatrie* that came out in Kraepelin's lifetime, many with very substantial updates and revisions, Kraepelin himself did only a little clinical work at the beginning of his career, spending most of his time writing. He relied on other people to see patients and produce case studies and findings, collating their work into the textbook format. The textbooks represent the accumulated knowledge of the wider medical community. The accountant metaphor need not be negative. He was clearly admirably suited to the position and simply producing the text alone for so many volumes single-handedly (without computers!) is no mean feat. Although Kraepelin's memoirs give the impression of having been much more than an 'accountant', it is also apparent that he was most comfortable when able to withdraw to country villas to do the work he is most famous for: recording and recounting developments in psychiatry. This excerpt touches on the difficulties of trying to produce a comprehensive textbook for such a rapidly evolving field:

Daß ich durch die immer wiederkehrende Notwendigkeit, mein Buch neu zu bearbeiten, gezwungen wurde, das ganze Gebiet der Psychiatrie im Auge zu behalten, habe ich trotz der damit verknüpften unendlichen Mühe für meine klinische Ausbildung als sehr nützlich empfunden. Es war mir wegen der mich sicher 1½ Jahrzehnte in Anspruch nehmenden Lehrbucharbeit natürlich nicht möglich, mich, wie ich es oft gewünscht hätte, mehr in Einzelfragen zu vertiefen, aber ich behielt dauernd ein offenes Auge für die Fragestellungen unserer Wissenschaft überhaupt. Zugeben muß ich, daß mein Verfahren, die Fortschritte meiner klinischen Erkenntnis nicht in wissenschaftlichen Einzeldarstellungen mit den übrigen Belegen und Beobachtungen, sondern in den einander folgenden Auflagen des Lehrbuches als jeweiligen Stand unseres Wissens hinstellen, ernste Bedenken gegen sich hatte. Pfl egten sich doch die von mir vorgetragenen Meinungen oft schon nach wenigen Jahren immer wieder zu ändern, und durfte ich mich auch durchaus nicht der regelmäßigen Übereinstimmung mit meinen Fachgenossen versichert halten, zumal ich ihnen nicht die Erfahrungsgrundlagen für meine Anschauungen mitteilte. Indessen mir fehlte bei der großen Arbeit, die ich zu überwältigen hatte, einfach die Zeit, nun auch noch ordnungsgemäß die von mir gewonnenen Anschauungen zu begründen, und meine Schüler, die ich vielfach dazu anzuregen suchte, haben diese Lücke leider nur in unvollkommener Weise ausfüllen können. Dennoch konnte ich mich nicht dazu entschließen, in mein Buch nur solche Meinungen aufzunehmen, die gerade allgemein anerkannt wurden, sondern ich fühlte mich gedrungen, das zu geben, was mir auf dem just erreichten Standpunkte der Wahrheit am nächsten zu kommen schien. (183-184)

Sukhareva's supervisor Gurevich makes this comment about the books:

Erst seit *Kraepelin* wurde eine einheitliche Klassifikation festgelegt und die verschiedensten psychischen Störungen wurden auf eine geringe Anzahl nosologischer Einheiten zurückgeführt. Allerdings wurden diese sog. großen Töpfe *Kraepelins* mancherseits mit leiser Ironie behandelt (und werden es zum Teil vielleicht auch noch heute). (458-459)

Kraepelin and the psychiatrists around him knew the objective of classifying mental illnesses could only be attempted, never achieved. The *DSM* faces not only the same problems Kraepelin encountered but, produced by the American Psychiatric Association, now contends with many more issues (funding, committees, individual interests, insurance codes), and is far more visible to the lay population and thus more

exposed to criticism, influence and pressure from the public than books of Kraepelin's time.

Visiting Sukhareva in the Soviet Union in 1968, Nancy Rollins reported on the enduring impact Kraepelin had made on Russian psychiatry:

The equation of mental disease with brain disease and precise description of mental symptoms paved the way in German psychiatry for the classification of psychiatric disorders by Emil Kraepelin. Through careful observation of the course of psychiatric illness, Kraepelin delineated the manic depressive psychosis and dementia praecox. Kraepelin has been criticized for equating prognosis with diagnosis, for in his formulation all patients who do not recover have dementia praecox, while all those who do, have a form of depressive psychosis. In a less extreme form, the Kraepelinian interest in an accurate description of the extended course of an illness has carried over into Russian psychiatry and is evident in the kinds of research conducted by Soviet psychiatrists in childhood epilepsy and schizophrenia. The emphasis in Soviet child psychiatry on diagnosis and classification left an overwhelming impression on me as I listened to case consultations and training sessions. (6)

Ernst Kretschmer (1888-1964)

Ernst Kretschmer is a difficult historical figure with the unfortunate distinction of featuring in Ernst Klee's *Personenlexikon zum Dritten Reich*. While he had many early successes in his career, he has come out on the wrong side of political, ethical, moral and scientific (largely, this will be discussed further) history. Born in October 1888, engaged to be married in 1913, PhD thesis completed in 1914, habilitation thesis begun in 1914, married in 1915, first child born in 1916, habilitation thesis published as a book in 1918, and don't forget there was a rather great war going on, he appears to be a man who wasted little time.

While we might think today that four years is a perfectly respectable time period between PhD and habilitation completion, the foreword to *Der sensitive Beziehungswahn* apologises for many delays as well as the book's gaps and unevenness, pointing out, in what might appear at first glance to be charmingly modest understatement, that, "Die äußeren Umstände sind ... nicht günstig gewesen⁸⁴," not to

⁸⁴ [The external circumstances have ... not been favourable.]

mention (the foreword does not) his marriage and the birth of his first child. Martin Priwitzer has written an excellent biography of Kretschmer as a PhD thesis called *Ernst Kretschmer und das Wahnproblem*, drawing heavily on Kretschmer's letters and other ephemera. Kretschmer did indeed serve as a doctor during World War I but, if his letters are anything to go by, spent much of his service in diverting leisure activities like swimming, horse-riding, sledding, rosehip gathering, newspaper reading for hours on end, and looking after dogs and children (59, 60, 62), which perhaps explains why the largest war the planet had ever yet been afflicted with passed him by as a mere unfavourable circumstance. Perhaps he was downplaying the severity or horror of the war for the benefit of his mother and fiancée, but a rather discommending letter excerpt expressing his delight at having his boredom relieved when some severely wounded and traumatised men arrive does not leave the impression of a warm and empathetic man. One could possibly interpret this as pleasure to be of use and joy at being able to assist those who were suffering, but I find that a struggle. I have not seen the original letters or the context surrounding the Priwitzer's excerpts. This excerpt from a letter of 7 December 1914 to Kretschmer's mother is as quoted by Priwitzer:

Seit etwa 14 Tagen habe ich nun wieder tüchtig zu arbeiten u. bin sehr froh darüber. Wir haben einen großen Transport von fast lauter Schwerverwundeten, die aus dem Kriegslazarett Chauny bei Soissons kamen; zu meiner Freude auch eine Anzahl Nervenranke, Soldaten mit Schädelchüssen, die schon der Heilung zugehen u. solche, die von den schweren Eindrücken des Krieges erschöpft sind, Schwermütige, die nachts umhergehen und schlimme Träume haben. (59)

Der sensitive Beziehungswahn was reprinted in 1927, 1950, and posthumously in 1966. It was still being read in German in the English-speaking sphere in its third and fourth reprints, as evidenced by book reviews, but it was probably not being read very widely. In his 1952 review of the 3rd edition (1950), Martin Scheerer calls it "this now-classical monograph". He writes that while Kretschmer is currently (1952) experiencing something of a revival among Germans, interest in his work is declining among Usonian. He says that in the USA, Kretschmer is "known mostly for his no-longer disputed (because so often refuted) theory of constitutional types". (I will look at these constitutional types in further detail shortly.) He blames Kretschmer's loss of favour on both "an overgeneralised reaction to what Kretschmer's name has come to stand for" and the strong interest in psychoanalysis. The 3rd edition, apparently, was identical to

the second and this review is not so much a review of the third edition as it is a review of a second reading of a book and praise for the value of reading a book twice. Scheerer surmises that, “more attention to Kretschmer’s characterological system and theory of paranoia may be fruitful for the clinical psychologist in this country.”

A 1967 review of the fourth edition is brief enough to include here:

The first edition of this book appeared in 1918 and led to a controversy about the psychogenesis of paranoid psychoses. Ernst Kretschmer claimed that delusions of reference could result from the reaction of a certain type of personality to social and psychological stresses. He used the word ‘sensitive’ for those individuals who are sensitive about some aspect of their personality and feel that this defect prevents them from achieving the success which they deserve. Kretschmer used the term ‘sensitiver Beziehungswahn’ for this reactive psychosis in the sensitive personality. Unfortunately, the author died before this fourth edition of his monograph was published. It has therefore been edited by his son, Wolfgang, who has added a final chapter on the history and present position of the concept of the ‘sensitive Beziehungswahn’. It is a pleasure to see a further edition of this book which has been out of print for some time. Despite the fact that it was first published nearly fifty years ago, this book should be read by all psychiatrists who are interested in paranoia and abnormal personalities.

(Fish)

Physique and Character

Kretschmer’s next book was *Körperbau und Charakter* in 1921, and this is where Kretschmer most obviously takes a poor turn. In all the literature of the 1920s discussing this book, we can see the beginnings of *Rassenlehre*. Here Kretschmer lays out the theory of constitutional types referred to by Scheerer. *Körperbau und Charakter* is an attempt to link physical body features to specific character traits with the ultimate goal of determining characterological pathologies and defects by sight and measurement alone, thus predicting future criminals, addicts or the insane before they have shown any signs of such behaviour. Maladaptive social behaviours at that time included homosexuality.

Körperbau und Charakter was successful in that it sold well, went into many editions and translations, and was widely discussed. Just four years after its first publication, in 1925, when Sukhareva’s paper on schizoid psychopathy in boys was first released in

Russian, this book was already into its fourth German edition and second English edition, translated by W. J. H. Sprott, with a Russian translation having also appeared in 1924. The “Note to the Second English Edition” by “C. K. O.”, refers to the book as “Kretschmer’s now classical work” (XV). Sukhareva’s paper discusses *Körperbau und Charakter* at length, and from her review of its reception till that point, it is clear the book was an ongoing topic of discussion within the field. While Sukhareva’s discussion of Kretschmer’s book in the Russian paper is primarily within her coverage of the history of the word ‘schizoid’ and its various uses and definitions (along with Ewald and later Sukhareva’s colleague P. B. Gannushkin, Sukhareva finds Kretschmer’s work here rendered meaningless by too broad a definition of schizoid and believes the work of those drawing on his suffers the same fate), in her case studies, Sukhareva does attempt to assign body types to her subjects, although always with the caveat that as the children are still in puberty, their present body shapes have little significance. To understand the implications of a child being described as having asthenic or pyknic proportions, I will go into Kretschmer’s constitutional types.

Kretschmer’s Constitutional Types

Analysed by Sukhareva and Osipova extensively in “Materialien” and to a lesser extent in Sukhareva’s papers on schizoid psychopathy in boys and girls, Kretschmer’s first constitutional types were the asthenic, used synonymously with leptosome or leptosomic, the athletic, the pyknic, and the dysplastic. The asthenic/leptosome had a small skull. The male was tall, thin and wiry, sporting “a deficiency in thickness combined with an average unlesened length” (21). One example given is of “a lean narrowly-built man who looks taller than he is” (21). The female was thin but short (23). The athletic constitution came with well-defined muscles and broad shoulders. Such people were strong with stamina and endurance. Athletic women are described as having masculine musculature and “unpleasant stolidity and massiveness” (27). The man of pyknic constitution was of average height, tubby, and had a short neck and “well-fitting” skin. The weight of a pyknic might fluctuate dramatically throughout their life. In the 1936 Sprott edition I read, Kretschmer endeavours to describe the changes a constitution might go through as a person ages. He states that “pure” forms are rare and most individuals are in fact of mixed constitutions. The dysplastic category appears to be a miscellaneous one for “special” cases that cannot be described as asthenic, athletic, pyknic or a combination of the three. In “Materialien”, Sukhareva and Osipova write:

It must be emphasised that all our cases fall within the pre-puberty period in which the asthenic habitus is characteristic. This fact gives our tasks relating to the correlation between body type and psychological makeup less significance. (501)

Of course, if they felt body types had no significance, they would not have expended so much effort describing them in the first place. In Sukhareva and Osipova's tables, the most frequent body type is "unpronounced", not "dysplastic". Clearly "unpronounced" is not what Sukhareva and Osipova understood by dysplastic.

Kretschmer reported he had found a "clear biological affinity" between asthenic, athletic and some dysplastic body types and the "psychic disposition" of people falling into the umbrella category schizophrene, further subdivided into schizothyme, schizoid and schizophrenic. The schizothyme individual displayed the normal or healthy manifestation of such traits ("normal biological bases of which only a small proportion comes to pathological culmination" (20)), the schizoid displayed more pronounced traits and the schizophrenic displayed the traits to an unhealthy or pathological degree. The traits accorded such people were a tendency towards abstract thought and an interest in details. They were introverted thinkers. Kretschmer often describes them and their relatives as autistic. The cyclic or circular group were found to have pyknic body types, with the normal or healthy manifestation of their traits being termed cyclothyme, the pronounced manifestation cycloid, and the pathological manifestation manic depressive. These people operated from an emotional basis and were more expressive than the schizophrene group.

Interestingly, most of Kretschmer's circular patients probably had thyroid disorders, as evidenced by their goitres, which he notes are "rich" in his region (87) (probably caused by iodine deficiency). Kretschmer observes that goitres are uncommon in the schizophrenes at his clinic. While thyroid disease is often accompanied by affective symptoms resembling manic depression, none of these patients would be diagnosed with a mood disorder now, and they would be treated by endocrinologists, not psychiatrists. Kretschmer raises the possibility of the circular patients having endocrine disorders, but even if it had then been known for certain that the symptoms were endocrine in aetiology, without knowing the treatment for the underlying problem⁸⁵,

⁸⁵ But iodine deficient thyroid conditions were already known in Kretschmer's time!

only the symptoms could have been treated, and the patients would thus, for all practical purposes, still have to be treated under psychiatry. This is again one of the problems with reading historical psychiatric texts at a time when many diseases have been differentiated out of psychiatry. The same will happen to future historians reading psychiatric texts of today.

What is Barykinetic? What About the Others?

Many secondary sources summarising Kretschmer's typology also list 'barykinetic' as one of his constitutional types, with the barykinetic individual most likely to have an athletic body. Some sources, the German Wikipedia entry on Konstitutionspsychologie being one, give barykinetic as the normal manifestation of what is epileptoid in its pronounced form and epileptic in its pathological state. Others give barykinetic as a normal or healthy personality type with catatonic as the pathological form, and epileptoid and epileptic being variants with no normal or healthy form. *The Macmillan Dictionary of Psychology* has an entry for "barykinetic personality":

A personality type in KRETSCHMER'S CONSTITUTIONAL THEORY, having robust and well balanced characteristics and associated with the ATHLETIC TYPE. (47)

However, if we view the entry for Kretschmer's constitutional theory (226), only the asthenic, pyknic and athletic types are listed, with the note that they correspond to schizophrenia, manic-depression and good mental health. The entry for leptosomatic type reads, "A synonym for asthenic type" (243).

Barykinetic is not referred to in any of the *Körperbau und Charakter* editions of the 1920s or 30s⁸⁶, nor are epileptoids and epileptics given any space. In the 1936 second revised Sprott translation of the book (as a 1945 reprint), a justification for the absence of the epileptic group is given:

In our exposition of the psychic constitutions, we have left epilepsy altogether out of our considerations; we have done so, in the first place, because characteristics which are not determined constitutionally, but primarily through trauma or damage to the generating cells, play a disproportionately large part, and are also very difficult to

⁸⁶ It is possibly an addition by Kretschmer's son, Wolfgang Kretschmer, who released further editions of *Körperbau und Charakter* after Kretschmer's death. I did not order the 1977 edition to verify this.

distinguish from characteristics which are in the main constitutionally genuine, so that to-day it would be difficult, and only possible with the very greatest caution, to make use of epilepsy as a clinical unity in any investigation into constitutions; but above all, because we cannot find from our inquiry into characterology so far, that epilepsy plays anywhere near as important a role as the pathological representative of similarly widespread personality-groups, of fundamental importance for normal psychology, as is the case with the circular and schizophrene classes. Probably the ‘epileptic personality’ only characterizes a small group of men with some excessively developed defect. That great mischief has been done by the diagnosis of epilepsy in regard to talented historic personalities, on insufficient evidence, is known to everyone. Among the few certain cases of epileptic geniuses (Dostoievski), how far significant connections can be shown between their psychiatric nature and their creative genius by the disease, is a question which naturally demands further careful investigation. In any case we must be prepared later on, if necessary, to rank an epileptic type between the schizophrenes and the circulars. (68-69)

It is interesting that Kretschmer excludes epilepsy on the basis of it being not “constitutionally genuine” but still includes his circular cases even while noting possible endocrine involvement. While this translation is from an edition later than Sukhareva and Osipova’s “Materialien”, as he mentions being prepared to include epileptics and epileptoids should evidence later arise proving them worthy of inclusion, I believe the epileptics and epileptoids absent from the earlier editions also. Sukhareva and Osipova clearly did not agree with him on this exclusion, as they included epileptoids among their constitutional types, considering epileptoids the pronounced form of the normal “sthenisch-impulsive Typus”. Sukhareva devoted a paper to epileptoid psychopathy in children in 1930⁸⁷. In a 1922 discussion of Kretschmer’s work called “Schizophrenie, Schizoid, Schizothyme”, Gottfried Ewald queries the absence of some of that era’s standard types:

Denn wo sind die Charaktere, die wir bisher als reactive labile, als hysterische, als phantastische zu bezeichnen pflegten? Wo sind die paranoid eingestellten und wo die epileptoiden? Wo sind die Haltlosen und die Sthenischen, die mit labilem Persönlichkeitsbewußtsein und die Starrköpfigen? Alle nimmt die weite Mutter des Schizoids in die Arme. (445)

⁸⁷ Sukhareva’s supervisor M. O. Gurevich also wrote a paper on epileptoid states in 1913.

If the absent types have been swallowed up by schizoid, why then did Sukhareva and Osipova distinguish the schizoid/schizothymes from the hysteric/reactive-labiles and the epileptoid/sthenics? They used Kretschmer's language but not in the way that he did.

'Schizoid' Enters the World Lexicon

Who coined the word? Given that it comprises two elements very familiar to anyone familiar with medical terminology and the composition of new medical words, it would be easy for any number of people to invent the word simultaneously and have any number of other people read the word with no explanation. *OED* incorrectly gives Kretschmer's 1921 book *Körperbau und Charakter* as the first recorded instance of 'schizoid'. N. Iu. Pyatnitskiĭ's 2018 paper "[To the historical origins of the notion of 'schizoid psychopathy' in the concept of Kurt Binswanger]" directs us to Kurt Binswanger⁸⁸'s earlier 1920 paper "Über schizoide Alkoholiker" as the first instance of 'schizoid psychopathy'. This paper is based on a lecture given in Zürich in 1918. However, Binswanger himself does not think he is using a new term:

Ob man die im nachfolgenden zu zeigende Charakterveränderung schon zur Schizophrenie rechnet, ob man sie Veränderung, „in der Richtung Schizophrenie“ nennt oder ob man sie noch in die Diagnose „schizoide Psychopathie“²⁾ eingereiht wissen will, hängt vorläufig noch von den verschiedenen Auffassungen über die Abgrenzung dieser Krankheitsbegriffe ab. (128)

The footnote on schizoid psychopathy could be any 21st century description of Asperger's syndrome:

²⁾ Hierher gehören autistische Menschen, die nach außen barsch, abweisend, oft verletzend sein können, deren Affektivität aber nicht ausgesprochen schizophran ist und die in gewissen Berufen hervorragende Werte schaffen können; ferner paranoide Charaktere mit sehr guter Affektivität, die sich für andere aufopfern können, die aber wegen ihres schweren Mißtrauens mit allen in Unfrieden leben; dann exzentrische Käuze mit sonderbaren Einfällen, die sie selbst nicht zu begründen vermögen, oder hochintelligente, die immer nur Examina machen, ohne je fertig zu werden, und dann wieder Leute, die überall Schiffbruch leiden, sich weder durch Worte noch durch

⁸⁸ Not to be confused with other Swiss psychiatrists surnamed Binswanger, all of whom are related.

Schicksale belehren lassen. Es sind dies solche Typen, wie sie auffallend häufig unter den Angehörigen von manifesten Dementia-*praecox*-Kranken zu finden sind. (128)

Binswanger still does not seem to be defining a term of his own invention but rather explaining a preexisting term to those potentially unfamiliar with it. This paper was written from the Zürich psychiatric hospital Burghölzli, then under the direction of Eugen Bleuler, credited by many with the invention of ‘schizoid’.

Sula Wolff and Jonathan Chick give this definition and etymology in 1980:

The psychiatric literature on schizoid personality begins with Kraepelin’s description in 1907 of certain traits: being quiet, shy and unable to make friends; found in children, especially in boys; and predisposing to dementia *praecox*. Eugen Bleuler coined the word ‘schizoid’ in 1908 for people who were ‘shut-in, suspicious, comfortably dull, sensitive, and pursuers of vague purposes’ (Nannarello, 1953). He saw the characteristic as a normal personality component. Kretschmer (1925) portrays schizoid people as unsociable, oversensitive but also cold and lacking in ‘affectionate resonance’, stubborn and pedantic. He does not describe his subjects as children. (85)

I’m not sure which passage of Kraepelin’s they are referring to. Given that the only book of his from 1907 is Diefendorf’s second edition (nothing of Kraepelin is listed in their bibliography), this may not strictly be Kraepelin: Diefendorf’s translation was an adaptation. Possibly they mean hysterical insanity, possibly idiocy (intellectual disability) but I can’t find a passage that is a clear match for this. Joseph J. Nannarello’s paper does not cite a 1908 work of Bleuler’s but rather the 1924 English translation of *Lehrbuch der Psychiatrie*. What Nannarello does write is that schizoid was coined by Bleuler *after* 1908. Why 1908? Probably because this is when Bleuler first used ‘schizophrenia’, both in a talk at the Deutscher Verein für Psychiatrie and in the association’s published proceedings⁸⁹. *Lehrbuch der Psychiatrie* was first published in 1916. Nannarello may have erroneously assumed the 1924 English translation was identical to the 1916 first edition, despite the translator’s preface, dated 1923, clearly stating that this is a translation of the fourth edition of 1923. In fact, the fourth edition is very different to the first, with whole paragraphs added or omitted. ‘Schizoid’ does not appear in the first few editions of Bleuler’s *Lehrbuch der Psychiatrie*. When it later

⁸⁹ “Die Prognose der Dementia *praecox* (Schizophreniegruppe)”

appears, it is in reference to Kretschmer. If this was the assumption Nannarello made, he would also have had to ignore the footnote, which, in the A. A. Brill translation Nannarello gives as his reference, directs the reader to, “For more information see Kretschmer Körperbau und Charakter, Springer, Berlin 1921, and Bleuler: Die Probleme der Schizoidie und der Syntonie, Zeitschr. f. d. gesam. Neurol. u. Psychiat. 1922.” (177)

Many online sources credit Bleuler with first use of ‘schizoid’, always citing Nannarello in doing so, never Bleuler directly, and apparently without reading Nannarello’s paper. The internet now seems to believe Bleuler invented the word schizoid in 1908. Perhaps Bleuler did invent this word in 1908 in a conversation in the Burghölzli clinic, Binswanger seemed to be using a preexisting word after all, but as far as written records are concerned, this 1908 claim is fake news. Pre-digital age Nannarello can be forgiven but not the internet, with much of Bleuler’s work now scanned in full⁹⁰. As mentioned, *OED* credits the first use to Kretschmer, and Kretschmer is usually credited with its coinage by psychiatrists of that period. However, Sukhareva also mentions Bleuler in her Russian language paper on schizoid psychopathy in boys:

The term ‘schizoid’ is not new – it is taken from Bleuler. Nor is the idea new that there exists a group of psychopaths whose symptomatology displays several features in common with schizophrenia – they are described by Kraepelin as belonging to the “*verschroben*” type and by Birnbaum as “*degenerierte Verschrobene*”. Among Russian authors, Prof. Gannushkin described a schizophrenic constitution as early as 1912.⁹¹
(160)

This leads one to wonder not only which work of Bleuler Sukhareva was reading and in what language, but which edition of Kretschmer. Perhaps the misattribution is copied from Ewald, whom I will come back to, or perhaps, as I suggested before, schizoid was such an obvious combination for medical terminology to produce that the only real coining going on was the introduction of ‘schiz-’ to the vocabulary of possible components⁹². As regards Gannushkin in 1912, the paper Sukhareva mentions is from

⁹⁰ Yes, one might very well ask if it matters that the internet believes this. Indeed it does not. It is merely depressing, although the argument can be made that it is representative of the wider situation of truth by common consensus.

⁹¹ Translation Richard Millington.

⁹² For example, “Über einige epileptoide Zustände” by Wilhelm Griesinger appears in 1886.

1914 (Russian academics are notorious for citing from memory) according to reprints in more recent Russian psychiatry readers. As my abilities to work with Russian are to date limited, I suggest Gannushkin as another worthy topic for anyone wanting to claim that no, Sukhareva, was not the first person to describe Asperger's syndrome. Towards the end of the paper, Sukhareva points towards other researchers describing the syndrome in youths and adults:

Schizoid types (or what Kraepelin calls *verschroben*) have not previously been described in the literature of childhood psychopathies. Rinderknecht (from Bleuler's clinic) describes some cases that have certain features in common with schizoid psychopathies (all of them are aged over 16). These are individuals who even in early childhood displayed autism, an inclination to negativistic behaviour, frequent hebephrenic or catatonic states. After puberty antisocial tendencies emerge. The author calls these cases *kriminelle Heboide* and categorises them as a particular type of schizophrenia without a progressive tendency and not leading to dementia.

The type of antisocial subjects described by Meggendorfer and labelled *Parathymie* are similar to Rinderknecht's cases. Meggendorfer also views them as a particular variety of schizophrenia. In his study, as in Rinderknecht's, the concept schizophrenia is understood very broadly. A feature that we consider characteristic of schizophrenia – progressiveness – is not considered essential by these authors. (184)

If young adults and adults with criminal tendencies are indeed to be classed within Sukhareva's schizoid psychopathy, perhaps the contemporary autistic community might be less eager to embrace her as part of their history.

Sukhareva states several times that her group of schizoid psychopaths most resemble Kraepelin's group of eccentrics (*Verschrobene*), but the terms she chooses to use in the end are Kretschmer's (it is Kretschmer who appends 'psychopathy' to schizoid). My guess is that Kretschmer's three-level system of schizothyme, schizoid and schizophrenic allows for greater continuity. If Kraepelin's *Verschrobene* aligns with schizoid psychopathy, he has nothing that corresponds to the 'normal' or non-pathological schizothyme. 'Schizoid psychopath' became a semi-standard term in Russian psychiatric literature for some time, its cementation probably more due to Gannushkin's typology than Sukhareva's work, but Russia was not exempt from the debates over meaning and precision of terms occurring elsewhere. From the late 1950s, other words began to replace schizoid psychopathy in Russian texts.

Sukhareva was not alone in using Kretschmer's term, and schizoid psychopathy was well written about in German during the 1920s, with, of course, many ideas of what it was. Simplistically, it was something like the broad autism phenotype of today but for schizophrenia. Things that could be described as schizoid included family members with various similarities to their schizophrenic relative, the retrospectively considered traits that a schizophrenic patient had shown before they became obviously ill, and such traits exhibited by people who were not, or not yet, schizophrenic. Many people mocked Kretschmer's broad description from the moment the book came out. Ewald's lengthy complaint of 1922 will be revisited later. Complaints of *Modediagnosen* and hotch-potches were not restricted to autism. Here is Hans Binder complaining the same of schizoid in "Zum Problem des schizoiden Autismus" in 1930:

Wir verzichten darauf, die ganze Problematik des Schizoidbegriffes in seinem historischen Werdegang nachzuzeichnen, weil dies schon von verschiedenen Seiten geschehen ist; dabei hat sich der kritischen Betrachtung immer wieder gezeigt, daß dieser Begriff, je weiter man ihn auszubauen suchte, desto mehr an Klarheit verlor und zu einem ‚Ziehharmonikabegriff‘ wurde, bei dessen Bearbeitung oft verschiedene Gesichtspunkte und Betrachtungsweisen durcheinandergingen. (662-663)

He says, and quotes Johannes Lange (the man working with Kraepelin at the time of Kraepelin's death) in his discussion, "die Vielartigkeit der beschriebenen Typen nicht mit dem Wesen und dem Grad der schizoiden Eigenart zu tun hat, sondern mit den Persönlichkeiten, die betroffen worden sind"⁹³, that people are looking too much at the individual person for their definitions, when these are individual people with individual personalities, each of whom may express the underlying disturbance in individual ways. If you've met one person with autism, you've met one person with autism, we say⁹⁴. Binder's end definition of the schizoid type is that "alle an einer gleichsinnigen Disharmonie ihres Trieblebens (Störung des Gleichgewichtes zwischen Selbstbehauptung und Selbsthingabe infolge primärer Insuffizienz des Gemeinschaftstriebes) leiden"⁹⁵ (675) His paper is an analysis of all definitions of the

⁹³ [the variation in the types described has nothing to do with the nature and degree of the schizoid trait but to do with the personalities affected]

⁹⁴ Yet we also generalise that Labrador retriever dogs are friendly and good with children.

⁹⁵ [all suffer from a concordant disharmony of their inner drive (disorder of the balance between self-asserting and self-giving due to primary insufficiency of the communal drive)]

schizoid type to that date, and an attempt to extricate the common factor(s). However, while the concepts he discusses are contemporaneous with Sukhareva, most of them recorded immediately after Kretschmer's book, this paper comes after Sukhareva's work on the topic. Still, if anyone is interested in scouring historical papers for vague references to things with vague resemblances to Asperger's syndrome, I refer them to Binder's *Literaturverzeichnis*.

Sukhareva's supervisor M. O. Gurevich has a small section on schizoid psychopaths in his paediatric psychiatry textbook *Психопатология детского возраста* [Psikhopatologiya detskogo vozrasta]. This was first published in 1927, the year of Sukhareva's paper on girls; however, I have only seen the 1932 edition. Gurevich, too, mentions first Kretschmer, then Kraepelin's "Verschroben" (in Latin characters).

Published in 1933, P. B. Gannushkin's *Клиника психопатий: их статика, динамика, систематика* [Klinika psikhopatii: ikh statika, linamika, sistematika] (Manifestations of Psychopathies, Statics, Dynamics, Systematic Aspects) lays out a typology still used in Russia today. The book contains a chapter on adult schizoid psychopaths. This is particularly significant as it may be a 'first' description of an Asperger's-type ASD as it appears in adults⁹⁶, although most English-language writing now equates Gannushkin's work with schizoid personality disorder (SPD) not autistic psychopathy. In this book, the criticism made by Ewald and Sukhareva that Kretschmer's schizoid categorisation is too broad is repeated:

The term 'schizoid' was introduced into psychiatry by Kretschmer, who uses it as a designation for psychopathic personalities that are close to schizophrenia in their constitutional peculiarities and character traits. The excessively broad scheme of schizoid psychopathy that Kretschmer has constructed allows him and his followers, however, to include within its framework not one but a whole series of more or less distinct groups of psychopaths. We prefer to reserve the term for just one group among Kretschmer's schizoids: those in whose psyche there is a resemblance to what – under other conditions of development – we are used to observing in schizophrenia in

⁹⁶ C.f. Barr's 1898 description of Kirtie M. Mansfield as possibly the first description of a Kanner's-type autism spectrum disorder in an adult

progressive form; here – in psychopathy – these character traits are not acquired, as in a process, but congenital and permanent.⁹⁷ (18)

However, addressing criticisms of *Körperbau und Charakter* in the 1922 “Preface to the Second Edition”, Kretschmer himself stated, “This book is only a preliminary canter: by means of patient co-operation on the part of others it may perhaps be possible to divide up the types, which we have differentiated for the meantime, into sub-groups, and to discover new ones to add to them.”⁹⁸ (xiv) By further differentiating, Sukhareva and Gannushkin were in fact acting on Kretschmer’s suggestion.

Gannushkin’s schizoid category seems reasonably similar to the category used by Sukhareva, Osipova and Gurevich to talk about children. It is conceivable that the people who fit his designation would have met the criteria for Asperger’s syndrome or ASD if they were seen clinically today, although, as mentioned, his designation is now considered more equivalent to SPD. Note his use of “process” and recollect van Krevelen’s later insistence that Kanner’s autism was a process but Asperger’s autism was innate. Sukhareva returns to this in her collected lectures in 1959.

Kretschmer’s description of schizoids, on the other hand, does not tally with today’s understanding of these syndromes at all. Among his examples are the famously mad poet Hölderlin and the Bavarian king Ludwig II. Hölderlin is today considered to have had schizophrenia, and while Ludwig II is considered to have been eccentric, descriptions of him being quite similar to Gannushkin’s schizoid subcategory “Dreamers”⁹⁹, neither historical figure ever appears in retrodiagnostic lists of people with Asperger’s syndrome or autism now. Kretschmer’s description is unscientific and literary to the point of absurdity:

⁹⁷ Translation Richard Millington. “Термин «шизоид» введен в психиатрию *Кречмером* и употребляется последним для обозначения психопатических личностей, по своим конституциональным особенностям и чертам характера близким к шизофреникам. Чрезмерно широкая схема шизоидной психопатии, построенная *Кречмером*, позволяет, однако, ему и его последователям включать в ее рамки не одну, а целый ряд более или менее отличных друг от друга групп психопатов. Мы предпочитаем оставить это название только за той частью шизоидов *Кречмера*, в психике которых есть сходство с тем, что мы – при других условиях развития – привыкли наблюдать при шизофрении, как в форме прогрессивной; здесь – в психопатии – эти черты характера оказываются не нажитыми, как в процессе, а врожденными, постоянными.”

⁹⁸ Sprott’s translation.

⁹⁹ Мечтатели/mechtateli, appearing in the Группа шизоидов, the schizoid group.

Schizoid men have a surface and a depth. Cuttingly brutal, dull and sulky, bitingly sarcastic or timidly retiring, like a mollusc without a shell – that is the surface. Or else the surface is just nothing; we see a man who stands in our way like a question mark, we feel that we are in contact with something flavourless, boring, and yet with a certain problematic quality about it. What is there in the deep under all these masks? Perhaps there is a nothing, a dark, hollow-eyed nothing – affective anaemia. Behind an ever-silent façade, which twitches uncertainly with every expiring whim – nothing but broken pieces, black rubbish heaps, yawning emotional emptiness, or the cold breath of an arctic soullessness. But from the façade we cannot see what lurks behind. Many schizoid folk are like Roman houses and villas, which have closed their shutters before the rays of the burning sun; perhaps in the subdued interior light there are festivities¹⁰⁰. (150)

Kretschmer's first everyday example of a schizoid is very extreme:

A shy girl, pious and lamb-like serves for months in the town: she is gentle and tractable with everyone. One morning the three children of the house lie murdered. The house is in flames. She has not lost her senses, she understands everything. She smiles uncertainly when she realises her act. (146-147)

This corresponds more with the current notion of a psychopath – someone who murders for their own amusement. Kretschmer's second example is a dreamy young man who is too clumsy to stay on a horse yet one day surprises everyone with eloquent poetry. Kretschmer also writes, “Bleuler calls it ‘Autism’ – the living inside oneself.” (147) This sounds as if Bleuler's ‘autism’ (for Bleuler, a trait of schizophrenia) was directly synonymous with Kretschmer's ‘schizoid’ (not schizophrenia but like it).

Although Sukhareva “cannot agree with the high praise lavished upon Kretschmer by some authors” (159), *Körperbau und Charakter* is the main focus of her literature review in “[Schizoid psychopathies in childhood]” (1925), and she notes that she “must acknowledge the importance of his book for psychiatry”, particularly considering “the large number of studies that take *Körperbau und Charakter* as their point of departure” (159). Given the amount of time she spends discussing Kretschmer's work, clearly because Kretschmer's ‘schizoid’ is the word she intends to apply to her cases,

¹⁰⁰ It appears Kretschmer was unwittingly treating vampires.

Sukhareva's own studies must now be included among studies departing from the point of *Körperbau und Charakter*.

Perhaps of interest to us now, knowing the course of history following Kretschmer's book, is that one of the objections raised at the time, and one addressed by Sukhareva, was that "Kretschmer's types are based not on individual but racial characteristics." (159) This is possibly the most serious objection. Sukhareva writes that, "The Kretschmerian problem of types thus becomes racial-psychiatric." (159) However, it is hard to discern whether Sukhareva sees this as a pro or a con. She gives as statement of fact, "Biological predisposition varies from one race to the next. We can distinguish more 'schizothymic' and more 'cyclothymic' races." (159) Again, if the contemporary autistic community felt that Sukhareva believed character and morphology were connected or believed in 'breeds' of humans, would they be so eager to embrace her as part of their history?

Another key point about *Körperbau und Charakter* is that it is premised on a spectrum understanding of mental health and illness, "ohne sichtbare Grenze" (viii). For Kretschmer, health or non-health is a purely quantitative, not qualitative, difference, even when talking about psychosis (and this theory also underlies Sukhareva and Osipova's "Materialien"). Gaupp's foreword to the book acknowledges this at the outset:

Indem Kretschmer, seinen Blick über die Mauern der Klinik hinausrichtend, das vielgestaltige Leben mustert, verschwimmen ihm die Grenzen zwischen Krankheit und Gesundheit immer mehr [...] (viii)

Which returns us to the questions when are autistic traits autism, when is a person with autistic traits autistic, when is impairment clinically significant, and when is disability disabling? Who is inside the clinic and who is "over the walls"? Sukhareva's work on schizoid psychopathy, Asperger's work on autistic psychopathy, Robinson and Vitale's study of circumscribed interests and Schneersohn's work on *Lesesucht* is all predicated on their subjects' inconstant positions across ability and disability, perhaps a position on top of the clinic walls, while Kirtie M. Mansfield and most of Kanner's infantile autism subjects are firmly within.

A Final Note on Kretschmer

Körperbau und Charakter was reprinted over and over during Kretschmer's lifetime, often with small updates, and continued to be reprinted after his death until a 26th edition in 1977. In 1929, at just 41, Kretschmer was nominated for the Nobel Prize in Physiology or Medicine. He died in 1964. His influence on Russian psychiatry continues today, with papers about his typology appearing as recently as 2017¹⁰¹.

Despert's Schizoid

J. L. Despert's "The early recognition of childhood schizophrenia" of 1944 contains this note:

Schizophrenic and Schizoid Behavior Compared. – A final point of interest bears on the differentiation between schizophrenic illness and behaviour in the schizoid personality. In the schizoid child, malignant characteristics such as affective dissociations and delusional and hallucinatory experiences are lacking. Although the child is withdrawn and his social adjustment is poor, he does not set himself apart from others by exhibiting autistic manifestations and dissociative phenomena. (SC:CP 115)

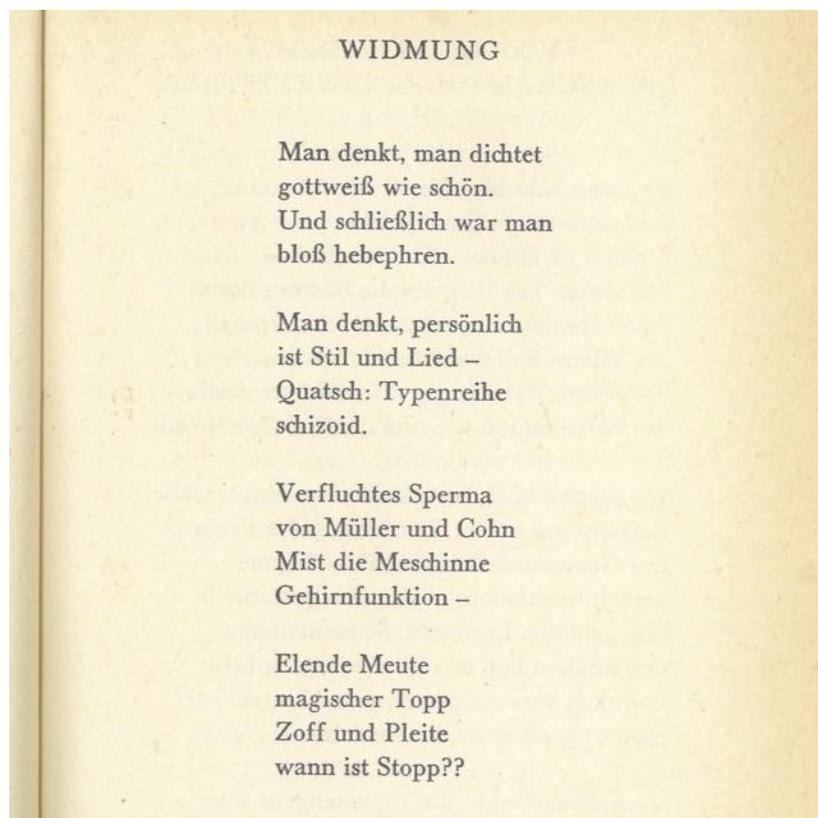
"Autistic manifestations" here seems to be autistic in the symptom-of-schizophrenia sense, however, we must also bear in mind that Despert considered the children of Kanner's studies schizophrenic and his early infantile autism a form of childhood schizophrenia. Is Despert's schizoid child equivalent to Sukhareva's schizoid child? Are either of these forms of schizoidia equivalent to the schizoid personality disorder of Wolff? To what extent do they overlap with the Russian schizoids, with the schizoid cluster of Gannushkin's 16-piece typology? Are any of these akin to Asperger's syndrome, to an autism spectrum disorder, or are they closer to the personality disorders, for example, schizoid, schizotypal, avoidant or compulsive? Can we equate them to modern nosological categories at all or must they be considered separate historical or geographical definitions? Some of these questions were answered in 1959.

Schizoid Typologies at Large

The notes to Gottfried Benn's *Gesammelte Werke* record this poem as having been

¹⁰¹ "[Doctrine of psychopathy typology: E. Kretschmer's concept of 'key experience' and inherited defect]", N. Iu. Piatnitskii/N.Yu. Pyatnitskyi, 10.17116/jnevro20171176159-65

inscribed for Gertrud Zenze in a copy of *Gesammelte Schriften* and dated “24.V.22”. As Benn was a doctor and this poem was not published in his lifetime, perhaps this does not quite count as “at large”, but it is a pretty detail found inadvertently. Given the date, I think we can safely assume “Typenreihe / schizoid” a Kretschmer reference.



“Widmung”, Gottfried Benn, 24 May 1922

In 1940, Mikhail Bulgakov died, ending all possible revisions to his ongoing project *Master and Margarita*, although it was not published until 1966. In addition to lunatics and Soviet psychiatric institutes, the novel also showcases a guest at Satan’s ball who is schizoid in the sense of Kretschmer and the language of Gannushkin (*mechtatel’* and *chudak*):

That young man over there was a dreamer and an eccentric from childhood. A girl fell in love with him and he sold her to a brothel-keeper.¹⁰² (303)

¹⁰² “Этот двадцатилетний мальчуган с детства отличался странными фантазиями, мечтатель и чудак. Его полюбила одна девушка, а он взял и продал ее в публичный дом.”

And here is Leo Kanner in 1941 chastising Usonian parents almost condescendingly for being too eager to label their children with Kretschmerian terms. This book is written for a lay audience, so I am calling this instance “at large”.

John and Jane are adorned with diagnostic adjectives which have the advantage of sounding very scientific [...] Some of them are: introvert, extravert, schizoid, cycloid, asthenic, pyknic, neurotic, neuropathic, psychopathic. Please don't look them up in your dictionary! Let the experts worry about them! (*IDoM*, 103-104)

Van Krevelen and Vedder were not alone in their horror of hearing medical vocabulary uttered by laypeople.

Gottfried Ewald (1888-1963)

Gottfried Ewald's lifespan was almost the same as Kretschmer's. He also features in *Personenlexikon zum Dritten Reich*: an active NS member who did not support the euthanasia policies and saved many patients from deportation to death camps. If only morality was consistently clear-cut.

In 1922, Ewald published a little-quoted paper, “Schizophrenie, Schizoid, Schizothymie. (Kritische Bemerkungen.)”. This paper covers schizoid psychopaths and Ewald also mentions Bleuler in relation to the coining of schizoid, but here, rather than interpreting this as another credit of the invention to Bleuler, I interpret this sentence as pointing out that schizoid is modelled on or derived from Bleuler's term schizophrenia:

[...] diese Psychopathentypen, die man nach *Bleuler* mit dem Namen der Schizoiden zu belegen sich gewöhnt hat – obwohl mir eine einigermaßen befriedigende Umgrenzung des Schizoids noch keineswegs gegeben zu sein scheint [...] (441)

However, I have been told that is reading too much into it and that this is yet another erroneous attribution, again with no book or article mentioned, much less a page number. It may be possible to interpret Sukhareva's, “Termin ‘shizoid’ ne nov, on vzyat u Bleilera.” in this way but that is even more of a stretch than imposing that meaning on the German.

The paper takes a wry tone and after lengthy descriptions of schizoid psychopaths, Ewald seems fed up:

[...] das Schizoid endlich ist der Sammelbegriff für alle abnormen Charaktere. [...] Alle nimmt die weite Mutter des Schizoids in die Arme. Das Schizoid ist wirklich zu dem Ziehharmonikabegriff geworden, den man ihm weissagen mußte. Die Schizophrenie war schon bekannt als großer Topf, ins Gewaltige erweiterte sich das Schizoid, und die Schizothymie umspannt 9/10 der Menschheit. Hier kann ich nicht mit. (445-446)

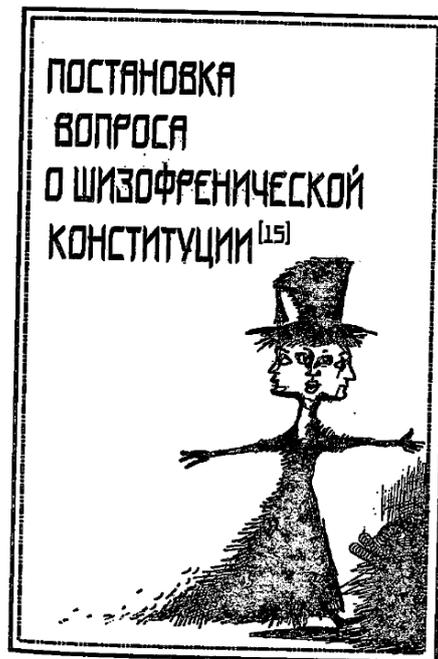
Ewald's *Temperament und Charakter* (1924) was used extensively as a resource for Sukhareva and Osipova's "Materialien zur Erforschung der Korrelationen zwischen den Typen der Begabung und der Konstitution" but his constitutional formula is not seen in Sukhareva's work after this.

Pyotr Borisovich Gannushkin (1875-1933)

P. B. Gannushkin studied under Sergei Korsakoff, after whom the leading Russian journal of psychiatry *Zhurnal nevropatologii i psikiatrii* was eventually named. Along with Sukhareva and Gurevich, he belonged to the "Moscow school" of psychiatry (as opposed to the "Leningrad school").

During the 1910s and 1920s, many researchers were questioning along the following lines: Was it possible to predict schizophrenia? Was there a schizophrenic personality? Were schizophrenia and manic depression simply extreme forms of aspects present in everyone to greater and lesser degrees? Was there latent mental illness in everyone, waiting only for the right (or wrong) circumstances and conditions? If so, could personality predict which type of mental illness an individual might succumb to?

Gannushkin's 1914 paper "[The state of the question of the schizophrenic constitution]" is an investigation into some of these questions in relation to schizophrenia. In reading any Russian work on schizophrenia, it is important to remember that the Russian psychiatric model ended up diverging from the Western model, and that for most of the Soviet-era and still, to a large extent, today, Russian labels do not map directly onto Western concepts. But in 1914, this was not yet the case, as Western researchers were asking these same questions and writing about schizoids, schizothymes, and constitutions or personalities that might predispose an individual to one or another form of mental illness. Gannushkin investigated the histories of schizophrenic patients, looking for unusual behaviours prior to the illness. He found that in many cases, both the patients and their family members had always been very odd. But he also found patients who had been 'normal' beforehand and whose relatives showed no signs of eccentricity.



From a 1998 reprint of Gannushkin's 1914 paper on the schizophrenic constitution

In Sukhareva's introduction to "[Schizoid psychopathies in childhood]", she gives Gannushkin's 1914 paper (recording it as 1912) on the schizophrenic constitution in conjunction with Kraepelin and Birnbaum's *Verschroben* categories as descriptions of schizoid personalities predating Kretschmer.

As mentioned earlier, in his 1933 book, Gannushkin appears to be both building on Sukhareva's descriptions of childhood schizoid psychopathy and continuing his work begun in 1914 by describing the adult schizoid psychopath in more detail. While I find his descriptions similar to autistic syndromes, others disagree. Gannushkin's work has been widely known in English for a long time and continues to have resonance in Russia, as evidenced by the reprints of his selected and collected works. Given that Gannushkin and Sukhareva both worked in Moscow and supposedly therefore shared similar views on terminology, nosology and delimitation, if the Anglophone world was to conclusively determine Gannushkin's schizoid psychopaths equivalent to SPD, would this not surely place Sukhareva's subjects in the same box? It was unfortunate of Gannushkin to die in 1933, long before the discussion about schizoid versus autistic transpired, before Sukhareva's switch from schizoid to autistic psychopathy in 1959,

and before the English SPD existed. Gannushkin's typology thus remains in a 1930s terminology stasis, and, while his work of the early 20th century aligns with Sukhareva's, we have no way of knowing what he would have made of her renaming of the syndrome in 1959. Nevertheless, perhaps discussion of the translation of his terms into modern English should be reopened.

Mikhail Osipovich Gurevich (1878-1953)

Mikhail Osipovich Gurevich is often given as the supervisor on Sukhareva's early papers. He did not achieve the same recognition in the USSR that Sukhareva did but, given his presence at the first round of Pavlovian sessions in 1950, we can assume he was academically higher up than Sukhareva at that time. The memoirs of the psychologist K. K. Platonov include biographical details and anecdotes about Gurevich.

The infantile-graceful body type used in Sukhareva and Osipova's "Materialien" (1925), not found in Kretschmer, comes from Gurevich's "Motorik, Körperbau und Charakter" (1925). While Gurevich did not invent 'epileptoid' (there was a paper on epileptoid states in 1868¹⁰³ and a paper mentioning them in 1871¹⁰⁴), he did write a paper on epileptoid states in psychopaths. As with all constitutional types, researchers don't fully agree on what an epileptoid character might be, but in general, it is an explosive personality type, prone to motor excitability and outbursts of rage. I interpret the epileptoid children of Sukhareva and Osipova's "Materialien" as corresponding to the type described by Gurevich.

Eugène Minkowski (1885-1972)

Eugeniusz Minkowski was born to a Polish Jewish family in Saint Petersburg in the Russian Empire. He was educated in Poland, to which the family had returned when he was 7. His medical training was undertaken at first the Imperial University of Warsaw, then Breslau University, then Göttingen University and completed at Munich University. He obtained his Russian medical certification in Kazan in Tartarstan and then moved back to Munich with his wife, a psychiatrist. During World War I, the Minkowskis worked under Bleuler, and Eugène volunteered as a medic for the French Army. His work during the war enabled him to become a French citizen and the

¹⁰³ Griesinger, W. "Ueber einige epileptoide Zustände." *Archiv für Psychiatrie und Nervenkrankheiten*. 1.2 (1868).

¹⁰⁴ Westphal, C. "Die Agoraphobie, eine neuropathische Erscheinung." *Archiv für Psychiatrie*. 3 (1871).

Minkowskis then moved to Paris where they remained. It was here that Minkowski wrote his many French works on schizophrenia, psychopathology, schizoidia, and the schizophrenic trait of autism. As such, Minkowski is ‘claimed’ by France. Sukhareva lists the 1925 “Contribution à l’études des mécanisme schizophréniques”, a paper co-authored by Claude, Minkowski and Tissy in the bibliography in “[Schizoid psychopathies in childhood]” but does not mention Minkowski in the text. He appears here in connection with schizophrenic processes, not in relation to schizoidia or autism-as-symptom-of-schizophrenia.

Henri Claude, Adrien Borel and Gilbert Robin

While it was the Russians who took the study of a schizophrenic constitution in earnest, going on to adopt and abuse the concept as national policy from around the 1960s, many researchers elsewhere were also interested in this during the 1920s. In 1923, Claude, Borel and Robin’s paper, “Considérations sur la constitution schizoïde et la constitution paranoïaque. Genèse des idées délirantes” was published. Sukhareva sees this paper as a response to *Körperbau und Charakter* and as evidence of Kretschmer’s good reception in France.

What Happened to the Diagnostic Category *die Verschrobenen*?

Sukhareva was not the first (surprise!) to apply the label to children. First published in 1911 and written by Ludwig Scholz (1868-1918), the second edition¹⁰⁵ of *Anomale Kinder*, reworked by Adalbert Gregor (1878-1971) in 1919, contains one of the tidiest definitions of psychopathy: “Mit dem Ausdruck Psychopathie oder psychopathische Konstitution bezeichnet der Arzt, kurz gesagt, die Grenzfälle zwischen geistiger Krankheit und geistiger Gesundheit [...]” (124). Psychopathy is figuratively located on top of the wall between the clinic and the rest of society.

This opens the chapter “Die Psychopathen”, in which we find a shoddy description of children considered *die Verschrobenen* (159-161), predating Sukhareva’s description by at least four years, if not 14. The 1922 edition of this book appears as a reference in Sukhareva’s 1959 collection of clinical lectures, credited to Scholz. Sukhareva certainly read this book but can I say with certainty that she read it before her papers on schizoid psychopathy? No, and a different work of Scholz is listed in the “[Schizoid

¹⁰⁵ Only because I have not seen the first edition.

psychopathies in childhood]” bibliography. At any rate, the barely two-page description of eccentric children, tucked between the Kraepelinian categories *die Haltlosen* and *die Phantasten und Lügner*, does not offer a clear picture of Sukhareva’s schizoid/autistic psychopathy or anything resembling Asperger’s syndrome. The first paragraph is closer to what is thought of as “gifted”, or to the most complimentary features of Kretschmer’s schizoid constitution:

Jede Schule hat einen oder den anderen Außenseiter, der sich durch absonderliche Ideen und ein bizarres Besserwissen nicht immer wohltuend hervorhebt. Es ist unnatürlich, wenn ein zwölfjähriger Junge im Ton der Selbstverständlichkeit die Existenz Gottes bestreitet, oder wenn kaum schulpflichtige Göhren über die Märchen als Dummheiten lächeln und ihnen mit peinlicher Kritik begegnen; und leider nicht immer sind solche Äußerungen älteren Leuten lediglich nachgeplappert, sondern entsprechen dem wirklichen Empfinden der Kinder. In den höheren Klassen bilden die verschrobenen Schüler einen wahren Schrecken für den Lehrer, den sie durch ihre Dialektik, durch überraschende Fragen und Gegenfragen in Verzweiflung setzen. Sie beweisen, daß Karl der Große ein im ganzen unfähiger Herrscher war, erklären Schillers Dramen für ziemlich unbedeutend und sind der Ansicht, daß Pindar viel klüger getan hätte, statt des Wassers den Wein als das Beste zu feiern. Und ihre Logik ist so rabulistisch, daß mancher alte Scholastiker seine helle Freude daran gehabt hätte. Dabei liegt ihnen Koketterie oft völlig fern; einzig ihr abstruser Gedankengang führt sie auf die wunderlichen Seitenpfade, wobei freilich der Reiz des Ungewöhnlichen auch ein übriges tun mag. (160)

The description is so complimentary, I almost suspect a hidden motive for such flattery as “[...] ihre Urteile sind unfehlbar.” (161) Moving on to adulthood, these brightest, cleverest, most outspoken school students then become anyone slightly unconventional. Gone is logic, science and rationality. They are now contrarian wellness-loving hippies:

Später schließen sie sich politischen oder religiösen Sekten an, sind Anhänger des Spiritismus, der freien Liebe, des Anarchismus, der radikalen Frauenemanzipation, und Dogmen und Gesetze reizen sie wie das rote Tuch den Stier. [...] Selbstredend sind sie auch erklärte Gegner der Schulmedizin, des Impfwanges, Anhänger der Homöopathie oder der Naturheilkunde, der Lehmkuren, des Gesundbetens, des Biomagnetismus, treiben bis zur Erschöpfung Luft- und Lichtsport, machen in Nacktkultur und Schönheit, nähren sich von grünem Salat und Nüssen, waschen sich nicht, schlafen auf dem bloßen Boden und sind oft nebenbei die ärgsten Hypochonder. (161)

Sadly, things do not turn out well for them. They are misunderstood and withdraw like snails into their shells. They could have been great and famous and had such huge plans, but the world was too stupid for them and the public didn't get them. They end their days surrounded by the only ones who never deceive them: their loyal friends the animals. "Eine wirre, verrückte Idee blitzt jedem von uns gelegentlich durch den Sinn," Scholz concludes, perhaps advocating the social model of disability, "Was unterscheidet uns von dem Geisteskranken? Daß wir sie abschütteln."

In 1956, *Drei formen missglückten Daseins* by Swiss psychiatrist Ludwig Binswanger (1881-1966) appeared. The book is subtitled *Verstiegenheit, Verschrobenheit, Manieriertheit*. This Binswanger was the grandson of psychiatrist Ludwig Binswanger der Ältere (1820-1880), son of psychiatrist Robert Binswanger (1850-1910), nephew of psychiatrist Otto Binswanger (1852-1929) and grandfather of psychiatrist Kurt Binswanger (1887-1981), whom N. Iu. Piatnitskiĭ credits as the first person to combine schizoid with psychopathy, and can be confirmed to have used schizoid prior to Kretschmer. Acknowledging Kraepelin, Ludwig Binswanger writes about both "verschrobene Psychopathen" and *Verschrobenheit* in relation to schizophrenia. His book spends several pages on linguistic analysis of the German "ver-" prefix and words the prefix can be applied to. Binswanger investigates expressions of *Verschrobenheit* within the framework of *Daseinsanalyse*¹⁰⁶, the psychoanalytical approach Binswanger began developing in the 1920s. Roberto Vitelli translates Binswanger's *verschroben* as "distorted/cranky" (24), moving it away from the more benign "eccentric". While Binswanger was a psychiatrist, psychoanalysis is many steps removed from either Kraepelin or Sukhareva and was not accepted in the USSR.

What did Sukhareva read after "[Schizoid psychopathies in childhood]"?

Sukhareva continued to work on schizoid psychopathy after the two-part study was published. The Russian paper "[On the problem of the structure and dynamics of children's constitutional psychopathy (schizoid form)]" appeared in 1930, the first volume of her clinical lectures contains a case study of a child initially diagnosed as schizoid but later shown to be schizophrenic, the second volume contains several chapters on constitutional psychopathy in which we see schizoid psychopathy renamed

¹⁰⁶ Referred to in English as both daseinsanalysis and existential analysis.

to autistic psychopathy and placed in the same category as syndromes resembling ADHD, OCD, GAD and cyclothymia.

The 1940 and 1955 editions of her clinical lectures contain solely Russian sources, a point commented upon by the Usonian reviewer of the 1940 textbook (A. J. R. 1941) and Leo Kanner (1960). As we know from her previous and later bibliographies that Sukhareva read widely in her field in several languages, this is certainly due to the isolationism the Soviet sciences experienced under Stalin, which I will detail further in Sukhareva's biography. Although Stalin died in 1953, Krushchev's denouncement was not until 1956, and the Stalinist period continued until then. The first post-denouncement edition, volume two in 1959, is opened up to a wealth of foreign influence and we see the return of English, German and French, some of which, Kraepelin and Kretschmer for example, was read by Sukhareva prior to Stalinism, but other sources are new. We find J. L. Despert's 1953 paper "Children of Divorce"; Theodor Heller's 1914 paper "Paedagogische Therapie"; the fourth edition of Kurt Schneider's *Die psychopatischen Persönlichkeiten* (1940); Moritz Tramer's *Lehrbuch der allgemeinen Kinderpsychiatrie* (1949); and, most intriguing of all, the 1955 edition of Leo Kanner's *Child Psychiatry*.

Under Brezhnev, with the political situation returning to repression, the compact 1974 [*Lectures in Child Psychiatry*] lists far fewer references altogether. Only five foreigners appear in the list: A. Homburger, L. Kanner, M. Tramer, W. Spiel, E. Kraepelin, and D. Janz. Leo Kanner's *Child Psychiatry* is a newer edition, that of 1962, and Tramer's *Lehrbuch der allgemeinen Kinderpsychiatrie* is the 1964 edition. Spiel's cited work is *Die endogenen Psychosen des Kindes- und Jugendalters*, the text explicitly presenting Sukhareva's schizoid psychopathy as synonymous with Asperger's autistic psychopathy.

Taking these reference lists alone is misleading, as many more people are mentioned in the texts themselves than are filed under "Literatura" at the end, and Sukhareva was in fact corresponding with the world outside the Soviet Union during this period. People are mentioned but their works are not cited in a way that allows for easy location, whereas works by Russian authors are. This was undoubtedly a political necessity. Sukhareva acquiesced to demands from above to the least extent possible while continuing her own wider reading and research interests.

The Literature Review At Last Comes to An End

Concluding this literature review, someone else has expressed my feelings on it far more eloquently:



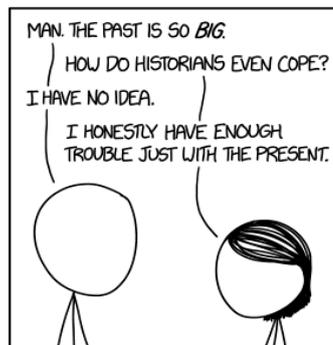
THE PUBLIC EVENTS OF THE LAST THREE MONTHS ARE OF THE CLASS WHICH WILL GO INTO ITS PERMANENT HISTORY. WE HAVE BEEN LIVING IN AN ATMOSPHERE OF HISTORY WHICH WILL BE IMMORTALLY PRESERVED. EVEN THE BRIEF SERIES OF IMPORTANT DATES TO BE COLLATED FOR THE USE OF THE SCHOOLBOYS OF CENTURIES HENCE WILL CONTAIN THE DAY OF THE ASSASSINATION, AND THE DAY OF THE DEATH OF PRESIDENT GARFIELD.

THE INTERMEDIATE EVENTS CO-RELATED, LIKE THE DEFEAT OF ROSCOE CONKLING, WILL BE OF GREAT INTEREST, BUT WILL SCARCELY BE LIKELY TO STAND PROMINENTLY OUT FROM THE PAGE OF HISTORY WRITTEN IN 1881. TO US WHO HAVE BEEN THE WITNESSES, SO TO SPEAK, OF THE TRAGIC INCIDENTS OF THE TIMES, IT SEEMS ENTIRELY PROBABLE THAT FUTURE GENERATIONS WILL EAGERLY SCAN EVERY FEATURE OF THE RECENT BEREAVEMENT WHICH THE NATION HAS SUFFERED.

HOW ACCURATELY WILL FUTURE GENERATIONS KNOW THE IMMENSE VOLUME OF GRIEF AND SORROW WHICH HAS ROLLED OVER THE LAND? WILL THOSE WHO COME AFTER US EVER BE ABLE TO UNDERSTAND THE EXTENT OF OUR LOSS? IS THERE ANYTHING IN THE FIRST CENTURY OF OUR HISTORY—EVEN THE DEATH OF THE GREAT LINCOLN—WHICH CAN BE USED AS A PARALLEL?

PERHAPS A CAREFUL READING OF THE DAILY PAPERS OF THE PRESENT PERIOD MAY GIVE SOME FUTURE ANTIQUARIAN A FINE IDEA OF THE FEELINGS OF THE NATION DURING THE PAST SUMMER. BUT THESE JOURNALS ARE SO LARGE, SO FULL OF DETAIL, THAT WE IMAGINE THE COMING AMERICAN WILL NEVER FIND TIME TO READ THE RECORD. HE MUST DEPEND ON A BRIEF STATEMENT, MEAGERLY COMPILED BY SOME DRY AND TEDIOUS HISTORIAN.

—THE BLOOMINGTON DAILY PANTAGRAPH
SEPTEMBER 30TH 1881



"History", Randall Monroe

The past is so big and there is so much more in it than I am even able to read, let alone talk about, and this thesis is too specialised for most people to read. Everyone else is consigned to a brief statement at the start of a book on ASDs, itself a summary of a brief

paper meagrely compiled by the dry and tedious historians. The past is doomed to being forever misunderstood.

III.

(From the sanatorium school of the Moscow Psychoneurological Children's Clinic
[Director: Prof. Dr *M. O. Gurevich*].)

The Particular Features of Schizoid Psychopathies in Girls

by

Dr G. E. SUKHAREVA,
Scientific Assistant

This report constitutes a supplement to our paper "Schizoid psychopathies in childhood" and can be viewed as a continuation of this work. The key finding of that paper forms our starting point: that there is a group of psychopathies which exhibit several external traits of the schizophrenic psyche (schizoid psychopathies). Symptomatically, this group is closest to the one designated "the Eccentrics" by Kraepelin. In the paper mentioned above, we called attention to the misapplied use of the term 'schizoid' which has lately come into circulation and suggested that this term be reserved for a small group of psychopathies with a specific symptomatology. Thanks to the material we presented, we were able to develop some criteria for differentiating this group from the characteristics of the schizoid psyche which appear during puberty even in normal individuals, as well as from the schizophrenias and schizoid reactions that arise exogenically.

In selecting our clinical material, we deliberately limited ourselves initially to describing only the cases of boys.

In devoting a special paper to the cases of girls, our intention is to single out those distinguishing features that sexual characteristics bring to the picture of the schizoid psychopathies.

The problem of the influence of sex differences on the symptomatology and course of various clinical forms deserves much more attention than it usually receives. The disparity between the functional evolutive and involutive features of the two sexes has great significance for psychiatry, not so much in a pathogenetic sense but more in terms of the pathoplasticity of different mental illnesses. Many psychiatrists have pointed out that various types of psychological illnesses do not appear in men and women with the same frequency, and progress differently. Women seem particularly predisposed to manic-depressive insanity. According to *Kraepelin's* data, women make up 70% of all cases of manic-depressive insanity. The psycho-physiological features of the sexes also have some bearing on the course and clinical picture of the psychosis. We see the pure forms (depressive and manic) far more frequently in men, while depression accompanied by fantastical delusions and fear, and complex manic states combined with stupor and episodes of mental confusion are more characteristic of women (*Kraepelin*). The number of males suffering from schizophrenia is somewhat larger. According to *Kraepelin's* data, 57.4% of 1054 cases of dementia praecox were men. However, if we consider the distribution of patients according to age groups, the proportional differences between the sexes are much more significant. From the ages of 20 to 25, the age of onset for the majority of schizophrenias, we find significantly more men (57.9-65.8%); however, towards the 35th year, the number of females catches up, overtaking the number of males by a great deal in the 45- to 55-year-old bracket. The cases of late onset schizophrenia are seen primarily in women. *Schroeder* reports 13 women and three men in 16 cases of late catatonia. Sex carries even greater weight for the incidence of individual types. Women tend particularly towards periodic types. According to *Kraepelin*, two thirds of these cases are women; he attributes

this to the impact of menstrual periods. Men outweigh women in the hebephrenic and catatonic types (63% and 59% according to data from *Kraepelin*). Women slightly outnumber men among the paranoid types.

In the field of constitutional psychopathic states, it has long been established that hysteria is particularly characteristic for the female sex, but that neurasthenia occurs more frequently in men. We find information on the differences of psychopathic manifestations in children of both sexes in the work of *Voigtländer* and *Gregor*. The authors describe several differences in the psyche of difficult boys and girls. Among the girls, the dominant traits are instability, untidiness, bossiness and lying; by contrast the following qualities appear among the boys: a level of indifference that can reach complete emotional numbness; depressed or agitated mood, introversion, rudeness, irritability. The male half is dominated by accounts of emotional apathy, the female half by accounts of lability and volatility. The author also details the features of antisocial behaviour in men and women. The crimes of women are supposedly always subjectively and emotionally coloured, with a sentimental element found even in women's antisocial behaviour. Emotional experiences play an important part with women; by contrast men behave much more directly and matter-of-factly.

Determining the differential features of the two sexes in material on children has the advantage that it is much easier to eliminate the influence of socioeconomic factors (profession, education, social circle etc.) here. This is why we believed a parallel between cases of schizoid psychopathies in boys and girls could be of certain interest. Here we set out several cases of schizoid psychopathies in girls as a supplement to the cases of schizoid boys we have already described. The age group is the same as with the boys: 12-14 years. Three of these cases were treated in the psychoneurological children's clinic, two in the institute for difficult girls. As in the previous paper, we concern ourselves here only

with cases that have been tracked over an extended period (2 to 4 years) and which appear diagnostically explained.

Case I. P. L, born 1913. Heredity. *Father*, 45 years old, Russian. Lively, active person. Very nervous, violent. Paternal *grandfather* died of throat cancer; has always been nervous and highly strung; an energetic and amusing person; *grandmother* – senile dementia from the age of 60; previously healthy physically and mentally. An *uncle* suffered from attacks of hysteria, a second *uncle* constitutionally neurasthenic, constant hypochondriac mindset. *Mother* – 43 years old, Latvian; considers herself healthy; introverted, quiet, reserved; *grandfather* (Latvian), freehold farmer, died of heart failure at 81; was grim, quiet and morose. *Grandmother*, a German, died of myelitis at 65. The grandfather's family consisted of ten children. All are living. Two have tuberculosis. No mental or nervous illnesses. In terms of character, most of the people are of a sullen disposition.

Personal anamnesis. Pregnancy and partus – N. Physical development normal. Of the infectious illnesses, she survived measles, whooping cough and a lung infection. Was a healthy and calm child while growing up, although she proved to be strong-willed and stubborn from a very early age. When she was only two, she was sometimes unmanageable, e.g. when going for a walk, she suddenly stopped, did not wish to continue, sat down on the ground on the footpath and all persuasion was in vain. Until the age of four she lived in Finland in good economic conditions, had enough care and shelter. At age four, she was evacuated to Czechoslovakia with other children from Leningrad. When she returned home from Czechoslovakia, she had become even rougher and more disobedient. At age five, she entered a kindergarten where she was considered a talented girl with “strong individuality”. After one year, she was transferred to a different kindergarten; this institution was not as well organised; her development took a less favourable turn here and she was considered troublesome. The girl already stood out due to her sullenness. “She lacked the happy face of a child,” said her mother, “her laughter was disturbing, it was so unnatural, so unchildlike.” She avoided large groups of children but tended to have deep and strong attachments to individual children, which were, however, likely to end abruptly and for no apparent reason. Her games with the children frequently ended in clashes as she always demanded individual attention from everyone. She was always distrustful, fractious; she always had the impression that she was being treated worse than other children; she always complained that people didn't love her, that her mother was being unfair to her, etc. She was often rough with her siblings, sometimes even cruel to the younger ones, occasionally hitting them. However, when they were not around, she missed them, was worried about them when they were sick and showed great concern and sensitivity towards them

at such times. “At times when I was sick or feeling out of sorts,” said the mother, “not one of my children was as tender and considerate towards me as L.” About herself, the girl always spoke very reluctantly and little. She was introverted and reticent even towards her mother and father. This introversion and the contrasts in her emotional structure made her a mystery to her parents. “She is sick,” the mother felt; “She’s a sleeping princess,” said the father. From childhood, she made her parents uneasy with her propensity for fabrications and lies. When she was seven, she once lost her way in the streets of the city, came home late in the evening and said that she had met her father, who was riding a horse, and who picked her up and brought her home (it later turned out she had made all of this up). She often told stories of being given particularly fine food to eat at the kindergarten, narrating everything with meticulous detail and even seeming to believe in her fabrications herself. During this time she had often slept fitfully, and had often been very afraid at night, waking her aunt to have her stay up with her. She always professed a great love of independence, would not tolerate refusals when she wanted something. At age nine, she ran away from the colony (40 km from Moscow) with the motivation: “They don’t like me there, I can’t live there anymore.” School attendance began at nine years of age. She went to school for two years. Learned satisfactorily; towards the end of the school year however, she needed home tutoring as she became strangely tired. She spent her free time aimlessly, had no interest in reading, showed no preference for games; she was unskilled with chores, she did everything clumsily: dropped everything, was uncoordinated. She took little interest in her clothing, was often untidily dressed, had no particular love of order for her things. She did not like to dress like everyone else; she went about with no overcoat in winter or wore odd stockings. In 1924, a motor disturbance became noticeable in the girl, sometimes also a tremor of the hands when working. At the advice of doctors, she was sent to the countryside in the summer and was admitted to the remedial school in autumn.

Physical condition. Her height corresponds to 15 years. Body type: asthenic with athletic traits. The stooped posture, disproportionally small skull and broad shoulders give the impression of dysplasia. Oval-shaped head, narrowing towards the top. Long face, blue eyes with sparse, fair eyelashes. High brow; upper jaw somewhat prognathic. Steep gums, irregularly placed teeth, long neck, shoulders very broad in relation to the pelvis. Long chest cavity. Large hands and feet. Fairly pale skin, pronounced cyanosis of the hands and feet. The subcutaneous fat layer is adequately developed. Head hair is blonde, straight. Urogenital apparatus – N. The signs of sexual maturity are present. Menses – abs. Internal organs: lungs – extended expiration on the right; heart – systolic noise on the apex cordis; left boundary laterally from the L. mamillaris. Gastrointestinal tract well. *Nervous system:* movements are strong enough,

somewhat slow and inept. According to Dr *Oseretzky's* scale, the motor skill corresponds to the age. Slack posture, slow gait, walks somewhat hunched. Facial expression slack but appropriate for the situation. Cranial nerves: weak asymmetry of the facial motor nucleus; pupils regular; reactions (light, accommodation, convergence) maintained well; mental reaction is likewise present. Jerk reflexes somewhat high. Mucous membrane reflexes: conjunctiva, cornea – N. Pathological reflexes not present. Sensory organs – N. Has been sleeping restfully lately. Laboratory tests: blood: Hb – 65%, erythrocytes – 4620000, leucocytes – 8000. Leucocytic formula – no divergence from the norm. Negative Wassermann in the blood.

Mental condition. Not very forthcoming. Speaks very unwillingly about her past. Gives only very superficial and unrelated information. When asked questions touching on her personal experiences, she becomes more closed off, withdraws even further. Considers herself healthy, contests everything: mood fluctuations, phobias, increased irritability. With longer and more careful exploration, it was discovered that she often feels sad. In answer to, “For what reason?” – she replies: “I will not say, it is my secret.” During the following conversation she answers stereotypically: “Don’t ask me, I won’t tell you anyhow, it’s my secret.” The discontented, dark tone is noticeable in her manner of speaking. She is determined to leave as soon as possible, is unsettled, makes many superfluous movements. Language poor: word production is very difficult for her. Her store of knowledge is likewise low. She can perform logical operations well only within the confines of the concrete. Where abstractions are required, the answers are much poorer. Thought processes somewhat slow and stiff; qualitatively within the normal range, however, quantitatively (functionally) significantly behind – due to incapacity for intellectual effort. Has no interest in intellectual work; where deliberation is required, she immediately has a negativistic reaction; – “I don’t know.” With constant encouragement and a little support, she gives significantly better answers. Testing in the laboratory resulted in + 1 year on the *Binet* scale.

She did not like being at the school, constantly repeated: “I’m just here for a short time, I’m leaving soon anyway.” Grew accustomed to the new conditions very slowly; expressed a distrustful, sceptical attitude towards everything: “Everything is bad here, the children are bad too, it was better at the other school.” Keeps herself apart from the communal life of the children, is not, however, apathetic. Is very observant; behaves as though she is studying and judging everything. Her dominant mood is calm; high spirits and heightened irritability were not observed. Is reserved and equable, one always receives the impression of a certain coolness from her. Pronounced affective colourations are only to be perceived where her self-assurance has been touched. Here one could even speak of an increased sensitivity. The constant desire to be better, combined with her feelings of inferiority,

creates an underlying affective tone of restlessness and a distrustful, suspicious attitude towards people. She apperceives people's behaviour towards her very finely; she also has the capacity for lively, empathetic understanding of others' experiences. She is not mean, happily shares her gifts with her girl friends, but all affective motions remain externally cold and weakly expressed. She has a sense of camaraderie, it is expressed through constant effort to protect anyone who has been slighted; but here too it is to do with an idiosyncratic, inflexible and hyperbolic sense of justice. Seems very affectionate towards her parents, particularly her father, whom she sees as an absolute authority. No aesthetic abilities of any kind could be observed. Her performance in the school has been adequate.

During her stay in the school, no substantial changes have been observed; she has become physically stronger, in recent times she has also begun to participate actively in the school's social life. Her mother observes a marked improvement. At home, the girl is much calmer, has less conflict with members of the household, has become tidier, sleeps well.

Summary. The hereditary components are as follows: on the father's side, sthenic, active natures with various neurotic traits; schizoid traits are dominant maternally: cold, grim, quiet people. The girl developed normally. Strong-willed, stubborn, markedly "individualistic" from an early age. At the same time, isolated neurotic traits: restless sleep, nightmares, hyperimaginative lies. Over the years, her idiosyncrasies have become increasingly prominent: on the one hand – her tendency towards autistic responses: introversion, reticence, little sociability; on the other hand – the contrastive nature of her emotional personality. Despite the emotional coldness and inertia of the affective responses, there is a great sensitivity and tactfulness in understanding others' experiences. Heightened impressionability when assessing the behaviour of those around her in relation to herself. Her awareness of her own inferiority with her high self-consciousness often effects a fearful underlying emotional tone.

Rudiments of the paranoid symptom complex: distrusting, suspicious behaviour towards other people, constant quest for justice. Intelligence low but within the normal range. Performance in school satisfactory. Somatic: asthenic body type, a certain angularity to her movements. Internal organs: myocarditis, indications of tuberculous

intoxication. A certain improvement during her stay in the remedial school.

Diagnosis: Psychopathic personality. – Schizoid

Course: stable with a small improvement.

Case 2. L¹⁰⁷. W., 14 years old, born 1912, girl from an uneducated working-class family.

Heredity: *Mother* died of stomach cancer at the age of 44; was nervous, highly strung and mean. Maternal *grandfather* – alcoholic, died as an old man. *Grandmother* was physically healthy, calm and equable. Maternal *uncle* – alcoholic, a person with a difficult character.

Father – died in the war; physically and mentally healthy. Nothing is known about his relatives.

Personal anamnesis. Pregnancy and birth – N. Was born a healthy child. Survived scarlet fever and measles. Was a very quiet child, seldom played with children, relatives found her calmness conspicuous. Was sometimes moody, disobedient and strong-willed. After the death of her father, the six-year-old girl was taken to a children's home where she spent one year before being placed in another; at the age of ten, she was sent to the medical observation centre with the following complaints: "avoids the greater company of children, only interacts with two to three girl friends, seeks out particularly weak and quiet girls as friends. Is intellectually normal but her interest is very difficult to engage in schoolwork." Testing in the observation centre's outpatients' unit (May 1922) demonstrated normal intelligence; she came across as a very introverted girl. She took her admission to the inpatients' ward of the observation centre calmly; here she was likewise very cagey and unapproachable. (She came under our observation in the observation centre.) She seldom came to class; if she was present, she refused to show her exercise book to the teacher. Her prevailing mood was an equable and lethargic one, sometimes a little light-hearted and silly – she would run all over the house, pull faces, fool around. She reacted to the comments of the adults with even greater agitation, was negativistic; would calm down spontaneously, however, if no one paid attention. She did not like to comply with the house rules of the institution. Rejected all suggestions to do any work, yet happily did things that were forbidden. Externally, she was emotionally superficial, never thought about her relatives; never wanted to go home on holidays. She did not have a single friend amongst the other students; her attitude towards the adults was indifferent, sometimes even hostile. No evaluation could be made of her performance in school as the girl did no schoolwork. Out of the aesthetic abilities, a talent for visual art was observed. The teacher considered her gifted not just technically but also artistically and creatively. The predominance of dark colours stood out in her drawings. She remained in the institution for two years; no kind of noticeable

¹⁰⁷ I have interpreted the "1. W." in the original as a misprint.

change in her psyche was observed during this period. In March 1924 she was placed in an institute for difficult girls, where she is now also under our observation.

Physical condition. She is tall for her age. Body type: normal, asthenic (not pronounced). Small face, normal facial features. Slight prognathism of the upper jaw. Head well-proportioned in relation to the torso; neck long and thin; flat chest. Right-sided, vaguely pronounced scoliosis. Fat layer sufficiently developed, slack muscular system. Thin, elastic skin; rosy cheeks. Hair dark blonde, coarse. Thyroid glands normal. Secondary sexual characteristics are becoming apparent. Menses – abs. Internal organs: heart and lungs – N. Tractus gastro-intestinalis – tendency to constipation.

Nervous system. Movements strong enough, coordinated, forceful, releasing, many superfluous movements. Facial expressions lively, intense grimacing during states of excitement. Cranial nerves – N; pupils – N; mental pupillary reactions present. Somewhat high patella reflex. Skin and mucous membrane reflexes normal. A certain hyperaesthesia of skin sensitivity. Loose, red dermographism; hands somewhat cyanotic. W. R. in blood negative.

Mental condition. Not very forthcoming during the examination. Discontented, gloomy appearance. Hides her gaze from the examiner. Gives short monosyllabic answers; she stubbornly refuses to answer questions about herself and her past and shares only a few external facts: “What do you want to know that for, I’m not going to tell you anything.” She is well enough oriented in her immediate surroundings. Her general level of education is not high but sufficient for a girl of her background. She has little knowledge, her language is poor and her answers lose much by this. Logical operations satisfactory; she has a definite tendency towards systemisation: to the question “What is a fork?”, for example, she gives the following answer: “An object which is made of something such as iron and has several appendages”; “What is a table?” – “A wooden cover with four legs.” She is not able to define abstract terms at all because she lacks the necessary vocabulary. Comprehension correct: she correctly understood and explained all the pictures she was shown. It is interesting that with all pictures depicting seeming impossibilities she was insistently determined to demonstrate that the picture was accurate, even though she had understood it correctly: “Doesn’t matter; this kind of thing happens; I like doing everything backwards too; this uncle is dressed very warmly in summer; I do the same thing: I wear a coat in summer but not in winter.”

Coordinated associations (often negativistic reactions: “Certainly not, boring, don’t want to anymore.” Contrastive associations occur: many negations. Memory satisfactory, predominantly of the mechanical type. During the testing using Prof. Rossolimo’s method, she showed high suggestibility and automatism, low attention and adequate higher processes. Good performance ability at

school. She comprehends suggested tasks well but prefers mechanical and automatic work. Often expresses an obstinate negativism: when asked to write something down, she answers “I don’t want to, I’m not doing it.” All persuasion and punishment are in vain. If she is left unattended, she sits down and gradually goes about her work; always refuses if she has to read something aloud. She is very shy, self-absorbed and insecure – becomes very embarrassed and turns red if she must answer. She strives to mask her embarrassment with laughter, grimaces and superfluous movements. She is very unsettled in class, wriggles around on the bench, jumps up, pulls and picks at the exercise books. She spends her free time alone or in the company of a single girl friend. Loses herself in the full crowd of children; is introverted, reticent, doesn’t let anyone into her inner world. Her mood is predominantly an apathetic one. The states of high excitability and foolishness are significantly less frequent than during her stay at the medical observation centre; on the other hand, in recent years the gloomy, distrusting, underlying emotional tone has become much more pronounced. She finds everything here very unpleasant, everything here meets with censure. To the question “What do you find pleasant?” – she answered: “Nothing, I don’t like anything.” To the question: “What do you dislike?” she gave the answer: “I dislike everything and everyone here is bad.” For some time she was close friends with a girl, became disconcerted if the friendship was spoken of, dropped the friendship immediately when the girl returned a ribbon she had given her; she felt so insulted by this and was so angry that she immediately tore this ribbon to pieces in front of the girl. Despite her pronounced external emotional flatness, she is very sensitive, her self-esteem is particularly vulnerable. She has a fine understanding of different emotional experiences. The teacher believed she was the most sensitive and intelligent girl in her whole group. Enjoys drawing but refuses to draw to a specification. Works in the bookbinder’s, performs well. Over the last year, the girl has become somewhat gentler and calmer; the loss of her mother (who died a few months ago) has been very hard for her. She says she has cried a lot in the night when no one can see her.

Summary. Hereditary stress from the mother’s side. Normal physical development. Not very sociable from a young age, abnormally calm for a child. Gloomy and moody at times. She has lived in children’s homes since the age of six and has been a difficult child here due to her unapproachability, pronounced negativism and tendency to foolish bad habits. An emotionally flat girl: has no longing for her relatives, no close girl friends. At the same time, she is very sensitive and feels injuries to her self-esteem very keenly. Normal intelligence, good schoolwork,

shows talent for drawing. Physically: asthenic body type (not pronounced); motor delays, clumsiness, many superfluous movements. A certain improvement could be confirmed during the observation: the girl has become gentler and calmer.

Diagnosis: psychopathic personality: “schizoid”. Course: stable with a small improvement in recent years.

Case 3. W. P., born 1909.

Heredity: Father died of typhus at the age of 42; was a gloomy, bad-tempered person with no interest in his family and children. Drank often. Lues was denied. There is no information about his relatives. *Mother*, 47 years old, works as a caretaker in a hospital, gives the impression of intellectual delay; as far as character is concerned, she is mild and weak-willed. Maternal *grandfather* and *grandmother* died at an advanced age – no further information. The mother had three pregnancies. 1. the older son, 20 years old, psychopath: disorderly, erratic, coarse, cheeky, can't fit in anywhere; 2. our patient; 3. a 14-year-old girl: calm, quiet, mentally retarded.

Personal anamnesis. Pregnancy and partus progressed normally. Was born in good health. There was a certain delay in physical development. She began talking and walking at the age of two. Survived varicella, measles and whooping cough. Was a weak girl growing up, often had bronchitis. The economic conditions were always very difficult. Raising the girl fell to the mother who was unable to manage her at all. The moody, capricious and unusual girl was very difficult to manage from earliest childhood. She was usually affectionate, considerate and kind-hearted towards her mother but sometimes she would suddenly, for no apparent reason, become rude, cheeky and derisive, even hitting her mother at such times. She was always very strong-willed and disobedient, always did the opposite of what she was asked to do. If she was told, “Go for a walk!”, the answer would be “No, I'm not going”, “Lie down then and have a rest” – at which she would hastily get dressed and sit at the gate for hours. She played little with the children and did not really get on with them. At the age of nine, the girl was taken to a colony in the Ukraine, where she remained until she was twelve. On her return, the mother admitted her to the medical observation centre in Moscow (February 1922), where she came under our observation.

Physical condition anno 1923. Her height and weight are appropriate for her age; her body is weak and dysplastic. Body type more towards asthenic. Head large, shape approaching square, face wide, narrow forehead with low-growing hair; large grey eyes; wide nose, small mouth, widely positioned teeth. Neck short, wide, narrow shoulders. Somewhat stooped. Scapulae alatae. Flat

chest. Residual symptoms of rickets. Enlarged superficial lymph glands. Hypertrophic tonsils. Subcutaneous fat layer poorly developed; slack muscle system. Thyroid glands – normal. Urogenital apparatus – normal. Menses abs. Internal organs: chronic catarrh of the apex of the lungs. Circulatory system: anaemic vein sounds. Heart – normal.

Nervous system. Slack posture, angular movements, awkward gait; a lot of grimaces, many superfluous movements; facial expressions appropriate to the situation. Cranial nerves – N; pupils – D = S, lively reactions. Heightened patella reflexes. Trachea reflex – abs. Sensitivity – N. Vision extremely low – short-sighted.

Mental condition. Intelligence low but within the normal range. General knowledge low. School knowledge even less sufficient. Logical operations involving concrete ideas normal. Using the *Binet-Simon* and *Rossolimo* methods, she shows a certain retardation. She is negativistic during the examination, many questions she does not want to answer at all. This negativistic attitude makes it difficult to assess her intellectual capabilities as it cannot be determined what is due to her intellectual disability and her unwillingness to answer. She also has a negativistic attitude in the inpatients' ward of the observation centre, does not adhere to the house regulations, is rude to the teaching staff. Throughout her two-year stay in the ward, she never showed her exercise books to the teachers; whenever a teacher tried to see her work, she always had extreme, affective explosions, and might tear up her exercise book, throw something in the teacher's face etc. Her rudeness, insolence, and negativism manifest periodically to a certain extent. Sometimes she is calmer and then works in class or in the sewing workshop. At these times, she does not give the impression of being retarded, gives intelligent answers, fits comfortably into her surroundings. Nonetheless, she is incapable of intellectual exertion. She always sticks to rote work; a certain inhibition is noticeable, a slowness in thought, something stiff in her psyche, an inability to adapt. When she is worked up, she pulls vulgar pranks, plays the clown, dresses in some strange outfit that stands out, pulls faces. At these times she is suspicious and distrusting, finds everything offensive and makes an effort to do as many unpleasant things to people as possible. These coarse outbursts are at odds with the underlying tone of her emotional personality. Overall, the girl is very emotive, sensitive, tender and affectionate. This combination of delicate sensitivity and coarseness make the girl's psyche strange and hard to understand. Her emotional lability also gives a bizarre impression: she is usually friendly and kind-hearted but sometimes for no reason she suddenly becomes distrusting and rude. This ambivalence is characteristic of all her affective reactions. She is constantly experiencing a simultaneous "I want to" and "I don't want to". She will want something intensely and at the same time impulsively fight against her own desires. She encounters the doctor happily; but if the doctor takes a step towards her she momentarily hides

or runs away, however, after this, she follows the doctor around for a long time and complains that she doesn't get enough attention. She wanted to visit the doctor in his apartment several times but as soon as the door was opened in response to her ringing the doorbell, she ran away at great speed. When among children, she keeps herself apart, she doesn't participate in group play, feels embarrassed about her clumsy movements. She has no close friends among the girls, is reticent. Towards the end of the second year of her stay at the observation centre she became somewhat more balanced. In 1924, she was placed in the institution for difficult girls. She stayed there for almost a year. She was employed at a factory but didn't last there for very long. According to the latest reports, she is now living with her mother, is employed as a messenger and is coping with her work. Has become somewhat calmer.

Summary. Hereditary burden: pathological character and alcoholism of the father, mild intellectual retardation in the mother. A noted delay in physical development. Many illnesses in childhood (frequent bronchitis). Pathological character anomalies from earliest childhood: negativism, pronounced ambivalence of the thymopsyche, inappropriate emotional reactions. All these features became more marked after admission to the children's home. Here she is not very amenable to pedagogical influence, refuses to show her work, is sometimes rude and cheeky. Low intelligence but within the normal range. Pronounced deficiency in motor skills: movements clumsy and angular, synkineses. Internal organs: chronic catarrh of the apex of the lungs. A certain improvement in recent years. Has become calmer and more balanced.

Diagnosis: Psychopathic personality: "schizoid". *Course* stable, a certain improvement following puberty.

Case 4. L. K., 13-year-old (born January 1913).

Heredity: *Father* died of exhaustion at the age of 76 (during the famine). Was always healthy, sociable and amusing. Musician: played the violin. *Grandfather* and *grandmother* died of unknown causes. Both were robust and healthy. No further information is available. Paternal *great-grandfather* – a Frenchman who emigrated to Russia. Musician: composer. The father's relatives are musically gifted. *Mother*, 47-year-old, considers herself neurotic, is being treated at the psychoneurological dispensary (where the diagnosis is "schizophrenia"). Gives the impression of an eccentric, unconventional person, poorly adjusted to life. Gives music lessons. Maternal *grandfather* died of sclerosis at 63, was an amusing and jocular person. Sometimes drank. *Grandmother* died during childbirth at the age of 25: was musically gifted,

an actress. Many neurasthenics in the mother's family and many musically talented people.

The mother had three pregnancies. 1. – spontaneous miscarriage. 2. – daughter from the first marriage, 24 years old; is also currently being treated by the psychoneurological dispensary (diagnosis: psychopathic personality). 3. – our patient.

Personal anamnesis: When the girl was born, her father was 64 years old, her mother 33. The mother was physically very weak during the pregnancy. Partus on time, long duration, no surgical intervention. Physical development normal. Of illnesses, only parotitis and frequent influenza. Poor sleep from childhood till now, frequent automatic movements in sleep (rocking torso motions). The difficult qualities of her character were already apparent at the age of three: she was disobedient, moody, often impossibly strong-willed. Intellectual development progressed well. She learnt to read independently at the age of five; showed talent for music early on: (ability to improvise). At the same time, a marked absent-mindedness became more noticeable with every year. Intelligent and perceptive, yet she could not manage the simplest requests. If she was sent to get something from the shop she forgot what she was supposed to be getting on the way there. Others noticed that she was extremely laggard: she ate very slowly, would take an hour to get dressed, would put on an item of clothing and sink into thought. Before doing anything, she had to make very elaborate preparations, took far too long, was often distracted by something, didn't finish what she started. Her character was not ill-natured but her manner had little of the childlike friendliness and gentleness. She enjoyed playing with children but preferred the company of adults; she particularly enjoyed hearing imaginative stories and fairy tales. She loved noisy play involving movement and rarely played with dolls. Until the age of seven, she lived in good economic conditions. Her parents were gentle and tender towards her. At the age of six, the girl was sent to a kindergarten where she was only able to stay for two months as she didn't fit in, would not tolerate the Froebelian games and invented her own ones. The teachers felt there was no point in her remaining in the kindergarten any longer. They considered her gifted but very absent-minded. At the age of seven, the girl was sent to a music primary school. Despite her musical talent, she made poor progress, did not enjoy doing "theory" or anything where effort or discipline was required. The time from the ages of seven to ten was extremely difficult for the girl, the economic situation had taken a sharp turn for the worse (poor nutrition, frequent moving from one city to another); her mother also obtained a divorce from her father during this time and fell in love with a mentally ill person. The girl lived with her mother and was subjected to constant physical and psychological trauma as her stepfather often beat her and treated her badly in general. She had no systematic schooling

until the age of ten. Home tutors were engaged who confirmed that she had every good ability but found her a very difficult student to manage. She understood everything very quickly but forgot it all just as fast. At the age of ten, the girl moved to Moscow with her mother and here started at an experimental model school. She was initially placed in the fourth group but was moved up to the fifth after just two months. The school considered her very gifted and well developed; her literary talents were discovered here for the first time. She attended the school for a year before being sent to the countryside for the following year at the behest of the tuberculosis doctor. She became healthy during her time in the country. At the beginning of 1924, the girl returned to Moscow where she again had to live under the difficult conditions of poor and inadequate nutrition. The girl's pathological characteristics now became much more evident and significant: her absent-mindedness, passiveness and slowness rendered her incapable of any form of independent work. From an educational perspective, she was even more difficult: she continued to become ruder, cheekier and more negativistic. All of this led the mother to turn to a psychiatrist who referred the girl to our clinic in March 1925.

Physical condition. Her height and weight exceed her age by two years. Her body type tends towards athletic. Dysplastic features: disproportionately large hands and feet. Head proportional to the torso. Skull: brachycephalic type. Broad face, well-pronounced cheekbones. Small facial features, indistinct profile. Teeth: broad, irregularly situated. Strong neck, broad, medium-long shoulders. Chest high and of regular, cylindrical shape. Skin somewhat pale, smooth, elastic, neither dry nor overly sweaty. Pale mucus membranes. Subcutaneous layer of fat adequately developed, evenly distributed. Muscular system well developed. Broad bones. Tonsils somewhat enlarged. Thyroid glands normal. Mammary glands correspond (manual inspection) to age. Secondary sexual characteristics are present. Menses since September 1925, regular, not very painful. Internal organs: lungs: expiration at the right apex, prone to frequent colds; circulation: clear heartbeat, pulse 72.

Nervous system: Movements – strong, adequately coordinated but somewhat angular and ungainly. Walks with immensely long steps. Examining her according to Dr *Oseretzky's* scale results in + two years. Closed eyelids and outstretched arms have a tremor. Face shows little expression. Voice fairly rough. Sensitivity present. Cranial nerves normal, pupils – D = S, reacting a bit slowly; mental reactions present. Reflexes – patellar – R. and Achilles – R. – lively. Jerk reflexes of the upper extremities slow. Skin reflexes – N. Mucous membrane reflexes: low. Pathological reflexes absent. Vegetative symptoms: white dermography, positive *Aschner*. Sleep – falls asleep with difficulty. Frequent rhythmical torso movements while falling asleep (explains that she uses this technique

to fall asleep). The same movements can be also observed during sleep. Masturbation has not been observed. Lab tests: *Wassermann* in blood negative; the blood test shows anaemia and slight leucocytosis. Leucocytic formula – no deviation from the norm. Urine test: nothing pathological.

Physical condition. Calm, oriented, adjusted to the new environment and people fairly quickly. Is utterly critical of her situation. She has a strong sense of her own inferiority linked to an anxious agitation. During testing, she constantly asks: “Am I normal?” “I have such large hands – does this happen or is it an illness?” etc. Complains about her own absent-mindedness, says she can’t do anything because she forgets it all so quickly. If some work is suggested to her, she declines circuitously: “I will never finish it, I won’t be able to do it.” Approaches work unwillingly and gets anxiously worked up. When working, she is helpless, indecisive, expects external support. Could not finish a very simple task, and this was not due to mental deficiency. Intellect good (above average); high general development. Cognition good, precise; good comprehension. Understands questions posed to her immediately, but instead of an answer often gives several responses, wavers and can’t decide which of the answers is best. Her answers are often very long, detailed, rational, but the thoughts are always right. Logical processes are coordinated, no absent-mindedness, no restriction of thought. She has the capacity for abstract thought. Provides good differentiation of abstract terms (What is the difference between love and friendship? – “Love is a human emotion; friendship – is a relation between human dispositions.”); answers relating to emotional experiences are always particularly good: she displays a very clear understanding of human emotions and relationships. Other answers less related to emotional aspects are not as good. Memory below average. On the *Binet-Simon* scale, she is a 15-year-old (+1 ½ years).

She does not enjoy speaking about her past: “I don’t like to confide,” she says, “and have no respect for people who tell everything about themselves.” “I’m more cold-blooded than nervous,” she says of herself. “I have never had strong feelings,” “Nothing particularly moves me,” “I have no close girl friends”. However, there is no sign of affective numbness here. The girl takes a definite interest in her surroundings. Greatly enjoys engaging in class, loves music, physical exercises and games – plays with great enthusiasm and risk. Markedly high “ego-complex” sensitivity. She is egocentric, always wants to be better than the others and gets worked up when this does not occur. In evaluating her own personality, there is a similar ambivalence. Alongside high estimation of herself and her abilities, striving to be better than the others – a constant anxiety and insecurity about her own capabilities. She interacts

easily with the school children but is not close to anyone. She always writes the same memento words in the autograph books of all the girls: "I'm slowly starting to get used to you." Her interactions with other people can neither be called good-natured nor ill-willed. She is egoistic and concerned with her own ends, but frequently also makes an effort for her schoolmates and stands up for them. Enjoys talking about principles and justice. In all her emotional activity there is a certain forcefulness and awkwardness, and little emotional warmth. Her behaviour can often be annoying and intrusive. She pesters people with endless questions and requests; is very insistent when she wants something. Overall, she is happy to comply with the house rules of the institute; but is sometimes very stubborn and rude. No pronounced negativism has been observed. She is very slow in her self-management, performs everything very clumsily. She completes assigned tasks poorly, is forgetful and inattentive when doing so, sometimes missing the main point. She is productive enough in her schoolwork; her performance is constantly improving. Special talents: she is musically gifted (ability to compose) and shows literary abilities (writes stories for the school children's magazine). She performs the gymnastics and rhythm exercises well.

Course. She has developed physically during her stay in the remedial school and became more robust. Menses began in September 1925. Her sleep has become more peaceful. The oscillating movements during her sleep have also disappeared recently. Marked psychological changes have also been noted. During the first month, her psychasthenic traits gradually wore away, she became more confident, learned how to work independently. Pursued the set goals with perseverance. In recent times the conflicting traits of her high opinion of herself have become more evident. Her tone is often rude, she enjoys showing off her physical strength, yells at the children, who are a little afraid of her. The underlying affective tone is, as earlier, calm. Strong emotional outbursts do not occur. As earlier, she remains introverted and not very approachable. She now stands on better footing in the children's social setting, participates in the school's social organisations.

Summary. Heredity: Significant hereditary burden (mentally ill mother, psychopathic sister) and musical talent (many gifted musicians in the family). Economic situation: satisfactory until the age of seven, later an extreme turn for the worse. Regular physical development. Good mental development. She had been an intelligent, gifted, musical child. However, her absent-mindedness, insufficient active impulses and sluggishness when working were noticeable from an early age. The girl could not adjust to kindergarten, did not like the children's games and Froebelian activities,

invented her own games and lived more in her own fantasy world. The teachers who worked with her considered her a gifted girl but difficult to educate on account of her high level of absent-mindedness. Her main character traits were introversion, reticence, and an absence of strong desires, sometimes being ill-mannered and stubborn. In the time before puberty, all these pathological features came to a head and the mother had to turn to the remedial school. On her intake, she showed an extremely pronounced psychasthenic syndrome: inability to exert herself, insecurity in connection with anxious agitation. Intellect good, above average. Tendency towards analysing and excessive rumination. Significant changes for the better during her stay in the remedial school. She has learned to work independently, has demonstrated high productivity in her schoolwork and music lessons. The following somatic characteristics have been noted: athletic body type with a few dysplastic features, anaemia and indications of tuberculous intoxication.

Diagnosis: Psychopathic personality: “schizoid”. Course: stable. Peaked in the pre-pubescent period. It is possible that the spike was also precipitated by the unfavourable living circumstances (frequent moving, poor nutrition, family conflicts). A significant improvement in the remedial school.

Case 5. N. W. (born 1913).

Heredity. *Father*, doctor, died of typhus at the age of 61. After the Japanese War¹⁰⁸, when he was 45 years old, he came up with grand ideas – he occupied himself with projects involving idiosyncratic inventions. He remained in his job, however, and was employed as senior doctor at various hospitals. Nothing is known about his relatives. *Mother* died of dysentery at the age of 46; had heart problems; she was of a highly strung and nervous character, suffered attacks of hysteria. Maternal *grandmother* was likewise unbalanced, hysterical. Nothing is known about the remaining relatives.

The mother had only one pregnancy: our patient.

Personal anamnesis. The father was 55 years old when the girl was born, the mother 36; nothing is known about the course of the pregnancy or birth. Physical development was normal. Survived measles and a lung infection. She was raised by her grandmother for the first three years, later by her parents.

¹⁰⁸ Russo-Japanese War, 8 February 1904-5 September 1905

The economic conditions were satisfactory until the death of the father (he died when the girl was six years old), after this they worsened considerably – the mother worked as a teacher at children's homes and the girl lived with her mother. The mother coddled the girl yet wound her up at the same time through her nervousness. She was a weak, sickly girl while growing up and her behaviour began causing big problems for her caregivers from an early age. She was always undisciplined and cheeky. She loved her mother very much but perpetually harried her, verbally abused her and even hit her. Once when she was very upset with her mother, she locked herself inside their rural house and left the mother waiting in the farmyard for hours. In the children's homes where she lived with her mother, she was constantly coming into conflict with the children, so much so that the mother was fired several times. The girl's intellectual development progressed normally. She learned to read at the age of six, was a bright girl, read a lot. At the age of nine, she went to school and performed well. When the girl was ten years old, her mother died. She was left in the care of one of the mother's female friends, who turned her over to the medical observation centre in August 1923.

She showed good development when examined in the outpatients' unit: high profile using Prof. *Rossolimo's* method. She was taken to the inpatients' unit of the observation clinic where she immediately proved to be a difficult girl. Very negativistic, blunt, cheeky. Did not comply with the institution's house rules and was placed in the specialist clinic for psychopaths after a few months. She remained there for about a year and was then sent to the institute for difficult girls. (Here she came under our observation.) The girl could not adjust here either: her rudeness, extreme negativism and constant tomfoolery disturbed the work of the entire class. She behaved disrespectfully and maliciously towards the teaching staff. Introverted, reticent. She always thought the teachers were insulting the children and treating them unjustly.

In March 1926 she was admitted to the remedial school of the psychoneurological children's clinic.

Physical condition. Her height exceeds the age of 16 years, the circumference of her thorax corresponds to 13 years, the circumference of her skull corresponds to 14 years. The relationship between lower and upper body lengths tends towards the eunuchoid type. Body type: asthenic-dysplastic. Tall, skinny, somewhat stooped. High, irregularly formed, almost tower-shaped skull. Long, thin, egg-shaped face. Small facial features. Long, thin neck; thin shoulders turning inwards; long, narrow chest; right-sided scoliosis. Muscular system satisfactory, subcutaneous fat layer sparsely developed. Thyroid glands – normal. Mammary glands can be clearly felt. Internal organs: expiration at the right lung apex. Clear heartbeat. Pulse – 82. Anaemic vein sounds. Gastrointestinal tract

– Norm. Urogenital system – N. Secondary sexual characteristics are becoming evident.

Menses – abs.

Nervous system. Movements strong enough, quick, forceful, somewhat angular. Many superfluous movements when she is agitated. Sometimes compulsive movements: nail biting. Clumsy gait. Facial expressions correspond to the situation. Voice loud, piercing. Cranial nerves: facial motor nucleus somewhat asymmetrical. Overall – N. Pupils D = S, registered reaction. Mental pupil reaction present. Patellar – R. somewhat high; slight tremor of the lids when eyes are closed. Sensitivity noted. Impaired vision – myopia. Hearing – N. Sleeps peacefully, falls asleep early. Lab tests: Negative *Wassermann* in blood. Leucocytic formula: low leucocytosis. Urine: nothing pathological.

Mental condition. Not very forthcoming. Gloomy, distrustful. Emotional contact cannot be made with her immediately and can only be made with difficulty. Provides detailed accounts of her own medical history. Her first memories are from her fourth year. She was doing well then, but she had a bad caregiver who hit her when her mother was not around. She did not like dolls and broke them to find out what was inside; preferred active games with boys. She was neither sick nor nervous. “I have never been afraid of anything. I climbed onto the attic and on top of roofs. I’ve always been very wilful, and I enjoyed doing things despite being told not to.”

If she is asked about something that touches on her personal life, she makes an unhappy face and answers: “Don’t interrogate me.” Does not like talking about life in the children’s homes. “Yes, I’m defective; I got up to mischief and insulted the teachers because I was angry; I could always control myself, but I was furiously angry; I always tested a new teacher: if she reacted, I would keep going and make her furious – if she stayed calm, I stopped.” She has never had close girl friends: “Sometimes I like someone or other but I don’t love them. I never particularly like anyone, I feel indifferent towards most people.” Her language is haphazard, vocabulary is poor, uses many specific expressions from children’s home jargon.

Experimental psychological examination: intellect normal. Associative processes coordinated: semantic associations prevail. Thought processes are structured; however, it is hard for her to define abstract terms (due to lack of words). Good memory. Combinative processes good: she performed all ten *Rossolimo* tests correctly. Attention: sufficient tenacity. Using Binet: + one year.

She was quite happy to be placed in the remedial school but gave no outward indication of her joy and spoke in the same discontented morose tone of voice: “Everyone here is so well-behaved, they will kick me out of here very soon.” For the first while she looked around her. Kept herself apart from everyone, did not engage in conversation with any of the children, responded little to questions. She made an effort not to draw attention to herself, did not want to do any gymnastics exercises or sing a solo during the singing lesson. She spent most of the time in the classroom and read or

worked on her classwork. After one to two months she had settled into the school enough that she was already able to participate openly in school celebrations. She became a little closer to the children, a little friendlier towards the teachers, gentler and more forthcoming. Mood calm. Not one affective explosion during this time. No cheerful excitement or increased irritability either. She was always equable and controlled and never cried. Ambivalence is characteristic of all her affective experiences. She is gloomy, a little spiteful and yet very sensitive. She gives a very fine rendition of emotional experiences on stage; she has a delicate sensitivity for the beauty of nature and books. She has intense intellectual interests which she satisfies by means of reading. Egocentric and particularly self-absorbed. She once confessed to one of the caregivers: "I wish that everything in the world was only there for me." She likes to be praised very much but is also very embarrassed when this happens; often expresses a fear that people will laugh and make fun of her. "I would rather you told me off than praised me."

Sthenic, very determined in her undertakings, she always finishes whatever she starts: "If I want something, I do it." Due to this perseverance she shows enormous productivity in her schoolwork.

As far as artistic endeavours go, she is a talented girl. Musical, sings well. Dramatic talent. Draws well.

Summary. Heredity: Father mentally ill, hysteria on the mother's side. Normal physical and mental development. Difficult from the earliest age. Wilful, moody, highly strung. Extremely pronounced ambivalence of affective reactions: loves her mother and mistreats her at the same time. Outwardly emotionally flat. Her most sensitive spot – the complex of her own ego, abnormally high and vulnerable self-esteem. She lived in multiple children's institutions from the ages of 10 to 13. She was very difficult everywhere, teachers found her difficult to influence. The following qualities could be observed: introversion, low approachability, anger, distrustful attitude towards the teachers, stubborn negativism, occasional tendencies to foolish behaviour. After admission to the remedial school, a pronounced change for the better: she became calmer, no negativism, no foolish behaviour (however, still remains introverted and not particularly sociable). Huge progress in schoolwork. Exhibited musical and dramatic abilities. Somatic characteristics: asthenic body type with dysplastic traits: eunuchoid proportions in the relation between lower extremities

and torso; angular movements. Motor agitation, compulsive movements (nail-biting).

Diagnosis: psychopathic personality (schizoid). *Course* stable. All of the girl's pathological traits peaked during her time in the children's institutions. (This can be seen as a psychogenic reaction to the sudden worsening of living conditions in a girl of schizoid constitution.) Rapid improvement in a favourable environment.

Based on the cases described above and the additional study of schizoid psychopathies in boys (which we have continued over the last year), we consider it possible to describe the symptomatology of the schizoid psychopathies more precisely. We have divided the observed symptoms into two groups: 1. primary symptoms that form the characteristics of the psyche of schizoid psychopaths, and 2. secondary symptoms that appear frequently but not always.

We count among the primary symptoms: 1. the autistic attitude, 2. the ambivalence of the thymopsyche, 3. the idiosyncratic thought processes: tendency towards the abstract and formal; automatism, 4. symptoms of motor skill deficiency: angularity, clumsy movements. Among the secondary symptoms: 1. the paranoid symptom complex – the distrustful, suspicious attitude towards the people around her (the constant feeling of being hurt, the erroneous interpretation of other people's behaviour), 2. the psychasthenic syndrome: insecurity, feelings of inferiority, tendency towards obsessive-compulsiveness and 3. symptoms which could be called "catatonoid" symptoms –, increased suggestibility, pronounced negativism, sometimes both at once, 4. related to this last group are the psychomotor disorders – tendencies towards stereotyped movements, foolish behaviour, automatism; impulsivity.

The symptomatology of the cases of schizoid psychopathies in girls cited here replicates the picture we describe in its fundamental traits. By analysing the individual symptoms, however, we can single out a number of specific characteristics that appear to be tied to sex.

1. The main difference is that for the girls, the *emotional disturbances* always come to the fore in the picture of schizoid psychopathies. It is precisely these emotional defects which mark the schizoid person with the stamp of vulgarity, quirkiness and eccentricity. The presentation of eccentricity among schizoid boys consists of tendencies towards superfluous abstraction, absurd rumination, stereotyped movements and motor deficiencies; with the girls on the other hand, we have, if we may describe it so, an emotional eccentricity arising from a complicated interplay of the strangest emotional combinations. The ambivalence of their emotional life, the constant presence of conflicting emotions – results in actions which appear vulgar, contradictory and incomprehensible. *Bleuler* explains this ambivalence as the disturbance of the uniformity of the dominant affect, which leads to a whole series of urges arising simultaneously without a single one of them being able to gain the upper hand. A distinguishing feature of the girls is also their great volatility of mood, where the mood changes of the schizoid girl differ very strongly from the hysterical lability of mood and the cyclothymic endogenous mood phases. These mood changes seem bizarre and contradictory (see case no. 3). The elements of psychasthenic proportion are more pronounced in the girls than in the boys. The constant combination of sensitivity and emotional numbness – the inner tension in combination with outward coldness – is even more glaring and noticeable here. What emerges is a picture of isolated sensitive spots against a backdrop of general emotional flatness. We have found such particularly sensitive spots, affectively coloured complexes, in the area of the “ego”-complex in our cases. All these children are very egocentric, strive to be something greater, and feel every injury to their self-esteem extraordinarily keenly. The ambivalence makes a mark here too: a high level of self-esteem and inflated self-estimation goes hand in hand with a feeling of inferiority which gives rise to a constant feeling of inner tension vented through seemingly inexplicable moods and tomfoolery.

We have also observed the features described in the schizoid boys, but the features never attain such a high degree. The dominance of affective disorders in the picture of schizoid psychopathies in girls may perhaps be explained by the particular features of the female psyche – by the higher emotional excitability and the multi-faceted nature of female affectivity.

That women overall appear to be more impressionable and to have richer emotional experiences is a fact no one disputes. Overall mood plays a more decisive role for women. Feelings influence their ways of dealing with things and their thinking to a great extent; women's memory, attention and capacity for judgement have a more vivid affective colouring. Volatility of mood is also much higher in women than in men.

2. The idiosyncrasies of schizoid thinking are less markedly pronounced with the girls. We have observed such schizoid symptoms as a pronounced automatism of thought (cases 1, 2, 3), sometimes a slightly plastic, somewhat restricted psyche and a certain autism of thought which manifested as a disconnect from the real world (weakening of the feeling of reality). The tendency towards the abstract, towards schematic and formal thinking which is characteristic of the schizoid boys is observed much less often in the girls (we saw this in only one case).

It is possible that this observation is not coincidental either and can likewise be explained by the particular qualities of the female psyche. In addition to the greater emotiveness of women, their thinking is more vivid, intuitive and visual; this hinders the operations required for abstraction. Women perceive the world in concrete images and are less capable of abstract and schematic thinking.

3. The symptom of autistic disposition is equally characteristic of both sexes. In three of the cases described, we are talking about a strongly pronounced autism, in two others it is a low or elective sociability. All these girls appear introverted, reticent, not particularly

approachable. All were “loners” from early childhood and mention it themselves. “I never had girl friends, I don’t like being close to people.” (Case 4.) “I don’t like anyone and I don’t hate anyone, everyone is the same to me.” (Case 5.) “I find all girls unpleasant, I don’t love anyone.” (Case 2.) “I only have one girl friend, apart from her, I don’t like anyone.” (Case 1.) The stamp of ambivalence also marks their behaviour towards their environment, their emotional relationships are often broken off quite suddenly, their feelings are often contradictory to their behaviour – they love and hate simultaneously (cases 1, 2, 3, 5).

They are the odd ones out in children’s social settings, sometimes they provoke hostile behaviour (cases 1, 3, 5), sometimes they simply don’t stand out. There is a theory that explains the autistic disposition of the schizoid children through their motor skill deficits: the awkwardness of their movements makes them fearful and shy, compels them to avoid interaction with people. *Oetli*, for example, writes that the dysfunctional changes in motor skills (particularly in the area of expressive movements) influence the attitude towards social feelings. Unwell schizophrenics with motor skill deficits become sociophobic, gradually withdrawing more and more and perceiving the external world as something hostile. Much here speaks against this argument: people who have recovered from encephalitis and have motor skill disorders, for example, display no autistic disposition.

In the schizoid psychopathies where the motor skill deficit is present from birth, however, this could have greater significance for their social attitude; but the motor skill disorder is not a sufficient cause here either.

4. We have observed the next symptom – the motor skill deficits – in all our cases. The motor skill disturbance manifests in the form of a general angularity and awkwardness of movements despite sufficient muscle strength and good dexterity. In three cases we also saw a motor unrest, many superfluous movements, synkineses. Setting these observations alongside those of the previous year (of boys), it can be said that the motor skill deficits in the boys are more strongly pronounced. Using Dr *Oseretzky’s* scale, the average retardation of the

schizoid boys = 2 to 3 years; the girls usually resulted in their own age (+ two years in one case). With the boys, we also observed extreme retardation in manual skill, physical education, lack of skill in drawing, writing etc., while in three cases, the girls had a good aptitude for gymnastics and manual skill.

We also have not found such pronounced disturbances in the areas of expressive movements, facial expressions, speech and language with the girls as we did with the schizoid boys. It may be that this superiority of the girls in the area of expressive movements is also attributable to specific sex differences. (It must also be mentioned here that the other issues related to motor skills – various speech disorders, enuresis, left-handedness – appear less often in the girls than in the boys.)

As for the somatic features and body types, our conclusions here approach what we discovered in the boys¹). Our cases are distributed among the body types as follows: athletic – 1, asthenic – 2, asthenic-dysplastic – 2 (it must be noted that our cases are all adolescents, during which age the asthenic and dysplastic usually predominate, and which our data does not demonstratively show)¹⁰⁹.

As far as the symptoms we have termed ‘accessory’ are concerned, we have observed the psychasthenic syndrome in two cases, and symptoms similar to the paranoid ones in three cases: a distrustful attitude to the people around them, sullen and morose tone of voice, a false interpretation of the way the people around them act towards them: they see offence and injustice everywhere. They also have a peculiar, rigid sense of justice which is tied in to a tendency to see underdogs whom they must protect everywhere – pedantic warriors for principles. We have seen *psychomotor* disturbances (tendencies towards stereotyped movements and foolish behaviour, impulsivity)

¹) It must be noted here that body types are less strongly pronounced in girls than in boys.

¹⁰⁹ Russian often over-negates for emphasis, while German is closer to English. This sentence sounds like oddly Russified German and could be intended to mean “and which our data slightly indicates.”

in the girls as well, if in a less pronounced form than in the boys. The *negativistic symptoms* have been observed more frequently in the girls than in the boys. Negativism could commonly be seen with a hysteroid quality, affected behaviour, a desire for attention. If no attention is paid to them, the negativistic symptoms disappear very quickly.

We must also note that a certain hysteroid quality can always be found in the schizoid girls; their jitteriness¹¹⁰, moodiness and oddness always give the initial impression of hysteria.

This is why the *differential diagnosis* of schizoid psychopathies in girls must always begin with hysteria. The following characteristics in our cases speak for schizoid psychopathy and against hysteria: 1. Autistic disposition; all these girls have been loners since childhood, not very sociable, introverted, while hysterics usually have a strong love for social settings where they can exhibit themselves. 2. Our cases lack the characteristic reactive lability and suggestibility of hysterics; our girls are much more independent, much firmer in their intentions, they are not easily influenced as they lack the requisite emotional receptivity. 3. The active, vivid affectivity which is characteristic of hysterics is not present in our cases. Throughout all the oddness of the emotional combinations which is peculiar to our schizoid girls, they all display a certain coldness; this makes it difficult to establish an emotional rapport with them. 4. Finally, the lack of the somatic stigmas of this form of illness (somatosensory disorders, attacks etc.) also argues against hysteria.

As with all cases of schizoid psychopathies, our cases must be differentiated first from *schizophrenia* and secondly from changes to the psyche caused by *puberty*. The differentiation can only be made here using observation and anamnesis; we cannot make a decision here based on a psychopathological analysis of the presenting condition.

Schizophrenia can be ruled out in our cases as there is no progression: according to the medical histories, the schizoid symptoms have been present since early childhood and show no sign of deterioration. The course

¹¹⁰ Or “eccentricity”, not clear which meaning is intended.

is definitely favourable in our cases, which is also not characteristic of schizophrenia (in three of the cases described we have seen a significant improvement over the years).

The same medical histories argue against the possibility of attributing the whole clinical picture merely to changes in the psyche caused by puberty. All these personal idiosyncrasies in our cases were already present from early childhood and in a few cases only came to a head during puberty (cases 4 and 5).

It seems just as important to make the distinction between our cases and schizoid reactions of exogenic origin (which arise under the influence of psychogenic events, brain diseases, narcotics, chronic infections such as tuberculosis etc.).

We have not been able to rule out the influence of some kind of exogenic factor (psychological trauma, tuberculosis etc.) in any of our cases, but an exogenic factor would be unable to explain the overall picture of the schizoid psychopathy satisfactorily in any of our cases. The features described all appeared so early, so strongly and so unchangingly throughout the entire life of the child that they are more likely to be attributable to the child's constitutional peculiarities. In recent times there have been papers in which the schizoid psychopathies are viewed as exogens of psychological reactions to tuberculous intoxication. A review of a large quantity of material on children immediately exposes the error of such a stance. Cases of schizoid psychopathies in children are fairly rare while indications of tuberculous intoxication affect the large majority of the child population. The emergence of this position may be attributed to a lack of clarity in terminology: the use of the term "schizoid" in its broad sense results in every neurotic manifestation of a child, every tendency towards introversion claiming the right to the diagnosis of "schizoidia".

We find no details in the literature on the particular features of the female psyche for different constitutional types. *Krestchmer, Bleuler et al.*, who have worked in this field, primarily have the male psyche in view. We have found a certain confirmation of our

observations in *Kraepelin*: in his description of the pre-psychotic personality of schizophrenics.

He notes that girls show the following pre-psychotic features (in contrast to boys): increased sensitivity, jitteriness, nervousness, obstinacy. *Voigt* also finds the same pre-psychotic characteristics in his material (103 Cases of Schizophrenia). *Schultze* likewise writes about the increased impressionability and moodiness of women who later became ill with schizophrenia.

Before we give the summary of our observations, we would first like to call attention to the following fact: the overall picture of the schizoid psychopathies is weaker in the girls than in the boys, the schizoid features of the girls appear less prominently. The rate of schizoid psychopathies (if we are to go by our not very comprehensive material) also seems to be lower in girls than in boys. These observations confirm the view of *Bleuler* who considers the schizoid traits to be predominantly male. In his opinion, women are much more syntonie; pronounced schizoid traits indicate a masculine character and are out of place in women.

These are the different features of the schizoid psychopathies we have been able to note in the girls.

The essence of our work can be summarised in the following sentences:

1. The clinical picture of the schizoid psychopathies in girls overlaps with that of schizoid boys in its main traits. As with the boys, it is largely to do with an inadequate unity and congruity of the psychological mechanisms, because of which a similarity to the absent-mindedness of schizophrenia emerges.

The differential features of the schizoid psychopathies of girls consist of the following: a) In the clinical picture, the affective disturbances come to the fore: ambivalence of emotions, inadequacy of affective responses, the presence of complicated and contradictory emotional combinations (these features

can be attributed to the stronger and more volatile affectivity of the female psyche). b) The schizoid nature of the thinking is not as pronounced in the girls; the tendency towards abstract, schematic thinking and absurd rumination occurs less often. These features can also be explained through the peculiarities of female thinking: It is more visual, practical and has a more vivid affective colouring, c) symptoms of motor skill deficits (particularly in the area of expressive movements: facial expressions, speech, language) are less strongly pronounced in the girls. d) The negativism can be observed more frequently in the girls and always has a hysteroid quality to it, e) the hysterical symptoms also occur much more often in the girls than in the boys, which is why schizoid psychopathies in girls are most commonly confused with hysterias.

4 Notes

In many sorts of illness it is quite indifferent how we describe and classify, if we can only understand and help the patient.

Eugen Bleuler, 1913 (875)

This chapter contains a discussion of the content and context of the paper “[Features of schizoid psychopathy in girls]” (1927), the translation of which appears in chapter 3, followed by some commentary on the approach taken for the translation process and discussion of a selection of translation problems encountered with some solutions found.

Notes on the Text

The two schizoid psychopathy papers and the paper on giftedness all appeared in both Russian and German. “[Schizoid psychopathies in childhood]” and “[Materials for the study of giftedness in children]”¹¹¹ (1925) were presented and published before “Schizoide Psychopathien im Kindesalter” and “Materialien zur Erforschung der Korrelationen zwischen den Typen der Begabung und der Konstitution” (1926). “Materialien” was published in *Zeitschrift für die gesamte Neurologie und Psychiatrie*, while the papers of case studies of schizoid psychopathy in boys and girls both appeared in *Monatsschrift für Psychiatrie und Neurologie*. “[Schizoid psychopathies in childhood]” (1925) is slightly longer than “Schizoide Psychopathien im Kindesalter” (1926). However, the paper “[Features of schizoid psychopathy in girls]” (1927) directs the reader not to “[Schizoid psychopathies in childhood]” but to “Schizoide Psychopathien im Kindesalter”, providing a full reference for *Monatsschrift für Psychiatrie und Neurologie*. The Russian paper on girls is abridged from the German. The introduction, running for several pages in German, is only two paragraphs in Russian. The Russian includes all five case studies but each case receives only a paragraph of attention. Sukhareva apologises for the brevity, acknowledging lack of space¹¹².

¹¹¹ “Материалы к изучению одаренности у детей” / “Materialy k izucheniiu odarennosti i detei”

¹¹² “Не имея возможности (за недостатком места) привести полностью истории болезни тих случаев, мы даем только краткое резюме.” (248)

*Monatsschrift für Psychiatrie und Neurologie*¹¹³ was founded in 1897 by Carl Wernicke and Theodor Ziehen, author of *Die Geisteskrankheiten des Kindesalters* and *Das Seelenleben der Jugendlichen*, referred to in Sukhareva's work. Articles could be printed in German, French or English. Among those on the advisory committee were Ernst Kretschmer, Eugen Bleuler's son Manfred Bleuler and Kurt Schneider, author of *Die psychopathischen Persönlichkeiten*. *Zeitschrift für die gesamte Neurologie und Psychiatrie* only ran from 1910 to 1944, which has probably contributed to "Materialien"'s obscurity.

The Children

In addition to children of other pathological persuasions (hysteroid, epileptoid etc.), "[Materials for the study of giftedness in children]" features 5 schizoid psychopathy (SP) boys, 1 SP girl, 4 introverted boys and 2 introverted girls. The introverted children are presented as the normal or non-pathological variation of the personality. "[Schizoid psychopathies in childhood]" features 6 boys. "[Features of schizoid psychopathy in girls]" features 5 girls, one of whom appeared in the paper on giftedness.

Chronologically, the papers on SP would have built on the few case studies of SP already found in the paper on giftedness for Russian and German readers, although the text in the papers on giftedness seems to postdate the reports on SP. The case study of the girl K. L. seems to have been written before her case study in "Materialien". Four of the boys feature in both the paper on giftedness and the paper on SP, for which we have had Sula Wolff's English version since 1991. Children who appear in both the papers on SP and the paper on giftedness are sometimes older in "Materialien" but never younger. Some of the text in "Materialien" is reused from the schizoid psychopathy papers.

Combining the case studies from all three papers and accounting for double-ups, Sukhareva described 7 SP boys and 6 SP girls in total.

The inclusion of the 'normal' introvert children are useful as comparison subjects or controls, particularly for anyone wondering whether Sukhareva's descriptions of schizoid psychopathy were actually descriptions of ordinary children or where Sukhareva (and Osipova) draw the line between pathological and normal. The latter is

¹¹³ The titles *Revue Mensuelle de Psychiatrie et de Neurologie* and *Monthly Review of Psychiatry and Neurology* appeared below the German.

harder to pin down, but the brief introverted case studies provide a glimpse of schizoid or autistic traits not qualifying the child for a diagnosis.

In 1959, Sukhareva mentions that schizoid/autistic psychopathy appears in fewer girls than boys, perhaps in alignment with European writings of the time. This is not mentioned in her first papers on SP. The female differences being described now: greater affect dysregulation, less idiosyncratic interests, and the similarities: autistic disposition, low or absent affective empathy, unimpaired cognitive empathy, systemising thought processes, motor skill deficits, are present in Sukhareva's text. Among traits not usually attributed to ASDs in the Anglosphere, Sukhareva includes extreme ambivalence and "negativism" – uncooperative behaviour and refusal to comply with any request¹¹⁴. While there is always a level of anachronism in attempting to impose modern diagnostic categories on historical ones, the former could be interpreted as impaired emotional cognition, Bermond's alexithymia type II (Hill & Berthoz). The latter is described by Sukhareva as a secondary symptom, one brought on by adverse life circumstances.

Negativism

In the 1925 second edition of *Über Psychologie und Psychopathologie des Kindes*, Theodor Heller calls negativism a *Willensstörung* (41), a will disorder, describing it in the chapter "Die psychopathischen Konstitutionen" thus:

Das Kind weigert sich zu tun, was ihm der Erwachsene aufträgt, nimmt die Gewohnheit an, bei den geringfügigsten Anlässen zu widerstreben und zu widersprechen und geht in seinen Handlungen einen Weg, der dem von seinen Angehörigen oder Erziehern vorgezeichneten oft geradezu entgegengesetzt ist. Unter normalen Verhältnissen bedeutet dieses Verhalten als Ungehorsam oder Widersetzlichkeit einen schlimmen Kinderfehler, der in der Regel scharfes erzieherisches Einschreiten zur Folge hat, welches die fehlende Autorität des Erziehers herstellen soll. [...] Der krankhafte Negativismus, der zunächst als Ungehorsam oder Widersetzlichkeit erscheint, ist aber wesentlich anders zu beurteilen. Er bleibt unverändert, trotz allen Erziehungseinflüssen, führt das Kind oder den Jugendlichen oft in peinliche, mit schwerer Unlust behaftete Situationen und macht sich trotzdem immer wieder als sinnloses Widersprechen und Zuwiderhandeln geltend. Am krassesten tritt dies

¹¹⁴ There is writing on Oppositional Defiant Disorder in connection with ASDs.

hinsichtlich der Nahrungsaufnahme zutage. Es gibt Kinder, die tagelang alle Speisen zurückweisen, von Kakao, Schokolade oder einigen, an und für sich ganz unzureichenden Näschiereien leben, obwohl nicht die mindeste Krankheitserscheinung seitens der Verdauungsorgane nachzuweisen ist. (42)

Negativism is not negativity but stubbornly refusing any request or offer for no clear reason – the child refuses even when it is something they want.

Abstract Thought

In interpreting what is meant by good abilities for abstract thought in children with schizoid psychopathy, these children can be contrasted with the oligophrenic (intellectually disabled) children who are described in Sukhareva's 1927 paper "Körperbau, Motorik und Charakter der Oligophrenen. II. Mitteilung. Untersuchungsobjekt: Mädchen" as lacking any ability for abstract thought.

Schizoid/Autistic Psychopathy in Children

While Sukhareva's work on this syndrome begins with the descriptor "schizoid psychopathy", it is, in the words of de Sanctis, "nur eine vorläufige" ("Dementia praecocissima catatonica" 9). In volume two of Sukhareva's clinical lectures (1959), schizoid psychopathy is explicitly renamed autistic psychopathy (278). From a Russian perspective, the trajectory from Sukhareva's earliest papers on schizoid psychopath to the ICD-10 code F84.5 is a clear and unbroken line. However, in contrast to *DSM-5*, which takes a symptomatological approach to nosology, Sukhareva's three-volume work on child psychiatry, also functioning as a classification system, takes an aetiological approach. While Kanner's, Asperger's and Heller's syndromes are all filed under the umbrella of "autism spectrum disorder" in *DSM-5*, in Sukhareva's nosology, the syndromes are not particularly close together: Heller's syndrome appears in her first volume, the work on major psychiatric disorders, and according to Rollins, Kanner's syndrome also appears here (71-77, 84-86)¹¹⁵; Asperger's syndrome (autistic psychopathy) appears in her second volume, the work on minor psychiatric disorders;

¹¹⁵ "Kanner's syndrome of infantile autism is, particularly in Leningrad, considered a manifestation of early brain damage. In Moscow, autism is seen as schizophrenic. The controversy involves whether the gross developmental and interpersonal disturbances should be regarded as a process or a state, in either case appearing so early that development at very basic levels cannot occur." (84) There follows a case study of a child the Leningrad school considered schizophrenic but whom Rollins considered to have Kanner's autism.

Kanner's syndrome in combination with intellectual disability, however, (oligophrenia with schizoid traits) would presumably come in the final volume on oligophrenia.

Quite significantly, and perhaps answering why Sukhareva did not push for more credit for her descriptions of schizoid psychopathy during her lifetime, Rollins records that, "Although schizoid personality as a variety of psychopathy appears in Sukhareva's classification, it is not frequently used." (86)

Can Any of Sukhareva's Work Be Connected to Kanner's Autism?

Possibly, but this depends on whether one places Kanner's syndrome more in the realm of childhood schizophrenia or more in the realm of intellectual disability. Kanner was a frequent citer of Sukhareva's work on childhood schizophrenia, but her extensive work on intellectual disability is less referred to.

Following the same pattern as the two-part schizoid psychopathy study, Sukhareva's 1928 paper "Körperbau, Motorik und Charakter der Oligophrenen. II. Mitteilung. Untersuchungsobjekt: Mädchen" is a follow-up to E. A. Osipova¹¹⁶'s first report on boys. The papers appear consecutively in the same journal with the same date of submission. Both Osipova and Sukhareva use first person plurals throughout the text, and Sukhareva's opens with "Unsere Mitteilung"¹¹⁷, affirming that her paper contributes to the same wider project as Osipova's. The two oligophrenia papers can be considered a single study and the work of a collective. Like the papers on schizoid psychopathy, these two papers again document different body types in depth: Kretschmer's pyknic, asthenic, athletic, dysplastic, and Gurevich's infantile-graceful, as well as mixed and unpronounced. The level of intellectual impairment is viewed in three degrees of severity. This is the same system that has been used for over a century and corresponds to F70-F72 in *ICD-10*. Children with the most severe form of intellectual impairment, "profound intellectual disability" or an IQ of less than 20 are omitted from the case studies. Heller's paper "Über motorische Rückständigkeiten bei Kindern" is used as a reference, among many other primarily German sources. E. A. Osipova's paper divides the boys into five constitutional categories: the syntones or extraverts; the schizothymes

¹¹⁶ Not S. V. Osipova who worked with Sukhareva on "Materialien".

¹¹⁷ Many of her reports are written in this manner, shunning the Western European myth of the great man, the single male discoverer. This approach is often considered feminist in the English-speaking world, but presumably in Soviet Russia, it was simply socialist. Anglophone feminists now might argue that this is what intersectional feminism truly is, that the great man myth arises in the intersection of capitalism and patriarchy, and that the discarding of these forms of oppression in early Soviet Russia demonstrates how feminism truly benefits all society not just women.

or introverts; the reactive-labiles whose pathological form is the hysteroid psychopaths and hysterics; the mixed and unpronounced types. This is not as strict a categorisation as Sukhareva will use in her paper on girls, and Osipova focuses far more on body types than character types.

The children studied by Osipova and her colleagues are 150 intellectually delayed boys from children's homes, remedial schools, and the psychoneurological children's hospital. Osipova does not give an age range. Out of the 150 boys, 54 fall in the introverted/schizothyme category. There are 9 severely disabled (F72) schizothyme boys, 21 moderately disabled (F71) schizothyme boys and 24 mildly disabled schizothyme boys. Osipova's description of introverted intellectually disabled boys is not enough to draw many conclusions on its own and there are no case studies, but I have highlighted some features that could tenuously correlate to an ASD involving intellectual disability:

[...] Es sind motorisch schlaffe initiativlose, wenig aktive Subjekte mit befriedigender Retentionsfähigkeit (Rm) und häufig dissoziierter Eindrucksfähigkeit (E+), d. h. mit **erhöhter Sensitivität in bezug auf alles, was mit ihrem Ich zusammenhängt und mit Gleichgültigkeit den emotionellen Eindrücken der übrigen außerhalb ihres Ichs liegenden Welt gegenüber**. Triebe m oder in der Richtung des Geltungsdranges erhöht. Temperament (T) durchschnittlich oder herabsetzt [sic]. Die hier vorherrschende Gestalt ist **der Typus eines schlaffen äußerlich gleichgültigen, häufig finsternen, verschlossenen, initiativlosen, unselbständigen Knaben, welcher manchmal, falls irgendeine mit seiner intimen Persönlichkeit zusammenhängende komplexhafte Situation berührt wird, mit einer unerwarteten Affektentladung reagiert**. Dieser schizothyme Typus unterliegt bei erhöhten Tr und R + leicht **einer weitgehenden Schizoidierung** – insbesondere bei ungünstigen Lebensverhältnissen; unter diesen Typen finden wir einen hohen Prozentsatz mürrischer, negativistischer, mißtrauischer und erböster **Kinder, die gern dauernd antisozial werden**. Neben dem beschriebenen vorherrschenden Typus kommen aber unter unseren asthenisch-schizothymen Oligophrenen auch sensitive Subjekte mit feinerem emotionellem Leben vor – sie erinnern, wie eine blasse Kopie, an **die hyperästhetischen Gestalten Kretschmers**.

[...]

Unter den Athletischen, deren etwas 50% zu den schizothymen Charakteren gehört [...], kommen nach unseren Beobachtungen **besonders häufig ausgesprochene gefühlsstumpfe Charaktere** vor. Es handelt sich hier um Individuen mit herabgesetzter Eindrucksfähigkeit, durchschnittlicher Retentions- und Leitungsfähigkeit, erhöhten

Trieben und durchschnittlichem Temperament – daraus resultieren **emotionelle Stumpfheit, Kälte und Grausamkeit** [...] (18-19)

Hyperaesthesia is increased sensitivity. Previously in Ziehen's *Die Geisteskrankheiten des Kindesalters*¹¹⁸ in 1906, which Sukhareva may have had, Ziehen had described hyperaesthetic children among his neurasthenics, "Sehr oft verbindet sich mit der neurasthenischen Hyperästhesie eine Hyperalgesie desselben Sinnesgebietes. So kenne ich neurasthenische Kinder, welche bei jedem etwas stärkeren Geräusch ,vor Schmerz aufschreien'." (83) A translation into modern English might run, "This increased sensitivity in anxiety disorders often goes hand in hand with increased pain in the same sensory area. I know children with anxiety disorders who scream in pain at any noise slightly louder than usual." Using Ziehen's description, hyperaesthesia potentially maps onto sensory processing deficits – a common feature of autism.

Sukhareva's paper looks at 173 oligophrenic girls aged 8-14 years. The girls are in an institute for the intellectually delayed and are orphans or "half-orphans". The same body types and three-tiered severity scale used for the boys are used for the girls. However, Sukhareva and her colleagues use a different character typology to categorise the personalities of the oligophrenic girls than E. A. Osipova and her colleagues. Here the constitutional types are schizoid, cycloid, epileptoid and hysteroid psychopathic traits, and their normal variations, introverted, syntonik, sthenic, impulsive and reactive-labile types. This is a more explicit use of 'schizoid' than Osipova's. Of 173 girls with intellectual disability, Sukhareva places 19 in introverted/schizothyme category and only 9 in the SP category. Of the 19 introverted types, none have severe intellectual disability (F72), 6 have moderate intellectual disability (F71) and 13 have mild intellectual disability (F70). Of the schizoid psychopaths (labelled as such on table on page 34), 2 have severe intellectual disability, 2 have moderate intellectual disability and 5 have mild intellectual disability.

Der schizoide Typus der geitesschwachen Mädchen hat ebenfalls eine Reihe Besonderheiten. Alle diese Mädchen zeichnen sich durch ihre Verslossenheit, affektive Ambivalenz, erhöhtes und leicht verletzbares Selbstgefühl und krassen Negativismus aus; der Negativismus der oligophrenen Schizoiden ist ein stumpfer und

¹¹⁸ The book was serialised over several years. Sukhareva references a 1915 segment in [Clinical Lectures in Child Psychiatry] vol. 2, 1959.

sinnloserer: ganz kritiklos tun derartige Mädchen stets das Gegenteil von dem, was ihnen gesagt wird. Die Ambivalenz ihrer Handlungen findet ihre Erklärung in dem Umstand, daß das erhöhte Selbstgefühl bei ihnen ein stetes Unzulänglichkeitsbewußtsein wachruft, weswegen sie zum Beispiel absichtlich unordentlich in der Kleidung sind, um schlechter auszusehen, als sie sind. (33)

Was den schizoiden und den intravertierten Typus anbetrifft, so sind sie für die Mädchen weniger charakteristisch. Auch haben bei den Mädchen die schizoiden Züge eine etwas andere Färbung, so daß hier im Vordergrunde affektive Störungen erscheinen, – krasse affektive Ambivalenz, kapriziöse, barocke Stimmungen, Koexistenz sich widersprechender Emotionen in jedem gegebenen Augenblick usw. Was die einzelnen schizoiden Typen anbetrifft, so sind die kalten anästhetischen gemütsstumpfen Subjekte unter den Mädchen viel seltener als unter den Knaben. Auch *Gregor* und *Vogtländer* weisen darauf hin, indem sie sagen, daß unter den schwererziehbaren Knaben häufiger emotionelle Stumpfheit, bei den Mädchen dagegen eher Stimmungs labilität beobachtet haben. (36)

Sukhareva's explicit use of "Schizoiden Psychopathien" in the table on page 34 demonstrates that "schizoid psychopathy", which Sukhareva explicitly replaces with "autistic psychopathy" in 1959, the two terms being used interchangeably by Russian authors throughout the 1970s, 80s and 90s and consistently equated with autism and Asperger's autism, was not exclusive to children with normal to above average intelligence and could also coincide with intellectual disability. Given that the primary differentiation between Asperger's autism and Kanner's autism has historically been without or with intellectual impairment and verbal delays, this is a significant point. And yet, Russian textbooks on child psychiatry did not group these two together as the *DSM* has done. The children are described using the same vocabulary, but for research purposes, they are studied separately, while the reader is still assumed to have knowledge of and expertise in child psychiatric and developmental conditions overall.

More information on Sukhareva's distinctions and her later thoughts on autisms can be gleaned from Nancy Rollins book *Child Psychiatry in the Soviet Union* (1972), written after the author's extensive travel and conversations with Soviet psychiatrists in 1968, including, of course, Sukhareva. A concise definition of oligophrenia comes from Sukhareva herself which Rollins received in a letter in September 1969:

We regard oligophrenia as a group of pathological states, varying in their etiology and pathogenesis, united by one general sign: They all present clinical phenomena of general psychic lack of development (associated with dysontogenesis of the brain). We assign to oligophrenia only those forms of general lack of psychic development which are characterised by two signs:

1. The existence of an intellectual defect, in various levels of its expression.
2. The absence of progressiveness. (Sukhareva in Rollins 76)

Rollins elaborates and critiques:

This latter factor Sukhareva feels is one of the distinctive features of her classification. She excludes all forms of degenerative disease or progressive deterioration, leading to dementia, and defines oligophrenia as a fixed state. I found it puzzling that having separated the dementias, Sukhareva did not list them as a separate category of gross childhood psychic disturbances. (76)

Also in Rollins, we find that the so-called Leningrad and Moscow schools differed in their interpretation of Kanner's autism and, from Rollins' perspective, not even consistently:

Kanner's syndrome of infantile autism is, particularly in Leningrad, considered a manifestation of early brain damage. In Moscow, autism is seen as schizophrenic. The controversy involves whether the gross developmental and interpersonal disturbances should be regarded as a process or a state, in either case appearing so early that development at very basic levels cannot occur. However, in Leningrad, in the preschool department of the Bekhterev Psychoneurological Institute, they showed me such a child and considered him schizophrenic. Dr. L. P. Saldina, who had worked in Moscow before coming to Leningrad, felt the difference between these two main centers was not significant. (84-85)

Sukhareva was of the Moscow school. It should again be noted that during this time, Kanner's syndrome was largely considered schizophrenic in the United States as well. Kanner appears once more in Rollins's book in a list of Western authors "particularly recognized by Soviet psychiatrists in the field of childhood schizophrenia" alongside Louise Despert, Loretta Bender and Charles Bradley (189).

While Rollins does not engage much with the schizoid (autistic) psychopathy diagnosis in *Child Psychiatry in the Soviet Union*, understandably, as there was no corresponding diagnosis in the USA at that time, she reproduces two of Sukhareva's classification systems in English, an earlier one and a later one, which are included in my appendix. These follow the same structure as the three volumes of her textbooks, and here it is easy to see that for Sukhareva, the psychopathies, including schizoid/autistic psychopathy, are distinct from any condition involving intellectual disability, which in turn is distinct from any condition resembling schizophrenia. Elsewhere in Rollins is a comment on the application of psychopathy to children with intellectual disabilities, here based on conversations with a psychoneurologist working in a boarding school for the intellectually disabled in Kiev:

The psychoneurologist was studying neurotic and psychopathic behavior syndromes among the retarded. She described hysteriform states, speech disturbances, and enuresis. [...] The diagnosis "psychopathy" is avoided, since the intellect is not normal; however, among the psychopathic-like states, she specifically mentioned hysteroid states or emotional instability and sexual deviations, including sadism. (62)

Although this is from a later period than Sukhareva's first papers on SP and comes from Kiev rather than Moscow, it does seem to tally with Sukhareva's work. Oligophrenic children are always described separately from the children with various psychopathies, and while oligophrenic children are sometimes said to have schizoid or hysteroid personalities, they are not included among studies of schizoid psychopaths. Oligophrenia is seen as "the leading syndrome" and this takes precedence over grouping according to personality. I surmise that a diagnosis of Kanner's syndrome would be made within the context of a leading syndrome of childhood schizophrenia.

Notes on the Translation

Coming from a translation background with medical terminology training, rather than a medical background with additional language skills, my approach is different to that of previous translators of similar texts, such as Sula Wolff, a trained doctor but not a trained linguist or translator. Previous translators of medical texts have made attempts to modernise the language, and have sometimes, as in the case of Diefendorf translating Kraepelin for functional purposes, altered and adapted the content, a practice that then brings interpretation into the scope of the translator's role. For medical professionals, such translations are no doubt very useful, and such approaches certainly have validity. For the historian, this practice might be seen to come at the expense of historical accuracy.¹¹⁹

Modernising the language completely becomes, from the perspective of someone with a translation background, contentious and fraught. In *Experiences in Translation*, Umberto Eco (translated by Alastair McEwen) writes that, "the rule ought to be never to enhance the author's vocabulary, even when tempted to do so." Although he is there speaking of translating texts with restricted vocabulary, this point seems relevant here also. If the source text does not read like modern native German, should the translation read like modern native English? And if it should not, how can a modern translator translate it using the English of 1926¹²⁰? That is not the goal, but neither is it to create a text that reads like it was written by an English-speaking doctor in 2019. My goal, rather, is to produce a version that documents Sukhareva's 1926 German version, with its historical and personal flavour, as fully and accurately as possible for modern English-language readers, be they medical professionals or lay people with an interest in autism history. In line with Eco's rule, this includes retaining the perceived errors and inconsistencies of the original.

In general, translators try to strike a balance between foreignisation and domestication – it is nice to retain some traits, quirks, idiosyncrasies of the original text while also enabling accessibility and readability. I do not want the text to be unintelligible, but it should be reflective of the original. I wanted to avoid imposing modern interpretations

¹¹⁹ We might here also consider the many translations of religious texts such as the Bible and the various purposes such translations attempt to fulfil.

¹²⁰ Without engaging in the extremely academic exercise of consulting a dictionary for every single word, avoiding any vocabulary first seen in English after 1926.

onto historical concepts. That is to some extent unavoidable, but should be minimised, although this is not something Sula Wolff aimed for in her translation – she made some modernising choices in 1996, such as “personality disorder” for “Psychopathie”, that are already out of date in 2019. From my perspective, there are some terms that should not be updated, especially if the diagnostic criteria have shifted, while there are others (e.g., imbecile, idiot and moron) that can be updated, because the diagnostic criteria have not changed, even though the words have.

As a translator by profession, I am experienced in translating functional texts whose primary purpose is to convey information. I also have experience translating texts from non-standard German, that is, older variants of German and German dialects. This text was more challenging than my usual work. Because the text is historical and medical, part of the difficulty is no doubt simply that I have more experience with historical ephemera and contemporary medical texts. But not only that, it was written in German by a native speaker of Russian. Sukhareva’s German is very good but still has a few quirks. Her writing is modelled on even earlier German texts with some of the theories modelled on theories since abandoned. Some of the text is difficult because it involves archaic terms no longer used in German or English, some because it involves terms that are not German but Russian, and some because it involves semi-scientific ideas and concepts that were later debunked or simply never pursued or developed further.

Another challenge is that I do not yet read Russian, only Cyrillic. When a child in a case study calls his teacher a ‘mare’, I need to enquire of Russian speakers and dictionaries about whether it is an insult or game. As I wrote in my MA thesis, this is easy to do when my own lacunae of knowledge are evident to me but very difficult when they are not. It is so hard to know what you do not know.

Previous translations of Sukhareva and of other psychiatry and psychology texts of this period, e.g. translations of Kraepelin and Kretschmer, further muddy the waters. Does one follow the example of those who have gone before? Previous translators have often been psychiatrists or psychologists themselves. Surely, one would think, they must have the terminology correct and know what they are writing about. However, A. Ross Diefendorf writes a long introduction to *Clinical Psychiatry: A Textbook for Students and Physicians* explaining just why he did not *translate* the sixth and seventh editions of Kraepelin but *adapted* them, and Sula Wolff’s translation of “Die schizoiden

Psychopathien im Kindesalter” has minor errors that betray holes in her own German proficiency¹²¹. Added to this, these translators are rarely able to agree on word choices, nor even, as we shall see below, on a uniform spelling of a person’s name.

While previous translators have contributed much historically to building translingual bridges in psychiatric research and commentary¹²², opening doors for greater recognition of past researchers, they were not especially useful tools for my translation.

Ssucharewa, Sucharewa, Sukhareva

The most glaringly obvious yet most easily solved difficulty is Sukhareva’s name. Her full name is Груня Ефимовна Сухарева. It is clear that “Ssucharewa” is a very strange transliteration of what would be ‘Grunya Efimovna Sukhareva’ (or Grunia, or Yefimovna) in English orthography, no matter which Latin alphabet orthography a reader or writer is most accustomed to. The expected transliteration into Latin script using German orthography would be ‘Grunja Efimowna Sucharewa’ (or Jefimovna) but the transliteration contains an initial double S. This spelling is not a one-off and is used consistently in almost all of her published German papers. As nothing indicates otherwise, I assume Sukhareva came up with this transliteration herself and used it deliberately.

The most reasonable explanation for the double S is that the spelling circumvents the common German pronunciation of S as IPA z and forces the pronunciation of IPA s on the reader or speaker. Sukhareva’s co-author Osipova is likewise spelt Ossipowa – with the double s. As “Ssucharewa” follows German pronunciation norms, I used “Sukhareva” according to English transliteration norms. Am I pandering to and reinforcing the normativity of English or broadening accessibility? Is this the good old translator’s chestnut of whether to foreignise or domesticate? Adam Feinstein used this spelling in *A History of Autism* following a discussion of the spelling with Olga Bogdashina, a Russian author of English-language books on autism for a popular audience. However, I can go further!

¹²¹ E.g. ‘Rock’ translated as the contemporary ‘skirt’, rather than the ‘coat’ appropriate to the time and context. In the Russian, it is a lab coat.

¹²² I am also indebted to Barbara Fasting, Douwe Draaisma’s translator.

In 1947, during Sukhareva's lifetime, her paper "Psychologic disturbances in children during war" was published in English in the *American Review of Soviet Medicine*. Her name here is "Sukhareva". In 1965, still during her lifetime, "Some Crucial Problems in the Understanding of Oligophrenia", appeared in *Soviet Psychology and Psychiatry* under the same name. These two instances of English publications might definitively¹²³ answer the question of her name's transliteration into English and put any fears about misrepresenting the author to rest were it not for a "G.E. Suhareva" appearing in 1972 for "The Problem of the Classification of Mental Retardation" published among the proceedings of the Fifth WHO Seminar on Psychiatry Diagnosis, Classification, and Statistics. But 1975 sees the "Sukhareva" spelling again in Mnukhin and Isaev's "On the Organic Nature of Some Forms of Schizoid or Autistic Psychopathy" – the authors were colleagues of Sukhareva. Authors writing on Soviet psychiatry during Soviet times¹²⁴ also used the Sukhareva spelling. Lourie and Rollins met Sukhareva in person. Despite the many appearances of Ssucharewa in English, citing her German papers, these instances are sufficient evidence that Sukhareva herself would find Sukhareva the more acceptable English spelling.

Interestingly, while any database of academic papers lists Sukhareva as "Ssucharewa" (understandably, since that is the name on the German papers), or indeed, sometimes as about ten different authors with different spellings, the German Wikipedia page about her has either corrected or misspelt her name, depending on your view, and she is now "Sucharewa". Listed as a co-author on the 1966 paper "Die Rolle der Viren in der Ätiologie der respiratorischen Infektionen bei Kindern." (Ritowa et al.), G. E. Sukhareva's sister Mariia is "M. E. Sucharewa" (single S). This is the sole paper found by M. E. Sukhareva in German. It seems that while German had been the language of psychiatry and psychology, it was not the language of virology.

The international and multilingual *Zeitschrift für Kinderpsychiatrie/Acta Paedopsychiatrica* used a variety of spellings over its years, including G. E. Ssucharewa, Grunia E. Ssucharewa, G. Ssuchareva (Tramer 1953, 121), G. E. Suharewa, and G. J. Suharewa (Sukhareva 1967), even misciting an Italian correspondence with

¹²³ "Definitively!" she says, conveniently ignoring the Sookhareva spelling used by *Sovetskaia Psikhonevrologiia* for their English and French summaries. I am ignoring this because the English in these summaries is so poor.

¹²⁴ Wortis in 1950, Lourie in 1963, Rollins in 1972.

Sukhareva as A. Ssucharewa (Stutte 1968 53). (The Italians had used Prof. Soukarewa with no initial.)

As far as G. E. Sukhareva's middle name is concerned and whether this should be Efimovna which more closely follows the Cyrillic letters or Yefimovna which more closely follows the Russian pronunciation, the standard I have applied is the Library of Congress's official Russian romanisation – Efimovna. (Applying Library of Congress romanisation to Сухарева also results in Sukhareva.) Changing Sukhareva's initials from G. E. to G. Y. would only confound future searches for her work even further. That said, I saw one English instance of G. Y. Suchareva (Lavretsky) and three of G. Ye. Sukhareva (Lourie; Kanner "Abstracts" 1971; Smulevich).

For the sake of future reference and as further demonstration of how difficult research involving multiple alphabets and languages can be, I include here some other spellings I have seen.

Czech: G. E. Suchareva

A paper by Sukhareva and citations of her work appeared in Czechoslovak journals (*Československá psychiatrie* and *Československá pediatrie*) between 1956 and 1980. The article was in Russian with summaries given in Czech and English. The same transliteration is used for both languages.

Finnish: Grunja Jefimovna Suhareva

While there was at time of writing no Polish or Chinese Wikipedia page for Sukhareva, there was a Finnish one. The bibliography appears to have been copied directly from the French Wikipedia page, listing selected works with titles in French and Russian and reproducing the same errors in years of publication and footnote numbers with absent footnotes. As far as I am aware, none of her work exists in Finnish.

French: Grounia Efimovna Soukhareva; Grounia Iefimovna Soukhareva

In their 2016 introduction to the French translation of "Die schizoiden Psychopathien im Kindesalter", A. Andronikof and P. Fontan describe her as "l'inventeur du syndrome dit d'Asperger". Their transliteration is the first; the French Wikipedia page uses the second.

German: Ssucharewa, Sucharewa, Suharewa, Ssucharewa, Szucharewa

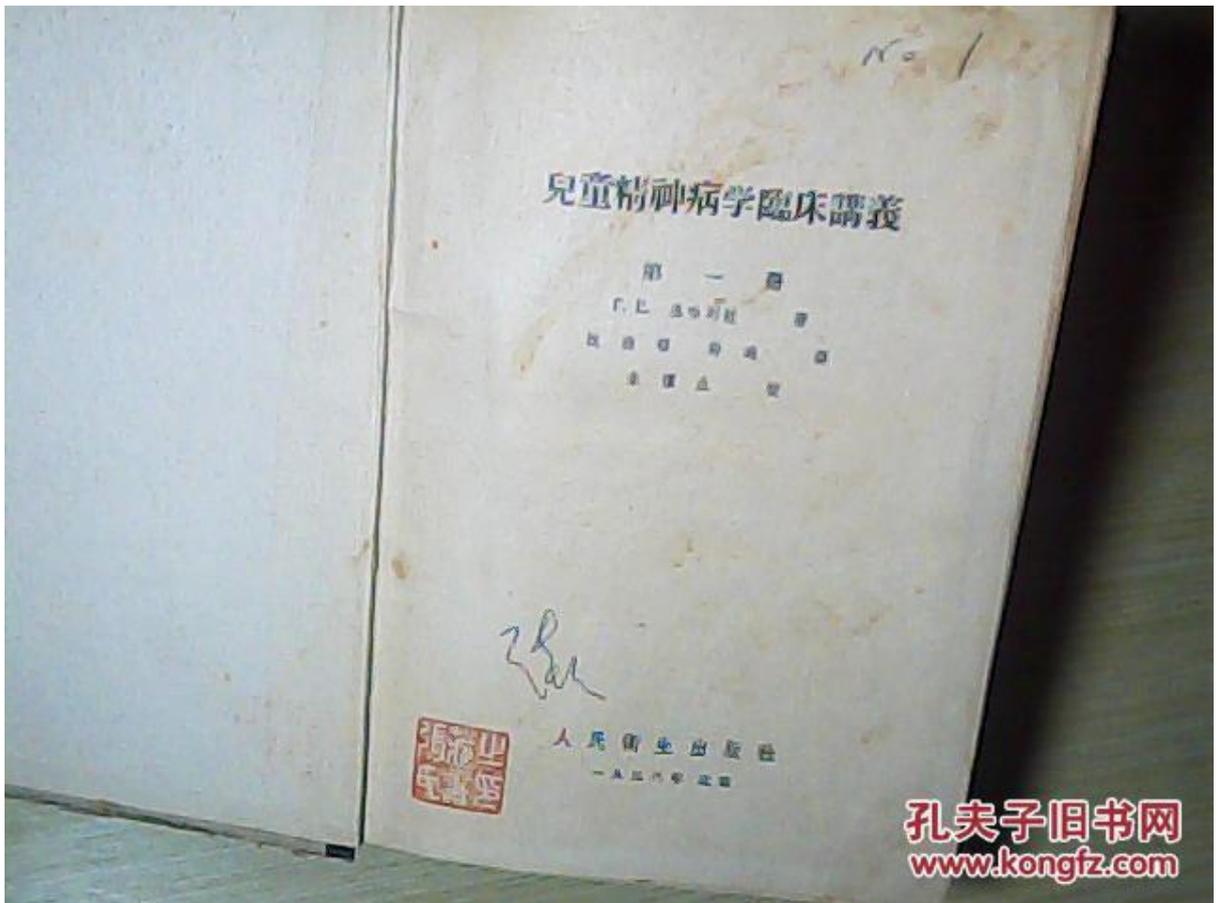
The last looks like a Hungarian spelling but is used by Werner Villinger, a psychiatrist in West Germany, in 1959.

Italian: Soukarewa

Infanzia anormale published a brief summary of the state of child psychiatry in Europe (Germany, Russia, Sweden, Switzerland) in their 1956 July to October issue, the Russian information sent to them by Sukhareva. I do not know what language Sukhareva wrote to them in, but if “Prof. Soukarewa” is truly an Italian transliteration, it is a very creative one.

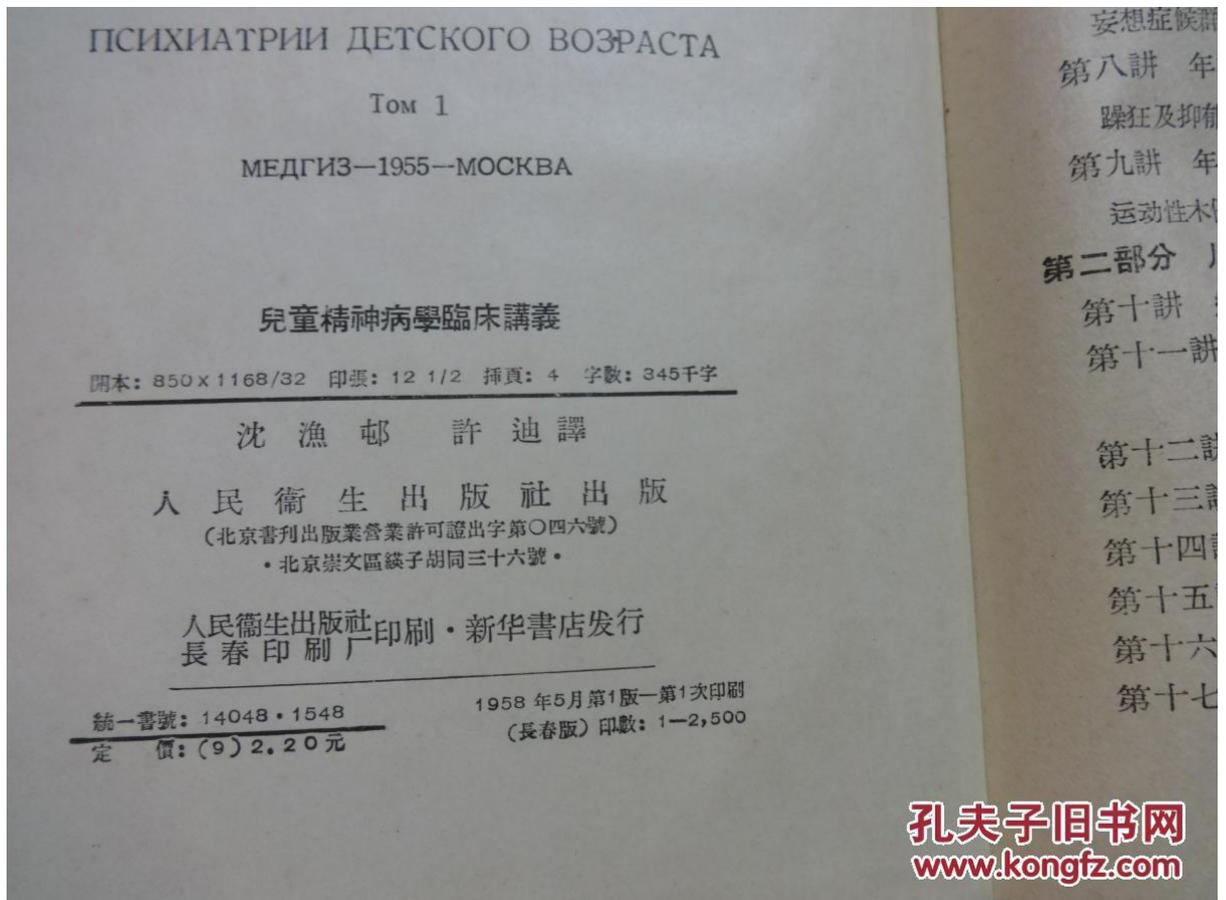
Mandarin/Pinyin: 蘇哈列娃/Suhaliewa

The first volume of Sukhareva’s clinical lectures was translated by Shen Yucun and Xu Di and published in Beijing in 1958 before the current level of character simplification. As 1958 was around the beginning of the Sino-Soviet split, this was really the only chance for Sukhareva’s textbook of 1956 to be translated into Chinese. Corresponding to the political situation of the time, I have found no signs of translations of subsequent volumes. The publisher’s details are recorded incorrectly on WorldCat. The blame for this seems to lie with university libraries in Hong Kong. Note the title page for the book showing Sukhareva’s surname in Chinese characters and her initials in Cyrillic! Dr Catherine Churchman from our Asian Studies programme informs me that this kind of code-switching is not unusual.



Title page of Mandarin translation of *Clinical Lectures* vol. 1

Seller 明瑞书屋, Kongfz.com



Publishing details from Mandarin translation of *Clinical Lectures* vol. 1

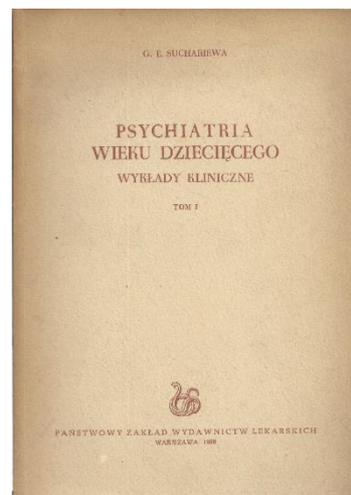
Seller 小胡再就业书店, Kongfz.com

Polish: G. E. Suchariewa; Grunâ Efimovna Suhareva; Grunia Efimovna Sukhareva

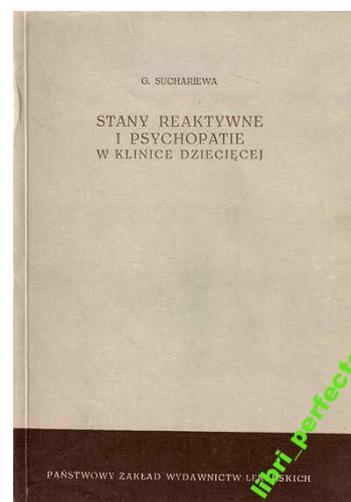
Volume 1 of Sukhareva's clinical lectures in child psychiatry (*Psychiatria wieku dziecięcego: wykłady kliniczne*) was published in Warsaw in 1958. It was edited by Eugeniusz Wilczkowski and Wojciech Pogorzelski and translated into Polish by Helena Flatau, Wojciech Pogorzelski and Edward Sobolewski. The author's name is spelt G. E. Suchariewa on the cover. Wilczkowski and Pogorzelski sometimes appear misentered in databases under the Polish genitive forms Wilczkowskiego and Pogorzelskiego, an additional complication for a researcher. Given the involvement of two editors and three translators, I would be interested to know how closely this textbook corresponds to the Russian, whether a full team creates a more diligent translation or whether it is an adaptation for Polish requirements, like Diefendorf's version of Kraepelin, adapted for the USA.

Stany reaktywne i psychopatie w klinice dziecięcej, translated by Helena Flatau, was published in 1965 under G. Suchariewa (no E initial). Polish library catalogues give *Kliničeskije lekcii po psichiatrii detskogo vozrasta* as an alternative title for this book, which is the Polish transliteration of the Russian title of Sukhareva's book of clinical lectures in child psychiatry. With its mention of "reactive states and psychopathies", the Polish title is different to the Russian volume 2. While I cannot find this used as a subtitle in the Russian, a similar heading appears in Nancy Rollins's 1972 English translation of Sukhareva's nosology: "Volume II, Minor Psychiatry: Borderline States" under which we find "I. Reactive states – neuroses and psychoses" and then "II. Neuropathy" and "III. Psychopathy" (255).

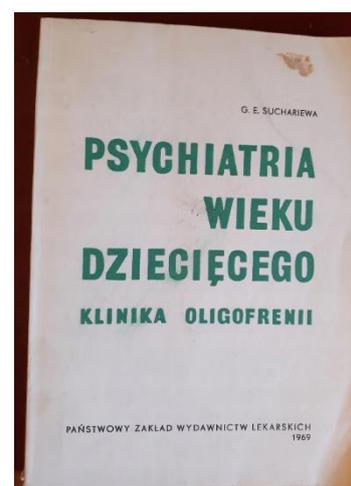
Psychiatria wieku dziecięcego: klinika oligofrenii was published in Warsaw in 1969, translated by Ewa Andrzejewska and Halina Traczyńska-Kubin, the latter being the author of several articles on psychiatry herself. This corresponds to



Polish Clinical Lectures vol. 1
Seller kokputer2, Allego.pl



Polish Clinical Lectures vol. 2
Seller libri_perfecte, Allego.pl



Polish Clinical Lectures vol. 3
Seller otokszazka on Allego.pl

volume 3 of the clinical lectures. The cover provides G. E. Suchariewa. The three volumes are remarkably different in cover design and give no outward indication of being connected.

In Polish library catalogues, Sukhareva is variously recorded as Grunâ Efimovna Suhareva and Grunia Efimovna Sukhareva, although the spelling Suchariewa is usually provided with the book's title. Helena Flatau is also recorded as Helena Flatau-Kruszewska.

Russians doing English/French: G. E. Sookareva

This spelling appears with the English and French summaries in *Sovetskaia Psikhonevrologiia* in 1935. The English and French is non-native.

Spanish: G. E. Sukhareva

A paper on the classification of oligophrenia or mental retardation was published as *El problema de la clasificacion del retardo mental* in the Pan-American Sanitary Bureau's journal in 1971.

Ukrainian: Груня Юхимівна Сухарєва

I found one Ukrainian library record (Kharkiv University library) for Sukhareva and one small biographical article about her online. The article was a direct translation from a Russian article. The only "original" Ukrainian work I found on her was a blog post listing four pieces of advice attributed to Sukhareva (and seen elsewhere in Russian) on bringing up difficult children. The four short biographical sentences emphasise Kiev and Kharkiv as Sukhareva's places of work over Moscow.

Vietnamese: G. E. Sukhareva

As a fellow communist country that maintained ties with the Soviet Union until its collapse, Vietnam might have had familiarity with Sukhareva's work and that of Soviet psychiatrists more generally. Like Ukrainian, Vietnamese is a language with a small online presence. I found one citation of Sukhareva in Vietnamese in a 2017 paper (Son). A site search of the paper's hosting site uncovered no further citations for Sukhareva, but many for her colleague, T. P. Simson, credited by Bashina and Pivovarova along with Kanner as the 'first' describer of Kanner's autism.

Orthographical issues are by no means restricted to historians looking in library catalogues but affect the lives of real people today. A 2007 Polish news article (“Wzięli ślub - ale nie są małżeństwem”) reported on Russian “Rosji Ludmiła Suchariewa” married to Polish Czesław Reszke and the bureaucratic problems the couple encountered due to different, yet correct, transliterations of Sukhareva’s name from Cyrillic into Polish, sometimes being told they were not married.



Illustration accompanying news article TVN24.pl

With documents from sworn translators giving either Soukhareva or Suchariewa, government records for the woman did not always match.

Historical vs. Modern Language

Leucocytes or leukocytes? Most dictionaries inform that both are acceptable. In Australian and New Zealand medical terminology, the combining form leuko- is used solely in relation to leukaemia. Leuco- is used for all other instances (Walker et al. 515). While I like the Russian and German air the k gives to leukocyte, I followed current standard use within my country (Aotearoa New Zealand) and used leucocyte.

When Sukhareva writes of *Automatismus* (192), what is she talking about?

Contemporary German has *Befehlsautomatismus* which encompasses both echolalia and echopraxia. With this knowledge, it would be easy for me to assume that that is the intended meaning, and thus easy to impose current definitions of ASDs on her case studies, case studies that were recorded prior to current definitions and conceptions of autism, and thereby further validating the belief that she is writing about the same thing. If I was taking a teleological view of this and expecting Sukhareva’s descriptions of SP children to be directly translatable into current autistic children, I could make this leap. As a translator, I can see that just as words do not match one for one, definitions of disorders and diseases are constructs as unstable as the languages we use to discuss them. Here I have used automatism without attempting to interpret it. We have no way of travelling back in time to find out whether this refers to echolalia and echopraxia or something else. In Sukhareva’s later published Russian clinical lectures, echolalia and echopraxia are explicitly used for other reasons. On 194, she mentions “einen ausgesprochenen Automatismus des Denkens”. Here I also wonder if this is what we now call perseveration, as indicated by this passage in “[Schizoid psychopathies]”:

He recognises signs of obsessiveness and automatism in himself: “Often there’s a word going round and round in my head, there’s no way I can get rid of it, and then suddenly I think that if I can’t, then something’s going to happen to me. It’s difficult for me to start something, I take ages thinking about it, then I can’t tear myself away.”¹²⁵ (171)

but again, I have left this as “automatism of thought”.

Motorik is frequently discussed. I translated this as “motor skills”, a phrase very familiar in contemporary texts on ASDs. However, there is nothing in Sukhareva’s text that can be translated as ‘gross motor skills’ or ‘fine motor skills’. The passage “Die motorische Störung äußert sich in der Form einer allgemeinen Eckigkeit und Plumpheit der Bewegungen bei genügender Muskelkraft und guter Handfertigkeit” (195), certainly seems to *describe* poor gross motor skills with normal or good fine motor skills but cannot be directly translated using these words, as their equivalents are not present. Poor gross motor skills with normal fine motor skills is a modern understanding of the sentence. On 196, we come across, “Weiter hatten wir bei den Knaben eine krasse [...] Unfähigkeit zum Zeichnen, Schreiben usw. beobachtet”. I identify this as ‘dysgraphia’, but again, do not feel it is appropriate to use this word. One can infer dysgraphia, given that it follows on from an extreme retardation in manual skill and sport and is seen in relation to poor drawing skill, but as with English, writing could mean handwriting or writing craft. If I had wished to remove ambiguity, I would indeed have used handwriting, but this is not present in the source. In the same vein, the extreme retardation in manual skill and sport could easily be replaced with dyspraxia.

The original text is often inconsistent: sometimes Latin medical terminology is used and at other times German to describe the same thing. On 175 we have “Magendarmtraktus in Ordnung.” In the next case on 179, this is “Tractus gastro-intestinalis – Neigung zu Verstopfungen.” I kept this inconsistency, as well as the inconsistent switching between the abbreviations “Norm.” and “N.” and inconsistent capitalisation (“abs.” cf. “Norm.”). Contemporary English medical terminology has shifted further from Latin than German has. For example, ‘nervus facialis’ and ‘nucleus nervi faciales’ (the second abbreviated variously as “Nn. faciales” and “N. n. faciales” in Sukhareva’s text) are both still standard terms in German. In English, these are ‘facial nerve’ and ‘facial motor

¹²⁵ Translation Richard Millington.

nucleus'. Unlike tractus gastro-intestinalis, I modernised this. I also modernised “status psychicus”, “status physicus”, “status praesens¹²⁶” and “pulsus” but kept “partus”, which felt more familiar than “pulsus”.

Some language has undergone semantic change for sociocultural reasons. An example is words subject to the euphemism treadmill such as those categorising intellectual ability (and my own phrasing here will almost certainly be considered inappropriate twenty or thirty years hence). Feeble-mindedness was formerly the broad term for intellectual disability, further subdivided by IQ range into moron (50-70), imbecile (25-50) and idiot (0-25). In Russian, these categories are дебильность (moron or debility), имбецильность (imbecile), and идиотия (idiot). These are the subcategories of the previously mentioned oligophrenia. Имбецильность (imbecile) was still in use in the Russian ICD-9 and equated to codes F71 and F72 for moderate and severe mental retardation. Дебильность (moron or debility) was F70, mild mental retardation, and идиотия was F73, profound mental retardation. As in English, all of these are in the process of being replaced with new language (directly translated from the English-language *ICD*), but the Russian euphemism treadmill appears to run at a much slower pace, and the moron, imbecile and idiot equivalents are still used by professionals today. In German, these terms were *Debität*, *Imbezilität*, and *Idiotie* (now *leichte, mittelgradige* and *schwere Intelligenzminderung*). The terminology was pretty much the same in Russian, German and English. Therefore, “Mutter, 47 Jahre, arbeitet als Wärterin in einem Krankenhaus, macht den Eindruck einer Debilen” (181) can be correctly interpreted as “gives the impression of a moron” in the language of the period, or as “gives the impression of someone whose IQ lies between 50 and 70” / “mild mental retardation” in the language of *ICD-10* and “gives the impression of mild intellectual disability” in the language of the forthcoming *ICD*. The second time the mother’s intellectual capacity is referred to (183), this is not as a possibility but a certainty: “Erbliche Belastung: [...] Debilitas bei der Mutter.”

I opted for “gives the impression of intellectual delay” for the first instance where there is no firm diagnosis, and “mild mental retardation” for the second where the diagnosis appears fixed. “Mild mental retardation” feels like a midway point between the historically accurate “moronic”, which is too outdated for ease of comprehension, and

¹²⁶ “Materialien” used “*Status* bei der Aufnahme”.

the almost too contemporary “mild intellectual disability”. I had also already used “intellectual disability” for “intellektuelle Unzulänglichkeit” (182), applied to the daughter. *Debilitas* is an instance where I prefer that a modicum of reading discomfort remains. Even now, the language used to talk about intellectual disability varies around the world: in the UK, it is now “learning disability”, while in Australia and New Zealand, a learning disability need not necessarily have anything to do with intelligence and could instead mean a number of disorders unrelated to intellectual ability including dyslexia, dyscalculia, ADHD or an ASD¹²⁷. How long will such a translation remain comprehensible? The euphemism treadmill keeps moving and just as ‘moronic’ is no longer easily understandable, ‘mild mental retardation’ may well soon be equally obscure.

As discussed previously, Sula Wolff, whose English translation of Sukhareva’s first paper on schizoid psychopathy was published in 1996, changed “schizoid psychopathy” to “schizoid personality disorder”, presumably feeling that ‘psychopathy’ was too imbued with stigma while ‘personality disorder’ was not. Now, of course, they both are. In 1972, Nancy Rollins used “Psychopathy (pathological development of the personality)” and “schizoid (autistic) personality” (256). I enjoy the abrasiveness ‘psychopathy’ has for the contemporary reader. Unlike *Debile* and *Debilitas*, each used only once, schizoid psychopathy is the main subject of the paper. As the term is defined by the author and discussed at length, I see no need to modernise it. Here, the reader is given time to understand the term within the context, which would not have been the case if I had called the mother a moron.

Russianisms

Having ‘faithfully’ translated “fremde Erlebnisse” as foreign experiences and continued with “foreign” throughout, my reader Dr Richard Millington observed that Sukhareva was using “fremd” in instances where the Russian would say ‘чужой’. “This is not quite the same thing – ‘чужой’ simply means belonging to another person, not one’s own,” he said. I then replaced this with “others’ experiences”.

Grundsymptomen and *akzessorische Symptomen* appear on 192. My first translation of these was basic symptoms and accessory symptoms. After reading Sukhareva’s later

¹²⁷ The UK also prefers ASC, autism spectrum condition, to ASD, autism spectrum disorder.

Russian work on the same topic, particularly her 1930 paper (summarised in chapter 5), I changed this to primary symptoms and secondary symptoms as a better reflection of her ideas as they were expressed in Russian.

Umgebung is usually ‘surroundings’ in English and is literally ‘that which surrounds’. This should be a reasonable translation and does not conflict with a passage like “eine mißtrauische Einstellung zu der Umgebung” (196), but “erhöhte Eindrucksfähigkeit bei der Bewertung des Verhaltens der Umgebung ihr [das Mädchen] gegenüber” (177) and “eine unrichtige Deutung des Verhaltens der Umgebung ihnen [die Mädchen] gegenüber” become rather more odd if we try to imagine the surroundings behaving towards someone in a way that can be correctly or incorrectly interpreted, particularly knowing that Sukhareva does not consider any of her subjects psychotic. Millington pointed me towards the word *окружающие*, and indeed, in Russian-German dictionaries, *окружающие* turns up *die Umgebung* (surroundings), *die Umwelt* (environment) and *die Anwesenden* (people, persons present). Neither translation works for all cases and some could go either way. Some instances of *Umgebung* are clearly *die Umgebung*, some are clearly *die Anwesenden*, and others (“Zu diesen Zeiten macht sie nicht den Eindruck einer Zurückgebliebenen, gibt gescheite Antworten, findet sich sehr gut in der Umgebung zurecht.” (182)) are unclear. I used the *die Anwesenden* interpretation only for instances where it could not possibly be *Umgebung*, i.e. when the ‘Umgebung’ appears to be active or participatory in a way that surroundings usually are not (177, 192, 196). On 179, I used “immediate surroundings” for “unmittelbares Milieu”.

Other medical terms of Latin or Greek derivation, easily translatable into English cognates, are peculiarly specific to Russia. While understandable to those in medicine from its components¹²⁸, oligophrenia, defined by the third edition of *A Dictionary of Psychology* as “an old-fashioned term for mental retardation” and by the fourth as “an old-fashioned term for intellectual disability”, has been little used in English but was the standard Soviet term and continues in Russian usage as an umbrella term today, much the same way that ‘mental retardation’ still exists as an umbrella term in *ICD-10* (and indeed, олигофрения is used precisely here, F70-F79, in the Russian version). Just as mental retardation is in the process of being removed from current English usage,

¹²⁸ oligo-: scanty, few, deficient; phren-: the mind; -ia: condition

oligophrenia seems to be in the process of being replaced with умственная отсталость. Mental retardation will not be used in the English *ICD-11*. It is nice to retain oligophrenia, particularly since Sukhareva's name is so closely associated with it in Russia.

Tuberculous intoxication is another such term appearing exclusively in Russian and Ukrainian literature. As recently as 2016, there was a paper on tuberculosis in children in the Saratov region mentioning tuberculous intoxication. This is potentially toxæmia/bacteraemia but, not being an infectiologist, I left this as it was, remembering also that tuberculous intoxication may be a concept in Russian-language medicine unaccounted for by English. Интоксикация does seem to have a somewhat broader meaning than 'intoxication'.

5 Summaries

Here I provide summaries of Sukhareva's two main Russian texts on schizoid/autistic psychopathy not existing in German (as far as I know). The first is a paper from 1930 detailing the life course of individuals with the syndrome and the syndrome's prognosis; the second is from volume 2 of Sukhareva's textbook. These show Sukhareva's wider work on the topic, aspects that remained consistent over time and areas where her thoughts changed. Page numbers in the source texts are indicated in brackets.

On the Problem of the Structure and Dynamics of Children's Constitutional Psychopathy (Schizoid Form) (1930)

[64] This paper elaborates on the findings of the research undertaken for the two-part collection of case studies, giving an overview of the life of the schizoid psychopath and the development of the psychopathological picture according to the child's age and the social and domestic life situations in which the child finds itself. [65]

Psychopathological symptoms are divided into primary, innate traits that are a matter of constitution, and secondary, reactive traits that vary according to life events and situations. The paper introduces a triad of impairments.

[66] In this report, we learn that 31 children were studied altogether over a period of 5 to 7 years. There were 18 boys and 13 girls. 19 of the children had already gone through puberty. The children had been at either the Psychoneurological Children's Clinic in the National Children's Hospital or at an orphanage¹²⁹ for girls with behavioural problems. The researchers were interested in establishing when symptoms of schizoid psychopathy first appeared. Due to the ages of the children studied, they were unable to determine this conclusively, but according to parental reports, symptoms were first noticed at age 2-3 in 6 cases, first noticed at age 4-5 in 14 cases and first noticed at school age in 2 cases. There was no information regarding 9 children in orphanages.

The earliest symptoms to become apparent are psychomotor symptoms. The children seem to switch between excitation and lethargy. Their movements are described as

¹²⁹ Orphans could be either "full" or "half" orphans.

stereotyped and aimless with little focus on play or occupation. The children are also reported as having a stiffness, clumsiness and angularity to their movements. They eat and chew slowly, they dress slowly, they begin an activity and abruptly stop. [67] They also switch between automatic obedience or submissiveness and “negativism” (i.e. complete refusal to do something requested of them, even if they want to do it). Other early symptoms include a “weak” need for emotional connection and “weak” attachment to others¹³⁰. The children come across as unaffectionate or cold.

Emotional symptoms for the girls in particular can appear during the preschool (4-5) period. The girls are noted to have inadequate emotional responses, strange combinations of moods, strong ambivalence. The intellectual features of schizoids appear later than the psychomotor features but still before they enter school. These are things like inclination to abstract thought, formalness, whimsy, and “automatism of associations”, as well as the intense focus of their interests. It is also observed that they do not play games with other children but prefer to invent their own games, and do not participate in kindergarten activities. They ask very many questions, almost to an obsessive degree, and often of the abstract kind, questions about life and death, sometimes hypochondriac in nature. The child who insisted he would not live long¹³¹ is given here as an example, and there is a new example of a child who dreaded each birthday from the time he was 5, fearing to become an adult.

The paper then moves on to schooling. It notes that this is a time when people are expected to begin “training” and the first time when they are really expected to begin integrating into the team. This is where the social features of schizoid psychopathy really become noticeable. Lack of social skills are not fully seen among the preschool aged schizoid psychopaths, nor is there any real isolation or seclusion even if there have been some elements of such behaviour. Now in school, children are seen to be unable to adapt *adequately* to the social environment. That is, they adapt, but not to the required extent. This continues to be a feature of schizoid psychopathy throughout their lives. The difficulties associated with school are not so much with schoolwork but with fitting into the “social collective”. This can be a traumatic experience for children. [68] Their poor motor skills, awkwardness and eccentricity all contribute to them becoming an

¹³⁰ Notably not a complete lack of a need for emotional connection or a complete absence of attachment. The children need emotional connection and are attached to others but not to the extent expected.

¹³¹ Case 1 or “Sh.” in the papers on schizoid psychopathy in boys.

object of ridicule or the butt of jokes, and the schizoid psychopath child withdraws and self-isolates. So here the isolation is not innate but a result of lack of social acceptance. They are not picked for team sports or group games and so devise solitary games.

Also during the pre-puberty period, appearing sometimes in preschool but growing stronger in school, is a tendency to goofiness, silliness, and speech or dress that is considered affected or “mannerist” by the researchers. These features are considered an adaptation on the part of the child to being in school, as a self-defence mechanism to deflect jokes by becoming the joker.

The researchers talk about the appearance during the school period of “new syndromes”¹³². The two new syndromes are psychasthenia¹³³ and paranoia¹³⁴. The psychasthenic syndrome is considered reactive – their position as outsiders and objects of ridicule leads to feelings of inferiority, fear of others, timidity and indecisiveness. The researchers conclude it is reactive as such traits disappear when the children are placed in better situations with more social acceptance. The paranoid syndrome is equally reactive and is more likely to be seen when schizoid features of the child include emotional coldness along with increased self-esteem and egocentrism. Such children who strive to constantly do and be better than they are and better than the others with a simultaneous awareness of their own inadequacies tend to grow suspicious and distrustful of others. These children are also highly principled, and rigidly inflexible. They have a strong, even exaggerated, sense of justice, a constant desire for the truth, and can be highly demanding of others as a result. [69] This is what the researchers call the paranoid syndrome – one less noticeable in earlier childhood but which grows along with the child and their personality.

The researchers have seen greater variation among the children during puberty than in the other constitutional psychopathies¹³⁵. Puberty in general is characterised by sexual interest overtaking all other interests but the way schizoids express this is considered unusual. They seem less interested in the opposite sex – many are more interested in themselves. Homosexuality or other variations of sexual interest (“pronounced

¹³² Perhaps not fully co-morbidities in the current understanding, but close to this.

¹³³ Traits of obsessiveness, compulsiveness, anxiety and phobias, to a lesser extent than OCD, insomnia, neuroticism.

¹³⁴ It’s not paranoia if everyone is after you!

¹³⁵ E.g. ADHD

perversions”) are considered more common in schizoids than in the general population. The disruption caused by puberty is considered more severe among schizoid psychopathies, with 4 children experiencing “psychopathic crises” during this period as a result.

What does a psychopathic crisis in a pubescent child look like? According to this paper, it is a deterioration of general functioning with an exacerbation of schizoid features. The impairments caused by puberty last several months to a year and the children recover once they have passed puberty. [70] Moving into their teenage or adolescent years, they become more balanced and calm. Two cases were exceptions here for whom puberty triggered a schizophrenic process. In general, schizoid psychopathy is not considered schizophrenia as it is not degenerative, and success or failure, improvement or lessening of symptoms, is more contingent on general life circumstances.

Of the children who successfully navigated puberty, 6 were able to work in “production” and live independently, 9 graduated from school, 7 went on to further education, either courses or university. The writers say that adapting to life has still been difficult for these adolescents, they are often helpless and confused about “vital issues” and they need external support in place, but they also note that they selected the most pronounced forms of schizoid psychopathy for the purposes of the study. More severe instances of schizoid psychopathy who have “low productivity” may be indistinguishable from sluggish schizophrenia and the researchers voice less confidence about delineating more serious forms.

The clinical picture of schizoid psychopathy includes both inherent traits that become more observable and differentiated from the regular population with age [71] and also secondary reactive traits that may be used to compensate. The triad of impairments they have managed to establish is: 1. psychomotor impairment – awkwardness, angular movements, bipolarity between excitation and lethargy, automatism, stereotypies; 2. emotional impairment – weak affective attachment to others, lack of unity of emotional experiences; 3. a difference in associative work and thinking – unusual associations, inclination to abstract thinking, automated thoughts, rigidity/inflexible thinking.

This triad is considered to be a core “biological insufficiency” in schizoid psychopathy. These are the features that are not reactive and remain unchanged by environmental circumstances.

They then move on to secondary and reactive features of schizoid psychopathy with notes that this topic, and in particular, the topic of the schizoid psychopath’s sense of self, warrants further attention and study. [72] The schizoid psyche is vulnerable to particular “irritants”. One source of distress is events that infringe upon the schizoid psychopath’s sense of self. Such events often led to conflict. Education involving coercion or strict punishment, situations that hurt their sense of self-esteem and make them feel inferior. Family problems such as conflict between parents, being separated from a parent, being jealous of another family member, can be causes of trauma for schizoid psychopath children.

The most commonly observed reaction in schizoid children to distressing (“harmful”) events like those listed above was a neurotic state. For brevity’s sake, the researchers do not go into great detail on the diversity of neurotic states observed, but it ranged from mild forms such as increased irritability, sleep disorders, night fears, to more severe forms with obsessive and hysterical reactions. They also emphasise that the children take a long time to recover from neurotic states and do so of their own accord: they “fix themselves”; therapy has no effect.

The second reaction described is one of personality changes. In unfavourable situations, schizoids become more schizoid: [73] slower, more absent-minded, more withdrawn, more autistic. They also develop new non-specific character traits such as rudeness, anger, cruelty and distrust. Schizoid psychopaths who live under harsh conditions and are unable to succeed in life become colder, bitter, distrustful and stubborn. Their negative traits are more pronounced, and they become more depressed. This was also true of schizoid psychopaths who had had to live in orphanages. Some exhibited character changes towards “emotional stupidity”.

The conclusion of the paper is that while many features of schizoid psychopathy are fixed or inherent, others are affected by circumstance and experiences. The fixed constitution determines the types of reactions or responses the individual has but there is

a broad range of possible experiences life can throw at them. They list three points to finish: [74]

1. the way schizoid psychopathy develops throughout a person's life is dynamic and can be considered the adaptation of any given person within a given environment.
2. schizoid psychopathy manifests in early childhood. Symptoms develop unevenly and under the influence of external events.
3. there are two kinds of symptoms: primary symptoms of "biological insufficiency", secondary symptoms seen as reactive states and personality changes caused by "a complex interaction of endogenous and exogenous factors".

Comment

This, combined with the two papers of schizoid psychopathy in boys and girls, presents a far more detailed clinical picture of the syndrome than Asperger's paper of 1943. I believe most of this 1930 paper aligns with our knowledge of Asperger's-style autism today.

Lecture 19 in *Clinical Lectures in Child Psychiatry* (1959)

Clinic for group-two psychopaths (continuation): autistic (pathologically withdrawn¹³⁶) and psychasthenic personality.

[278] Kraepelin called this group “eccentrics”, Kretschmer, Bleuler and Gannushkin (who described a schizophrenic constitution before Kretschmer) used “schizoid”.

Gurevich and Giliarovskii used “pathologically withdrawn”. The authors of this work have been using the term “schizoid” in previous works but now believe this needs to be replaced with “autistic, pathologically withdrawn individuals”¹³⁷.

According to Gannushkin, autistic psychopathy in adults features these symptoms: autistic isolation from the external world, lack of inner unity and consistency in the psyche, paradoxical or disharmonious emotional life and behaviour. Gannushkin also observed a subtle aesthetic sense, great pathos and an ability to be self-sacrificing in matters of principle and humanity. They show a lot of sensitivity for fictional people but struggle to understand the emotions of the real people around them.

[279] These psychopathies in children were described by many authors (Gurevich, Morgan, Simson¹³⁸, Pevzner, Ozeretskiĭ) and the group of schizoid or autistic psychopathies was also delineated by the author and her colleagues in their study of constitutional psychopathies in 1925. This is an uncommon type appearing more often in boys than in girls and is difficult to distinguish from schizophrenia. Such children are noticeably different from others at an early age (e.g. 3-4 years old). Some of the children overly react to external stimulus, noises and new things, others have “excessive motor anxiety”, others are very lethargic or passive.

Their play is noticeably different from other children and there is a metaphorical fence between them and their peers. They prefer the company of adults with whom they can have conversations about topics other children are not interested in. Their mental development seems accelerated while their motor skills may be underdeveloped. They usually learn to read very early, often teaching themselves without adult input by

¹³⁶ Or pathologically closed. Mnuikin and Isaev (1975) translate this as “pathologically reserved”.

¹³⁷ Мы также считаем целесообразным заменить термин «шизоид» (которым мы пользовались в прошлых работах) названием аутичные, патологически замкнутые личности.

¹³⁸ In 1971, Kanner affirms that T. P. Simson’s 1929 description is indeed autism (“Abstracts” 110).

reading posters and ads. They ask excessive questions and accumulate information quickly. The questions they ask are not usual ones for children.

They are interested in abstract questions, the origins of the world, causes of life and death, geography. Many are extremely good at maths or intellectually gifted. This group can also include child prodigies although these children may be unable to eat, dress, or wash properly, tie their shoelaces, make their bed. Writing is noticeably difficult for them and they tend to have poor handwriting due to their weak motor skills. [280] They do not enjoy games involving physical activity.

The children often appear to move awkwardly and have an unusual gait. They are aware of their poor motor skills. They display less variety of facial expression and their expressions are often serious and adult-like. They also have adult-like tone of voice and a rich vocabulary, as well as good memory for words and numbers. They are extremely well-read and have large stores of information. They are very fond of reasoning. Their reasoning processes take circuitous routes and use many unnecessary words but are correct and involve a high level of logic. They are capable of generalisations and abstractions, and in general deal better with abstract concepts than concrete images. Some are very schematic and logical.

Some may be shy, others may be very talkative, particularly to adults on abstract topics, but they are reticent about personal experience and it takes a long time to gain their trust. They are very introspective and are well aware of their inadequacies.

[281] They do not do well in teams. They have difficulty with other children who tend to bully them. Under the right teaching conditions, they can gradually gain the respect of other children and become valued for their knowledge and sense of fairness.

They seem lacking in emotion on the outside but often have quite intense emotional experiences going on underneath. They have elements of both emotional coldness and sensitivity and can be deeply affected by family disagreements. Some seem to be misanthropes yet are very sensitive to art and nature. For most, their most vulnerable point is their awareness of their inadequacy accompanied by a conviction of their own superiority.

[282] Their instinct for self-preservation and defence appears underdeveloped, while often their sexual impulse is heightened and usually manifests as masturbation. They experience greatest pleasure when reading books and prefer books to playing with other children. They have less need for human interaction than is usual which is why ‘autism’ is one of the main symptoms. Most such children are reserved and reluctant to share their experiences.

They perform satisfactorily in school and can be top of the class, but they often underachieve or underperform for their intellectual abilities. They are absent-minded and easily distracted by internal stimuli. It is difficult for them to both start work and finish work, and they struggle with time management, often being late. When unsupervised, they do not organise themselves. They don’t fit in well within the education system, sometimes because of lack of motivation and stubbornness, sometimes because of excessive pedantry and rule-keeping. They can bother the other children by playing up. They can also be difficult to put up with because of their pedantry, inflexibility and insistence on fairness.

[283] Physiological deficits often seen in these children include autonomic nervous system dysfunction¹³⁹, low blood pressure, and colitis, while as teenagers they often display uneven appetite and hypoglycaemia through forgetting to eat.

*Case study of a 10-year-old boy*¹⁴⁰. He previously had school refusal due to social difficulties and came to the sanatorium school¹⁴¹ because teachers were unhappy with him – he completed his work, but was absent-minded and fidgety, read books and talked to himself during class.

[284] He had little facial expression, correct speech with a large vocabulary and produced long sentences. In the sanatorium school, he did not adjust well to the new situation. He was very truthful and fair and acquired a level of authority among the children, although he did not make any real friends. He often forgot about school tasks he was supposed to complete or left his books on the tram. He initially did not participate in class, but read books he had brought with him, paying little attention to

¹³⁹ Vegetative-vascular dystonia.

¹⁴⁰ While this child does not appear in the previous papers on schizoid psychopathy, the case study is presumably from the same period, as the boy was drafted into the army during WWII and killed.

¹⁴¹ A remedial day-school.

the people around him. Later he began to work independently but often without finishing tasks. He was not susceptible to outside influence and was completely independent in his actions and opinions. In general, he was depressed. He refused to take part in PE and did not enjoy physical work. His favourite activity was reading about history and social science. He wanted to learn about all the revolutions in the world. While in the sanatorium school, his social skills improved and after a year, he went to a regular school and later on to higher education but never really got on with his peers. He was drafted into the army during the Great Patriotic War and was killed at the front.

Autistic psychopathy is less common in girls with less typical patterns. The typical traits of autistic psychopathy, such as the thinking style, inclination for the abstract and schematisation, are less pronounced. They have less obvious motor deficits and better abilities with facial expressions, body language and voice modulation. Girls have more affective disturbances with contradictory emotions and bizarre combinations. Their mood is labile but is distinguishable from the lability of bipolar affective disorders. They have a combination of emotional sensitivity and dullness, often appearing cold on the outside while experiencing intense inner tension. [285] The capriciousness and quirkiness of their moods often gives the impression of a mood disorder; however, their attitude is autistic. They are asocial, reserved and do not get on well with their peers. Their need for contact with others is weakly expressed, as with the boys.

The researchers have studied the dynamics of autistic psychopathy over many years and how it varies according to age and environmental factors. They noted that the main traits appear very early and are most noticeable when the children enter school. Autistic psychopaths have adequate, sometimes high, intelligence, motor deficits and poor self-service skills. They are not very cheerful. They are sad, serious and are not drawn to other children. During preschool, they observe other children's games but do not take part. When they enter school, their deficits in social interaction become more evident, they are emotionally reserved and prefer adults or older children who share their intellectual interests. Their thinking patterns are more noticeable during school too, such as their tendency to abstraction and reasoning. Puberty is frequently very difficult for them and exacerbates their pathological traits. They become more prone to philosophising and rhyming. Their mood becomes more disordered and they become

more irritable and rude. Secondary neurotic syndromes develop more during this period as they experience life failures and difficult situations.

The most frequent pathological reactions seen in children with autistic psychopathy are:

1. neurotic syndromes, 2. foolish states, 3. temporary reactive states resembling catatonia.

1. Neuroticism. They experience fears, sleep and appetite disorders following conflict, and a sense of inferiority. The awareness of inferiority often leads to depression, and the dissatisfaction with themselves and other children often leads to escapism. Many have a constant fear of the future.

[286] 2. Foolishness. One way of coping with their failures and poor adaptation is clowning and ridiculous games. This is stronger during puberty. Some are able to explain their behaviour as a desire to attract attention and gain acceptance.

3. Catatonic-like states. Children with autistic psychopathy often enter reactive states resembling catatonia following mental trauma, some resembling a speech disorder with stuttering. They are more frequent in younger children but can also be seen in teenagers. A 17-year-old boy would go to bed and cry for several days without talking after any life failure.

The researchers found through long-term observation that the prognosis for this form of psychopathy is usually favourable but contingent on how the child is raised, with training for motor skills and independent activity needed. As the child grows older, he or she should become better able to adapt to the environment, see improvement in motor skills and a lessening of fidgeting, as well as less foolishness. Most of the patients the researchers observed later became “useful members of society”. Only 12% of cases showed signs of schizophrenia during puberty.

6 Life and Work

She was short in stature, rather stout, indifferent to external appearances. The qualities I saw in her of warmth, compassion and wisdom made an enduring impression.

Nancy Rollins on Sukhareva in 1968, 1972

Biography

Family Background

There is little information of Sukhareva's personal biography on hand. Five celebratory articles about her have appeared in Russian journals so far; two in her lifetime¹⁴², and three after her death¹⁴³. This is where I have drawn the bulk of her biographical information from, with other bits and pieces gathered from contemporaneous English-language reports on the state of Soviet psychiatry, in which Sukhareva's name invariably appears. Celebration of a person's career in Soviet Russia seems largely focused on a person's work, with little interest shown in their personal lives. First I will remark that Russia was among the last users of the Julian calendar to make the switch to Gregorian, which it did on 14 February 1918 under Lenin. The dates 1-13 February 1918 were dropped and the difference in calendars today is still only 13 days. Sukhareva was born during the Julian calendar but all her work was published under the Gregorian calendar. The strategy I have chosen to take with pre-1918 dates in Sukhareva's life is the strategy of completely ignoring this 13-day difference.

¹⁴² "Груня Ефимовна Сухарева (к 70-летию со дня рождения)." [Grunia Efimovna Sukhareva (on her 70th birthday).] *Zhurnal neurologii i psikiatrii im. S.S. Korsakova*. 62 (1962): 1116.

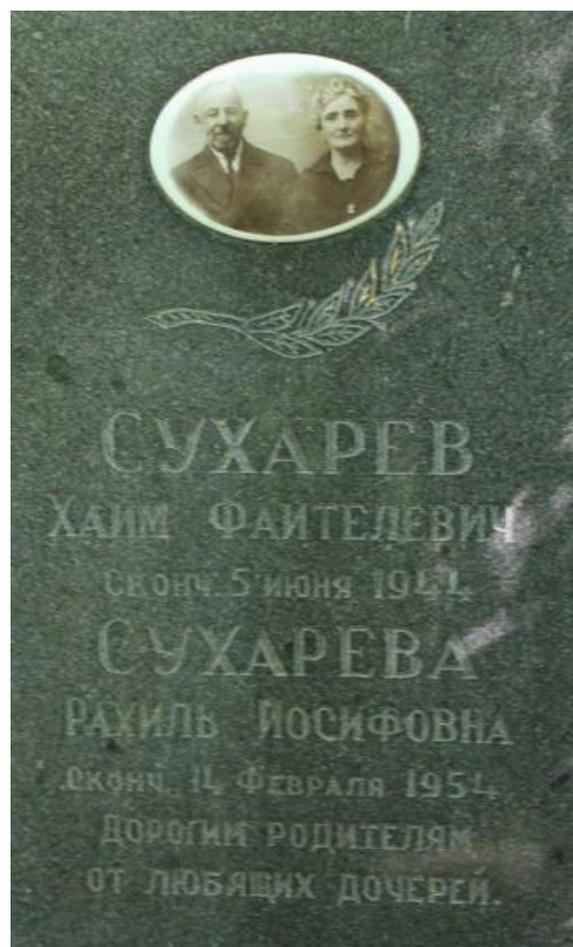
"Груня Ефимовна Сухарева (к 80-летию со дня рождения)." [Grunia Efimovna Sukhareva (on her 80th birthday).] *Defektologiya*. 1 (1972): 88.

¹⁴³ "Груня Ефимовна Сухарева." [Grunia Efimovna Sukhareva.] *Zhurnal neurologii i psikiatrii im. S.S. Korsakova*. (1981): 1744.

Goriunov, A. V. "Г.Е. Сухарева (к 120-летию со дня рождения). / G.E. Sukhareva (the 120th anniversary of birth)." [their translation!] *Zhurnal neurologii i psikiatrii im. S.S. Korsakova*. 112.4 (2012): 67-71.

Goriunov, A. V., I. I. Lazareva and Iu. S. Shevchenko. "Г.Е. Сухарева: жизненный путь и научно-педагогическое наследие (к 125-летию со дня рождения). / G.E. Sukhareva: a course of life and scientific/pedagogical heritage (to the 125th anniversary of birth)." [their translation!] *Zhurnal neurologii i psikiatrii im. S.S. Korsakova*. 117.4 (2017): 59-63.

Sukhareva was born in Kiev under the Russian Empire on 11 November 1891 and died in Moscow on 26 April 1981 (aged 89), a year nicely symmetrical to that of her birth. Her grave is in the Jewish section of Vostriakovskoe cemetery in Moscow. Sukhareva's date and place of birth and death are given consistently across sources. There is an online grave record for her plot in Vostriakovskoe, where we can see she is buried alongside her parents. Sukhareva's younger sister Mariia Efimovna Sukhareva, also a researching doctor of paediatric medicine, is buried elsewhere in the same cemetery with her husband I. Lerner, who appears to have been an academic writing about education and pedagogy. From this grave record, I infer that Sukhareva never married or had children, something stated as fact on the Jewish-Ukrainian Russian-language website JewishNews.com.ua, published by the United Jewish Community of Ukraine. An online Russian-Jewish encyclopaedia documenting Russian Jews of note records Sukhareva's parents as Chaim Faitelevich and Rakhil (Rachel) Iosifovny. No source is given for the information, but the names on the stone next to Sukhareva's are indeed Khaim Faitelevich Sukharev and Rakhil' Iosifovna Sukhareva. This gravestone gives only dates of death. Khaim Sukharev died on 5 June 1944 and Rakhil' Sukhareva died on 14 February 1954. The inscription reads "To dear parents from loving daughters." In the same Sukharev plot is another stone with inscriptions in Hebrew and Russian. The Russian name here is F. Kh. Sukharev. The online record for this grave gives the birthdate as 1896 but from the photo of the grave, this seems to be a mistake. It looks far more like 1864 which would be a better match for Sukhareva's father. This would put his age at 27 when Sukhareva was born, 33 when Mariia was born and 80 when he died. The inscription on this grave appears to read, "To a dear man from wife and children". If the webpage with the photo of the grave was correct about the year of birth, this would have to be a brother of Sukhareva with exactly the same name and year of death



Gravestone of Sukhareva's parents
Toldot.ru



Gravestone of Sukhareva
Toldot.ru

as his father. This seems unlikely, and I maintain that the information about the grave on this webpage is incorrect. The Russian Wikipedia corroborates Sukhareva's parentage by listing the two sisters as "Grunia Efimovna (Khaimovna) Sukhareva" and "Mariia Efimovna (Khaimovna) Sukhareva" in its list of notable people surnamed Sukharev. However, in the same Wikipedia, the word "Khaimovna" does not reappear on G. E. Sukhareva's page. M. E. Sukhareva does not yet have a page. Efimovna appears to be a Russianised version of the patronym Khaimovna.

Education and Early Career

Opportunities for women to receive tertiary education in Ukraine and Russia were still very new at the turn of the century but were quite progressive for Europe at this time. In the early pre-Stalin years of the Soviet Union, women in the cities could be very independent with many rights and good access to education. Tertiary education classes had been available to women in the late 1800s but were shut down in 1889. University professors pushed to have the classes for women resumed, and in 1906, segregated history, philology, physics and maths departments were opened for women. 1907-1909 saw the opening of legal, medical, economic and commerce departments. The medical department transformed into the short-lived Kiev Women's Medical Institute in 1916. Russian biographies of Sukhareva usually say that she graduated from the Kiev Women's Medical Institute in 1915; however, this was most likely its predecessor, the women's medical department of Saint Vladimir. In 1920, the Women's Medical Institute was merged with the Faculty of Medicine from Saint Vladimir University, forming the Institute of Health. In 1921, the Institute of Health was renamed Kiev State Medical Academy and renamed again that year as Kiev Medical Institute. Several name changes later, its official English name is currently (2018) Bogolomets National Medical University, a name it has managed to retain since 1995¹⁴⁴. Such renaming and reorganisation of institutions and locations is typical in times of political upheaval (and of no assistance to research!).

But the fate of these Kievan tertiary institutes does not presently concern us. The following details are largely paraphrased from A. V. Goriunov's article for the 120th anniversary of Sukhareva's birth, published in *Zhurnal Nevrologii i Psikhatrii* in 2012 and translated for me by Dr Richard Millington. In 1917, Sukhareva went to a Kiev

¹⁴⁴ "History of University." *Bogolomets National Medical University*. bogomolets-nmu.com/history-of-university/. [sic]

psychiatric hospital first as an intern, progressing on to doctor and head of defectology, another field specific to Soviet medicine. In 1921, Sukhareva moved to Moscow to work at a medical observation unit for disabled children ('defective' in Soviet terminology) at the Moscow Department of Public Education. In 1923, she started at the Institute for the Protection of Child and Adolescent Health. This is where she wrote the paper translated in this thesis. Here Goriunov's information starts to confuse my own information. Goriunov claims that Sukhareva was the head of the Psychoneurological Clinic at the Institute of the Protection of Child and Adolescent Health from 1923 until 1933, but the papers published in German in 1926 and 1927 say "Aus der Sanatoriumschule der Psychoneurologischen Kinderklinik in Moskau [Direktor Prof. Dr. M. O. Gurewitsch]." Sukhareva herself is given as merely "Dr. G. E. SSUCHAREWA, wiss. Assistent". It is possible that Gurevich was the director of the school at the clinic while Sukhareva was the director of the whole clinic, but if so, crediting herself as a mere scientific assistant seems odd. In two 1925 papers by Gurevich¹⁴⁵, he gives himself not as the director of the school, but of the whole clinic ("Aus der Moskauer Psychoneurologischen Kinderklinik. – Direktor: Prof. Dr. M. Gurewitsch.") Another paper by Gurevich published in 1926¹⁴⁶ comes from the Laboratory of the Moscow Kastshenkov Insane Asylum under the directorship of Dr P. Brukhanski, while a 1927 paper¹⁴⁷ comes from the Moscow Psychoneurological Children's Clinic again (no director given here). Added to this confusion is the fact that while papers published in German say where the paper was written, the date given is the date the paper was received by the journal which may well be long after the original work was completed or after it was published in Russia. All that is clear is that the Moscow Psychoneurological Clinic was a residential one with a school.

Described as a "wiss. Assistent" (note the masculine form) in German papers from 1925 to 1927, Sukhareva appears without a position title in 1928 and 1929, and then in 1932, she is titled "Priv.-Doz. Dr. med."

In a 1953 review of Soviet psychiatry, Moritz Tramer describes the children's psychiatric institutions in 1926, the era of Sukhareva's first papers on schizoid psychopathy. Initially, there was a move to delineate child psychiatry as a separate

¹⁴⁵ "Über die Formen der motorischen Unzulänglichkeit." and "Motorik, Körperbau und Charakter."

¹⁴⁶ "Zur pathologischen Anatomie der malariabehandelten progressiven Paralyse."

¹⁴⁷ "Über die Einteilung der Psychopathien."

discipline from psychiatry, and the focus was on “defectology”, which included intellectual disability, deafness, muteness and blindness. This term was soon abandoned as it connoted untreatable, and there was later a push to reconnect child psychiatry with adult psychiatry. In 1926, the Soviet Union had 211 institutes with 8,266 “anormale”, abnormal or divergent, children. By 1930, there were 50 institutes dedicated to psychiatric work with children.

According to Goriunov, from 1928 to 1933, Sukhareva also worked part-time at Psychiatric Clinic No. 1 of the Moscow Medical Institute as an assistant and lecturer. This cannot be the same clinic as the children’s clinic since Goriunov mentions that the director of this clinic was P. B. Gannushkin, adding that Gannushkin “contributed greatly to the development of her scientific interests expressed in a series of studies in the field of psychopathy”. While Gannushkin wrote many pieces in the 1900s, his key work on psychopathy was not until 1933, after Sukhareva’s work. Gurevich, whom the German papers imply was Sukhareva’s supervisor at that time, also wrote a paper on psychopathy in 1927¹⁴⁸. Surely Gurevich, who had spent time in Germany and had worked under both Kraepelin and Gannushkin, was a bigger influence. The 1914 Gannushkin paper Sukhareva references in 1925 is not on psychopathy per se but on the search for the schizophrenic constitution. This may be a semantic quibble.

Sukhareva is Established as an Authority in Soviet Child Psychiatry

In 1931, Sukhareva became a consultant and scientific director for the P. P. Kashchenko Moscow Psychiatric Hospital. This was a position she held until 1951. She seems to have held many such consulting positions simultaneously.

In 1933, she returned to Ukraine to take up a position as head of department of child psychiatry at the Kharkiv Neuropsychiatric Institute, one of the institutes in the newly formed All-Ukrainian Psychoneurological Academy, the latest reorganisation of the 1922 Ukrainian Scientific Research Psychoneurological Institute (as at 2016, the Institute of Neurology, Psychiatry and Narcology of the National Academy of Medical Sciences of Ukraine). I do not know whether this restructuring from institute into an academy of institutes in 1932 had anything to do with Sukhareva’s appointment. She

¹⁴⁸ Ibid. This brief paper is on the validity of psychopathy as a classification given its spectral nature and the difficulties this poses to nosology. Amusingly, the ideas in this paper are also ones enjoying renewed discussion in recent times.

continued to consult for the institute years after she left, even while in Moscow.

Goriunov says she was the institute's primary consultant.

The 1936 second issue of *Zeitschrift für Kinderpsychiatrie* features a report in German on the “II. Städtische Konferenz für Kinderpsychoneurologie” held 24-26 May 1935. According to this report by author D. E., there were 315 attendees, with representatives from every psychiatric institute, outpatient clinic and dispensary in Moscow and the heads of scientific and psychiatric institutes from 26 other cities. The keynote presentation was given by Dr Osipova. While initials are not given here, this would be E. A. Osipova, the author of the first report on oligophrenic character types. The report mentions 11 speakers and their papers by name, the titles presumably translated by “D. E.”. Sukhareva spoke on the third day of the conference, presenting her paper “Zum Einheitsproblem der Schizophrenie (aus dem städtischen psychiatrischen Kinderkrankenhaus imeni Kaschtschenko)”. Sukhareva's talk was followed by a talk on “Psychopathologische Besonderheiten bei Propfschizophrenie” with the speaker here given as “E. Osipova”. This in turn was followed by a lecture on dementia infantilis – Heller's syndrome. With 315 attendees but only 11 speakers, we can conclude that Sukhareva was already highly respected in 1936.

Reginald Lourie, who visited the USSR in 1962, reports that training in child psychiatry as a specialisation did not begin in Russia until “about 1930”, when a programme at the Moscow Institute for the Protection of the Health of Children and Adolescents began. He further states that formal postgraduate training began in 1935 in “a Department of Child Psychiatry of the Central Institute for the Advanced Training of Physicians” and continued until being interrupted by the Great Patriotic War. Formal postgraduate training requires formal postgraduate teachers and Goriunov confirms that Sukhareva was not only one of these teachers but the head or chair of the department referred to by Lourie.

1935 is also the year Sukhareva defended her doctoral thesis in medical science, then becoming a professor and taking up the newly created position of head of child psychiatry at the Central Institute for [Advanced Training of Physicians/Medical Specialisation/Medical Development¹⁴⁹] in Moscow. In the sense that she was the first

¹⁴⁹ Various translated across sources.

person to hold this position, she may be considered at least the founder of child psychiatry in Russia. She remained its director until 1965 but carried out other work while doing so. In 1938, she founded the Department for Child and Adolescent Psychoses at the Central Institute of Psychiatry. At this point in her history, Goriunov kindly feeds my fascination with the grand Soviet custom of elaborate renaming by mentioning parenthetically “later the Moscow Institute of Psychiatry of the RSFSR Ministry of Health and now the Moscow NII of Psychiatry of Rus-Health”. She retired from leading this department in 1969 but continued to consult for the department until 1979, three years before her death.

According to a brief report on the state of child psychiatry in Russia in the July-October 1956 issue of *Infanzia anormale*¹⁵⁰, the paediatric ward/clinic/hospital within the Moscow psychoneurological hospital had beds for 250 children and was made up of eight departments with the children divided by illness, age and severity. 15 doctors worked in the children’s section, which was also a teaching hospital, with 30-40 doctors being trained at any one time. While at the hospital, the children received school lessons, art classes, occupational therapy and physical education. The report was compiled using information sent by Sukhareva at the journal’s request. (“La psichiatria infantile in Europa” 382-383)

Great Patriotic War

World War II was fought on the Eastern Front from 22 June 1941 to 9 May 1945. During this time, Sukhareva and the staff of the Moscow Psychiatric Hospital were evacuated to Tomsk where they treated injuries in an evacuation hospital set up on the Tomsk Psychiatric Hospital grounds. Goriunov does not provide more specific dates but most evacuations occurred in late 1941. In “Child Psychiatry” in Wortis’s *Soviet Psychiatry* of 1950, he mentions Sukhareva’s “Psychologic disturbances in children during war” and T. P. Simson’s “Behavior of children exposed to the German army occupation”, both published in English in the *American Review of Soviet Medicine*, and the impact the violence of the invasion had on children. Wortis finds it unusual that Sukhareva placed little value on the psychoanalytical theories finding prevalence in the

¹⁵⁰ The journal also comments that Prof. Sukhareva has recently published “un chiaro ed aggiornato libro di lezioni di neuropsichiatria infantile”, which is more complimentary than Leo Kanner was about the book.

USA such as dream interpretation, repression and projection in her approach to children's trauma – her approach was more medical than psychological.

In “Psychologic disturbances in children during war” (1947/48), Sukhareva is recorded as “Director of the Children's Clinic at the Central Institute for Psychiatry, Ministry of Health, USSR.” This text refers to “the pediatric department of the Kashchenko Hospital in Moscow”, which it says is “one of the largest psychiatric institutes in the USSR.” It has two sanatoria for boys and girls and is directed by E. A. Osipova.

The Pavlovian Sessions

A series of extremely significant events, not only in Sukhareva's career but in Soviet sciences as a whole, is not mentioned in Goriunov's piece or any of the other bibliographic pieces appearing for Sukhareva's 70th and 80th birthdays and death. The events took place in response to Stalin's request to institutionalise the teachings of I. P. Pavlov (1839-1936), winner of the 1904 Nobel Prize in Physiology or Medicine, and repeatedly featured Stalin's words, “no science can develop and flourish without a battle of opinions, without freedom of criticism.”

Although occurring only in the 1950s, the events can be seen as the culmination of a process set in motion by Stalin's rise to power two decades earlier. George Windholz tells the story of psychiatry in the Soviet Union so:

The course of psychiatry in Russia changed dramatically with the October 1917 revolution. Suddenly, practising psychiatrists became employees of the Soviet State, depending on benefits bestowed upon them by the authorities. Whereas in the 1920s the political atmosphere in the Soviet Union still allowed psychiatrists to follow Western ideas, such as psychoanalysis, their intellectual freedom came to an end with Stalin's rise to power in the 1930s; from then on Soviet psychiatrists had to consider psychiatric theory from the Marxist position. Because it was not easy to find a common ground for modern psychiatry and Marxism, Soviet psychiatrists solved the dilemma by repeatedly declaring that Soviet psychiatry was materialistic and therefore correct. (Windholz 1999 333)

Although Pavlov was publicly very outspoken about his opposition to the Bolsheviks, the Bolsheviks recognised early on that his ideas, that humans, animals and the land can be physically moulded by the conditions around them, could be used in support of their

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politics. “*Ideologically*”, wrote Bukharin, “he works for us¹⁵¹” (in Todes 1995, 406). David M. Fetterman reports that a government push towards Pavlovianism had begun, at least within education, in the 1930s even before Pavlov’s death. Fetterman summarises the application of Pavlovianism to child psychology and pedagogy:

Historical materialism rests on a doctrine of equal ability. Pavlovian psychologists argue that all children are equally capable of learning; consequently, giftedness is not considered an innate or even partially innate characteristic. Intelligence test results suggested genetic differences in Soviet society. To disprove this possibility, Soviet psychologists concluded that the Western adopted tests were better measures of environmental influence than they were of innate ability. (181)

Fetterman writes that intelligence testing was in vogue after the revolution for quite some time but fell out of favour during the 1930s, with 1936 seeing intelligence testing banned altogether. During the 1920s and early 1930s, the work of Sukhareva and her colleagues does involve intelligence testing for all children and there is much interest in grouping according to ability, as we see with the 1925 “Materialien” on giftedness and personality types. It cannot be said that Sukhareva ceased believing in differences in intelligence – she went on to write an entire textbook on oligophrenia – but intelligence testing disappears from her work.

Soviet Pavlovianism came to a head in the early 1950s following Stalin’s decision to use a new framework for science and his request that all science in every area from linguistics to psychiatry be conducted on the basis of Pavlov’s theory of higher nervous activity: i.e. everyone is conditionable, there is no nature, only nurture, humans can succeed under the conditions of socialism, away from the contaminating influences of the capitalist environment.

In 1950, the Joint Scientific Session of the USSR Academy of Sciences and the USSR Academy of Medical Sciences was held. This was very much like the mock trials but for science. Because it involved two academies, it is frequently referred to as the Joint Session. It lasted from 28 June until 4 July. The inaugural address, reports and resolution were published in English by University Press of the Pacific. The speeches

¹⁵¹ N. I. Bukharin in a letter of 1929. «Но он самый крупный физиолог в мире, материалист, и, несмотря на все свое ворчанье, идеологически работает на нас (в своих сочинениях, а не в речах)» (in Todes 1998, 47).

are adulatory towards Stalin, effusive in praise for the progressive cause, “materialism”, the Party, the Soviet Government and the Motherland, and fast approach deification of Pavlov. “Reactionary” scientists from capitalist countries are condemned for their anti-materialist idealism and refusal to see the Pavlovian light. Speakers during the session confess to their failure to be sufficiently evangelistic of Pavlovian concepts, and any use of foreign ideas such as cerebral pathology as the starting point for work is heavily condemned. The report has many mentions of Professor Gurevich, present as a representative of psychiatry and one of those accused of being insufficiently Pavlovian and forced to confess his sins and figuratively self-flagellate. This was all heavily ironic as during his life, Ivan P. Pavlov (1849-1936), no fan of Soviet ideology, had continually complained about being forced to conduct science on a framework of Marxism-Leninism. Having achieved enormous distinction and recognition and being rather elderly, he had been free to voice his criticisms where others were not. By the time of the sessions, Pavlov was long gone.

Pavlovianism was only one aspect of the scientific approach celebrated and enforced at the Joint Session. The other aspect met Stalin’s need to isolate and insulate the Union. Windholz writes:

The post-war situation seemed to convince Stalin that the Soviet Union must defend itself from the threat posed by Western powers by imposing strict conformity to Stalin’s doctrine. This would mean hostility to nearly all ideas coming from the West and a chauvinistic attitude toward everything Russian. To Russian chauvinism Stalin added a patina of Marxism-Leninism and materialism, and opposition to philosophical idealism. (1999, 330)

Not only were scientists insufficiently Pavlovian, many were insufficiently patriotic. Some were chastised for not taking enough credit and for giving this credit to non-Russian scientists, either in full or in part, for discoveries they should have been taking full ownership of. Any discovery or scientific method the Soviet government saw as suited to its purposes had to be purely Soviet in origin. Evidence indicating otherwise was denied.

Following this first session, smaller sessions took place within the individual scientific and medical specialisations. The joint session of the Academy of Medical Sciences of

the USSR and the Board of the All-Union Society of Psychiatrists and Neuropathologists was held over 11-15 October 1951. In a 1991 paper, Popov and Lichko call this “the most somber event in the history of the All-Union Neurologic and Psychiatric Association”, writing that the report “read like an invective” against many Soviet psychiatrists including Gurevich and Sukhareva. The report for this session is not translated into English but Windholz has created an English summary (1999).

What was anti-Pavlovianism in the context of psychiatry? Recall the experiment Pavlov is most famous for, the salivating dogs. A good Pavlovian psychiatrist attributed all human behaviour and misbehaviour to environmental conditioning. Drug addiction and alcoholism were a product of the capitalist system. There was no genetic predisposition to such behaviour. Belief in genetic predisposition or constitutional pathology was a shirking of duty on the part of the doctor. It was nihilistic to say nothing could be done¹⁵². A good doctor should treat the citizen and reform them for life in the collective, not throw up their hands and say they can do nothing.

Psychiatrists whose ideas found acceptance outside the Soviet Union or who had published widely in non-communist countries were looked upon with as equal suspicion as those openly flaunting foreign influence. Gurevich and his colleagues were further found to be at fault for embracing ideas the Communist party did not find ideologically useful, for example, those of Kraepelin, Kretschmer, and Freud, or for attributing ideas the party found useful, such as the Kraepelinian nosological system, to Westerners instead of such Russians as S. S. Korsakov. It is likely Gurevich’s high profile during the Pavlovian sessions and high level of “error” is what caused his name to fade from the history of Russian psychiatry, while Sukhareva, whose name was not an especially important one during this time, rose to much higher prominence.

Stalinism and Pavlovianism in Sukhareva’s Work

Stalinism and Pavlovianism changed Russian scientific literature and they affected Sukhareva’s texts quite explicitly. Where previously her work had been full of sources and references in multiple languages from around the globe, from her 1940 textbook until Khrushchev’s 1956 denouncement of the cult of personality and aspects of Stalinist policy, all work is entirely devoid of non-Russian names.

¹⁵² This had also been Bettelheim’s view.

There is another connection between Pavlov and Sukhareva. One of the earliest things the Bolsheviks did was attempt to reform the education system, doing away with the hierarchical system of doctoral degrees and professorships. This reform was short-lived, and 1934 saw the reinstatement of doctoral degrees and professorships as one of the conditions Pavlov negotiated from the Bolsheviks in exchange for not emigrating. In 1935, Sukhareva received her doctoral degree and was made both a professor and the first director of the Soviet training programmes in child psychiatry.

In 1940, she released her first textbook, [*Clinical Lectures in Child Psychiatry, Book 1*], clearly intending right from the beginning to release more. In 1955, following the Pavlovian Sessions, Sukhareva did not release [*Clinical Lectures in Child Psychiatry, Book 2*] as we might have anticipated but [*Clinical Lectures in Child Psychiatry, Vol. 1*]. This is the second edition, but the publishing details make no mention of this.

The second edition opens with a patriotic foreword (3) praising the grand achievements of “our country”. While the 1940 edition has but a single mention of Pavlov, the edition of 1955 contains 78 instances of either Pavlov or Pavlovian, listing Pavlov five times in the bibliography, with all foreign sources again entirely absent. Although Sukhareva read German, French and English, even occasionally citing Italian sources, not a single work in a language other than Russian is found in the 1940 or 1955 editions. The first lecture explicitly mentions the 1950 session, which can perhaps be interpreted as a subtle explanation or apology for the revised edition. This section also explicitly states in the language of the sessions themselves that errors were made in psychiatry (5, 9-10) and that psychiatry is now “correct”, “proper” and “right”.

Yet this cursory glance at the outward appearance of extreme Pavlovian patriotism in the 1955 second edition, after Sukhareva had been publicly denounced for idealism and allowing herself to be seduced by corrupting foreign influences, is deceptive. On closer inspection, it becomes apparent that many of the outside influences are in fact still there. Occasionally, there are references to foreign researchers but not specific works. The basic ideas are still present, their authorship merely erased, much like Gurevich’s forced reattribution of the Kraepelinian nosological system to Korsakov and his attribution of the integrative theory of psychiatry to himself. Importantly, Sukhareva’s textbook cannot be used by others to find further literature for extended reading. Instead there are

vague mentions of unattributed “work” or “papers”. Sukhareva’s writing does become nationalistic, in the sense that all Soviet work is presented as truthful and all “Western” work is presented as wrong or even as Soviet work, but it is hard to believe that her nationalism is genuine.

The next volume of Sukhareva’s lectures came out in 1959, after Khrushchev’s denouncement. Popov and Lichko provide examples of the range of behaviours following the 1956 speech:

It is known that fear easily engenders faith. It becomes a psychological defense, a means of self-justification. Belief in the Pavlovian doctrine was probably shared not by everyone or not with equal intensity. When the very first possibility offered itself, in the late 1950s, the Pavlovian doctrine gradually disappeared from A. V. Snezhnevsky’s works and reports. O. V. Kerbikov, however, tried to classify a variety of personality disorder types in terms of Pavlovian doctrine until his death in 1965. (89-91)

Their example of Snezhnevsky here is slightly contradictory with “when the very first possibility offered itself” and “gradually disappeared”. What can we say of Sukhareva after 1956? There are still 73 instances of Pavlov or Pavlovian in her 1959 textbook, but Pavlov appears in the bibliography only once (perhaps this is what is meant by gradually disappearing as soon as the possibility offered itself), and the bibliography is now packed full of foreign references again, both old and new. This last adjective is significant. The range of references demonstrates that despite institutional isolation, Sukhareva remained informed about what was happening in her field elsewhere. In fact, in 1955, after Stalin’s death but still before the denouncement, she had posted her textbook to Leo Kanner who, while demonstrating awareness of the political situation, nevertheless dismissed it for its extreme chauvinism and lack of non-Russian references. It was risky for Sukhareva to correspond with him at all.

The third volume came out in 1965. This book contains only three mentions of Pavlov and he does not make it to the bibliography. An abridged version of the lectures aimed at a slightly wider audience of both teachers and medical practitioners was released in 1974. This book has only five foreign references. It is hard to know what to make of that since this book is so short; however, repression was coming back under Brezhnev, and Soviet psychiatrists have reported that the memory of the Pavlovian sessions and,

let's say, the behaviour they conditioned, stayed with the scientists who experienced them for a very long time. In 1992, Popov and Lichkov reported, "Younger psychiatrists, not being witnesses of these events, have no idea of the atmosphere of those years, of how similar 'sessions' and statements were prepared and reported." (89)

In 1998, Helen Lavretsky wrote:

Russian society has never fully recovered from the extermination and oppression of intellectuals and scientists that took place in the 1930s through 1950s. The result was several 'politically passive' generations of people and scientists who followed orders from the authorities and never asked any questions simply because they were not interested in being killed or ostracized like those who dared to dissent. (551)

Given that Sukhareva was not killed or ostracized, it is reasonable to say she was not an outspoken dissenter. But nor was she an enthusiastic supporter of the Communist party, and she was certainly a reluctant adherent to research isolationism and chauvinism. She did what she had to to continue working but no more. It is remarkable that any work was conducted under such circumstances, let alone such quantity of it.

Not a single Russian biographical piece on Sukhareva mentions the Pavlovian sessions. No articles mention the first edition of volume 1. The second Pavlovian edition of volume 1 of her lectures has become the canonical version, even though, from a Western perspective, this should be more suspect. All volumes of Sukhareva's clinical lectures are still used in child psychiatry training in Russia today. The sessions which dramatically transformed Russian science writing, changed the behaviour of Russian scientists and their interactions with each other for decades, and which played a role in the dismissal of Russian work by Anglo-European countries, the sessions at which Sukhareva was accused of being unpatriotic and hostile to her Motherland are ignored in Russian literature about Sukhareva.

Child Psychiatry After Stalin

In 1962, Lourie reported that:

In 1955, the Department of Psychiatry was re-established in the Central Institute under Professor G. Ye. Sukhareva. This is centralized at the Division of Child Psychiatry in

the No. 1 Pediatric Ward of the Kashchenko Municipal Clinical Psychoneurological Hospital in Moscow. Four other training centers are reported to exist in Moscow, Leningrad, Kharkov, and Svirdlovsk. The program is in the midst of its participation in the current national seven-year plan.

Attempts to keep track of the constant restructuring come to confusion. Lourie's report came about as follows.

Following Krushchev's denouncement in February 1956, the Soviet Union moved towards opening itself up, signing cultural agreements with Norway and Belgium in 1956, and with the United Kingdom and France in 1957. McCarthyism having somewhat subsided, the "Agreement Between the United States of America and the Union of the Soviet Socialist Republics on Exchanges in the Cultural, Technical and Educational Fields" was signed in 1958. This agreement and Kennedy's 1961 President's Panel on Mental Retardation led to a six-person team travelling to the USSR on a study mission in 1962 to explore child psychiatry with a focus on mental retardation. They spent three weeks in the USSR, visiting Moscow, Leningrad and Kiev, and making a few "excursions" to less major facilities. They met with and were shown around by Soviet child psychiatrists. In Moscow, they visited the Child Psychiatry Hospital, at that time headed by Sukhareva. They met Sukhareva, Ushakoff, Moslayeva and Vrono. At the Bekhterev Institute of Psychiatry they met Abramovich. At the Leningrad Institute of Paediatrics, they met Mnukhin and Bogdonova. On returning to the United States, Reginald Lourie wrote a report on how child psychiatry in the USSR functioned.

Lourie described three types of doctors in the field of child psychiatry. The first were child psychoneurologists, usually considered equivalent with child psychiatrists. These were psychiatrists who went on to specialise in children by way of a four-month course. The second were child neuropathologists, who could be either psychiatrists or paediatricians. Lourie said these doctors "do therapy with the neuroses of childhood, including the behaviour disorders" (570). The third group were paediatricians who specialised in psychiatry, taking a three-month course. Lourie confusingly called this group "paediatric psychoneurologists" but presumably "psychoneurological paediatricians" would have been a better description. This third group was employed in "general medical dispensaries known as polyclinics, in schools, nurseries, and

institutions”. Sukhareva appears to have belonged to the first category, although her training obviously preceded the system she established. The dispensaries and polyclinics provided outpatient medical services and employed specialists from many disciplines. Lourie reported that the eventual goal was to have specialists in child psychiatry in all Russian polyclinics but that in 1962, child psychiatry specialists were only in the polyclinics in large cities. He also reports a shortage of adult psychiatrists at that time, mentioning “increasing reluctance to ‘convert’ adult psychiatrists to child psychiatry” (571). Listing the tiers of training Russian psychiatrists go through, Lourie gives the sequence of titles practitioner, assistant, docent, doctor of science, professor, then academician. His description is confusing, and I am not convinced he understood the system fully. He reports that everyone in the Soviet Union, including psychiatrists, works six hours a day, six days a week and retires at sixty. Yet Sukhareva worked well beyond sixty and at the time of Lourie’s visit to the USSR was already 71.

Russia was the only Soviet Republic where a child psychiatrist could be trained, and Lourie mentions that at that stage, the Ministries of Health in Georgia, Moldavia, Lithuania and Estonia had sent no doctors for training. He also mentions more general complaints about training inefficiency. He cites I. P. Pavlov’s teachings on higher nervous activity as the underlying basis of clinical thinking about childhood mental illness but also inserts a summary of Sukhareva’s classification system:

In general, children’s mental disorders are considered to have organic bases. Professor Sukhareva, the dean of Soviet child psychiatry, feels that such disorders fall into three etiological groups: (1) hereditary (biochemical abnormalities); (2) embryonal pathology, occurring often four to eight weeks after conception (usually infectious, i.e., toxoplasmosis, lues, rubella, etc.); (3) brain damage, pre- or postnatal. Psychoneuroses are, according to Professor Abramovitch, made possible by a damaged nervous system which is exposed to environmental stress or improper training. (573)

Abramovitch’s reported comments are very much in line with Soviet ideology. Lourie also described the situation at children’s psychiatric hospitals. Of course, Lourie’s visit took place much later than the first papers on schizoid psychopathy but at a similar time to Sukhareva’s clinical lectures and is thus still of interest. Hospitals in large cities were well staffed with adequate play space, one hospital even having its own animal park. There was a strong emphasis on education. Psychotherapy took place, sometimes on a

daily basis, but was “rational” (the quotes here are Lourie’s) and did not involve psychoanalysis, a point the Russians were keen to stress, expressing some antipathy to Freud¹⁵³. Classes and dormitory rooms contained groups of 20-30 children, with the children sleeping and learning in the same groups. The Russians called occupational therapy “ergotherapy”, the same term used in German. Preschool children had rooms that could accommodate their mothers. The hospitals were primarily for diagnostic and short-term therapeutic purposes with the average stay there between two weeks and six months. In Sukhareva’s clinical lectures, she repeatedly stresses the importance of a long diagnostic process, one that involves observing the child under many different conditions not merely seeing them in a clinical setting. The setup described by Lourie was ideal for this, a process impossible under the system used in New Zealand today. After a hospital stay, children could go back into the community where they would be seen by the specialists at the dispensaries or polyclinics, to a summer camp for more therapy, or to a residential forest school (no explanation for this is given, but forest schools are also mentioned in Sukhareva’s clinical lectures). There were also other institutions: “80 residential treatment centers and more than 100 special colonies for children with chronic mental disease, including severe oligophrenia.” (574)

A 1967 paper published in *Acta Paedopsychiatrica* provides Sukhareva’s postal address: Rusakovskaia 4, 37, Moscow B 140, USSR, an unassuming, if not bleak, apartment building still there today judging from Google Street View. In the foreword to Nancy Rollins’s 1972 book on Soviet child psychiatry, Mark G. Fields mentions such accommodation as one of the hardships faced when conducting research inside the USSR:

Moscow or Leningrad, in contrast to European capitals, can hardly be called swinging. Soviet professional colleagues, generally, will not be able to extend much hospitality to a foreigner because of the cramped conditions under which they live (44 percent of Leningrad physicians, for example, live in communal apartments and share cooking and

¹⁵³ This was commented on by others earlier. Paul V. Lemkau in 1951, “Freudianism and all other psychological systems which ascribe primary psychological functions to the person are incompatible with Soviet philosophy at the present moment, because it is assumed in them that the individual is not completely modifiable by environmental contacts but has some capacity for individual organization in the selection and evaluation of these contacts.” Eliot Slater in 1952, “Freud and the unconscious are almost totally disregarded, and, though Freud himself is not without honour, psycho-analysis is obsolete.” Moritz Tramer in 1953, “*Freud und Adler werden als Reaktionäre bezeichnet, deren Lehren daher verworfen.*”

other facilities with other dwellers in the same apartment), and also because it is healthier not to make too close contact with a foreigner. (xiii)

But he also adds that for the foreign visitor, perception of life in the Soviet Union was always coloured by preconceptions:

[...] for many left-wing intellectuals in Western Europe it was inconceivable that there should exist a system of social stratification in a “socialist” society. Often such individuals (of whom André Gide was one of the first in 1936) are embittered and disappointed by what they see. On the other hand, the conservative businessman or congressman, fed on *Reader’s Digest* stories about concentration camps and endless days in the lives of Ivan Denisoviches, find that people in Moscow and other cities laugh, the hotel has hot water, the caviar is good, the ballet splendid, the subways marvellous, the labor unions spineless, the secret police manifestly absent – and they come back impressed, even feeling they might have been sold a bill of goods by those hostile to the Soviet Union. (xiv)

I think it is safe to assume that while Sukhareva reached the height of her profession and pay scale in the USSR, working well beyond the age of retirement, she did not live in especially comfortable circumstances, no more so than anyone else, but she had hot water and caviar at least!

Rollins describes Sukhareva in her place of work in the late 1960s:

Soviet child psychiatrists, especially in Moscow, tend to follow the grouping of their beloved teacher, Grunya Efimovna Sukhareva, who is practically unknown in the West. The privilege of knowing her was perhaps the most valuable experience I had in the Soviet Union. In November 1968, Grunya Efimovna was already in her seventies. She was short in stature, rather stout, indifferent to external appearances. The qualities I saw in her of warmth, compassion, and wisdom made an enduring impression. The first two were evident in the way in which she handled patients and in the devotion she inspired in her staff, trainees, and former trainees I met in other parts of the country. Her wisdom included intellectual clarity, though perhaps not great originality. Her psychiatric interests have been extremely broad. She has made contributions to the organization of psychiatric services, research in schizophrenia and epilepsy, and the training and teaching of child psychiatrists and psychoneurologists. (73)

Legacy in the Soviet Union and Post-Soviet Russia

Sukhareva was very important to the development of Russian psychiatry and neurology. The online Russian academic dictionary credits her with having founded child psychiatry in the Soviet Union. Other places credit her with having founded child psychiatry. As this carries on today we cannot put this down to simply a communist state's predilection for hyperbole, although we can possibly ascribe it to Russian patriotism more generally. Sukhareva makes three appearances in *Большая советская энциклопедия* (*Bol'shaia sovetskaia entsiklopediia*). The 1979 English translation *The Great Soviet Encyclopedia* is available online in its entirety. Work of Sukhareva's from 1959 and 1965 respectively was used as a reference for the entries "Neuropathy" and "Oligophrenia". She appears in "Periodic psychosis" as a psychiatrist contributing to the development of the concept. In 1979, the *Great Soviet Encyclopedia* described itself as "the first Marxist-Leninist general-purpose encyclopedia; one of the world's largest modern encyclopedias." Published from 1926 to 1981, the 30-volume *Большая советская энциклопедия* set was intended as a resource for universities, schools and libraries that would both educate and inspire patriotism while teaching Communist values. Sukhareva may well appear in other editions of the encyclopaedia or even in *Большая российская энциклопедия* (*Bol'shaia rossiiskaia entsiklopediia*), which is essentially a reinstatement of the first encyclopaedia but published in 2002 under Putin. Neither Sukhareva's supervisor Prof. Dr M. O. Gurevich or any of her co-authors nor her sister Mariia make any appearance in the encyclopaedia.

Publication Abroad

A piece celebrating her 70th birthday in 1962 says her books were translated in China, Japan, Poland, Czechoslovakia and the USA, among others. The Chinese and Polish translations of her books have been mentioned in "Notes". I could not find work in Japanese or Czech, but I did find papers in English, Spanish and, recently (2016), in French. A paper appears in a Czechoslovakian journal in 1956, but it is in Russian with merely Czech and English abstracts. I found no translations of her books into English. A more comprehensive list of works follows. Sukhareva's publications abroad are further documented in "Reception History".

Incomplete List of Sukhareva's Published Articles and Books

Sukhareva's obituary in *Zhurnal nevrologii i psikiatrii* in 1989 says she published over 150 works, including 6 books. In compiling this list, I have attempted to create the resource I wished I had had during this project: a list of works with original titles, romanisation (where necessary) and translation. It has been put together using a combination of PubMed's database, which provides only English translations of titles (not the originals), and through chasing bibliographies and reference lists elsewhere, mostly in Russian publications. It is incomplete. It almost certainly contains many inaccuracies, although I have done my best to eradicate these. I have seen very few of the works listed and am reliant largely on the citations of others.

Year

Original title. Author G. E. Sukhareva unless otherwise stated.

"Romanisation." Author.

[Translation.]

Publication.

Romanisation. Place of Publication.

"Original title." Author.

[Translation.]

Publication. Place of publication.

1920

Исследование расстройства вкусовых восприятий у больных прогрессивным параличом и эпилептиков.¹⁵⁴

"Issledovanie rasstroïstva vkusovykh vospriiatii u bol'nykh progressivnym paralichom i ëpileptikov."

[Disorders of taste perception in patients with progressive paralysis and epileptics.]

1921

¹⁵⁴ Mentioned in Goriunov, Lazareva and Shevchenko (2017).

Анализ детских фантазий как метод изучения эмоциональной жизни ребенка.

“Analiz detskikh fantazii kak metod izucheniia émonsional’noï zhizni rebenka.”

[Analysis of children’s fantasy as a method of studying the emotional life of the child.]

in Психология интимной жизни ребенка.

Psikhologiia intimnoï zhizni rebenka. Kiev.

1924

Проблемы классификации психических заболеваний детского возраста (по материалам
врачебно-наблюдательного пункта).

“Problemy klassifikatsii psikhicheskikh zabolevanii detskogo vozrasta (po materialam
vrachebno-nabliudatel’nogo punkta).”

[Problems of classification of mental diseases of childhood (based on the materials of the
medical-observation post).]

in Медицинский журнал.

Meditsinskiï zhurnal. 6 (1924).

1925

Шизоидные психопатии в детском возрасте.

“Shizoidnye psikhopatii v detskom vozraste.”

[Schizoid psychopathies in childhood.]

in Вопросы педологии и детской психоневрологии Сборник трудов

психоневрологической и педологической школы санаторий-клиники

государственного института физкультуры и врачебной педологии. Выпуск 2-й /

М.О. Гуревич.

*Voprosy pedologii i detskoï psikhonevrologii: Sbornik trudov psikhonevrologicheskoi i
pedologicheskoi shkoly sanatorii-kliniki gosudarstvennogo instituta fizkul'tury i
vrachebnoï pedologii.* 2nd ed. Ed. M. O. Gurevich. Moscow: Zhizn' i Znanie, 1925.

Материалы к изучению одаренности у детей.

“Materialy k izucheniiu odarennosti u detei’.”

in Вопросы детской психоневрологии.

Voprosy detskoï psikhonevrologii. 1925.

1926

“Die schizoiden Psychopathien im Kindesalter.” G. E. Ssucharewa.

[The schizoid psychopathies in childhood.]

in *Monatsschrift für Psychiatrie und Neurologie*. 60 (1926): 235-261.

“Materialien zur Erforschung der Korrelationen zwischen den Typen der Begabung und der Konstitution.” G. E. Ssucharewa und S. W. Ossipowa.

[Materials for research into the correlations between types of giftedness and the constitution.] G. E. Sukhareva and S. V. Osipova.

in *Zeitschrift für die gesamte Neurologie und Psychiatrie*. 100.1 (1926): 489-528.

1927

Особенности шизоидных психопатий у девочек.

“Osobennosti shizoidnykh psikhopatii u devochek.”

[Features of schizoid psychopathy in girls.]

in *Современная психоневрология*.

Sovremennaia psikhonevrologiia. 10 (1927).

“Die Besonderheiten der schizoiden Psychopathien bei den Mädchen.” G. E. Ssucharewa.

[Features of the schizoid psychopathies in girls.]

in *Monatsschrift für Psychiatrie und Neurologie* 62.3 (1927): 171-200.

1928

Циклотимии и циклоидные психопатии.

“Tsiklotimii i tsikloidnye psikhopatii.”

[Cyclothymia and cycloid psychopathy.]

in *Вопросы детской психоневрологии*.

Voprosy detskoï psikhonevrologii. 1928.

Особенности моторики у олигофренов.

“Osobennosti motoriki u oligofrenov.”

[Features of motor function in oligophrenics.]

in *Вопросы детской психоневрологии*. Т. III

Voprosy detskoï psikhonevrologii. Vol. 3. 1928.

“Körperbau, Motorik und Charakter der Oligophrenen. I. Mitteilung. Untersuchungsobjekt: Knaben.” E. A. Ossipowa.¹⁵⁵

[The physique, motor skills and character of oligophrenics. 1st report. Subject of investigation: boys.] E. A. Osipova.

in *Zeitschrift für die gesamte Neurologie und Psychiatrie*. 114.1 (1928): 1-21.

“Körperbau, Motorik und Charakter der Oligophrenen. II. Mitteilung. Untersuchungsobjekt: Mädchen.” G. E. Ssucharewa.

[The physique, motor skills and character of oligophrenics. 2nd report. Subject of investigation: girls.]

in *Zeitschrift für die gesamte Neurologie und Psychiatrie*. 114.1 (1928): 22-37.

“Zur Klinik der Psychopathien im Kindesalter (Zykloide Formen).”

[On the clinical picture of psychopathies in childhood (cycloid forms).]

in *Monatsschrift für Psychiatrie und Neurologie*. 67 (1928): 86-126.

1929

“Der infantil-grazile Körperbautypus und seine somato-psychischen Besonderheiten.” G. E. Ssucharewa und I. B. Schenfil.

[The infantile-graceful body type and its somato-psychic features.] G. E. Sukhareva and I. B. Shenfil.

in *Zeitschrift für die gesamte Neurologie und Psychiatrie*. 119.1 (1929): 613-630.

“Über die Psychopathologie der Tuberkulose bei Kindern.” G. E. Ssucharewa und E. A. Ossipowa.

[On the psychopathology of tuberculosis in children.] G. E. Sukhareva and E. A. Osipova.

in *Zeitschrift für die gesamte Neurologie und Psychiatrie*. 119.1 (1929): 666-678.

1930

Динамика и структура психопатии.

“Dynamika i struktura psikhopatii.”

[Dynamics and structure of psychopathy.]

in *Журнал невропатологии и психиатрии*.

Zhurnal nevropatologii i psikhiatrii. 30.6 (1930)

¹⁵⁵ Not by Sukhareva, included here as it forms part 1 of a two-part study for which Sukhareva wrote part 2.

[Possibly the same article as the one below?]

К проблеме структуры и динамики детских конституционных психопатий (шизоидные формы).

“К проблеме структуры и динамики детских конституционных психопатий (шизоидные формы).”

[On the problem of the structure and dynamics of children’s constitutional psychopathy (schizoid form).]

in Журнал невропатологии и психиатрии.

Zhurnal nevropatologii i psikhiatrii. 30.6 (1930): 64-74.

“Zur Frage der epileptoiden Psychopathien: Begriffsbestimmung und Abgrenzung am Kindermaterial.”

[On the question of the epileptoid psychopathies: definition and differentiation based on children.]

in *Zeitschrift für die gesamte Neurologie und Psychiatrie.* 123.1 (1930): 626-645.

1932

“Über den Verlauf der Schizophrenien im Kindesalter.” Trans. W. A. Belaussoff.

[On the course of schizophrenias in childhood.]

in *Zeitschrift für die gesamte Neurologie und Psychiatrie.* 142.1 (1932): 309-321.

1933

Дифференциация понятия эпилептоидной психопатии.

“Differentsiatsiia poniatiiia épileptoidnoï psikhopatii.”

[Differentiation of the concept of epileptoid psychopathy.]

in Вопросы детской психоневрологии.

Voprosy detskoï psikhonevrologii. 1933.

К проблеме дефектности при мягких формах шизофрении.

“К проблеме дефектности при мягких формах шизофрении.”

[On the problem of defectiveness in mild forms of schizophrenia.]

in Невропатология психиатрия и психогигиена.

Nevropatologiya, psikhiatriia i psikhogigiena. 2.5 (1933): 24-38.

Прогностика шизофрении до детей и подростков. Г.Е. Сухарева и Э.И. Коган

“Prognostika schizofrenii do deteĭ i podrostkov.” G. E. Sukhareva and É. I. Kogan.

[Prognostics of schizophrenia for children and adolescents.]

in Советская психоневрология.

Sovetskaia Psikhonevrologiia. 6 (1933): 120-131.

Детская психиатрия.

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[Child psychiatry]

in Медицинская Энциклопедия.

Meditsinskaia Èntsiklopediia. 27 (1933): 676.

1934

Современное состояние вопроса о детской нервности.

“Sovremennoe sostoianie voprosa o detskoï nervnosti.”

[Current state of the field on childhood nervousness.]

in Вопросы психоневрологии детей и подростков.

Voprosy psikhonevrologii deteĭ i podrostkov. Moscow, 1934. 1419.

Резидуальные психические явления у детей после травмы головы. Г. Е. Сухарева и Д. Л.

Эйнгорн.

“Rezidual’nye psikhicheskie iavleniia u deteĭ posle travmy golovy.” G. E. Sukhareva and D. L.

Ėĭngorn.

[Residual mental phenomena in children after head injuries.]

in Психиатрическая больница на путях реконструкции.

Psikhiatricheskaia bol'nitsa na putiakh rekonstruktsii. Moscow.

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Резидуальные психические изменения после травм головы у детей. Г.Е Сухарева и Д. Л.

Эйнгорн.

“Rezidual’nye psikhicheskie izmenennia posle travm golovy u deteĭ.” G. E. Sukhareva and D. L.

Ėĭngorn.

[Residual mental changes in children after head injuries.]

1935

К проблеме единства шизофрении¹⁵⁶.

¹⁵⁶ Presented at the 1935 2nd Municipal Conference for Child Psychoneurology in Moscow.

“К проблеме единства шизофрении.”

[On the problem of the unity of schizophrenia.]

in Советская психоневрология.

Sovetskaia psikhonevrologiia. 6.

Клинико-психопатологические особенности вяло текущей шизофрении (на подростковом материале).

“Kliniko-psikhopatologicheskie osobennosti vialo tekushchei shizofrenii (ia podroostkozom material).” G. E. Sukhareva and I. V. Shur.

in Невропатология, психиатрия и психогигиена.

Nevropatologiia, psikhiatriia i psikhogigiena. 4.11 (1935): 1-14.

Резидуальные состояния при бурно протекающих формах шизофрении ремитирующего и интермитирующего типа. Г.Е. Сухарева и Э.И. Коган.

“Rezidual’nye sostoiianiia pri burno protekaiushikh formakh shizofrenii remitiruiushchego i intermitiruiushchego tipa.” G. E. Sukhareva and É. I. Kogan.

[Residual states with rapidly flowing forms of schizophrenia of remitting and intermittent type.]

in Невропатология, психиатрия и психогигиена.

Nevropatologiia, psikhiatriia i psikhogigiena. 4.11 (1935): 47-56.

Особенности структуры дефекта при различных формах течения шизофрении (на детском и подростковом материале).

“Osobennosti struktury defekta pri razlichnykh formakh techeniia shizofrenii (na detskom i podroostkovom materiale).”

[Features of defect structures in various forms of schizophrenia (in childhood and adolescence material).]

in *Nevropatologiia, psikhiatriia i psikhogigiena*. 4.11 (1935): 57-62.

Credited as (supervisor?) for the other papers in the book – К. А. Новлианская, М. Р. Кононова, Е. А. Осипова and I. B. Shur, D. L. Ėingorn

1936

Клинико-психопатологические особенности одной своеобразной формы остroteкущих шизофрений. Г. Е. Сухарева и С. С. Перская.

“Kliniko-psikhopatologicheskie osobennosti odnoi svoeobraznoi formy ostrotekushchikh shizofrenii.” G. E. Sukhareva and S. S. Perskaia.

[Clinical and psychopathological features of one peculiar form of acute schizophrenia.]

Possibly the same paper as above, cited by Sukhareva in 1956:

Клинико-психопатологические особенности остро протекающих форм пубертатных шизофрений. Г. Е. Сухарева и С. С. Перская.

“Kliniko-psikhopatologicheskie osobennosti ostro protekaiushikh form pubertatnykh shizofreniia.” G. E. Sukhareva and S. S. Perskaia.

[Clinical and psychopathological features of acute forms of pubertal schizophrenia.]

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Nevropatologiia, psikhiatriia i psikhogigiena. 5 (1936).

О причинах чрезмерного расширения диагностики шизофрении.

“O prichinakh chrezmernogo rasshireniya diagnostiki shizofrenii.”

[On the causes of excessive expansion of the diagnosis of schizophrenia.]

in Невропатология и психиатрия.

Nevropatologiia i psikhiatriia. 12 (1936).

О некоторых дискуссионных проблемах в области шизофрении¹⁵⁷.

“O nekotorykh diskussionnykh problemakh v oblasti shizofrenii.”

[On some debatable problems in the field of schizophrenia.]

in Невропатология, психиатрия и психогигиена.

Nevropatologiia, psikhiatriia i psikhogigiena. 5.9 (1936).

1937

Клиника шизофрении у детей и подростков. Часть I¹⁵⁸.

Klinika shizofrenii u detei i podrostkov. Chast' I.

[Clinic of schizophrenia in children and adolescents. Part I.]

Publisher: Госмедиздат УССР.

Kharkiv: Gosmedizdat USSR, 1937. 107.

Закономерности построения клинической картины психоза.

“Zakonomernosti postroeniia klinicheskoi kartiny psikhoza.”

[Regularities in the construction of a clinical picture of psychosis.]

in Советская психоневропатология.

Sovetskaia psikhonevropatologiia.

¹⁵⁷ Appears under [Materials for the All-Union Congress of Neuropathologists and Psychiatrists].

¹⁵⁸ Not sure if this is a book or an article in an unknown publication.

Значение возрастных особенностей в клинике психических заболеваний детского
возраста.

“Znachenie vozrastnykh osobennostei v klinike psikhicheskikh zabolevanii detskogo vozrasta.”

[The significance of age features in the clinic of childhood mental illnesses.]

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Sovetskaia psikhonevrologiia.

1938

Клиника эпилепсии у детей и подростков.

“Klinika èpilepsii u detei i podrostkov.”

[Clinic of epilepsy in children and adolescents.]

in Проблемы теоретической и практической медицины и эпилепсия. Т.VIII

Problemy teoreticheskoi i prakticheskoi meditsiny i èpilepsii. Vol. 8. Moscow. 234-261.

[Problems of theoretical and practical medicine and epilepsy.]

Undated citations found in the 1940 Clinical Lectures:

Олигофрения. Г. Е. Сухарева и Л. С. Юсевич. БМЭ, т.21, стр. 810.

“Oligofreniia.” G. E. Sukhareva and L. S. Iusevich. *BME.* Vol. 21. p. 810.

[Oligophrenia.]

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[The psychopathological picture of head injuries in children.]

Психопатология туберкулеза у детей. Г. Е. Сухарева и Е. А. Осипова

“Psikhopatologiia tuberkuleza u detei.” G. E. Sukhareva and E. A. Osipova.

[Psychopathology of tuberculosis in children.]

Структура посттравматических состояний.

“Struktura posttravmaticheskikh sostoianii.”

[The structure of post-traumatic conditions.]

Пути детской психиатрии в СССР и ее задача на данном этапе.

“Puti detskoï psikhiatrii v SSSR i ee zadacha na dannom ètape.”

[Directions for child psychiatry in the USSR and its current role.]

1940

Основные принципы психиатрической диагностики.

“Osnoviye printsipy psikhiatricheskoï diagnostiki.”

[Basic principles of psychiatric diagnosis.]

in Вопросы детской психиатрии.

Voprosy detskoï psikhiatrii. Moscow. 5-28.

Некоторые дискуссионные вопросы современной психиатрии в свете данных изучения посттравматических состояний.

“Nekotorye diskussionnye voprosy sovremennoï psikhiatrii v svete dannykh izucheniiia posttravmaticheskikh sostoianii.”

[Some discussion of modern psychiatry in light of data on the study of posttraumatic conditions.]

in Труды ЦИП. Т. I

Trudy TsIP¹⁵⁹. Vol. 1.

Клинические лекции по психиатрии детского возраста. Книга I.

Klinicheskie leksii po psikhiatrii detskogo vozrasta. Book 1. Moscow: Medgiz, 1940.

[Clinical Lectures in Child Psychiatry.]

1943

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“Psikhogennnye tipy reaktsii voennogo vremeni.”

[Psychogenic types of wartime reactions.]

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Nevropatologïia i psikhiatriia. 12.2 (1943): 3-10.

1945

Психогений тип реакции с депрессивно-бредовым синдромом.

“Psikhogenniï tip reaktsii s depressivno-bredovym sindromom.”

[The psychogenic type of reaction with depressive-delusional syndrome.]

¹⁵⁹ Tsentral'nogo Instituta Psikhiatrii NKE RSFSR.

1946

Периодические психозы на фоне резидуальной церебральной неполноценности.

“Periodicheskie psikhozy na fone rezidual’noĭ tserebral’noĭ nepolnotsennosti.”

[Periodic psychoses against a background of residual cerebral deficiency.]

in Невропатология и психиатрия.

Nevropatologiya i psikhiatriia. 4 (1946).

1947

Узловые проблемы детской психиатрии как сравнительно-возрастной дисциплины.

“Uzlovye problemy detskoĭ psikhiatrii kak sravnitel’no-vozzrastnoĭ distsipliny.”

[Nodal problems of child psychiatry as a comparative-age discipline.]

in Невропатология и психиатрия.

Nevropatologiya i psikhiatriia. 2 (1947).

Значение сравнительно-возрастного метода при изучении шизофрении.

“Znachenie sravnitel’no-vozzratnogo metoda pri izuchenii shizofrenii.”

[The value of the comparative-age method in the study of schizophrenia.]

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Trudy TsIP. Vol. 3

1947/48

“Psychologic disturbances in children during war.” (Trans. ?)

in *The American Review of Soviet Medicine*. 5.1 (Dec 1947-Jan 1948): 32-37.

1948

Клинические закономерности возникновения и развития психогении.

“Klinicheskie zakonomernosti vozniknoveniia i razvitiia psikhogenii.”

[Clinical regularities in the emergence and development of psychogenesis.]

Психосензорные формы энцефалита у детей. Г. Е. Сухарева, Е. Е. Сканави, М. С. Певзнер, В. Я. Дефнов, Е. А. Осипова, Л. И. Гелина.

“Psikhosenzornye formy éntsefalita u deteĭ.” G. E. Sukhareva, E. E. Skanavi, M. S. Pevzner, V. Ia. Defnov, E. A. Osipova, L. I. Gelina.

[Psychosensory forms of encephalitis in children.]

in Труды III Всесоюзного съезда невропатологов и психиатров.

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1951

Узловые вопросы в проблеме отграничения шизофрении.

“Uzlovye voprosy v probleme otgranicheniia shizofrenii.”

[Nodal questions on the problem of the delimitation of schizophrenia.]

in Труды Института психиатрии Минздрава РСФСР.

Trudy Instituta psikhiatrii Minzdrava RSFSR. Moscow.

1955

Клинические лекции по психиатрии детского возраста. Т. I.

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1956

Эпизодические психозы в отдаленном периоде мозговых инфекций и травм у детей.

“Épizodicheskie psikhozy v otdalennom periode mozgovykh infektsii i travm u detei.”

[Remote episodic psychoses following cerebral infections and trauma in children.]

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1958

Предпосылки к организации психоневрологической помощи детям.

“Predposylki k organizatsii psikhonevrologicheskoi pomoshchi detyam.”

[Prerequisites for the organisation of psychoneurological service to children.]

in Вопросы детской психоневрологии.
Voprosy detskoi psikhonevrologii. 20-29.
[Questions in Child Psychoneurology]

Psychiatria wieku dziecięcego: wykłady kliniczne. T.1. G. E. Suchariewa; Eugeniusz Wilczkowski; Wojciech Pogorzelski; Helena Flatau; Edward Sobolewski
[Clinical Lectures in Child Psychiatry. Vol. 1]. G. E. Sukhareva. Ed. Eugeniusz Wilczkowski and Wojciech Pogorzelski. Trans. Wojciech Pogorzelski, Helena Flatau and Edward Sobolewski. Warsaw: Państwowy Zakład Wydawnictw Lekarskich, 1958.

儿童精神病学临床讲义.第一册. Г.Е. 苏哈列娃 著 沈渔邨 许迪 译 朱滨生 校
[Clinical Lectures in Child Psychiatry. Vol. 1] G. E. Sukhareva. Trans. Shen Yucun and Xu Di. Revised by Zhu Binsheng. Beijing: Remin Weisheng Chubanshe, 1958.

1959

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[Clinical Lectures in Child Psychiatry.]

[Organisation of psychoneurological aid for children in the RSFSR.]

in Вопросы охраны материнства и детства.
Voprosy okhrany materinstva i detstva. Nov-Dec. 4 (1959): 54-59.

О работе психоневрологического кабинета для детей и подростков при психоневрологическом диспансере и детской поликлинике. Г. Е. Сухарева и М. И. Лапидес.
“O rabote psikhonevrologicheskogo kabineta dlia detei i podrostkov pri psikhonevrologicheskom dispansere i detskoj poliklinike.” G. E. Sukhareva and M. I. Lapidés.
[About the work of the psychoneurological room for children and adolescents at the psychoneurological dispensary and children’s polyclinic.]

1960

О задачах научных исследований в области детской психиатрии.
“O zalachekh nauchnykh issledovaniĭ v oblasti detskoj psikhiatrii.”
[On the tasks of scientific research in the field of child psychiatry.]

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Zhurnal nevropatologii i psikiatrii im. S. S. Korsakova. 60.7 (1960).

1964

О некоторых узловых вопросах учения об олигофрении.

“O nekotorykh uzlovykh voprosakh ucheniia ob oligofrenii.”

[On some crucial problems in oligophrenia.]

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1965

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[Psychogenic pathological reactions (neurosis).]

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Klinicheskie lektsii po psikiatrii detskogo vozrasta. Vol. 3. Moscow: Medgiz, 1965.

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[Reactive States and Psychopathies in the Clinic of Children]. G. Sukhareva. Trans. Helena Flatau. Warsaw: Państwowy Zakład Wydawnictw Lekarskich, 1965.

“Some crucial problems in the understanding of oligophrenia.” Trans. William M. Mandel.

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1967

“Znachenia sravnitel'no-vozrastnogo aspekta pri izuchenii zakonomernostei techeniia shizofrenii u detei i podrostkov.”

[The significance of comparative age in the study of the regularities in the course of schizophrenia in children and adolescents.]

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Zhurnal nevropatologii i psikiatrii im. S. S. Korsakova. 67.10 (1967): 1495-1501.

“Die Bedeutung der vergleichenden Berücksichtigung des Lebensalters für die Untersuchung der Verlaufsgesetzmässigkeiten der Schizophrenie bei Kindern und Jugendlichen. /

The importance of considering the effect of age for the study of fixed rules in the course of schizophrenia in children and adolescents. /

La signification de la prise en considération comparative de l'âge chronologique pour l'étude des critères évolutifs de la schizophrénie des enfants et des adolescents. /

Importancia de la consideración comparativa de la edad para la investigación de las formas de curso en la esquizofrenia infantil y juvenil.”

in *Acta Paedopsychiatrica*. 34 (1967): 307-320.

1969

К вопросу о критерии дифференциации эпилепсии (по данным детской клиники). I.

“K voprosu o kriterii differentsiatsii épilepsii (po dannym detskoï kliniki). I.”

[Criteria for differentiating epilepsy (according to data from a children's clinic) I.]

in Журнал невропатологии и психиатрии им. С.С. Корсакова.

Zhurnal nevropatologii i psikhiatrii im. S. S. Korsakova. 69.10 (1969): 1526-1530.

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1970

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“Rol' voznrastnogo faktora v klinike detskikh psikhozov.”

[Role of the age factor in the clinical picture of psychoses in children.]

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1971

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[The problem of mental retardation classification.]

in *Boletín de la Oficina Sanitaria Panamericana*. (August 1971): 157-163.

[Bulletin of the Pan American Sanitary Bureau.]

1972

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“K voprosu o kriteriakh diagnostiki oligofrenii u detei.”

[On the issue of diagnostic criteria for oligophrenia in children.]

in Журнал невропатологии и психиатрии им. С.С. Корсакова.

Zhurnal nevropatologii i psikhiatrii im S. S. Korsakova. 72.9 (1972):1342-1347.

“The problem of the classification of mental retardation.” G. E. Suhareva. Trans. ?

in Supplement to *The American Journal of Psychiatry. 128.11 (May 1972): 31-35.*

Спорные вопросы в определении понятия психопатии.

“Spornye voprosy v opredelenii poniatiia psikhopatii.”

[Controversial issues in the definition of the concept of psychopathy.]

in Журнал невропатологии и психиатрии.

Zhurnal nevropatologii i psikhiatrii. 72.10 (1972): 1516-1520

1974

Лекции по психиатрии детского возраста. Избранные главы.

Leksii po psikhiatrii detskogo vozrasta. Izbrannye glavy. Moscow: Meditsina, 1974.

[Lectures in Child Psychiatry. Selected Chapters.]

1996

“Schizoid personality disorders of childhood.” Trans. Sula Wolff. In “The first account of the syndrome Asperger described? Translation of a paper entitled ‘Die schizoiden Psychopathien im Kindesalter.’”

in *European Child & Adolescent Psychiatry. 5.3 (1996): 119-132.*

2002

Значение возрастных особенностей детей и подростков в клинике психических заболеваний.

“Znachenie vozrastnykh osobennostei detei i podrostkov v klinike psikhicheskikh zabolevaniy.”

[The significance of age features in the clinic of childhood mental illnesses.]

in Психология аномального развития ребенка. Т.1

228

Psikhologiiia anomal'nogo razvitiia rebenka. Vol. 1. Ed. V. V. Lebedinskogo, M. K. Bardyshevskoi. Moscow: MGU, 2002. 83-100.

Группировка психопатий.

“Gruppirovka psikhopatii.”

[Grouping of psychopathies.]

in Психология аномального развития ребенка. Т.2

Psikhologiiia anomal'nogo razvitiia rebenka. Vol. 2. Ed. V. V. Lebedinskogo, M. K. Bardyshevskoi. Moscow: MGU, 2002. 254-271.

Преимущественные для детского возраста психогенные реакции.

“Preimushchestvennye dlia detskogo vozrasta psikhogennye reaktsii.”

[Predominant psychogenic reactions among children.]

in Психология аномального развития ребенка. Т.2

Psikhologiiia anomal'nogo razvitiia rebenka. Vol. 2. Ed. V. V. Lebedinskogo, M. K. Bardyshevskoi. Moscow: MGU, 2002. 593-61?.

2016

“La psychopathie schizoïde dans l’enfance.” Trans. A. Andronikof, P. Fontan. In “Grounia Efimovna Soukhareva : la première description du syndrome dit d’Asperger.”

in *Neuropsychiatrie d l’enfance et de l’adolescence*. 64.1 (2016): 58-70.

2019

“The Particular Features of Schizoid Psychopathies in Girls.” Trans. Charlotte Simmonds. In

“The first account of the syndrome Asperger described? Part 2: the girls.”

in *European Child & Adolescent Psychiatry*. (2019): 1-16.

7 Reception History

The history of science is science itself, the history of the individual is the individual.

Goethe translated by Leo Kanner, 1973

The juxtaposition of science and individual is a realistic reminder of the interdependence of the two; it tends to put aside the age-old “Which-came-first?” controversy which no historian thus far has been able to settle to anybody’s satisfaction.

Kanner on Goethe, 1973

This chapter looks primarily at the reception of Sukhareva’s work in Anglo-European literature – I do not yet have the necessary skills for a comprehensive review of her reception in Slavic texts, but this history also looks at the reception of political conditions in 20th century medical literature and the effects those conditions had on the exchange of medical knowledge. Discussion of such topics may seem tangential to Sukhareva, but they are central: in chapter 6, I traced the huge changes in the number of Pavlov citations and citations of foreign researchers from one edition of her textbook to the next in response to the changing political climate, and so in this chapter, we take a small look at the political climate on the other side. With my research conducted over 2016 to 2018, during the Trump presidency and Brexit, these topics have acquired fresh relevancy beyond the niche interests of academics and historians. Scientists, including those studying ASDs, are already again being affected by a return to conditions similar to those of the Cold War. This chapter concludes with a brief analysis of how Sukhareva’s reception in Anglo-European spheres may have increased the perceived value of her work in Russia.

Soviet Psychoneurology

Opening the English-language reception with Soviet texts, *Sovetskaia*

Psikhonevrologiia [Soviet Psychoneurology] sometimes published summaries of its articles in English and French. Subscribers to or viewers of the journal therefore did not need to be Russolexic to gain some knowledge of psychoneurological research conducted in the Soviet Union. However, the English and French in these abstracts is quirky and takes some deciphering. Sukhareva is given as Prof. G. E. Sookhareva in

both English and French, a somewhat acceptable phonetic spelling in English but a misleading one for French pronunciation. There are no foreign language summaries for “Osobennosti shizoidnykh psikhopatii u devochek” [Features of schizoid psychopathy in girls] in 1927, but there are summaries for “K probleme edinstva shizofrenii” [On the problem of the unity of schizophrenia] in 1935, wordily translated as “A contribution to the problem of the unity of schizophreny (on a material of infantile and puberty forms)” and “Contribution au probleme de l’unité de schizophrénie (sur le matériel des forms infantiles et celles de la puberté)”.

Eugen Kahn, 1931

The earliest mention I could find of Sukhareva in an English-language text is in *Psychopathic Personalities* in 1931. This is the translation of a section in the fifth volume of Oswald Bumke’s *Handbuch der Geisteskrankheiten*, the volume being published in 1928. The book-length section “Die psychopathischen Persönlichkeiten” was written by Eugen Kahn, who emigrated to the USA in 1930 to take up a teaching position at Yale. The translation is by H. Flanders Dunbar and published by Yale University Press. In this book, Kahn includes both of Sukhareva’s case study papers on childhood schizoid psychopathy in his bibliography, the one on boys and the one on girls, as well as Sukhareva and Osipova’s paper on giftedness and constitution, thus providing the interested Usonian German-reading reader of his work all the necessary information for further investigation. But the book is focused on vague characterological classification with descriptions resembling those found in Kretschmer’s *Körperbau und Charakter* or even Scholz and Gregor’s *Anomale Kinder*, and it is unsurprising that this book has sunk into the sediment of history. Kahn’s liberal uses of autism and autist bear no resemblance to anything these words represent today. His mention of Sukhareva appears in “The Problem of Schizoid Types”. He does not consider her descriptions of schizoid psychopathy in children a new nosological entity, but rather descriptions made with yet another private definition of ‘schizoid’, further muddying the waters surrounding the term.

The efforts of Claude and his co-workers have been in the same direction, to give the schizoid *une physiognomie Clinique beaucoup plus limitée* without entirely forgetting that in psychiatry there exist no *limites nettes*. The French authors attempt to differentiate the *Constitution schizoïde* from the other psychopathic “constitutions” – the paranoid, mythomaniac (pseudologistic), emotive-psychasthenic, that is, those with

whom the schizoid seems to have features in common. For them schizoidia is not a manner of behaviour (*attitude*), but instead a permanent condition (*état habituel*); frequently psychopathically tainted, the schizoid shows even in childhood a tendency toward loneliness and dreaminess. Adjustment to external reality is an eternal difficulty for the schizoid and he fails in practical life which he likes to neglect; he prefers his inner world to the outer world, he does not act and struggle because he *will* not. Schizomania and schizophrenia are, so to speak, the psychoses of choice for the schizoid.

As a further representative of clinical procedure Ssucharewa may be mentioned. She has attempted to outline a psychopathic group setting out with schizoid children “whose clinical picture shows many features in common with the schizophrenic although being sharply separated from schizophrenia with regards to pathogenesis.” The author assumes “that the schizoid psychopathies spring from a basis of an innate insufficiency in those systems which are affected in schizophrenia (but here under the influence of other factors.”

One might well question whether the so-called schizoid types established by these individual authors are all correctly seen. (335-336)

Four Citations, Two Papers, 1938

At Guy’s Hospital in London, R. A. Q. Lay brings Sukhareva into English texts on childhood schizophrenia with his citations of three of her papers in 1938, dealing with the issue of citing a German transliteration in English by providing “Ssucharewa [Sukhareva]”. One is Sukhareva’s 1932 paper “Über den Verlauf der Schizophrenien im Kindesalter”, which went on to become a classic in citation lists in papers on childhood schizophrenia. Lay’s paper is comprehensive, covering all schizophrenia- or autism-like syndromes recorded at that point. These include de Sanctis’s dementia praecocissima and tardive aparetic-aphasic phrenasthenia, Heller’s dementia infantilis, Lange’s cases, and Kramer and Pollnow’s hyperkinetic disease (not at all similar to ADHD). He provides cases studies of his own, one of which includes the comments, “The mother was a schizoid psychopath, who showed during attendance at the clinic a frankly schizophrenic episode. She had always been dreamy, brooding and ‘artistic’, and was very unhappy at home before marriage.” (118) Lay mentions Sukhareva’s 1932 work on childhood schizophrenia several times in the paper and two other papers by Sukhareva, not mentioned in the text, appear in his bibliography. The titles are not given, but one is a German paper from 1928, “Zur Klinik der Psychopathien im Kindesalter (Zykloide Formen)”; the other is a Russian paper from 1933 “[On the problem of defectiveness in

mild forms of schizophrenia]” appearing in *Sovetskaia nevrologiia, psikhiatriia i psikhogigiena*.

J. L. Despert is the next person to bring Sukhareva into an English text in “Schizophrenia in Children”. While Despert’s use of it here is probably how Leo Kanner became aware of this paper, Despert herself read it independently of Lay, as her paper was based on a talk given in 1937. Either of these citations may be what drew Hilmar Philipsen-Prahm’s attention to it in Denmark, although Philipsen-Prahm is more likely to have seen the paper independently than Kanner.

A Book Review, 1941

Under the heading “Recent neuropsychiatric publications issued in Soviet Russia (1939-1940), an “A. J. R.” reviewed Sukhareva’s first textbook, [Clinical Lectures in Child Psychiatry, Book 1]. This is astonishing as the first textbook is so little known in Russian, let alone English¹⁶⁰. The review appeared in *American Journal of Insanity*, now *American Journal of Psychiatry*. It appears the book was sent to the journal for review. Singling out a monograph by Shmar’yan and Sukhareva’s textbook, the review is interesting for its Western perspective on Soviet work.

From time to time, and with increasing frequency, this JOURNAL has been receiving neuropsychiatric publications from Soviet Russia and we have been interested to note their rapidly changing character. Not so long ago the publications reaching us were either largely of a diffuse and speculative nature, or they consisted merely of summaries of foreign publications, principally Germany’s. The more recent publications are obviously based on abundant clinical experience, dealt with for the most part in a fairly competent way and occasionally even in an original way. (151)

The reviewer notes firstly that Russia is going to enormous effort to develop their neuropsychiatric services so that all citizens can have access to such services, and notes secondly the Russian integration of neurology and psychiatry under the assumption that there is a medical or organic basis for most mental illness.

¹⁶⁰ Although it is used by Joseph Wortis for his “Child Psychiatry” chapter in *Soviet Psychiatry* (1950).
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Sukhareva's book is referred to as "another outstanding example of the newer psychiatric works in Soviet Russia" but Sukhareva's sex is highlighted, in contrast to Shmar'yan who is simply a professor: "Professor G. E. Sukhareva, who is a woman director of one of the child psychiatric clinics in Moscow." The review describes the contents of the second volume of the text¹⁶¹. In "Child Psychiatry" in Joseph Wortis's 1950 *Soviet Psychiatry*, Wortis too mentions this second volume with a description detailed enough that it seems the volume might exist. I was not able to find "book 2", or indeed any catalogue entry for it or any citation of it, finding only the volume 2 that came out in 1959, after [*Clinical Lectures in Child Psychiatry book 1*] was republished as [*Clinical Lectures in Child Psychiatry vol. 1*] in 1955.

A. J. R.'s review is overall positive:

In my opinion this text would compare favourably with any similar work published in German, French or English, but is by no means a book slavishly modelled on foreign treatises. On the contrary, the author seems to be hardly aware that there are texts on child psychiatry in Western Europe or in the United States. She states that "in many of the bourgeoisie countries scientific thought in the field of psychiatry is passing through a crisis, but with us in the U. S. S. R. all conditions have been created for the successful development of the sciences in general and of the medical sciences in particular." She knows as little about what goes on there as most of us here know about what goes on over there. (151)

Sukhareva was well-informed of international developments in child psychiatry in 1940, perhaps more than Anglophone writers, but Stalinism was already affecting what academics could cite in their references and to whom discoveries could be attributed, and as we see here from A. J. R., the chauvinistic policies did affect the international reception and credibility of Soviet work.

Three Citations, Two Papers, 1942-1945

"Studies on the prognosis in schizophrenic-like psychoses in children" (first read in May 1942, published January 1943) is unusual for referencing not only the 1932 German paper on the course of schizophrenia in children but also a Russian paper on the

¹⁶¹ "The second volume of this text deals with borderline types, reactive conditions, neuroses, psychopathic states, manic-depressive psychoses and mental deficiency."

prognosis of childhood schizophrenia from *Sovetskaia psikhonevrologiia* by “Ssucharewa¹⁶² and Kogan”, and for criticising some of the findings. The criticisms directed at Sukhareva and Kogan by the authors R. S. Lourie, B. L. Pacella, and Z. A. Piotrowski are to do with the Kretschmerian body types. “We could see no definite relationship,” the authors write, “between Kretschmerian body type, course and outcome of the illness as had Ssucharewa and Kogan who felt that dysplastic and asthenic individuals in their pre-psychotic make-up had a poor prognosis.” (547) So the Kretschmerian types were short-lived. However, the authors confirm other findings of Sukhareva’s and are able to match them with results of others such as Despert (548). This is also the Lourie who later met Sukhareva in Moscow in 1962.

Hilmar Philipsen-Prahm’s citation appears in a paper first presented to the Danish Psychiatric Society on 20 March 1943 before being published in English in *Acta Psychiatrica Scandinavica* in 1945. This is “Episodic psychosis in a seven-year-old boy: a casuistic report”, a long, detailed study of a boy who has a dramatic regression, and who, over the period of a year following a narrow miss with a car¹⁶³ shows features of classic autism. As the child then recovers, going on to show merely schizoid features, some of which are also displayed by his father, the staff of the Himmelev Children’s Asylum rule out Heller’s syndrome (56). The paper includes photographs of the child and some of his drawings. By the end of his stay, he more resembles a child with Asperger’s syndrome. The staff finally succeed in persuading him to submit to intelligence testing but suspect that his actual intelligence is above average, while his results indicate average intelligence. In the list of references, Philipsen-Prahm includes Despert’s “Schizophrenia in Children”, the 1935 edition of Kanner’s textbook *Child Psychiatry* (prior to Kanner’s descriptions of early infantile autism), Sukhareva’s “Über den Verlauf der Schizophrenien im Kindesalter” and the 1942 edition of Tramer’s *Lehrbuch der allgemeinen Kinderpsychiatrie*.

Right from the beginning, even for readers of Russian, Sukhareva’s name in English was associated with childhood schizophrenia.

¹⁶² Sukhareva’s name here is transliterated in the German way, perhaps for consistency with the other paper, although the titles of both papers are translated into English.

¹⁶³ Recall one of de Sanctis’s children who saw her mother hit by a tram.

Children During War

The first instance of Sukhareva's work being published in English is in the 1947/48 edition of *The American Review of Soviet Medicine*. The paper is "Psychologic disturbances in children during war", sadly an area with which Sukhareva now had about 30 years' worth of experience. However, this paper is largely a report on a project undertaken by the paediatric department of Kashchenko Hospital in Moscow, in which 858 case histories from 1943 were analysed. The results of the study were then presented by four doctors at a conference at the Ministry of Health's Central Institute of Psychiatry. Sukhareva is reporting on the outcome of their study in her capacity as "Director of the Children's Clinic at the Central Institute of Psychiatry, Ministry of Health, USSR" (32). This paper records not only an increase in psychiatric conditions due to exposure to trauma, but also an increase in psychiatric symptoms due to exposure to toxins and increased rates of infection. The suffering of the traumatised children described is almost exclusively at the hands of German soldiers. The degree of scientific objectivity and lack of emotional language towards Germans in this paper is truly remarkable, and at the same time, the paper does not read as cold, unfeeling or lacking in compassion. The paper also describes the cumulative effect of successive traumatic events and increased sensitisation¹⁶⁴. Although the work described appears to be the work of a collective rather than Sukhareva alone (it is not even clear to what extent she was personally involved in the work herself), the paper references another Russian-language work of Sukhareva's from 1943: "Psikhogennye tipy reaktsii voennogo vremeni" [Psychogenic types of reaction in wartime] (37).

Against Isolationism: The American-Soviet Medical Society and the American Review of Soviet Medicine

Following the foundation of the Anglo-Soviet Medical Committee in 1942, the USA imitated the British and began the American-Soviet Medical Society in 1943 to exchange medical information with its then ally, Russia. Russia had enormous experience in war medicine, while the USA did not. Few Usonian doctors read Russian, a great gap in Usonian medical literature was perceived, and as a result, the *Review* was founded to benefit Usonian medicine. It was a short-lived journal, running from 1943 to 1948, published by the American-Soviet Medical Society in New York and edited by

¹⁶⁴ "Mechanism of sensitization and adaptation takes place, as in cases with physiologic stimulation." (35) sounds suitably Pavlovian and this well before the Pavlovian sessions. What was she doing wrong? This question is answered by the 1943 Russian paper on psychogenic reactions in wartime in which different disturbances are affiliated with different regions of the brain.

Henry E. Sigerist. Sigerist was then at Johns Hopkins University in Baltimore, Maryland, the same institute of Kanner's affiliation, although both the *Review* and the Society were independent.

The first issue began with these lines from Walter B. Cannon, the president of the Society:

The medical profession is the world's greatest fraternity: wherever a doctor may go in civilized society, he is welcomed by his fellow doctors. International meetings, excursions of physicians to foreign lands, and wide ranging cooperative study of disease by medical experts attest the universality of our professional interests and the community of our efforts. As disease itself is no respecter of national or racial differences, so the doctors in their humane service do not respect them. (Sigerist 5)

and included V. V. Lebendenko's hopes that the journal would "prove an important step in the mutual sharing of scientific achievement among nations which will enrich the life of man after the plague of fascism has been cleansed from the earth."¹⁶⁵ Even President Harry Truman added some words for a 1946 issue: "May the good offices of the medical profession help to bring about the betterment of humanity and assist in the building of a broader understanding as a foundation for a lasting peace."¹⁶⁶

The Society posted many Usonian publications to the USSR – journals and books donated by publishers, reprints of collected papers from university departments – and facilitated the translation and publication of Russian medical books. The *Review's* editor Henry Sigerist, both a doctor and historian of medicine, humbly noted in 1948, towards the journal's cessation, that, "It was not founded to 'help the Russians' during the war, but for the sober exchange of medical information which would benefit both parties and us more than them, since more Russian physicians read English than American doctors Russian." (7) In 1945 and 1946, members of the ASMS visited the Soviet Union and were shown around the medical institutions they were interested in. Soviet scientists also presented papers alongside Usonians at the ASMS's annual meetings. The *Review* struggled along with no institutional support or funding, subsisting on Society memberships, subscriptions, minimal advertisement sales, and the

¹⁶⁵ "Greetings from the USSR", *ARSM* 1 (1943): 8 in Kerber (231).

¹⁶⁶ "Harry Truman to American-Soviet Medical Society, December 14, 1945", *ARSM* 3 (1946): 281 in Kerber (231).

occasional donation. It survived the sporadic receipt of documents during the unreliable war years and was kept alive by people who genuinely cared about the exchange of information, but it did not survive McCarthyism. When Russia was an ally, the journal was enthusiastically received. When political circumstances changed, the *Review*'s subscribers and purchasing advertisers dropped dramatically. Sigerist writes of his disappointment and even bewilderment at what he saw as emotional subscription motives, antithetical to the true goals of science. "This is a strange behaviour that we would not expect from people trained in scientific methods of thought." (7)

In "A USA-USSR Experiment in Medical Journalism: The American Review of Soviet Medicine", Richard E. Kerber documents how Sigerist and the Society, initially praised and lauded in Usonian media, quickly fell out of favour with the onset of the Cold War. In January 1939, Sigerist appeared on the cover of *Time Magazine*. By 1944, he was deemed unfit for public service. In January 1946, *Medical Economics* described him as the "U.S. mouthpiece of Soviet Medicine" and Kerber says, "The Society was demonized in the U.S. press." (234) Sigerist was investigated by the FBI, and in 1947, he returned to Switzerland where he had studied medicine, never visiting the USA again. The journal ceased publication in 1948. Sigerist devoted his remaining years to the history of medicine, dying in 1957.

Written from Switzerland to inform readers of a reduction in issues with the intent to increase "as soon as conditions permit" (8), one of Sigerist's editorials in 1948 has many passages which are slightly heartbreaking for the ease with which they could appear in editorials today: "The international brotherhood of the medical profession cannot be stressed strongly enough today when misunderstanding, suspicion and vicious propaganda are poisoning relations between the nations." (5) "We [...] are determined [...] to strengthen human and scientific relations between the two countries both of which will gain through cooperation and both lose if they are forced into isolation." (5) The Society "created mutual understanding and good will in a world that is greatly in need of them. In the field of medical science Americans and Russians met on common grounds where they could shake hands without mental reservation, where in spite of different tongues they spoke the same language." (7) The founders of the Society and the *Review* "are not guided by emotions but by a sincere interest in medical science and by the desire to make the results of research available to suffering humanity irrespective of border lines" (7). "The United States and the USSR are two great countries in which

medical science is making great strides, two countries that have the brains and the means to carry out research on a vast scale. It would be perfectly foolish to ignore the results of the other country's work." (8)

The below obituary for the journal appeared in the *British Medical Journal*, 16 April 1949.

AMERICAN REVIEW OF SOVIET MEDICINE

The October, 1948, issue of the *American Review of Soviet Medicine*, recently received, contains the announcement that the publication is to be suspended indefinitely. The *Review* first appeared in October, 1943, sponsored by the American-Soviet Medical Society, under the presidency of the late W. B. Cannon. It was designed to publish translations of important papers from Russian medical literature, survey articles of various aspects of Russian medicine by American experts, news of current medical events in the U.S.S.R., reviews of Soviet medical books, etc. Edited throughout its existence by Dr. Henry E. Sigerist, the *Review* made possible a wide exchange of medical information between the Soviet Union and the English-speaking countries, while the American-Soviet Medical Society was able to build up an extensive library of Russian literature. In a valedictory editorial Dr. Sigerist writes: "Much to our regret we are unable to [continue publication] for reasons which are so obvious that we need not elaborate on them." As the difficulty in obtaining medical literature from the U.S.S.R. has not appreciably increased since 1943, other factors must be responsible for the decision to discontinue the *Review*. The American-Soviet Medical Society is to continue in being, and will keep its members informed of medical developments in the U.S.S.R. by issuing mimeographed reports whenever there is an opportunity.

With the United Kingdom not experiencing red panic to the same extent, the author of this piece is either somewhat bemused by or being darkly ironic about the "reasons so obvious", in their remark "other factors must be responsible".

Richard E. Kerber describes Sigerist, Cannon and the *Review* as "victims of rapidly changing political conditions that, under the watchful and suspicious gaze of American authorities, came to imbue their professional activities with a new and threatening meaning." (235) Kerber's conclusion is worth including:

[...] the ARSM, founded on idealism and a desire for the dissemination of medical knowledge in an anti-fascist cause, served a useful purpose in a war against one enemy, but foundered due to its associations with another. This little-remembered effort remains a paradigm of the complexity of deploying science and medicine for political ends. (235)

If the Society had survived long enough to facilitate the translation and publication of Sukhareva's clinical lecture volumes of 1955 and 1959 and if Anglo-American psychiatrists could have felt apolitical interest in this work, Anglo-American psychiatry might not have been so far behind Russian psychiatry on autistic psychopathy. Both could have benefited from comparing and replicating results.

Similar Publications

From 1945, there was the *Sociedad Cubano-Soviética*, a sister society to the ASMS. This society published *Revista Cubana de Medicina Soviética*. In France, there was a Commission Médicale Du Centre Culturel Et Économique France-U.R.S.S., which published *Cahiers de Médecine Soviétique* from 1953 to 1957. The contents of these journals are unindexed and uncatalogued, and I have not been able to review them. I do not know if work by Sukhareva and/or her colleagues appeared in these publications; given the high profile of Sukhareva's work in the USSR, it seems unlikely her work would *not* appear here.

Symposium on Soviet Science, 1951

In 1951, the political heat in the USA had not yet died down and this was also precisely when the heat in the USSR was being turned up. It is astonishing that 1951 saw the American Association for the Advancement of Science hold a symposium on Soviet Science in Philadelphia on 27 December. Ivan D. London presented a paper on Soviet psychology and psychiatry and talked about the Pavlovian sessions, informing the West of the extreme conditions Soviet psychiatrists worked under and mourning. "Whether this retrogression, however, represents a total loss to world science should not be answered in the glib affirmative, at least not for the present." (26)

Anglo-European Reports on Soviet Child Psychiatry

Due to her high position, many general reports on Soviet child psychiatry (or child psychoneurology) mention Sukhareva. There are several of these, among them the

chapter on child psychiatry in Wortis's 1950 *Soviet Psychiatry* (Wortis became the subject of an SISS investigation in 1953 as a result); *La Psychiatrie Soviétique* in 1953, a French translation of Lourie's book; Tramer's brief German-language report in 1953; van Krevelen's French-language report in 1964, and *Child Psychiatry in the Soviet Union* by Nancy Rollins, published in the USA in 1972. This last makes extensive use of Sukhareva's work. None of these reports are interested in schizoid/autistic psychopathy, focusing largely on intellectual disability, psychoses and epilepsy, with unwarranted interest in the USSR's lack of interest in Freudian psychotherapy. In general, the authors seem to be reading Sukhareva's collections of clinical lectures, including Tramer who mentions her first 1940 book, but schizoid/autistic psychopathy slips by unremarked upon. The closest we get to it is a paragraph under 'Borderline States' in Rollins's chronologically late book, and this is not in relation to any of Sukhareva's studies but to another 1961 study by L. I. Golovan on compulsive states in children.

Kanner's References

As mentioned in the literature review, Leo Kanner references Sukhareva's German work on childhood schizophrenia. The first reference is in 1949 in "Problems of nosology and psychodynamics of early infantile autism". The paper is again Sukhareva's 1932 "Über den Verlauf der Schizophrenien im Kindesalter." It appears in a reference list containing English, German and Italian sources, including Theodor Heller, Sante de Sanctis and other authors on Heller's syndrome. While Kanner never cites other papers by Sukhareva (although he publishes an abstract of hers in 1971), he was familiar with some of her later work and corresponded with her in the 1950s.

In 1955, Kanner mentions Sukhareva in "Notes on the follow-up studies of autistic children", a paper that also discusses work being done on autism-like syndromes around the world and which cites similar work carried out prior to Kanner's own. Again it is in relation to childhood schizophrenia, work that postdates her papers on schizoid psychopathy. No reference is given here, but I assume it is the same 1932 paper. This is still the period of McCarthyism in the USA and is only two years after the death of Stalin in the USSR. The Soviet scientists are still, to a large extent, cordoned off, so it may be unsurprising that people are not widely discussing Sukhareva's work at this time. Sukhareva is mentioned along with three other researchers who were also women:

It [early infantile autism] certainly does present a picture of sufficient specificity to be sifted out and recognized as being unlike other psychotic behaviour constellations, but there surely can be no objection to its inclusion in a broadly conceived framework of “schizophrenia.” Differences in onset, content and course of schizophrenia in children have been discussed for some time. Ssucharewa and Grebelskaya-Albatz in Russia and Despert in this country have distinguished cases with acute onset and cases with insidious onset. After the publications of the first eleven cases of autism from our clinic, Despert and Mahler were among the first to study autistic children concurrently with our own work. It was Mahler who, on the basis of phenomenology and the nature of mother-child relationship, eventually worked out the helpful division between autistic and symbiotic infantile psychoses, presented in her excellent papers of 1949 and 1952. (CP 79-80)

That four women are bundled together here does not appear intentional. Their gender is not highlighted. They appear alongside each other simply for the relatedness of their work. This to me argues against the idea that the work of women doctors was being intentionally suppressed in the United States by a curmudgeonly, patriarchal profession. Instead, I think this passage further evidence that research carried out by women was valued and respected. Whether the profession held unconscious biases that unintentionally prevented women from achieving higher positions or required them to do twice as much work to receive the same level of recognition as men is a different question.

Kanner cites the childhood schizophrenia paper again in 1958 in a work on early infantile autism co-authored with Leonard I. Lesser, and again in 1959 in “History and present status of childhood schizophrenia in the USA” in *Acta Paedopsychiatrica*, a journal which had published papers by Sukhareva in the past. This paper is a thorough review of work in the field beginning in the 1800s and also covers the work of Heller and de Sanctis, complaining that work “which had been given a great deal of attention in Austria, Italy, and Germany, had received no notice in America.” (140) Again, this is contrary to the picture painted of Kanner in current Usonian media of a man who sought to downplay the significance of work similar to his conducted elsewhere. Rather, we see him here bemoan its lack of recognition. On page 143, he writes, “In the 1930’s, *Louise Despert*, in a fashion similar to that of *Ssucharewa* in Russia and *Lutz* in Switzerland, suggested a distinction between cases with acute onset and cases with insidious onset.” This paper distinguishes childhood schizophrenia from “autism”, which Sukhareva is

likewise able to do throughout her corpus. The paper concludes by recognising two authors, Potter and Despert, as having done the groundwork for this area of study in the USA, by acknowledging a great deal of statistical and terminological imprecision in the field, and by affirming the existence of not just childhood schizophrenia but childhood schizophrénias à la Bleuler.

Sukhareva's paper on childhood schizophrenia is cited by Kanner again in 1962 in "Emotionally disturbed children: a historical review" and by Kiyoshi Makita in Japan in "The age of onset of childhood schizophrenia" in 1966, but its appearance in English-language bibliographies really takes off during the 1970s. In 1967, there is also an English-language paper by D. Arn. van Krevelen ("Prognosis of Childhood Neuroses and Psychoses") that cites not only Sukhareva's childhood schizophrenia paper, but also the 1955 edition of her clinical lectures and a Russian paper of 1933 co-authored with E. I. Kogan. The Sukhareva and Kogan paper is from [*Soviet Psychoneurology*]; however, "Prognosis of Childhood Neuroses and Psychoses" appeared in *Acta Paedopsychiatrica*, seemingly not widely read in the Anglophone countries. Van Krevelen's bibliography for this paper includes multiple texts in English, Italian, German and French, with a sole Dutch text of his own authorship.

Zeitschrift für Kinderpsychiatrie/Acta Paedopsychiatrica

Zeitschrift für Kinderpsychiatrie was founded by Moritz Tramer in 1934. It served as publisher for the proceedings of the International Congress of Child Psychiatry from 1937 onwards. It was conceived as a trilingual journal for articles to be published in German, English and French, but even in its first issues, articles appeared in Italian. In 1952, it published Fischel Schneersohn's three-part study of children addicted to reading. Schneersohn was a regular contributor to the journal over the years. From 1953, it was issued under its Latin title *Acta Paedopsychiatrica*. Following Tramer's death in 1963, van Krevelen became the chief editor, renewing the journal's focus as an international journal and expanding its scope. Under van Krevelen's editorship, the journal was subtitled *The International Journal of Child Psychiatry*, and its official languages grew to English, French, German, Italian and Spanish, with article summaries in all four of the other languages.

In addition to being frequently cited by the journal's many contributors, sometimes as Ssucharewa, sometimes as Grunia E. Sucharewa, one author even citing Sukhareva's

work published in Czechoslovakia, we can assume Sukhareva was also one of the journal's readers. One article appearing in a Soviet journal in 1967 also appears under the names Grunia E. Sucharewa (subject index (111)) and G. J. Sucharewa (byline (307)) in *Acta* the same year, titled "Die Bedeutung der vergleichenden Berücksichtigung des Lebensalters für die Untersuchung der Verlaufsmäßigkeiten der Schizophrenie bei Kindern und Jugendlichen." While the body of the article is in German, the title is also given in English, French and Spanish, with lengthy summaries in those languages taking up almost an entire page each. This itself is unusual, as some reports in *Acta* receive merely a single sentence in summary. Unlike the Soviet summaries, the language here is impeccable. Contributors to this volume include R. Vedder, D. Arn. van Krevelen, L. Kanner, Laretta Bender, W. Spiel and L. Eisenberg. The issue contains such interesting international topics as Dutch work on hyperkinesis (ADHD), mental health on *kibbutzim*, Hebrew dyslexia, a comparison of German and English dyslexia epidemiology, the adaptation of children of Spanish immigrants to Geneva, Swedish psychiatrists' views on the effects of films, the state of child psychiatry in French Canada, observations in Japanese homes, van Krevelen's trip to Brazil, a paper on the Montessori method by Maria Montessori herself despite having deceased, and even a paper by a Turkish doctor.

Title pages in 1967 and 1968 also list E. Mildred Creak, L. Kanner, J. Lutz, L. Michaux and H. Stutte as editors. In these years, the journal's council consisted of 12 psychiatrists, among them Hans Asperger and Sante de Sanctis's son Carlo de Sanctis. 29 people were on the advisory board including Walter Spiel (who connected Sukhareva's schizoid psychopathy with Asperger's autistic psychopathy) and Hermann Stutte. Not only did Leo Kanner know of Sukhareva, he was an editor of a journal that published and frequently cited her work, a journal for which Hans Asperger was a council member. The people may not have met and did not necessarily all correspond, but we can consider them collaborators.

In "The Removal of National Barriers in Child Psychiatry", Kanner reports that in 1969 the *Acta* editorial board consisted of 46 child psychiatrists from 28 countries across 4 continents. (316) Kanner kindly provides his own "statistical survey of the nationalities of the authors of the original articles and of the books and papers reviewed or abstracted in the *Acta* during the year 1966":

Original articles: Germany 10; Holland, Israel and Switzerland 4 each; France, Japan, United Kingdom, and U.S.A. 2 each; Argentina, Belgium, Bulgaria, Poland, Portugal, Spain and Sweden 1 each.

Abstracts and book reviews: U.S.A. 100; France 33; Germany 19; United Kingdom 17; Italy 16; Japan 13; Switzerland 9; Holland 6; Scandinavia 5; Canada, Mexico, and Scotland 3 each; Argentina, Austria, Belgium, Brazil, Bulgaria, Czechoslovakia, Israel and Turkey 2 each; Greece, Hungary, Marocco, Russia, Senegal, and Yugoslavia 1 each. Among the 100 U.S.A. items, not fewer than 41 are sympathetic and meaningful abstracts (by STUTTE) from the Journal of the American Academy of Child Psychiatry, whose editorial board had once declined to print a tribute to TRAMER "because" he was not an American.

Countries contributing to Acta Paedopsychiatrica in 1966 (316-317)

He adds a note addressed to me, although he did not anticipate I would not be a man:

A future historian of child psychiatry may have a need to hunt around for source material here and there and everywhere. But arriving at 1964, when VAN KREVELEN took over the editorship of the Acta, he would heave a sigh of relief. He would no longer have to play the detective. It's all there in the Acta. DICK VAN KREVELEN has for many years been active in the promotion of an international orientation in child psychiatry. [...] All this and an amazingly polyglot talent which makes him feel linguistically [sic] at home in many parts of the globe has made it possible for him, through the medium of the Acta, to gather child psychiatrists "from all corners of the earth." Through his incessant efforts, the Acta have become a model symbol of the "One World," of which mankind has always dreamed and will continue to dream. In the Acta, national barriers have been removed. Its pages are open for anyone anywhere who has a contribution to make to child psychiatry. Thanks to DICK VAN KREVELEN, TRAMER's "international mission" is being accomplished¹⁶⁷. (317)

The great tragedy and irony of *Acta Paedopsychiatrica* is that while its intention was to be a multilingual international journal that would transcend geographic borders, raising itself and its readers above and away from whatever was going on politically at the time, today, in an age when the sharing of information should be even easier than before, the original editors and contributors now dead and gone, it is locked up behind paywalls. The journal has been fully digitised but not even a table of contents can be viewed for free. The articles within are not indexed by any library or catalogue and one can only order the information within if one already knows that it exists, and even then, the cost

¹⁶⁷ The laudatory nature of this piece is accounted for by it being a tribute to D. Arn. van Krevelen in honour of his 60th birthday.

of accessing a single page is far more than a year's subscription to the journal ever cost. Is "truth" elitist? When only the wealthy can access history, it is no surprise that so much misinformation abounds or that misinformation is given so many awards and accolades. All this is grossly contrary to the spirit of the journal and its original intention and instead perpetuates the situation the journal was attempting to overcome. Great would have been my relief indeed if there was ever a possibility of reading the contents pages of *Acta* or if its articles were indexed and catalogued. Enormous has been my frustration at being only permitted single word searches of its fully digitised and OCR'd pages and being allowed not even a glimpse of the surrounding text as with Google Books, but merely an affirmation of whether this word appears or not, with the additional imposition of limits on the number of pages a library can borrow from another due to copyright law despite no way of purchasing such archival issues elsewhere. I found *Acta*, but it was then detective work simply to acquire even single pages.

In 1969, van Krevelen's editorial to the January/February edition was this appropriately rude note on Anglocentrism in Anglo-American psychiatry:

EDITORIAL

Foundations of Child Psychiatry

Fondements de la psychiatrie infantile - Grundlagen der Kinderpsychiatrie -
Fundamentos de la psiquiatria infantil

Contrary to the tradition of noticing publications in the field of child psychiatry in the abstracts-part of this journal, I consider it important to review the book which lately has been edited by E. MILLER in England¹ in the form of an editorial. It may be seen that the conception of this book poses a problem, which is connected with our mutual understanding and with the way by which progress of our discipline may be achieved.

Undeniably this "handbook of reference", as it is assumingly announced, is an evidence of the gulf between Anglo-American and European Child Psychiatry, which until now nobody has been able to bridge.

Whoever would mean that scientists as AICHHORN, ASPERGER, HOFF, SPIEL in *Austria*, DIATKINE, HEUYER, LAFON, POROT, SCHACHTER in *France*, BENNHOLDT-THOMSEN, HOMBURGER, STUTTE, VILLINGER, ZIEHEN in *Germany*, BOLLEA, SANTE and CARLO DE SANCTIS in *Italy*, FONTES in *Portugal*, GREBELSKAJA, SSUCHAREWA, USCHAKOW in *Russia*, DE AJURIAGUERRA, FELDMANN, FRIEDEMANN, HAFFTER, LUTZ, TRAMER, ZÜBLIN in *Switzerland*, have been or still are the main promoters of child psychiatry, is not strengthened in that opinion, as he will look in vain for references to their work.

Of the *American* founders of child psychiatry who have been forgotten or neglected I only mention the names of ALLEN, BRADLEY, HEALY, LOURIE, RABINOWITCH, FRANKLIN ROBINSON, SHIRLEY and SZUREK.

This leads me to the conclusion: Even the foundations of American Child Psychiatry are too weakly represented in this insular book of 714 pages.
v. K.

¹ Foundations of Child Psychiatry (E. Miller ed.), Pergamon Press, Oxford/London 1968.

Here we see Sukhareva placed alongside Asperger, Ziehen, de Sanctis and Tramer as one of "the main promoters of child psychiatry". The tragedy of the gulf continues. Even as technology offers many bridges (high volume scanning, the indexing of catalogues worldwide, instant search, optical character recognition, multilingual language recognition and spellcheck, extraordinarily good machine translation, electronic document exchange) by which we might traverse the gap, in this metaphor,

we still need people to walk across the bridge or to engage with the many bridges for longer than a few seconds.

Against Parochialism

In 1960, Leo Kanner wrote a small opinion piece in *The American Journal of Psychiatry* headed “American Child Psychiatry, Ltd.?” The precipitating event for this small comment was his receipt of “a complimentary copy of a Russian textbook of child psychiatry by a leading representative of the speciality”¹⁶⁸ and his indignation that “Not one of the innumerable references gave the slightest indication that any work had ever been done outside the geographic boundaries of the Soviet Union.” (1040) He does not mention that it was impossible for Soviet researchers at that time to acknowledge the work of outsiders, even if they were drawing on such work (and they were!). He then investigates whether child psychiatry in the USA is in a better position and discovers to his dismay that it is not. Surveying bibliographies in 1958, he discovers but 4.3% in languages other than English in the field of mental abnormality and 3.2% in child psychiatry. He writes:

This is slightly better than the total omission of non-domestic investigators in the Russian textbook but hardly a cause for self-congratulation. The impression is given that we here do not know about, or do not care for, work done elsewhere. (1040)

He berates Usonian child psychiatrists for the ignorance of key names in the field such as Ziehen, de Sanctis, Homburger, van Krevelen, Stutte, Lutz, Heuyer, Michaux and Tramer – here he flags Tramer as the ‘founder’ of child psychiatry, at least of the term – and chides them for their lack of interest in German, French, Italian and Scandinavian periodicals. “[...] this seeming snub,” he writes, “is not reciprocated by the men abroad,” pointing out that Usonian work was well read and cited in Europe. He does not attribute this to nationalism or chauvinism, to the “smug conviction that we are in sole possession of the key to progress.” (1041) He believes the cause is solely monolingualism and the inaccessibility of international literature. Yet this would also have been a good list in which to include Sukhareva – as van Krevelen did – or Asperger.

¹⁶⁸ Sukhareva’s but he does not mention her here by name.

Kanner raises parochialism again in 1969 in *Acta*, perhaps by way of apology to European readers – he had bemoaned *Zeitschrift/Acta*'s small Usonian readership in 1960. “The Removal of National Barriers in Child Psychiatry”, Kanner’s article on Usonian psychiatry’s refusal to look beyond its own self-sustaining sphere of research, is much harsher than the previous editorial. From Kanner’s description, Usonian psychiatry might as well be adhering to a private version of North Korean *juche*. The article contains such gems as the paragraph excerpted above, his call (repeated from the previous editorial) to teachers and reviewers to make it a point to “look beyond the linguistic frontiers and to give our students and readers the benefit of familiarity with the work in child psychiatry done in other areas” (313), the quoting of Aubrey Lewis’s question of whether “psychiatrists look sufficiently outside the limits of their own country to find out what is being thought and observed elsewhere” (314) and Lewis’s statement that “no country has had a monopoly in original ideas” (314), Kanner’s repeated indignation that few Usonian child psychiatrists had heard the names of Ziehen, de Sanctis, Homburger, Tramer, Heuyer, van Krevelen, Stutte, Lutz, and Michaux, “all of whom have helped substantially to build the speciality”¹⁶⁹ (313), and Kanner’s plea to the 1962 Fifth International Congress of Child Psychiatry:

Science has no geographic boundaries. The teachers of our discipline ought to be more willing than many have been to communicate to the oncoming generation a respect for the major contributions which have come, and are coming, and will come from our colleagues in many lands and presented in many tongues. It is up to the teachers to convince their students that valuable work is being done in more places than their own bailiwicks. This would include a knowledge of the matrices of our specialty ... I should like to be able to predict that in the future, as parts of our globe have come closer together because of the marvels of transportation, so will our researchers and practitioners come closer together in a concerted effort of collaboration. (315)

Here Kanner documents his postal exchange with Sukhareva, for which we had a teaser in “American Child Psychiatry, Ltd.?” In 1955, Sukhareva posted him a copy of what Kanner records as being *Clinical Lectures on Developmental Child Psychiatry*. Silberman lists Russian as one of Kanner’s languages, yet Kanner’s early years were spent in a Yiddish-speaking region and even there he had attended a German school (Neumärker). I do not know how fluent a reader of Russian he would have been. The

¹⁶⁹ All of whom Sukhareva was familiar with.

information Kanner provides is the same observations on her bibliographies that I myself made. Indeed, he writes a paragraph almost the same as one I had already written:

Russia was not included in the Lewis survey¹⁷⁰ but another experience may throw some light on conditions there. In 1955, I received from G. E. SSUCHAREWA a complimentary copy of her *Clinical Lectures on Developmental Child Psychiatry*, which had just come off the press. This was during the Stalin regime. I was, of course, familiar with Dr. SSUCHAREWA's work and had quoted her repeatedly, especially in connection with her valuable studies of childhood schizophrenia. I knew that she was well acquainted with the international literature. Yet in the 447 pages of text, there was not the slightest hint that anything had been done in the field by anybody not a native of the U.S.S.R. There was no name index or subject index but a bibliography was appended at the end of the book; not one of the 212 items had its origin beyond the boundaries of "Mother Russia"; not even residents of the "satellite countries" seemed to qualify. A second, revised edition appeared in 1959. This was after Stalin had left the scene of action and the censors had begun to relent somewhat. This time the bibliography had 230 references; of these, 182 were Russian and 48 originated elsewhere (24 German, 12 French, 4 Swiss, and 2 each American, British, Italian and Austrian). Undoubtedly, Dr. SSUCHAREWA had been aware of those before but, in a somewhat relaxed political milieu, was able to acknowledge this publicly. (314-315)

Kanner most likely had at least a rudimentary or working knowledge of Russian. It does not take a Russian reader to locate and analyse a bibliography, especially when the non-Russian authors are given in Roman script. However, it does take a Russian reader to know that the "2" on the 1959 book does not denote a second edition (which the 1955 copy was) but a second volume, not a revision, but completely new, unseen material – which Kanner did not seem to know. There is also the point that the politically acquiescent editions of volume 1 (1940, 1956) do mention foreign researchers in the body of the work but they do not assist the reader in locating the source material, something Kanner again seems unaware of. Kanner is one of the two Usonian cited in the 1959 volume. It sounds here as if Kanner made the effort to acquire volume 2 himself. Did Kanner post Sukhareva a complimentary copy of his book too? As Kanner was at Johns Hopkins University, with which the American-Soviet Medical Society had

¹⁷⁰ A survey undertaken by Aubrey Lewis of the extent to which publications from individual countries cite work taking place without their national borders.

been associated, he could potentially have found someone to assist him in reading the book if it was difficult – but perhaps the political situation was too precarious. And yet, the book was mailed to him from the USSR, surely a suspicious event in itself.

From reading the work published in *Acta* by Kanner and van Krevelen and the other articles appearing there on autism-like conditions, I can suggest one reason Kanner never mentioned Asperger was that he had no need to but it may be unconvincing. They were both involved in the same journal. Kanner was not writing about *Grenzzustände* himself. And I can continue this argument with myself as sole interlocutor:

One place Kanner might have mentioned schizoid or autistic psychopathy was in his response to Robinson and Vitale's paper in 1954¹⁷¹, but back then Asperger's work on autistic psychopathy had not yet entered full swing on the European citation circuit, and Asperger's own research interests were not confined to such a small subject area. The earliest date I can pinpoint for Kanner knowing about Asperger's work is 1958, when Kanner read and quoted van Krevelen's "Zur Problematik des Autismus", a paper containing a comparison of the two autisms. Is Kanner required to mention Asperger? Asperger was known for more than the syndrome with which he is now eponymous. His textbook *Heilpädagogik* went into multiple editions over the years. Asperger's work was greatly discussed throughout European literature and Sukhareva's work was well recognised and cited even when not lengthily discussed. As a participant in the European 'conversation', much of which was happening in English, Kanner may not have been cognisant of any onus on himself to spread the news and knowledge of these researchers. Yet he felt an onus to spread the news of Ziehen, de Sanctis, Homburger, Tramer, Heuyer, van Krevelen (who wrote extensively on Kanner's and Asperger's autisms), Stutte, Lutz and Michaux. Could Sukhareva not have appeared in such lists? Kanner knew of her as a leading psychiatrist in the field and had received correspondence from her – but was he actually able to read her work? What about Asperger, could he have appeared in these lists?

Kanner could also have mentioned Asperger's or Sukhareva's work in his 1962 paper "Emotionally disturbed children: a historical review". Kanner was a prolific publisher of papers but a heavy recycler of material. The line "Ssucharewa in Russia, Lutz in

¹⁷¹ Instead he mentions someone far more obscure than Hans Asperger.

Switzerland, and Despert in this country distinguished between cases with acute and insidious onset” appears in many papers. In “Emotionally disturbed children”, Kanner gives a history of various strange children and includes de Sanctis’s syndromes, dementia infantilis and childhood schizophrenia. When he arrives at his own period, he refers to himself in the third person as part of the established history:

On the other hand, there was a decided disinclination to house an assortment of heterogeneous clinical entities under one supposedly common etiologic roof. Kanner, in 1943, outlined the syndrome of early infantile autism. Mahler, in 1949, described a form which she named symbiotic infantile psychosis. In the same year, Bergman and Escalona called attention to what they called children with unusual sensitivity to sensory stimulation. In 1954, Robinson and Vitale added the group of children with circumscribed interest patterns. (101)

Why mention Robinson and Vitale’s description of what is nothing if not Sukhareva’s and Asperger’s schizoid/autistic psychopathy? Why mention this but not Asperger’s description, which Kanner was aware of from van Krevelen but perhaps had not read for himself? It is not because Kanner was not reading German texts, or at least German titles – he was aware of Schneersohn’s reading addicted children in Tel Aviv! But Schneersohn’s paper was published in a *Swiss* journal, the neutrality is important, and was well after the war. Asperger’s paper, published in 1944, may not have been so easy to acquire.

And then Kanner might have mentioned schizoid/autistic psychopathy in 1971 in “Childhood psychosis: a historical overview” in the first issue of the first volume of *Journal of Autism and Childhood Schizophrenia*. (We will return to this interesting journal shortly.) This paper partly recycles the 1962 historical review, with Kanner repeating the same names and disorders again. But now he uses the English spelling of my subject’s name: “Sukhareva in Russia” with the footnote “Also known in the Western literature as Ssucharewa.” (17) Kanner’s own contribution to the field has been expanded a little:

In 1943 Kanner reported the syndrome of early infantile autism as “a pure culture sample of inborn autistic disturbance of affective contact.” (17)

As he then mentions that “constitutionality” or “innateness” was considered the starting point for any schizophrenic process, this might have been an ideal place to insert something about constitutional psychopathies of the schizoid variety. By this time there should be very many reasons to include schizoid/autistic psychopathy in the history of disorders a journal of autism and childhood schizophrenia might be interested in covering. There have been so many comparisons of the two autisms by 1971. Perhaps, we might argue, the reason it does not appear here is that he is giving a history of childhood *psychosis* and psychotic symptoms are not the main feature of schizoid/autistic psychopathy. Perhaps, we might argue, Kanner was truly a *clinical* doctor – he spent more time with patients than he did reading the literature of his field. Hm. He certainly spent a great deal of time *publishing* in his field. Is it not the responsibility of a writer to be also a reader?

There is a difference in how authors like R. A. Q. Lay or Lange portrayed themselves in their work and how Kanner portrayed himself. These first two place themselves in a large field among many others all working to solve the same or similar problems in many countries. They give a picture of knowledge being shared around the globe. There is also a difference in how Kanner and Sukhareva present themselves in their work. Sukhareva’s writing uses many first-person plurals. The work is usually presented as the result of a team, of contributions by her alongside her colleagues. It cannot be argued that Kanner does not take the Great Man approach also seen in Kretschmer’s work – the lone scientist discovering great things on his own. The arguments I have made in favour of Kanner’s recognition of women can also be countered with the claim that he *did* see medicine as the realm of men: this is explicitly stated in “American Child Psychiatry, Ltd.?” where he talks about “the men abroad” (European psychiatrists) and “their confrères across the ocean” (Usonian psychiatrists)^{172, 173}. We cannot here interpret these male words as meaning ‘(hu)mankind’.

But we do find many instances over the years of Kanner passing judgement on ignorance, acknowledging his colleagues and advocating for greater exchange. An

¹⁷² In central Europe they were nearly all men, but there were many women in psychiatry in the USA and even more in the USSR.

¹⁷³ Caveat: In “Historical perspective on developmental deviations” in 1973, Kanner writes, “A substantial portion of humanity, treated as subordinate, made its claim for equality. In a society, dominated by adult males, women had been relegated to the triad of ‘children, kitchen and church.’ [...] The more secure among the males, having no cause to be jittery about their status, were in favour of opening to women the doors to the halls of learning and to remunerative occupations.” (191)

attempt by Kanner to publish an 80th birthday tribute on the life and work of Moritz Tramer in the United States was thwarted on grounds of irrelevancy. In 1969, Kanner was a vocal critic of isolationism in any country, whether in the United States or Russia, whether self-imposed through ignorance and linguistic insufficiency or imposed by a paranoid government. Kanner criticised Usonian blindness and would surely criticise anyone undertaking a history of autism research without at least a reading knowledge of the languages in which its foundations were laid. Kanner was not hostile to foreign work, but his environment was hostile during the worst of times and uninterested during the best. Isolationism in science exists primarily as a choice. It is always possible to evade geopolitics. Sukhareva's engagement with the community beyond the USSR is an excellent example of this. Viewing the history of autism research through an isolationist lens is only possible if you yourself are a contributor to and participator in this isolationism, if you yourself do not read other languages, engage with other researchers from other countries, source international journals and have the work you cannot read translated.

Yet with all his spoken support of cross-border exchange, it is odd that Kanner so insistently cites only "Über den Verlauf der Schizophrenien im Kindesalter", taking no interest in Sukhareva's other work, that he publishes, possibly commissions, discussion of Kanner's versus Asperger's autisms yet does not participate. And it could also be argued that selecting more obscure, lesser-known researchers to acclaim is in fact a way of taking more credit oneself. Who is going to follow up such infrequently cited papers as Schneersohn's (of poor quality and in German) or Robinson and Vitale's? Kanner's reference to Sukhareva in *American Journal of Psychiatry*, where he complains that Usonian psychiatrists know too few outside researchers, does not include her name. And for all his recognition of female doctors in general, there was very likely still a 'glass ceiling' and unconscious biases, if not conscious ones.

Oligophrenia and the WHO Seminar of 1969

Sukhareva next appears in English in association with her work on oligophrenia, the Soviet term for intellectual disability¹⁷⁴.

¹⁷⁴ Although this term was used in English and it appears several times in Kanner's texts, it is now associated with Soviet texts.

In 1965, “Some crucial problems in the understanding of oligophrenia” was published in *Soviet Psychology and Psychiatry*. This was a translation of a paper that had appeared in Russian the year before in *Zhurnal nevropatologii i psikhiatrii imeni S. S. Korsakova*. This paper demonstrates much engagement with the global field, the reference list including British, Usonian, Russian and French sources ranging from 1892 to 1962, but most sources are from the 1950s and early 1960s with two papers from the 1962 London Conference for the Scientific Study of Mental Deficiency. There is no more self-imposed ostracism from the wider scientific community.

Soviet Psychology and Psychiatry was founded in 1962. It was published under this name until 1966 and then as *Soviet Psychology* until 1991. From the dissolution of the Soviet Union in 1992, the publication has operated as *Journal of Russian and Eastern European Psychology*.

A second paper on oligophrenia, specifically on its classification, was presented at the Fifth Seminar on Psychiatric Diagnosis, Classification and Statistics of the World Health Organisation, held 29 October to 4 November in 1969 in Washington, D.C. The first print publication of this paper I found is in Spanish (“El problema de las clasificacion del retardo mental”) in 1971 in *Boletin de la Oficina Sanitaria Panamericana*, the journal of the Pan-American Sanitary Bureau (now the Pan American Health Organisation). In a footnote, the paper is described as the seminar’s “documento de trabajo No. 6” (157), working document no. 6.

The second publication I found is in English (“The problem of the classification of mental retardation”), in a supplement to the *American Journal of Psychiatry* called *The Classification of Mental Retardation* in 1972. *The Classification of Mental Retardation* appears to be something like an abridged proceedings of the seminar, although it was published later than the Spanish. The introductory report on the seminar informs me that if I should like to see a full copy of the English report, I may write to Norman Sartorius, M.D. in Geneva, Switzerland, and that if I should like to see a full copy of the Spanish report, I may write to the regional WHO office in Washington, D.C. (5)¹⁷⁵. The Spanish language paper also makes mention in a footnote of a document no. 5, a.k.a. WHO Technical Report Series no. 392 (157). This document does not appear in the online

¹⁷⁵ The supplement is not paginated and the page numbers used here correspond to the pages of the PDF.
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archives for the WHO Technical Report Series. It is therefore possible that there is an earlier English or Spanish language print publication of this paper that I did not find.

In the English paper, Sukhareva's name is given as G. E. Suhareva, M.D. The English paper contains the note, "Dr. Suhareva is Scientific Consultant of the Moscow Research Institute of Psychiatry, Ministry of Health, Moscow, U.S.S.R." (51) The supplement makes no mention of translators and contains the same linguistic footnote regarding oligophrenia as the Spanish¹⁷⁶. I will assume that the Spanish has been translated from English, as presumably the seminar itself was held in English, but it is odd that the Spanish version was printed first. The seminar proceedings also raise the question of who "read" the paper¹⁷⁷, as Sukhareva's name does not appear in the list of participants or people otherwise associated with the conference, not even as a participant "invited but unable to attend" as was the case with Dr H. Rotondo from Peru. Had Sukhareva made a trip to the USA, this could contribute much to her supposed place in the history of autism research. I would then have made a case that she was herself involved in the Anglophone world of child psychiatry during a time when autism was much discussed by experts and laypeople and that she made no publicly recorded commotion about having been ignored as a researcher in this field. It would also have been interesting had she met one of the other seminar attendees Leon Eisenberg (1922-2009), a child psychiatrist who worked closely with Leo Kanner at Johns Hopkins University in the 1950s and did much work on autism himself. However, it is not clear to me that Sukhareva was the person who read or presented her paper in Washington. From the Soviet Union, "Dr. Z.N. Serebrjakova, Chief Specialist in Psychoneurology, Ministry of Health of the U.S.S.R." and "Dr. A.V. Sneznevskiji, Director, Institute of Psychiatry of the Academy of Medical Sciences of the U.S.S.R." are listed as participants who were also members of the nuclear group (16), presumably able to attend. Perhaps Serebrjakova, whose institutional affiliation is, like Sukhareva's, given as the Ministry of Health, read the paper. No further Soviets appear in the other categories of participants, nor are there participants from other Communist countries.

This paper was well received in Australia. Pitt, Roboz and Plant from Victoria write in 1974:

¹⁷⁶ "Throughout this paper the Russian term 'oligophrenia' has been translated as 'mental retardation'." (31) / "término ruso 'oligofrenia' se ha traducido en este texto como 'retardo mental'." (157)

¹⁷⁷ In Spanish, the paper was merely *presentado*.

We have been impressed with Suhareva's classification (Suhareva, 1972), who like Yannet (Yannet, 1956), has arranged the many causes in a temporal and logical manner, namely gene defects, chromosome defects, intrauterine pathology and perinatal and postnatal pathology. In view of our own experiences, we have sought to amend this slightly, as set out in Table 2.

And in New South Wales in 1975, Hughes and Greenman write in response:

A modification of the Heber (1959) medical classification as used by Pitt et al. (1972) has been adopted as a basis of a general classification. Despite certain defects it is not only still useful for general statistical purposes but also for comparison with previously published surveys of a similar kind. Current official classifications, derived from this basic model, also have significant defects and it therefore seems likely that future refinements in classification, leading eventually to international usage, will be along the lines of Suhareva's (1972) classification with modifications of the type suggested by Pitt et al. (1974).

However, it does not appear that anything came of this prediction and Sukhareva's appearance in English-language work on intellectual disability ends here. Curiously, this English-language paper is cited by V. V. Kovlev for the "Oligofrenii" entry in the current online *Bol'shaia meditsinskaia entsiklopediia*. Does this mean it was never published in Russian?

The Great Soviet Encyclopaedia

Sukhareva's work was used as a reference source for the entries "Oligofrenii" and "Nevropatii" in *Bol'shaia sovetskaia entsiklopediia*, published in three editions over the periods 1926-47, 1950-58 and 1969-78. The *Great Soviet Encyclopaedia*, an English translation based on the third edition of the GSE, was produced from 1974-83 by Macmillan, acquired by Gale Group in 2010 and recently made available online at TheFreeDictionary.com, where the entries "Oligophrenia" and "Neuropathy" can be viewed. She is also mentioned in "Periodic psychosis" but has no entry for herself as a person. While the Russian version of the encyclopaedia was distributed to Anglophone countries and others beyond the Eastern bloc, possessing the set was somewhat of a hassle for holding libraries, as directives to physically excise entries or pages and to replace them with the enclosed updates would frequently arrive via post according to

who was in or out of political favour. I think it unlikely many regular readers or psychiatrists were consulting the *Great Soviet Encyclopaedia* in “Western” countries either in Russian or English on a regular basis and see no reason for Sukhareva to have gained any special attention outside the U.S.S.R. through this avenue. However, there she is.

Kanner, Asperger, Sukhareva and the *Journal of Autism and Childhood Schizophrenia*

Journal of Autism and Childhood Schizophrenia was founded in 1971 with Leo Kanner as the editor. Not only was van Krevelen’s analysis of the differences between Kanner’s and Asperger’s autisms “Early infantile autism and autistic psychopathy” published in (and presumably commissioned for) the first issue of the journal, but the first issue also contains a review of Soviet literature on autism and childhood schizophrenia (“Abstracts”). Again standing against isolationism, Kanner’s introductory notes to the abstracts run:

It is essential for the sake of the broadest possible orientation that contributions made anywhere, particularly outside the English-speaking area, be reported to our readers. Since access to contributions published abroad is generally limited due to language barriers, we plan to emphasize material forthcoming from the non-English-speaking countries of the European continent, the Soviet Union, Japan, Latin America, and the rest of the world. (106)

Going on to summarise the work overall, Kanner writes:

As a beginning, we examined 14 Russian-language periodicals that were published from January to November 1970. [...] Our survey of Soviet contributions indicated that Russian researchers are investigating essentially the same problems that are the focus of interest of Western workers. The problem of nosology is central to most papers and the relationship to specific language disorders is probed in considerable detail [...]. Although the Russians have subdivided the clinical varieties comprised under the term *childhood schizophrenia*, they have not separated autism from the cluster even though a group of Soviet clinicians headed by Prof. S. Mnukhin of Leningrad had attempted to do so in 1967. It appears that most Soviet investigators do not share the prevailing Western opinion that childhood schizophrenia does not exist as a separate category. (106-107)

I beg to differ, and if Kanner had read the two volumes of Sukhareva's textbook he possessed (and for all I know, he may have acquired the third volume when it appeared), he would have known more about Soviet nosology. Nancy Rollins's English translation of Sukhareva's nosology was not published until 1972.

All but one of the abstracts were put together by Scripta Technica, described as "an organization affiliated with the publishers of this journal." The summary of "The syndrome of autism in children" by V. M. Bashina and G. N. Pivovarova was written by Kanner himself, who mentions consulting some of the original sources Bashina and Pivovarova cite. This was the finding that led me to question my previous assumption that Kanner did not read Russian and to conclude that he had some knowledge of it. "The authors," Kanner writes, "who are well versed in the Western literature, give a comprehensive summary extending from Kanner (1943) and Asperger (1944) to almost, but not quite, the present." (110) So there is at least one mention of Asperger by Kanner, but this hardly constitutes personal engagement in the discussion. Bashina and Pivovarova's paper presents a historical overview, yet the 'first' investigation pointed to is a rather late one in the scheme of things and comes from Mnukhin, whose 1948 paper appears in my timeline as yet another possible independent description of an autism spectrum disorder.

They cite Prof. S. Mnukhin of the Leningrad College of Pediatrics as the first Soviet clinician who in 1967 made autism the subject of a special investigation. This is because, as the authors declare categorically, "in Soviet literature autistic disorders of children are always covered primarily within the framework of schizophrenia and schizoid psychopathy." (110)

Indeed, but Sukhareva's nosology places schizophrenia in the volume of major psychiatric disorders, while schizoid psychopathy is in the volume of minor disorders – quite unlike the broad category "autism spectrum disorder" of *DSM-5* today. Kanner continues in slightly patronising tone but with a good understanding of linguistic issues, "They may be forgiven for finding it difficult to correlate terminologies current in non-Russian areas with terms and concepts of local coinage, though they do try valiantly to think of possible common denominators." Asperger had also struggled to map Usonian ideas of autism and schizophrenia to European ones ("Autistisches Verhalten im

Kindesalter”)¹⁷⁸. But the review is still more interesting as it reveals a more nuanced understanding of the political situation than I had previously assumed Kanner to have had; although it is now the 1970s, and with warming relations and more scientific and cultural exchange, there was undoubtedly more awareness overall. Here we find Kanner both putting down Russian nationalism while simultaneously acknowledging Russian work and praising the end to the isolationism hereto seen in Soviet bibliographies:

It seems that, probably not in the authors’ awareness, the well-known tendency to claim Russian precedents for innovations outside the USSR, has somehow crept into the account. Much is made of a 1929 treatise by T. P. Simson on *Neuropathy, Psychopathy and Reactive Conditions in Childhood*. In a chapter titled Autistic Children, a syndrome was described which indeed had much in common with early infantile autism and was said to “constitute a reason for including such children in the group of schizoid psychopaths.” But, aside from the semantic nebulosity shared to this day by many people everywhere, it must be conceded that Simson’s chapter can be seen as one of the precursors of later, more concise delineations. Of the 84 cited in the bibliography, only 17 have their origin in the USSR. Most of the others are in English, a few are German and Dutch, and two each are French and Japanese. The authors conclude: “In this article, we attempted to show how infantile autism, which is most likely closest to schizophrenia and schizoid psychopathy, has been described at different times in different countries, including the USSR.” (110-111)

Kanner was indeed aware of the Russian conception of autism and interchangeability of schizoid and autistic psychopathy. Kanner’s knowledge of autistic psychopathy has already been demonstrated by his publication of van Krevelen’s paper on the distinction between the two autisms for the first issue of his journal. This is also evidence that despite Sukhareva changing from schizoid to autistic psychopathy in 1959, schizoid psychopathy was still in use.

The abstracts from Soviet serials put together by Scripta Technica based on 1970-published papers considered relevant to autism and childhood schizophrenia make

¹⁷⁸ And also van Krevelen: “Elsewhere I (1967) have related my unforgettable discussion with a distinguished colleague in New York. With the aim of convincing me of the frequency of childhood schizophrenia, he boasted that it would be easy to show me a thousand schizophrenic children. Being aware of the babel of tongues, I asked him, ‘And what about mentally defective children?’ After a moment of reflection, he answered, ‘In this city, probably nine or ten!’ He was amazed when I offered to demonstrate the same for him in my country, but the other way round.” (“Childhood schizophrenia: diagnostic considerations and social implications” 136)

frequent mentions of schizoid personalities and schizoid psychopathy, but there is no mention of Sukhareva's contribution to SP literature. A paper by Sukhareva is included here, with the title given as "Role of age in the clinical course of childhood psychoses" and her name as "G. Ye. Sukhareva". Sukhareva is again described as "a leading authority in Soviet child psychiatry" (111). Unlike the Usonian review of her 1940 textbook, no mention is made of her sex. With Sukhareva's appearance in the very first issue of *Journal of Autism and Childhood Schizophrenia*, perhaps it can be argued that Sukhareva has been part of the discussion all along.

Elsewhere in the first issue of the journal is another mention of Asperger, this time in Leon Eisenberg's unfavourable review of I. Newton Kugelmass's *The Autistic Child*. Finding many faults, Eisenberg also takes issue with Kugelmass's history of medicine, complaining:

The author traces the origins of autism to Itard's account of the wild boy of Aveyron, whom the author appears to consider an idiot-savant. He passes from this to the cases reported by DeSanctis [*sic*] without calling attention to Lutz' analysis of these cases – an analysis that resulted in his discarding most of them because of the frequency of evidence of gross neurologic impairment. He contends that Kanner's syndrome was "confirmed" by Asperger in 1944 although Asperger (misspelled by the author as Ansperger) described a different group of children (autistic psychopaths) and could not in any event have read Kanner's paper at the time he wrote his own. Moreover, he implies that the terms "atypical child," "symbiotic psychosis," and "childhood schizophrenia" are interchangeable with early autism and states that all are "variants of a unitary disease"(!). (103-104)

Eisenberg, who worked with Kanner, did not consider Asperger's autism synonymous with Kanner's. The third issue of the journal contains abstracts from German papers, all written by Kanner. Given that Europe was heavily engaged with the Kanner's vs. Asperger's debate, it is unsurprising to find two papers here further engaged in differentiation. Recorded in *JACS* under the translated title "Classification of autistic syndromes in childhood", G. Nissen's paper "assumes that a heredo-genetic factor 'probably' underlies all autistic syndromes of childhood." (359) Kanner reports that Nissen files Asperger's autistic psychopathy and Kanner's early infantile autism in the same basket. The next abstract is for K. Hartmann's paper, given as "Psychopathology of the schizophrenic psychoses of childhood". Without passing judgement or comment

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on the work itself (indeed, Kanner considered a summary worth passing on to Anglophone readers), Kanner writes:

Another table juxtaposes verbal snapshots of four syndromes considered specifically: Heller's dementia infantilis, Kramer-Pollnow's disease, Asperger's autistic psychopathy, and Kanner's early infantile autism. The author found it useless at the present state of our knowledge to argue whether and to what extent any of these syndromes represent nosological entities. Without etiological clarity, neither the syndromes themselves nor the schizophrenias generally can be so designated. It is equally useless to debate whether and how these syndromes are related to schizophrenia so long as the origin of either is unknown. (359)

As expected, Sukhareva's schizoid psychopathy is not mentioned here. Issue 1.3 includes a review by Jacob Lutz of Doris Weber's book *Der frühkindliche Autismus unter dem Aspekt der Entwicklung*. The book was not available in English but of course, "Special attention is given to [...] the distinction between Kanner's and Asperger's syndromes." Thanks to non-German-speaking psychiatrists reading issue 1.1, autistic psychopathy appears in a footnote by Anglophone psychiatrists in 1.3. Dramatic reveal, the non-German-reading Anglophone psychiatrists who first(?) mention Asperger's autistic psychopathy do turn out to be Lorna and John Wing.

Possibly Asperger's autistic psychopathy (Bosch, 1970; Van Krevelen, 1971) is due to the presence of the impairments in a very mild or partial form, but sufficient to prevent the person concerned from understanding subtle social cues, which depend on nonverbal communications, thus making him appear naïve or eccentric. Van Krevelen's (1971) article showed how dependent the patient he described was on set rules for social conduct. This author also mentioned the frequent occurrence of visuo-spatial problems in this condition. (263)

This footnote gives ground to my theory that the Anglophone world was simply less interested in milder, less clinically significant presentations during the 1950s, 60s and 70s. Anglophone child psychiatry was largely preoccupied with childhood schizophrenia and more severely impairing autism. While aware of the existence of both the Soviet schizoid/autistic psychopathy and the European (primarily Dutch/German) autistic psychopathy, researchers were not looking at such things in great depth or

detail; the minimal attention Robinson and Vitale's paper "Children with circumscribed interest patterns" received is witness to that.

More Childhood Schizophrenia

In 1971, Despert brings up Sukhareva, Grebelskaya-Albatz and childhood schizophrenia again in "Reflections on early infantile autism", with the qualifier, "Early infantile autism, first delineated 6 years later (Kanner, 1943), was, of course, unknown and not mentioned at the time." There seems here to be some level of equation on Despert's part of Sukhareva's and Grebelskaya-Albatz's childhood schizophrenias with Kanner's early infantile autism. Again, it is Sukhareva's 1932 paper.

Now "Über den Verlauf der Schizophrenien im Kindesalter" really enters the citation circuit. In 1973 it is cited by Kiyoshi Makita in "What is this thing called childhood schizophrenia?", by I. Kolvin in "Research into childhood psychoses: a cross-cultural comparison and commentary", and by Margot Prior and Malcolm B. Macmillan in "Maintenance of sameness in Children with Kanner's syndrome". In 1973/74, van Kreveken cites it in a book chapter, returned to below. In 1974, Erwin Friedman cites it in "Early infantile autism revisited" and Robert T. Miller cites it in "Childhood schizophrenia: a review of selected literature". At this point, interest declines, with Christian Eggers using it for "Course and prognosis of childhood schizophrenia" in 1978, Victor D. Sauna for "Infantile autism and childhood schizophrenia: review of the issues from the sociocultural point of view" in 1983. Another reference appears in "Childhood catatonia, autism and psychosis past and present: is there an 'iron triangle'?" in 2013, this time due to recent interest in Sukhareva as a 'founder' of autism. This quantity of citations for the 1932 paper is not seen in German in any period, although it is cited by German authors publishing on childhood schizophrenia in *Acta Paedopsychiatrica*. "Über den Verlauf der Schizophrenien im Kindesalter" became a classic for English-language work on childhood schizophrenia, a paper that everyone must at least mention. While it is also cited by authors publishing in German, it is not cited to nearly the same extent, and when it is cited, it is by authors engaging with the sphere of English-language work. This is another odd example of the kinds of bubbles that can emerge in research.

Translation of Sukhareva's Classification

In 1972, Nancy Rollins's *Soviet Child Psychiatry* was published as the results of her

research trip to the USSR. In addition to her physical description of Sukhareva and extensive conversations with her reported in the book and covered in my chapter on Sukhareva's life and works, Rollins includes the Soviet classification system for child psychiatry (252-257), based on Sukhareva's three textbooks, themselves based on her lectures, forming part of the curriculum she developed to train both psychiatrists to specialise in children and paediatricians to specialise in psychiatry. Rollins's book made extensive use of Sukhareva's published work as well as information gathered in person and from personal correspondence. Rollins's translation of Sukhareva's classification is included in my appendix.

Nosology

In 1973/74, the *International Journal of Mental Health* ran a special issue titled *Perspectives on Childhood Psychosis: I. A Soviet View with Critiques and Reactions*. This issue was centred around the translation of M. Sh. Vrono's monograph "Schizophrenia in childhood and adolescence: clinical features and course". "The present monograph," Vrono writes, "is the product of research on childhood and adolescent schizophrenia conducted by us in conjunction with workers in the Department of Child Psychiatry of the Central Institute for Advanced Medical Training (Department Chief, G. E. Sukhareva) and the Clinic for Childhood Psychoses of the Institute of Psychiatry of the USSR Academy of Medical Sciences (Institute Director, Professor A. V. Snezhnevskiy)." Here again is the Soviet attribution of work to a collective. Vrono engages at length with European (including French, which I have not looked at in great depth), Usonian and Soviet literature on childhood schizophrenia and the way perspectives differ in various locations. Early infantile autism is included here as a schizophrenic disorder. Kanner here is interpreted by Russians as a promoter of the schizophrenogenic parenting theory (12). Pavlov's theory of "unity of environment and organism" (15) is still the foundation of Soviet psychiatry, even in the 1970s. The rest of the issue contains responses to Vrono's monograph, including one by Kiyoshi Makita. As might be expected for discussion of work conducted under Sukhareva, she comes up many times in this issue. In his first chapter, Vrono presents her as the author of "the most dependable approach to the study of schizophrenia", this being "a clinical method based, for the present, on a psychiatric examination combined with long-term observation and catamnestic follow-ups" (15), as well as someone who repeatedly reminds us that transitional periods of development can superficially resemble schizophrenia and of the need to distinguish between normal growth and destructive

processes. (16) Vrono's second chapter on incidence and classification draws heavily on Sukhareva's work. Gurevich, Simson and Mnukhin also make many appearances. D. Arn. van Krevelen contributed the chapter "Childhood schizophrenia: diagnostic considerations and social implications" to the discussion of Vrono's work. Here, Sukhareva is mentioned shortly into the first paragraph as the provider of a potential solution to the familiar problem of hodge-podgeism:

Child psychiatry is leading the way toward an era in which Kraepelin's nosological system, once eagerly awaited, seems to have served its turn. Present-day investigators are inclined to think in behavioural rather than in nosological categories. "Atypical children" may manifest an autistic or even a schizophrenic "behavior." No longer is there room for a factor or a constellation of organic factors, known or still unknown, coming from within (endogenous) or from without (exogenous). Child psychiatry is eager to leave the medical field, even before it had obtained a firm footing there. For this reason Vrono's study is most welcome, as it emphasizes the importance of the nosological approach, a method which, in his country, Sukhareva (1932, 1967) and Grebelskaya-Albatz (1934, 1935) are among the earliest proponents. The nosological approach protects us from boundlessly expanding the concept of childhood schizophrenia and thus prevents us from tossing more material into the "pseudodiagnostic wastebasket into which a variety of heterogeneous clinical pictures are thrown indiscriminately" (Kanner, 1958).

Now Sukhareva's childhood schizophrenia paper is being cited for the same reason the Australians lauded her contribution to intellectual disability research: her approach to classification. The problem van Krevelen elucidates does not seem to have abated since then. This is exactly what we see now with the all-encompassing ASD category in *DSM-5*. The behavioural approach may be useful for the psychologist, therapist or pedagogue, but it is a hindrance to medical research. Sukhareva's papers referred to here are "Über den Verlauf der Schizophrenien im Kindesalter" but also "Die Bedeutung der vergleichenden Berücksichtigung des Lebensalters für die Untersuchung der Verlaufsgesetzmässigkeiten der Schizophrenie bei Kindern und Jugendlichen" of 1967, a post-Stalin German paper in *Acta Paedopsychiatrica*. While the main chapter spells her name Sukhareva, she is listed in the bibliography as Suchareva. The 1967 paper is unlisted on WorldCat. It is depressing to consider the quantity of articles not yet indexed by libraries and which, without manually going through every issue of every journal, we may only find out about if someone happens to cite them. What about

all the interesting history no one has cited? Van Krevelen's references for this chapter include Asperger, Bleuler, Despert, Grebelskaya-Albatz, Kanner, Kraepelin and Tramer. The texts are mostly in German and English, but there is French and Dutch. In one instance ("The misuse of the diagnosis childhood schizophrenia"/"Der Missbrauch der Schizophreniediagnose im Kindesalter"), a paper is cited twice, a 1958 English version and a 1960 German version. Van Krevelen's thoroughness in his research and familiarity with his field far exceed Kanner's. Possibly Kanner spent more time in clinical work, but that is speculative.

Russian Contributions to the English Literature

In 1974, Sukhareva's colleagues D. N. Isaev and V. E. Kagan contributed "Autistic syndromes in children and adolescents" to *Acta paedopsychiatrica*. This is yet another paper I was unable to acquire due to limited library funds.

In 1975, S. S. Mnukhin and D. N. Isaev's paper "On the organic nature of some forms of schizoid or autistic psychopathy" was published in *JACS*¹⁷⁹. For Samuil Semenovich Mnukhin (1902-1972), a Leningrad psychiatrist and professor and another person sometimes credited as having founded child psychiatry, this was a posthumous publication. Dmitrii Nikolaevich Isaev (1929-2014) was Professor of Psychiatry at the Leningrad Paediatric Medical Institute. The issue's editor Lorcan O'Tuama writes, "Their report is of additional significance since it presents what is probably the first detailed account in the English language of clinical experience with childhood psychosis in the Soviet Union." (99-100) "The purpose of this paper," Isaev and Mnukhin begin, "is to describe a symptom complex generally termed *autistic psychopathy*, to emphasize the role of exogenous organic factors in its etiology, and to distinguish it from schizophrenia." While autistic psychopathy was not yet much discussed in the USA, it was in Europe and by European writers writing in English. But why mention "schizoid or autistic"? Mnukhin and Isaev present some background:

Early workers, notably Krepelin [*sic*] and Birnbaum, delineated the clinical picture of abnormal personality and emphasized its characteristic disorders of behaviour and thought. Ozeretskii (1938) noted the preference of schizoid psychopaths for solitude,

¹⁷⁹ From the title of this journal we can see that despite H. Mosse ranting in English and German from 1957 to 1960 that, "The present trend to diagnose children with severe emotional and mental symptoms as schizophrenic is scientifically wrong" (791), people continued to do so.

their tendency to reasoning, obsessional interests, motor incoordination, and impulsiveness. The terms *pathologically reserved* and *autistic* were also applied to this group (Gurevich, 1932; Giliarovskiĭ, 1954; Sukhareva, 1959).

More recently, behavioural disturbances related to but separable from classically described schizophrenia have become of intense interest to psychiatrists. Kanner's description of *infantile autism* (Kanner, 1942-1943) spurred interest in this group of patients. Asperger (1944) observed autistic psychopaths and stressed their tendency to show motor incoordination, marked scattering of abilities, impoverished affect, and thought disturbance; they are incapable of putting themselves into the state of mind of another person. (101)

The 1959 reference is lecture 19 in volume two of Sukhareva's clinical lectures, summarised earlier. I here blame Mnukhin and Isaev for neither mentioning Sukhareva's work on schizoid psychopathy between 1925 and 1927 nor including her as an "early worker". What follows in their paper are four case studies of children who sound peculiar but in no way psychotic, despite what the journal's editor writes. Mnukhin and Isaev sound far less sympathetic to their subjects than Sukhareva¹⁸⁰ and more pessimistic about their possibilities for future success. Mnukhin and Isaev also do not seem to see a separation between Kanner's and Asperger's autisms, although autistic psychopathy is applied to more intelligent children. They mention "attention defects, affective disturbance" and "*stimulus-bound* behaviour" (106), aspects of autism receiving attention in the English-language literature only this century. From the bibliography, we can see that Russian psychiatrists are still reading German, despite 1975's temporal distance from the Tsars, that they are also reading Dutch and English, and that a great deal of relevant work is being conducted in Russia.

Indirectly, in 1978, "Diagnosis and definition of childhood autism", Michael Rutter writes:

A special problem exists with respect to the differentiation of autism and autistic psychopathy, a condition first described by Asperger (1944). Autistic psychopathy is said to resemble autism in many respects but it is thought to be a personality trait not evident until the 3rd year of life or later and with a good social prognosis (van Krevelen & Kuipers, 1962; van Krevelen, 1971). Intelligence is unimpaired but coordination and

¹⁸⁰ E.g. considering them intellectually retarded, fit only to be educated in schools for children with intellectual disability, despite their elaborate sentences, good rote memory and love of reading.

visuo-spatial perception are poor, and there are gross social impairments and obsessive preoccupations or circumscribed interest patterns (Mnukhin & Isaev, 1975; Isaev & Kagan, 1974). Such cases undoubtedly exist but it remains uncertain whether they constitute a distinct syndrome different from mild childhood autism. (145)

Here is another English language author equating the “schizoid or autistic psychopathy” of Mnukhin and Isaev, which is the “schizoid or autistic psychopathy” of Sukhareva, with Asperger’s autistic psychopathy. This is where Sukhareva could have entered the English-language literature on autism as a ‘first’ describer, had Mnukhin and Isaev highlighted her, yet she was not necessarily seen as a ‘first’ describer by collectivist-thinking Russians. Was Sula Wolff the ‘first’ person to recognise that Sukhareva’s schizoid psychopathy was Asperger’s autistic psychopathy? Not quite. Aside from Walter Spiel in 1961, there was also the situation in the USSR. Autistic psychopathy was a. a confirmed synonym in Russian for schizoid psychopathy¹⁸¹, itself well written about by Russian authors in the 1920s and 1930s, b. recognised by Russians as the same autistic psychopathy written about elsewhere, and c. recognised by Russians as the same autistic psychopathy described by Asperger in 1940. But with Mnukhin and Isaev not explicitly pointing someone like Michael Rutter or indeed, anyone, to Sukhareva as an earlier author of detailed case studies of children, the connection went unnoticed until Sula Wolff reestablished it.

In 1979, Isaev and Kagan¹⁸²’s paper “A system of treatment and rehabilitation of hyperactive children” appeared in *International Journal of Mental Health* for a themed issue on intervention strategies with hyperactive children. This paper refers to work by M. O. Gurevich¹⁸³ from 1925 and 1927 and a paper by Sukhareva. Original titles and transliterations are not given in the reference list, but Gurevich’s 1925 work is the collection [*Problems of pedology and child psychoneurology*] that “[Schizoid psychopathies in childhood]” appears in. The 1927 work is his textbook [*Child Psychiatry*]. Sukhareva’s paper is her 1940 “[Some views on the principles of psychiatric diagnostics]”.

¹⁸¹ Mnukhin and Isaev suggest the terminology used shows the user’s inclination towards more of a schizophrenia-based theory of the psychopathy or more of an organic fetal brain damage theory (101). Russian use of schizoid psychopathy continues into the 1990s (Bashina).

¹⁸² Victor Efimovich Kagan (1943-). Still publishing as at July 2018.

¹⁸³ Spelt correctly in the article, M. O. Gurevich appears in the bibliography as M. P. Gurevich for the 1927 work.

Soviet Union

As is customary, celebratory articles about Sukhareva appeared for significant birthdays:

1962: “Груня Ефимовна Сухарева (к 70-летию со дня рождения)” [Grunia Efimovna Sukhareva (on her 70th birthday)]” in *Zhurnal nevrologii i psikiatrii im. S.S. Korsakova*.

1972: “Груня Ефимовна Сухарева (к 80-летию со дня рождения)” [Grunia Efimovna Sukhareva (on her 80th birthday)]” in *Defektologiya*.

1981: “Груня Ефимовна Сухарева.” [Grunia Efimovna Sukhareva] in *Zhurnal nevrologii i psikiatrii im. S.S. Korsakova*.

2012: “Г.Е. Сухарева (к 120-летию со дня рождения) / G.E. Sukhareva (the 120th anniversary of birth)” [their translation!] in *Zhurnal nevrologii i psikiatrii im. S.S. Korsakova*.

2015: Детская Психиатрическая больница № 6 [Children’s Psychiatric Hospital No. 6] is renamed Научно-практический центр психического здоровья детей и подростков им. Г.Е. Сухаревой [G. E. Sukhareva Scientific and Practical Centre for Child and Adolescent Mental Health] with a plaque installed. Tribute article published on institute’s website.

2017: “Г.Е. Сухарева: жизненный путь и научно-педагогическое наследие (к 125-летию со дня рождения). / G.E. Sukhareva: a course of life and scientific/pedagogical heritage (to the 125th anniversary of birth)” [their translation!] in *Zhurnal nevrologii i psikiatrii im. S.S. Korsakova*.

There are three interesting things about these articles. The first is that they are all both published in Russia and in Russian. I found so far found no laudatory



70th birthday, 1962
Photo of text Benjamin Zajicek

хроника

Груня Ефимовна Сухарева
(к 80-летию со дня рождения)



Исполнилось 80 лет со дня рождения и 55 лет научной и педагогической деятельности заслуженного деятеля науки РСФСР профессора Груни Ефимовны Сухаревой. Г. Е. Сухарева является одним из ведущих психиатров нашей страны, основателем новой клинической дисциплины — психиатрии в развитии детей. Ряд ее исследований является организаторской ролевой помощи детям, что привело к созданию сети лечебно-образовательных учреждений для детей и подростков. Г. Е. Сухаревой обучилась 100 научных работ, часть из которых выполнены на иностранных языках: Польша, Чехословакия, ГДР, ФРГ и других стран. Обобщением многолетней и творческой работы являются три научных работы по психиатрии подростков, представляющие собой монографии в мировой литературе по психиатрии подростков широкого круга специалистов. Одной из важнейших заслуг Груни Ефимовны является ее неустанная работа по подготовке психиатров. Можно без преувеличения сказать, что подготовлены тысячи психиатров, работающих в различных областях науки и деятельности Союза в прошлом не были ученики Груни Ефимовны. Под руководством Г. Е. Сухаревой получено более 40 докторских и кандидатских диссертаций. Работа Г. Е. Сухаревой по психиатрии подростков и психиатрии в развитии детей и подростков имела значение для дефектологической практики.

80th birthday, 1972



Obituary, 1981
Photo of text, Benjamin Zajicek

academic articles about her in Ukrainian, nor is there a Ukrainian Wikipedia page for her. To be fair, Ukrainian has a very small online presence. The few Ukrainian mentions of Sukhareva seem direct translations from Russian or are on Jewish sites. She is indeed 'claimed' as a national hero by Russian-speaking Jews and appears in Russian Jewish encyclopaedias.

According to one of the celebratory articles appearing while she was alive, she was awarded the Order of Lenin. According to all the articles, she was also given the title Honourable Scientist of the RSFSR situating her in Russia rather than Ukraine. This is reported by almost every biographical article about her and is stated on her 2015 plaque, yet she does not appear in any lists of people who were given this award, and I cannot find a source willing to commit a year to this. Honourable Scientist awards did exist for other Soviet republics, and it was possible to receive an honourable scientist award from more than one. Despite her status within the USSR as the founder of child psychiatry and the work she did in Ukraine, Sukhareva was not one of these dually lauded people.

The second interesting thing is that not a single Russian biographical piece on Sukhareva mentions the Pavlovian sessions where, in 1951, Sukhareva was deemed insufficiently patriotic. No articles mention the first edition of volume one. The second Pavlovian edition of volume one of her lectures has become the canonical version, even though, from a Western perspective, the gratuitous mentions of Pavlov, rising from once in the first edition to 78 times in the second, should render it more suspect. All volumes of Sukhareva's clinical lectures are still used in child psychiatry training in Russia today. The sessions which dramatically transformed Russian science writing, changed the behaviour of Russian scientists and their interactions with each other for decades, and which played a role in the dismissal of Russian work by Anglo-European countries, the sessions at which Sukhareva was accused of being unpatriotic and hostile to her Motherland, are completely ignored in Russian literature about Sukhareva.

The third interesting thing is the degree to which the celebration of Sukhareva in Russian writing has been affected by outside recognition of her. Throughout the 20th century, Sukhareva's name was primarily mentioned in Anglo-European psychiatric literature in relation to childhood schizophrenia, not because her 1932 paper was superior to her other work or the only thing she could contribute to world child psychiatry, but more likely due to ignorance of the rest of her work. Russian praise of

Sukhareva and selected works lists generally include this paper. Schizoid/autistic psychopathy is omitted from her 1962 and 1972 celebrations, first appearing in her obituary in 1981, her death following Asperger's by a few months and Kanner's by a few days. In the 21st century, writing about Sukhareva changes.

1996 Onwards

Following Sula Wolff's 1996 translation, Sukhareva began to creep slowly into the history of autism research. Awareness of autism grew in parallel with the growth of the world wide web, and so too did awareness of Sukhareva. On the Anglophone web, Sukhareva's name is found almost exclusively in connection to autism and Asperger's syndrome, despite the English-speaking world having access to but one of her papers on the topic and despite her work on schizoid/autistic psychopathy comprising a very small percentage of her corpus. With English now one of the world's most influential languages, this has affected the German and Russian web as well. Although German readers have access to more of Sukhareva's texts than English readers, in relation to autism, only the paper translated by Sula Wolff is mentioned. This phenomenon is not restricted to blogs and forum posts but is found in serious books and publications. While Russians have access to Sukhareva's 1930 paper and her 1959 textbook, the case studies of girls are unnoticed; the Russian paper had been greatly abridged. And although Russian recognition of Sukhareva has been large for a long time, recent international recognition of her work on autistic syndromes has prompted this aspect to feature more prominently in descriptions of her. Now, in addition to being the founder of child psychiatry, she has also become the founder, inventor or discoverer of not just Asperger's syndrome, but the larger concept of autism.

Goriunov's 2012 article for Sukhareva's 120th birthday declares:

There is not a single area of childhood psychiatry to which Sukhareva did not make a significant contribution, a fact that has been recognised by international specialists. In the book *Childhood and Adolescent Psychiatry*, edited by Christopher Gillberg and Lars Hellgren (2004), it is noted that 20 years before the classical descriptions of childhood autism by Leo Kanner and Hans Asperger, "the Russian doctor Grunya Efimovna Sukhareva" had described similar conditions.

A footnote admits:

It should be noted that Sukhareva conducted her study practically at the same time as another notable Russian childhood psychiatrist: T.P. Simson. They made similar observations about schizoid psychopathy in children and early-onset schizophrenia.

If heroes and villains in the tradition of Christianity and Disney are more specific to Anglophone culture than, say, Japanese, the sudden desire to replace Asperger with someone more suited to 2018 sensibilities may be understood in this context. In declaring Sukhareva the premier founder of these syndromes, Russian authors are also buying into the Anglo-European Great Man myth, the idea that single geniuses like Kraepelin, Kretschmer and Kanner are responsible for astounding inventions and discoveries, rather than achieving things built on the work of those before and in collaboration with the people around them. Yet the Great Man myth is as much a Soviet tradition as it is an anti-communist one. The cults of Stalin and Pavlov existed within this too. Statues of Pavlov went up as soon as he died, with a renewed interest in Pavlov statues during the Pavlovian period. The institute Sukhareva worked at was only renamed after her in 2015, after she had begun to gain English-language traction online, and her commemorative plaque at the institute is modest.



*Plaque at Sukhareva's former place of work, 2015
Photo Leonrid*

Conclusions

No scientific discovery is named after its original discoverer.

Stephen Stigler, 1980

At the conclusion of my allocated time and funding, new information continues to come to my attention. I am acutely aware of the many gaps I have left. Inconclusively, I make the following points.

From the perspective of some Russians, e.g. Mnukhin and Isaev, Goriunov, Sorokin, there is a clear unbroken line of research from Sukhareva's descriptions of schizoid and then autistic psychopathy through to the *ICD-10* F84.5 condition Asperger syndrome and the *DSM-5*'s autism spectrum disorder. From 1997, Russia's Ministry of Health has been trying to align Russian psychiatry more closely with the *ICD* (Sorokin) but historically, the Russian concept of schizophrenia¹⁸⁴ has not mapped directly onto the Anglophone one, which in turn did not map directly onto the central European one. While Sukhareva does not feature in the ASD trajectory in Bashina and Pivovarova's 1970 paper, she features prominently in Bashina's 1995 book *Ranniia detskaia shizofreniia (statika i dinamika)*, although it is T. P. Simson's 1929 work that receives credit as the first description of autism. Bashina does not present Sukhareva's work on schizoid psychopathy as synonymous with Asperger's autism, and the broader concept of autism is discussed within the wide Russian umbrella of schizophrenia, the autistic syndromes described by Kanner and Asperger presented here as borderline schizophrenic states, in other words, still schizoid: not schizophrenia but like it. In Russian literature as in Anglophone literature, whether autism is more schizoid or more autistic is still debated, with individuals holding different positions.

Asperger cannot be expected to have known about Sukhareva's papers on schizoid/autistic psychopathy and should not be blamed for failing to mention her.

¹⁸⁴ Schizophrenia in Russia did not need to include psychosis and mood disorders such as bipolar fell within the schizophrenic spectrum (Lavretsky 543). With overlapping conditions such as schizoaffective disorder existing in Western psychiatry, we should be able to see that it is indeed difficult to draw boundaries.

There was also no way for him to know she was Jewish, as was recently claimed (Zeldovich 2018).

Both Kanner's and Asperger's autisms were well-known, written about, diagnosed and discussed in European child psychiatry from the time of Kanner's and Asperger's reporting till the present day. It was primarily the USA that was left out of the conversation, due in part to the distractions of McCarthyism, in part linguistic and geographical barriers and in part the USA's infatuation with Freudian psychoanalysis and greater interest in childhood schizophrenia than milder presentations. That said, Russians during this period showed no greater interest in the milder presentations than was shown in the USA, and I quote again Rollins's comment of 1972 that, "Although schizoid personality as a variety of psychopathy appears in Sukhareva's classification system, it is not frequently used." (86)

The phrase 'Asperger syndrome' was in use well before Lorna Wing brought it into Anglo texts, as was eponymous distinguishing of the two autisms.

Child psychiatry as a field should not be blamed for Sukhareva's lack of recognition outside the USSR. The fault lies mostly with Stalinist and McCarthyist isolationism and, given the government interference and many abuses of psychiatry, a justified suspicion of the credibility of Soviet work.

Kanner and Asperger were not enemies or rivals. Asperger was very engaged with Kanner's work and both were on the board of *Acta Paedopsychiatrica*, a journal Sukhareva published in. As an editor, Kanner published, possibly commissioned, work on both syndromes and wrote abstracts for papers on differentiation. He quoted and referenced van Kreveken's papers on differentiation multiple times. Yet it is still conspicuous that Kanner did not give his own thoughts on the comparisons or publicly enter the discussion. Asperger visited the USA and saw first-hand what Usonianians understood autism to be, while Kanner provided no similar thoughts on the matter.

Sukhareva's descriptions of schizoid/autistic psychopathy are close to the modern understanding of an Asperger's-style autism, possibly even closer than Hans Asperger's descriptions, which included sadistic behaviour and intentional cruelty. Her descriptions

of schizoid/autistic psychopathy in girls resemble current descriptions of ASDs in girls with unimpaired intelligence.

Terms and definitions are hard and people don't agree. Even those speaking the same language have their own idiolects and opinions.

Monolingualism, chauvinism, isolationism, parochialism have significant long-lasting effects on the exchange of knowledge and research. The USA was decades behind Europe in its awareness of autistic syndromes, the Anglo-European world almost a century behind Russia in its recognition of the female autism phenotype. Language skills should be valued and their acquisition funded. Isolationism and protectionism must be fought.

All work builds on the knowledge of those that have come before and is a product of history. Even my own work is not the first of its kind. Bashina and Pivovarova laid out a similar argument in 1970. Leo Kanner translates a line from their paper, "The authors conclude: 'In this article, we attempted to show infantile autism, which is most likely closest to schizophrenia and schizoid psychopathy, has been described at different times in different countries, including the USSR.'"

HISTORICAL CONTEXT	SUKHAREVA'S LIFE	PUBLICATION CONTEXT	AUTISM CONTEXT/ FIRST MENTIONS	PEOPLE
	1809	<i>Observations on Madness and Melancholy</i> , John Haslam	Possible description of Asperger's-style autism in case XXXII.	Adolf Kussmaul born, Graben. John Haslam dies, London.
	1822			Ivan Petrovich Pavlov born, Ryazan.
	1844			
	1849			
	1851	<i>Lehrbuch der Nervenkrankheiten der Menschen</i> , 2nd ed., Moritz Romberg	Mention of echolalia accompanied by intellectual disability in an 11-year-old boy.	
	1853	<i>A Manual of the Nervous Diseases of Man</i> , Romberg, trans. Edward Sieveking	Echo behaviour wrongly translated as mimicking music.	
	1856			Feb. Emil Kraepelin born, Neustrelitz. May, Sigmund Freud born, Příbor.
	1857	<i>Lehrbuch der Nervenkrankheiten der Menschen</i> , 3rd ed.	Further examples of echolalia, unlikely related to autism.	Jan. Vladimir Mikhaïlovich Bekhterev born, Sorali. Apr. Paul Eugen Bleuler born, Zollikon. Jul. Alfred Binet born, Nice.
	1851			Ludwig Binswanger born, Kreuzlingen.
	1860			Martin W. Barr born. Dec. Grigoriï Ivanovich Rossolimo born, Odessa.
	1862			Sante de Sanctis born, Parrano.
	1863	<i>Die Gruppierung der psychischen Krankheiten und die Einteilung der Seelenstörungen</i> , Karl Kahlbaum	Precursor to Kraepelinian classification model.	
	1864			
	Possible birth of Sukhareva's father Kham Faitelevich Sukharev.			
	1868			Ludwig Scholz born.
	1869			Theodor Heller born.
	1870			Vladimir Ulyanov born, Simbirsk.
	1873			Jun. Moritz Romberg dies, Berlin. August Homburger born.
	1875			Mar. Pyotr Gannushkin born, Novosyolki. Jul. Carl Jung born, Kesswil.
	1876			Kirtie M. Mansfield born c. 1876

			1877	<i>Die Störungen der Sprache. Versuch einer Pathologie der Sprache</i> , Adolf Kussmaul	Reference to echolalia accompanied by intellectual disability.	Oswald Bumke born, Slupsk.
			1878			Apr. Adalbert Gregor born, Chemivtsi Sep. Mikhail Gurevich born, Sosnytsia.
			1881			Dec. Ioseb Jughashvili born, Gori. Ludwig Binswanger born, Kreuzlingen.
			1882			Moritz Tramer born, Ostrava.
			1883	<i>Compendium der Psychiatrie Zum Gebrauche für Studierende und Aerzte</i> , Emil Kraepelin		
			1885			Eugeniusz Minkowski born, St Petersburg. Fischel Schneersohn born c. 1885/88, Kamianets-Podilskyi.
			1886	“Über einige epileptoide Zustände”, Wilhelm Griesinger		
			1887	<i>Psychiatrie. Ein kurzes Lehrbuch für Studierende und Aerzte</i> . 2nd fully revised ed., Kraepelin		Jan. Kurt Schneider born, Crailsheim. Mar. Kurt Binswanger born, Basel May Eugen Kahn born, Stuttgart. Oct. Werner Villingger born, Besigheim.
			1888			Jul. Gottfried Ewald born, Leipzig. Oct. Ernst Kretschmer born, Wüstenrot.
			1889	<i>Psychiatrie. Ein kurzes Lehrbuch für Studierende und Aerzte</i> . 3rd largely reworked ed., Kraepelin		Apr. Adolphus Hitler born, Braunau am Inn.
			1890	<i>The Principles of Psychology</i> , William James		Margaret Ribble born, Wythe County.
			1891	Russian translation of Kraepelin 2 nd or 3 rd ed. published in St Petersburg		Apr. Henry Sigerist born, Paris.
			1892			Juliette Despert born.
			1893	“Über den psychischen Mechanismus hysterischer Phänomene”, Sigmund Freud and Josef Breuer		Jürg Zutt born.
				<i>Psychiatrie. Ein kurzes Lehrbuch für Studierende und Aerzte</i> . 4th fully revised ed., Kraepelin		
		11 November, Sukhareva is born.				

Accession of Nicholas II of Russia.	1894					Leo Kanner born, Klekotiv. Joseph Roth born, Brody.
	1895	I. Lerner, Sukhareva's future brother-in-law is born.		<i>Studien über Hysterie</i> , Sigmund Freud		
	1896			<i>Der geborene Verbrecher</i> , Eugen Bleuler <i>Psychiatrie. Ein Lehrbuch für Studierende und Aerzte</i> , 5th fully revised ed., Kraepelin "Zur Ätiologie der Hysterie", Freud.	First use of 'Psychoanalyse', Freud.	
	1897	Sukhareva's sister Maria is born.				Aug. Lauretta Bender born, Butte.
1 Mar. Russian Social Democratic Labour Party (RSDLP) founded.	1898			"Some Notes on Echolalia with the Report of an Extraordinary Case", Martin W. Barr Russian translation of Kraepelin 5 th ed. printed in St Petersburg	Case study of 22-year-old Kirtie M. Mansfield, mostly likely an adult with Kanner's-style autism. Autoerotismus used by Havelock Ellis.	
	1899			<i>Psychiatrie. Ein Lehrbuch für Studierende und Aerzte</i> , 6th fully reworked ed., Kraepelin Kraepelin's first mention of manic depression psychoses.		Karl Kahlbaum dies, Görnitz.
	1900			<i>Die Traumdeutung</i> , Freud		S. S. Korsakoff dies, Moscow.
	1901					Aleksandr Shmar'yan born. Vladimir Ulyanov begins using the pseudonym Lenin.
	1902			<i>Clinical Psychiatry A Text-Book for Students and Physicians</i> , 1 st ed., Allen Ross Diefendorf, based on Kraepelin 6 th ed.		May Adolf Kussmaul dies, Heidelberg. Samuil Mnukhin born, Pochinok.
	1903			Vol. 1 of <i>Psychiatrie. Ein Lehrbuch für Studierende und Aerzte</i> , largely revised 7th ed., Kraepelin		Bruno Bettelheim born, Vienna.
8 Feb. Russo-Japanese War begins. Pavlov wins Nobel Prize for Physiology or Medicine, becoming first Russian Nobel laureate.	1904			Vol. 2 of <i>Psychiatrie. Ein Lehrbuch für Studierende und Aerzte</i> , 7th ed., Kraepelin <i>Zur Psychopathologie des Alltagsleben</i> , Freud	Kraepelin's first classification of psychopathic personalities.	Pavlov is awarded the Nobel Prize in Physiology or Medicine.
22 Jan. Bloody Sunday 5 Sep. Russo-Japanese War ends.	1905			Binet's first intelligence scale.		
	1906			"Sopra alcune varietà della demenza precoce", Sante de Sanctis	De Sanctis's syndrome.	Feb. Johann "Hans" Asperger born, Vienna. Oct. Joseph Wortis born.

13 May-1 Jun. 5 th Congress of RSDLP held in London. Clashes between Bolsheviks and Mensheviks.		1907	<i>Clinical Psychiatry A Text-Book for Students and Physicians</i> , 2 nd ed., Diefendorf, based on Kraepelin 7 th ed.	Reinier Vedder born, Amsterdam.
		1908	<p>“Über Dementia Infantilis: Verblödungsprozess im Kindesalter”, Theodor Heller</p> <p>“Dementia pracocissima catatonica oder Katatonie des früheren Kindesalters?“, Sante de Sanctis</p> <p>“Die Prognose der Dementia Praecox – Schizophreniegruppe“, Bleuler</p> <p>“Die ‚kulturelle‘ Sexualmoral und die moderne Nervosität“, Freud</p> <p>Binet’s second revised intelligence scale.</p> <p><i>Psychiatrie. Ein Lehrbuch für Studierende und Ärzte</i>, fully revised 8th ed., Kraepelin</p>	<p>Heller’s syndrome or childhood disintegrative disorder.</p> <p>De Sanctis describes a syndrome resembling Asperger’s syndrome.</p> <p>First use of ‘schizophrenia’, Bleuler.</p>
		1909	<i>Psychiatrie. Ein Lehrbuch für Studierende und Ärzte</i> , fully revised 8th ed., Kraepelin	Dirk Arnold van Krevelen born. Aug. Hermann Stutte born, Weidenau.
		1911	<p><i>Dementia Praecox oder Gruppe der Schizophrenien</i>, Bleuler</p> <p><i>Anomale Kinder</i>, L. Scholz</p> <p>Binet’s third and last revised intelligence scale.</p>	Alfred Binet dies, Paris.
Communist Party of the Soviet Union (CPSU) founded. <i>Pravda</i> founded.		1912	<p>“Das autistische Denken“, Bleuler</p> <p>“Autistic Thinking“, Bleuler</p>	Ioseb Jughashvili begins using the pseudonym Stalin.
		1913	<p>“Über die epileptoiden Zustände bei Psychopathen“, M. O. Gurevich</p>	
28 Jun. assassination of Franz Ferdinand. 28 Jul. World War I begins.		1914	[The state of the question of the schizophrenic constitution], Gammushkin	Beginning of work that will later involve studies of schizoid psychopathy in adults.
	Sukhareva graduates from the Kiev Medical Institute for Women.	1915		
		1916	<p><i>Lehrbuch der Psychiatrie</i>, 1st ed., Bleuler</p> <p>“Sopra una sindrome della Frenastenia cerebropatica postnatale ‘Sindrome aparetico-afasica tardiva’“, de Sanctis</p>	Jung and Bleuler debate <i>autisches Zurückziehen, Autismus, Autoerotismus</i> and <i>Introversion</i> . De Sanctis describes a syndrome closely resembling Heller’s syndrome.
8-16 Mar. February Revolution, Russia 15 Mar. Nicholas II abdicates.	Sukhareva becomes an intern in one of Kiev’s psychiatric hospitals.	1917	<i>Collected Papers on Analytical Psychology</i> , Jung, trans. C. E. Long	

7-8 Nov. October Revolution, Russia 8 Nov. Ukrainian War of Independence begins.						
Feb. Russian calendar change. 10 Jun. Ukrainian People's Republic established. 16 Jul. execution of Russian Imperial Romanov family 11 Nov. World War I ends. Feb. Polish-Soviet war begins. 28 Jun. Treaty of Versailles.	1918	<i>Der sensitive Beziehungswahn</i> , Ernst Kretschmer	Description of <i>die Verschiobenen</i> in children and other forms of childhood psychopathy.	Gerhard Bosch born. Ludwig Scholz dies.		
19 Aug. Tambov Rebellion begins. 7-17 Mar. Kronstadt Rebellion 18 Mar. Treaty of Riga. Ukrainian People's Republic ends. Mar. Polish-Soviet war ends. Jun. Tambov Rebellion ends. Ukrainian-Soviet War ends. Russian famine (Povolzhye famine) begins. New Economic Policy introduced.	1919	<i>Anomale Kinder</i> , Scholz & Gregor <i>Lehrbuch der Geisteskrankheiten</i> , Oswald Bumke <i>Das autistisch-undisziplinierte Denken in der Medizin und seine Überwindung</i> , 1st ed., Bleuler "Über schizoide Alkoholiker", Kurt Binswanger				
3 Apr. Stalin becomes General Secretary of the Central Committee of CPSU. Russian famine ends having killed roughly 5 million people. 30 Dec. Soviet Union founded.	1920	"[Disorders of taste perception in patients with progressive paralysis and epileptics]" Sukhareva moves to Moscow to work at the medical observation point for defective children at the Moscow Department of Public Education. "[Analysis of children's fantasy as a method of studying the emotional life of the child]" Sukhareva's sister Maria graduates from the Kiev Medical Institute.	Possible first use of <i>schizoide Psychopathie</i> and schizoid.			
	1921	<i>Körperbau und Charakter</i> , Kretschmer <i>Das autistisch-undisziplinierte Denken in der Medizin und seine Überwindung</i> , 2nd revised ed., Bleuler	First use of schizoid according to <i>OED</i> .			
	1922	<i>Anomale Kinder</i> 3 rd ed., Scholz & Gregor		Leon Eisenberg born, Philadelphia.		
	1923	<i>Lehrbuch der Psychiatrie</i> , Bleuler <i>Die psychopathischen Persönlichkeiten</i> , Kurt Schneider				
21 Jan. Lenin dies.	1924	<i>Stroenie tela i kharakter</i> , Russian translation of Kretschmer's <i>Körperbau und Charakter</i> . Moscow-Petrograd.		Jan. Vladimir Lenin dies, Gorki. Mar. Sula Wolff born, Berlin. Kanner emigrates to the USA.		

	(based on the materials of the medical-observation post)]”		“La constitution schisoïde”, H. Claude, A. Borel and G. Robin			
	“[Schizoid psychopathies in childhood]” “[Materials for the study of giftedness in children]”	1925	<i>Physique and Character</i> , Kretschmer, trans. W. J. H. Sprott	1925	Descriptions of schizoid psychopathy/Asperger’s syndrome in children.	
	“Die schizoiden Psychopathien im Kindesalter” “Materialien zur Erforschung der Korrelationen zwischen den Typen der Begabung und der Konstitution”, (with S. V. Osipova)	1926	<i>La notion de perte de contact vital avec la réalité et ses applications en psychopathologie</i> , E. Minkowski <i>Vorlesungen über Psychopathologie des Kindesalters</i> , August Homburger	1926	Homburger refers to autism as symptom of childhood schizophrenia. Emil Kraepelin dies, Munich.	
Stalin sends his opponents, including Trotsky, into exile, consolidating power.	“[Features of schizoid psychopathy in girls]” “Die Besonderheiten der schizoiden Psychopathien bei den Mädchen”	1927	<i>Psychiatrie: ein Lehrbuch für Studierende und Ärzte</i> , 9th ed., Kraepelin and Johannes Lange Russian translation of Bleuler’s “Das autistische Denken”, Ya. M. Kogana <i>Temperament und Charakter</i> , Gottfried Ewald “Über die Einteilung der Psychopathien”, Gurevich <i>La schizophrénie: Psychopathologie des schizoïdes et des schizophrènes</i> , Minkowski <i>Die psychopathischen Persönlichkeiten</i> , Eugen Kahn	1927	Comprehensive description of schizoid psychopathy/Asperger’s syndrome in girls and sex differences.	Oct. Ronald Laing born, Govanhill. Dec. V. M. Bekhterev dies, Moscow.
	“[Cyclothymia and cycloid psychopathy]” “[Features of motor function in oligophrenics]” “Körperbau, Motorik und Charakter der Oligophrenen, II. Mitteilung: Mädchen” “Zur Klinik der Psychopathien im Kindesalter (Zykloide Formen)”	1928		1928	Sukhareva’s syndrome mentioned as an example of something that is not schizophrenia (2 papers on schizoid psychopathy, 1 paper on giftedness).	Sep. G. I. Rossolimo dies, Moscow. Oct. Lorna Tolchard born, Gillingham.
	“Der infantil-graziile Körperbautypus und sein somato-psychischen Besonderheiten”, (with I. B. Shenfil) “Über die Psychopathologie der Tuberkulose bei Kindern”, (with E. A. Osipova)	1929	<i>[Neuropathy, Psychopathy and Reactive Conditions in Childhood]</i> , T. P. Simson	1929	Simson describes a syndrome confirmed by Kanner to be early infantile autism in her chapter [Autistic Children].	Dmitriï Isaev born.
	“[Dynamics and structure of psychopathy]”	1930		1930	Overview of the life of the schizoid psychopath, prognosis,	Eugen Kahn emigrates to USA. August Homburger dies.

		“[On the problem of the structure and dynamics of children’s constitutional psychopathy (schizoid form)]” “Zur Frage der epileptoiden Psychopathien: Begriffsbestimmung und Abgrenzung am Kindermaterial”			how the individual is affected by environmental conditions.	
		Sukhareva becomes a consultant and scientific director for the P. P. Kashchenko Moscow Psychiatric Hospital. She holds this position until 1951. Sukhareva first (?) cited in English.	1931	<i>Psychopathic Personalities</i> , Kahn	Sukhareva’s syndrome mentioned as example of something that is not schizophrenia in English.	
		“Über den Verlauf der Schizophrenien im Kindesalter”, trans. W. A. Belaussoff	1932	First issue of <i>Nevropatologiya, psikihtriia i psikhogigiena</i> [<i>Psychopathology in Childhood</i>], Gurevich		
		Sukhareva returns to Ukraine to take up the chair of Childhood Psychiatry at the Kharkiv Psycho-Neurological Institute. “[Differentiation of the concept of epileptoid psychopathy]” “[On the problem of defectiveness in mild forms of schizophrenia]”	1933	“Die Dementia infantilis (Heller) in ihrer klinischen Bedeutung und ihre differentialdiagnostische Abgrenzung gegen die hyperkinetische Erkrankung (Kramer-Pollnow) sowie psychische Folgezustände nach postvaccinaler Enzephalitis”, Wilhelm Lange	Description of children with echolalia, stereotypes, motor unrest, agitation, whom others cannot make contact with and who seem disconnected from their surroundings. Probable Kanner’s-autism.	Feb. P. B. Gannushkin dies, Moscow. Sep. Donald Triplett born, Forest.
		Academic titles and doctoral degrees reinstated in USSR.	1934	“Zur Klinik der Schizophrenie des frühen Kindesalters”, E. Grebelskaya-Albatz	Tramer describes “phonographism” in children.	
		Sukhareva defends her doctoral thesis. Sukhareva goes back to Moscow to become head of Childhood Psychiatry at the Central Institute for Medical Specialisation. Sukhareva founds the Department for Child and Adolescent Psychoses at the Central Institute of Psychiatry.	1935	<i>Child Psychiatry</i> , Leo Kanner		Sante de Sanctis dies, Rome.

	<p>“[Features of defect structures in various forms of schizophrenia (in child and adolescent material)]”</p> <p>“[On the problem of the unity of schizophrenia]”</p> <p>“[Clinical and psychopathological features of one peculiar form of acute schizophrenia]” with Perskaia</p> <p>“[On some debatable problems in the field of schizophrenia]”</p> <p>“[Clinic of schizophrenia in childhood and adolescence. Part I.]”</p> <p>“[Regularities in the construction of a clinical picture of psychosis]”</p> <p>“[The significance of age features in the clinic of childhood mental illnesses?]”</p>	<p>1936</p>	<p>“Zur Frage der infantilen Schizophrenie”, C. Baumann and R. Vedder</p> <p><i>Physique and Character</i>, Kretschmer; trans. W. J. H. Sprott, 2nd ed. revised by E. Miller</p>	<p>Case study on developmental regression in two children with discussion of their ‘autism’.</p>	<p>I. P. Pavlov dies, Leningrad.</p>
<p>12 Mar. Germany annexes Austria.</p> <p>9 Nov. Kristallnacht, Germany.</p>	<p>“[Clinic epilepsy in children and adolescents. Problems of theoretical and practical medicine.]”</p>	<p>1938</p>	<p>“Das psychisch abnorme Kind”, Hans Asperger</p> <p>“Schizophrenia in children”, J. L. Despert</p> <p>Leo Kanner examines Donald Triplett, “case 1”.</p>	<p>Asperger’s earliest possible description of Asperger’s syndrome. Not recognised as such by Asperger himself.</p>	<p>Theodor Heller replaced as founding head of his children’s institute in Vienna with a butcher by National Socialists, attempts suicide, dies as a result.</p>
<p>1 Sep. Germany invades Poland.</p> <p>3 Sep. Britain and France declare war on Germany.</p>	<p>1st ed. of [<i>Clinical Lectures in Child Psychiatry</i>], vol. 1</p> <p>“[Basic principles of psychiatric diagnosis.]”</p> <p>“[Some debatable questions of modern psychiatry in light of data on the study of posttraumatic conditions]”</p>	<p>1939</p>			<p>Henry Sigerist appears on cover of <i>Time</i>.</p> <p>Jul. Eugen Bleuler dies, Zollikon.</p> <p>Sep. Freud dies, London.</p>
<p>22 Jun. Germany invades the Soviet Union. Great Patriotic War (Eastern Front of WWII) begins.</p>	<p>[<i>Clinical Lectures</i>] favourably reviewed in <i>Usonian</i> journal.</p> <p>At some point during the war, Moscow Psychiatric Hospital staff (and Sukhareva) are</p>	<p>1940</p>			<p>Uta Aurnhammer born, Rockenhausen.</p>

Mass extermination of European Jews begins. Oct. Evacuation of Moscow. Dec. USA enters World War II. 22 Aug. Battle of Stalingrad begins.	evacuated to Tomsk to treat war injuries.	1942	Anglo-Soviet Medical Committee founded.		
2 Feb. Battle of Stalingrad ends.	"[Psychogenic types of wartime reactions]"	1943	"Episodic psychosis in a seven-year-old", a probable description of an autism spectrum disorder, read at the Danish Psychiatric Society. American-Soviet Medical Society and <i>American Review of Soviet Medicine</i> founded. "Autistic disturbances of affective contact", Leo Kanner	Another independent description of a childhood illness resembling but not quite being schizophrenia. Kanner's earliest possible description of classic autism.	Sigerist is founder and editor of <i>ARSM</i> .
Jun. US and British troops land in Normandy. 1 Aug.-2 Oct. Warsaw Uprising.	Sukhareva's father dies.	1944	"Die ‚Autistischen Psychopathen‘ im Kindersalter", Hans Asperger "Early infantile autism", Leo Kanner		Sigerist deemed unfit for US public service.
Apr. Hitler dies. Allies defeat Nazi Germany. Aug. Atomic bombing of Hiroshima and Nagasaki.	Apr. Hitler dies. Allies defeat Nazi Germany. Aug. Atomic bombing of Hiroshima and Nagasaki.	1945	"Episodic psychosis in a seven-year-old boy", Hilmar Philipsen-Prahm Sociedad Cubano-Sovietica and <i>Revista Cubana de Medicina Sovietica</i> founded.		Apr. Adolf Hitler dies, Berlin.
Joseph McCarthy enters office as senator. Harry S. Truman signs Executive Order 9835, aka "Loyalty Order".	Maria Sukhareva defends her doctoral thesis. Maria Sukhareva becomes a professor. "[The value of the comparative-age method in the study of schizophrenia]"	1946			
		1947			Sigerist moves to Switzerland.
	"Psychologic disturbances in children during war" "[Psychosensory forms of encephalitis in children]"	1948	Final issue of <i>ARSM</i> . "[On a special type of irregular mental retardation in children]", S. S. Mnukhin	Another independent description of an autism spectrum disorder.	
Aug. First successful Soviet atomic bomb test, Kazakhstan. Jun. Korean War begins. The first Pavlovian session (sciences and medical sciences). Dec. US Senate Subcommittee on Internal Security (SISS) established.		1949	<i>ICD-6</i> <i>Soviet Psychiatry</i> , Joseph Wortis		
		1950			Jan. Oswald Bumke dies, Munich. Gurevich and Shmar'yan accused in Pavlovian sessions. Peter Szatmari born.

Mar. Rosenberg trial begins. Oct. The Pavlovian session for psychiatry and neuropathology.	“[Nodal questions on the problem of the delimitation of schizophrenia]” Sukhareva accused in Pavlovian sessions.	1951			Gurevich and Shmar'yan accused again in Pavlovian sessions.
McCarthy becomes chairman of SISS, starts inquiry into US Army. Jun. Rosenbergs executed. Jul. Korean War ends. Sep. Khrushchev becomes leader of USSR. Army-McCarthy hearings.		1952	“Die Lesesucht bei Kindern”, Fischel Schneersohn <i>DSM-I</i> <i>La Psychiatrie Soviétique</i> , Wortis	A description of compulsive reading in children.	
McCarthy kicked off the SISS.	Sukhareva's brother-in-law, I. Lerner, dies. 2 nd ed. of [Clinical Lectures in Child Psychiatry], vol. 1 Sukhareva posts Leo Kanner a copy of [Clinical Lectures].	1953	“Children with circumscribed interest patterns,” J. Franklin Robinson and Louis J. Vitale Pavlovian Society established at Johns Hopkins University. <i>ICD-7</i>	An independent description of an Asperger-style autism.	Mar. Joseph Stalin dies, Kuntsevo. Wortis investigated by the SISS. Nov. M. O. Gurevich dies, Moscow.
Feb. Khrushchev denounces Stalin. Cultural exchange agreements between USSR and Norway, USSR and Belgium. McCarthy exits office as senator by means of death. Cultural exchange agreement between USSR and France, and USSR and UK. Oct. Sputnik 1. Space race begins. Oct.-Nov. Hungarian Uprising.	“[Remote episodic psychoses following cerebral infections and trauma in children.]” appears in two journals.	1954			
Cultural exchange between USSR and USA.	“[Prerequisites for the organisation of psychoneurological service to children]”	1955	Deutsche Vereinigung für Jugendpsychiatrie holds annual conference with theme of autism. “Zur Problematik des Autismus”, van Krevelen “The specificity of early infantile autism”, Kanner	Vigorous debate on the differences between Kanner's and Asperger's autisms. Van Krevelen proposes renaming autistic psychopathy schizoid psychopathy.	
		1956			
		1957			Mar. Sigerist dies, Pura. May Joseph McCarthy dies, Bethesda.
		1958			F. Schneersohn dies, Tel Aviv. Aug. Simon Baron-Cohen born.

					Van Krevelen outlines differences between Kanner's and Asperger's autism in a paper, Kanner reads and quotes van Krevelen's paper. Sukhareva renames schizoid psychopathy autistic psychopathy.	
				1959	[Clinical Lectures in Child Psychiatry], vol. 2 “[Organisation of psychoneurological aid for children in the RSFSR]” “[About the work of the psychoneurological room for children and adolescents at the psychoneurological dispensary and children's polyclinic]” (with M. I. Lapidés)	
				1960	“[On the tasks of scientific research in the field of child psychiatry]”	Early infantile autism and autistic psychopathy appear separately in a child psychiatry classification system. Asperger compares European and Usonian conceptions of autism. Sukhareva's schizoid psychopathy compared to Asperger's autistic psychopathy.
Apr. First manned space flight (USSR). Construction of Berlin Wall.				1961	<i>Klinische Psychiatrie</i> , ed. C. E. Benda et al. “Autistisches Verhalten im Kindesalter”, Asperger. “Autismus infantum (infantile autism)”, van Krevelen. <i>Die endogenen Psychosen des Kindes- und Jugendalters</i> , Walter Spiel	May-Jul. W. Villinger accused of being a T4-Gutachter and will go to trial. Jun. C. G. Jung dies, Küsnacht. 15 Jun. A. S. Shmar'yan dies, Moscow. Aug. Villinger dies, Innsbruck. Possible suicide. Is not tried.
Oct. Cuban Missile Crisis.				1962	<i>Kinderen met leer- en gedragsmoeilijkheden</i> , 2nd ed., R. Vedder <i>Der frühkindliche Autismus</i> , Gerhard Bosch “The psychopathology of autistic psychopathy”, van Krevelen and Christine Kuipers	Formal attempt at differentiation between K's and A's autisms. Attempt to introduce Asperger's autism to English-speaking audience. Table of differences between A's and K's autisms published in English.
President Kennedy is assassinated, USA.				1963	“On the relationship between early infantile autism and autistic psychopathy”, van Krevelen.	May Moritz Tramer dies, Bern. Jul. Gottfried Ewald dies, Göttingen.
Oct. Khrushchev is removed and replaced by Brezhnev as leader of USSR.				1964	“[On some crucial problems in oligophrenia]” “Some crucial problems in the understanding of oligophrenia”	Feb. Ernst Kretschmer dies, Tübingen.

U.S. ground troops deployed in Vietnam.	[Clinical Lectures in Child Psychiatry], vol. 3 “[Psychogenic pathological reactions (neurosis)]” (with L. S. Iusevich)	1965			
	“[The significance of comparative age in the study of the regularities in the course of schizophrenia in children and adolescents]” “The importance of considering the effect of age for the study of fixed rules in the course of schizophrenia in children and adolescents”	1967	“Hypertexia – specific word recognition skills in young children,” N. E. Silberberg and M. C. Silberberg <i>The Empty Fortress</i> , Bruno Bettelheim <i>ICD-8</i> “[Syndrome of early infantile autism or Kanner’s syndrome in children]”, S. S. Mnukhin, A. E. Zelenetskaia and D. N. Isaev	Hyperlexia first used in English. Denotes enhanced character recognition with poor comprehension rather than compulsive reading. Infantile autism included in ICD under schizophrenia.	Oct. Kurt Schneider dies, Heidelberg.
Prague Spring. Student uprisings throughout the West. Moon landing.	Sukhareva is visited by Nancy Rollins from the USA. A paper by Sukhareva is presented at the 5 th WHO Seminar in Washington, D.C. Does Sukhareva visit the USA? Unknown. Kanner mentions volumes 1 and 2 of [Clinical Lectures]. Sukhareva retires from leading the Department for Child and Adolescent Psychoses at the Central Institute of Psychiatry but continues to consult for it.	1968	<i>DSM-II</i>	Childhood schizophrenia included in DSM.	
		1969	5 th WHO Seminar on Psychiatric Diagnosis, Classification, and Statistics held in Washington, D.C.		
		1970	<i>Infantile Autism</i> , Bosch, trans. Derek and Inge Jordan	Use of ‘Asperger syndrome’ in English and comparison of A’s and K’s autisms. Table of differences appears again.	
	“[The problem of the classification of mental retardation]” (Spanish)	1971	<i>Journal of Autism and Childhood Schizophrenia</i> established with Kanner as editor. First issue publishes a review of Soviet literature on the topic. “Early infantile autism and autistic psychopathy”, van Krevelen in Kanner’s journal. “Multiple impairments in early childhood autism”, Lorna Wing and John K. Wing	Revised table of differences. Multiple differentiations of Kanner’s and Asperger’s autisms published this year. Kanner affirms T. P. Simson’s autistic children syndrome is the same as his syndrome.	Jul. Margaret Ribble dies, Warrenton. Sep. Khrushchev dies, Moscow.

						Asperger syndrome receives attention by non-German speaking Anglophone psychiatrists.	
	“The problem of the classification of mental retardation” Sukhareva’s nosology published in Rollins.	1972	<i>Child Psychiatry in the Soviet Union</i> , Nancy Rollins			Sukhareva’s nosology appears in English. Schizoid psychopathy is translated as “schizoid (autistic) personality” – no comparison drawn with Asperger syndrome as this does not yet exist in the USA.	S. S. Mnukhin dies.
		1973					Jan. Eugen Kahn dies, Houston.
Last US troops leave Vietnam.		1975	“On the organic nature of some forms of schizoid or autistic psychopathy”, S. S. Mnukhin and D. N. Isaev			Russians using schizoid psychopathy and autistic psychopathy interchangeably in English.	
		1976	“Differences between mentally retarded and normally intelligent autistic children”, L. Bartak and M. Rutter			USA begins catching up to Europe.	
		1978	<i>ICD-9</i>				
Dec. Soviet invasion of Afghanistan.	Sukhareva retires from consulting.	1979	“Schizoid personality in childhood: a comparative study of schizoid, autistic and normal children”, Wolff and A. Barlow “Problems of infantile autism”, Asperger <i>Journal of Autism and Childhood Schizophrenia</i> renamed <i>Journal of Autism and Developmental Disorders</i> .				D. Am. van Krevelen dies,
		1980	<i>DSM-III</i>				J. Zutt dies. Oct. H. Asperger dies, Vienna.
	Sukhareva dies, Moscow.	1981	“Asperger’s syndrome: a clinical account”, Lorna Wing				3 Apr. Leo Kanner dies, Sykesville. 26 Apr. G. E. Sukhareva dies, Moscow.
Nov. Brezhnev dies.		1982					Apr. H. Stutte dies, Marburg a. d. Lahn. ? J. L. Despert dies. Nov. Brezhnev dies, Zarechye.
Gorbachev becomes leader of USSR. Glasnost and perestroika begin		1985					
		1987					Jan. Laurretta Bender dies.
		1988	“Lifelong eccentricity and social isolation II: Asperger’s syndrome or schizoid personality disorder?”, Digby Tantam “Asperger syndrome”, Tantam			Efforts to distinguish Asperger syndrome from schizoid conditions, behaviours and personalities.	

Fall of the Berlin Wall. Collapse of Communist regimes in Eastern Europe.		1989	<p>"Asperger's syndrome: a review of clinical features", P. Szatmari, R. Bremner and J. Nagy</p> <p>"Asperger syndrome: some epidemiological considerations", I. C. Gillberg and C. Gillberg</p> <p>"Family characteristics of autistic children", Sukhdev Narayan, Barbara Moyes and Wolff</p> <p><i>Autism and Asperger Syndrome</i>, ed. Uta Frith</p> <p>"Asperger's syndrome", Wolff</p> <p>"Schizoid personality in childhood and adult life", Wolff</p> <p><i>ICD-10</i></p>	English attempts at formal diagnostic criteria for Asperger syndrome.	Mar. Bruno Bettelheim dies, Silver Spring.
Disintegration of USSR.		1990			
		1991		Asperger's 1944 paper in English translation.	
		1993		Asperger syndrome included in ICD.	
		1994	<i>DSM-IV</i>	Asperger syndrome included in DSM.	
		1995	<p><i>Loners: the life path of unusual children</i>, Wolff</p> <p>"Schizoid personality in girls: a follow-up study – what are the links with Asperger's syndrome?", Wolff and Ralph J. McGuire</p>		
	"The first account of the syndrome Asperger described?", Wolff & Sukhareva	1996	<p>"The first account of the syndrome Asperger described?", Wolff & Sukhareva</p> <p>"Are autism and Asperger syndrome different labels or different disabilities?", E. Schopler</p>	Wolff's translation of "Die schizoide Psychopathien im Kindesalter" appears linking it with Asperger syndrome.	
		1997	"The history of ideas on autism", Wing		
		2013	<i>DSM 5</i>	Asperger syndrome, Heller syndrome folded into autism spectrum disorder.	

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Appendix

- a. "Die schizoiden Psychopathien im Kindesalter." by G. E. Sukhareva

IV.

(Aus der Sanatoriumschule der Psychoneurologischen Kinderklinik in Moskau [Direktor Prof. Dr. M. O. Gurewitsch].)

Die schizoiden Psychopathien im Kindesalter.

Von

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wiss. Assistent.

Die Frage der „Schizoiden“ und der „Zykloiden“ hat gegenwärtig schon eine große Literatur gezeitigt und *Kretschmers* Buch „Körperbau und Charakter“ wurde zum Ausgangspunkte einer ganzen Reihe verschiedenartiger Arbeiten. Übersehen wir das gesamte Material, welches über die *Kretschmersche* Typologie vorliegt, so ergibt sich, daß diese Frage auch heute noch im Stadium des Kampfes verschiedener Anschauungen sich befindet. Am meisten umstritten erscheint das Problem des schizoiden Typus. Der Einführung des Schizoidbegriffs in die psychiatrische Klinik wurde seitens vieler Psychiater mit ernster Kritik begegnet. *Bunke* betrachtet diesen Begriff als eine künstliche Konstruktion; *Wilmanns* hält die von *Kretschmer* gegebenen Typen für unbestimmt und wenig scharf umgrenzt. Nach *Ewalds* Meinung ist der Schizoid ein Sammelbegriff, welcher alle Gruppen von psychopathischen Persönlichkeiten in sich aufnehmen kann.

Diese strenge Kritik der *Kretschmerschen* Typologie findet ihre Erklärung in der Verschwommenheit des schizoiden Typus, welcher von *Kretschmer* in seinem „Körperbau und Charakter“ aufgestellt wurde. In der Charakteristik der schizoiden Temperamente gibt er einige meisterhafte künstlerisch beschriebene Züge der schizoiden Psyche; der Begriff des Schizoids bleibt aber dessen ungeachtet wenig scharf umgrenzt und unbestimmt. In einer literarisch-geistreichen Beschreibung einzelner schizoider Typen verliert sich die Klarheit des klinischen Begriffs, verschwimmt die Grenze zwischen dem Kranken und Gesunden, dem Charakterologischen und Psychotischen. Der Begriff des „Schizoids“ wird zu einem allumfassenden, da seine Beziehungen

zu dem normalen Schizothymiker und zu anderen Gruppen der psychopathischen Persönlichkeiten zu unbestimmt sind.

Wie es mit einem ungenügend bestimmten und unscharf begrenzten Begriff immer zu geschehen pflegt, ging man auch in dem Gebrauche des Ausdrucks „Schizoid“ allzu weit. Es entstand eine ganze Reihe neuer Ausdrücke unklaren Inhalts: „schizophil“, „schizoman“, „schizoaffin“ usw. Und, wie es ebenfalls immer zu geschehen pflegt, führte auch hier der Gebrauch des Ausdruckes im erweiterten Sinne zum Verluste des ursprünglichen Sinnes.

Auf diese Gefahr der Erweiterung des Ausdruckes „Schizoid“ und auf die daraus resultierende Verwechslung der Begriffe weist auch *Kretschmer* selbst in einer seiner letzten Arbeiten hin. Er empfiehlt hier diesen Ausdruck sehr vorsichtig zu gebrauchen und ihn nur für eine kleine Gruppe psychopathischer Persönlichkeiten zu behalten.

Den zweiten Punkt, welcher viele Einwände contra *Kretschmer* hervorgerufen hat, bildet die Frage über die Beziehungen des Schizoides zur Schizophrenie. In *Kretschmers* Arbeit („Körperbau und Charakter“) ist der Unterschied zwischem dem Schizoid und der Schizophrenie wenig deutlich. *Kretschmer* ist der Ansicht, daß die Übergänge vom Schizoid zur Schizophrenie sehr fließende sind und erblickt in dem schizophrenen Prozeß nur eine Zuspitzung bestimmter konstitutioneller Gruppen.

Eingehend behandelt diese Frage *Ewald*. Die Parallele, die *Kretschmer* zwischen dem Schizoid und der Dementia praecox zieht, hält er für vollkommen willkürlich und stellt die Frage, was die Schizophrenen mit den schizoiden Psychopathen gemeinsam haben, falls das am meisten charakteristische Symptom der Schizophrenie in dem progressiven Zerfall der Persönlichkeit zu erblicken ist. — Darüber schreibt auch *Bumke*, indem er für unmöglich erachtet, daß „eine organische Krankheit, so wie die Dementia praecox, sich schließlich bis zu einem normalen Temperament verdünnt.“

Andererseits kann nicht geleugnet werden, daß eine ganze Reihe Forschungen, wie auf dem Gebiete der Erbbiologie, so auch auf dem der Klinik, die Tatsache, daß zwischen der Gruppe der schizoiden Psychopathien und der Schizophrenie irgendein Zusammenhang existiert, bestätigt. Auf das Vorhandensein in den schizophrenen Familien eines besonderen Typus von Psychopathen mit schizoiden Eigentümlichkeiten machen viele Autoren

aufmerksam (*Medow, Hoffmann, Rüdin, Kahn, A. Schneider* u. a.). Auch die klinischen Forschungen über die präpsychotische Persönlichkeit des Schizophrenen weisen auf ihre Ähnlichkeit mit dem Bilde der schizoiden Psychopathien hin (*Kraepelin, Bleuler, Gannuschkin, Künkel, Giese* u. a.).

Diese klinischen und erbbiologischen Tatsachen wurden von verschiedenen Forschern verschieden bewertet; eine Reihe von Autoren betrachtet schizoide Psychopathien als den Ausdruck einer konstitutionellen Anomalie; dagegen sind andere Autoren der Ansicht, daß es sich bei diesen Psychopathien um latente und abortive Schizophrenien („verkappte Schizophrenien“ *Bumke*) handelt und daß die präpsychotischen Eigentümlichkeiten nichts anderes sind, als schizophrene Frühsymptome.

Jedoch stellen auch die Vertreter des zweiten Standpunktes die Existenz eines besonderen Typus von Psychopathen mit einzelnen schizophrenen Eigentümlichkeiten nicht in Abrede. Diese Eigentümlichkeiten werden von *Kraepelin* als Resultat einer ungleichmäßigen Entwicklung der zusammenwirkenden seelischen Leistungen betrachtet.

Auch diese Frage über die Beziehungen von Schizoid und Schizophrenie wurde von *Kretschmer* in seinen späteren Arbeiten einer Revision unterzogen. Im „Konstitutionsproblem in der Psychiatrie“ schreibt er, daß die Schizophrenie bei einem Schizoid sich nicht auf dem Wege einer einfachen Kumulation schizoider Eigentümlichkeiten entwickelt; bei der Vererbung der Schizophrenie wird die schizoide Komponente noch durch irgendeinen Erbfaktor ergänzt; es ist noch ein komplementärer Impuls, der auf die Keimmassen einwirkt, notwendig. Hier nähert sich der Standpunkt *Kretschmers* den Anschauungen von *Kahn*, welcher bei der Vererbung der Schizophrenie zwei Komponenten unterscheidet: 1. die Anlage zur Schizoidie (schizoide Konstitution) und 2. die Anlage zu dem schizophrenen Krankheitsvorgang.

Wir sehen, daß der Begriff der schizoiden Psychopathie, sein Umfang, sein Inhalt, seine klinische Bedeutung (letzteres im Zusammenhange mit der Frage über die Beziehungen des Schizoids zur Schizophrenie) durch *Kretschmer* selbst revidiert und bedeutend abgeändert wurde.

Die schizoide Psychopathie in diesem engen Sinne wird von vielen Klinikern akzeptiert, auch von denen, die *Kretschmer* gegenüber Einwände gemacht hatten. Auch *Ewald*, welcher der

Kritik der *Kretschmerschen* Typologie viel Aufmerksamkeit gewidmet hatte, leugnet nicht, daß es eine Gruppe von Psychopathen gibt, welche eine große psychologische Ähnlichkeit mit den Schizophrenen besitzen. Diese symptomatologische Ähnlichkeit zweier ganz verschiedener klinischer Formen erklärt er durch ihre gemeinsame Lokalisation in bestimmten Hirnsystemen. In einer von seinen letzten Arbeiten macht *Berze* eine Reihe kritischer Bemerkungen (contra *Kretschmer*) über den schizoiden Typus, endet aber mit der Anerkennung, daß es eine Gruppe von Psychopathen gibt, die besonders zur Schizophrenie veranlagt sind und die er die „apperzeptiv-übererregbaren“ Psychopathen nennt. Diese Gruppe stellt eine konstitutionelle Anomalie dar, welche sich in einer Übererregung bestimmter nervöser Systeme äußert, wodurch auch ihre leichte Verwundbarkeit und der genetische Zusammenhang mit der Schizophrenie sich erklären. Anologe Arbeiten liegen auch aus der Klinik von *Kleist* vor (*M. Loewy, A. Schneider*). Die psychopathische schizoide Konstitution erklären diese Autoren durch die angeborene Unzulänglichkeit bestimmter Hirnteile (Kleinhirn, Basalganglien, Stirnsystem), und zwar derjenigen Systeme, welche nach *Kleist* als das anatomische Substrat des schizophrenen Krankheitsvorganges betrachtet werden müssen.

Die Streitfrage über die schizoiden Psychopathien kann am ehesten am klinischen Material gelöst werden (an gut studierten und dauernd beobachteten Fällen). Das Kindermaterial hat in dieser Hinsicht den Vorzug, daß es in bezug auf verschiedene äußere Momente (seitens Milieu, der kulturellen Verhältnisse, der Berufe; Alkohol, anderer Narcotica usw.), die die wesentlichsten Züge des Bildes vertuschen, viel reiner ist.

Wir ziehen in Betracht, daß die Fälle kindlicher Psychopathien, verhältnismäßig wenig in der Literatur beschrieben wurden, und sind deswegen der Meinung, daß es nicht ohne Interesse wäre, das Material der schizoiden Psychopathien welches während der letzten drei Jahre bei der Psychoneurologischen Kinderklinik zur Behandlung kam, zu fixieren. Da wir mit den differentiell-diagnostischen Schwierigkeiten, welchen wir bei der Abgrenzung der schizoiden Psychopathien von der präpsychotischen und postpsychotischen Persönlichkeit der Schizophrenen begegnen, rechnen müßten, so wählten wir nur diejenigen Fälle, wo wir gute Anamnesen hatten und wo unsere Beobachtung lange Zeit hindurch gedauert hatte. Andere

weniger ausgesprochene Formen aus unserem klinischen Material, bei denen gewisse diagnostische Schwierigkeiten in Frage kommen könnten, lassen wir hier außer der Betrachtung. Im ganzen führen wir weiter unten sechs Fälle schizoider Psychopathie an; alle Fälle betreffen Knaben im Alter von 2 bis 14 Jahren. Die durchschnittliche Aufenthaltsdauer in der Klinik beträgt 2 Jahre.

Fall 1. M. Sch., 13 Jahre, Jude, aus intelligenter Familie. Heredität; *Vater* 63jährig, an Angina pectoris leidend; weich, herzlich, reizbar, manchmal heftig und grob; pathologisch argwöhnisch. *Großvater* väterlicherseits an Cancer gestorben. Die *älteste Tante* nervös, argwöhnisch, launisch; ihre *Tochter* leidet an Zwangszuständen. *Onkel* schwärmerisch, wenig anpassungsfähig. *Mutter* gichtleidend, — reizbar, in der Jugend unmotiviert ängstlich, hatte Angst vor leeren Zimmern; ist, ihrer eigenen Meinung nach, gegenwärtig viel ruhiger als früher. *Großvater* mütterlicherseits grob, reizbar; hat getrunken. *Großmutter* starb an Tuberkulose.

Unser Knabe ist das letzte Kind in der Familie; bei seiner Konzeption war der Vater 50jährig, die Mutter 40jährig; Partus zwei Wochen vor dem Termin. Körperliche Entwicklung regelmäßig; frühere Erkrankungen: nur Masern und Appendicitis.

Ist in einer materiell gut gestellten Familie aufgewachsen; war stets mit den Sorgen seiner Angehörigen umgeben. Von früher Kindheit auf beunruhigt der Knabe seine Eltern: er ist anders als alle übrigen Kinder geartet. Schon in der Wiege war eine erhöhte Erregbarkeit vorhanden, eine besondere Empfindlichkeit den Schallreizen gegenüber, zuckt bei jedem Geräusch zusammen. Mit zwei Jahren konnte bei ihm absolutes Gehör festgestellt werden, mit vier Jahren konnte er lesen. Scheu, schreckhaft, meidet die Kindergesellschaft, argwöhnisch, oft hypochondrische Beschwerden, spricht gern über Krankheit, weist ein erhöhtes Interesse zu der Frage über den Tod auf. Wenn er einen Sarg sieht oder wenn von einem Verstorbenen die Rede ist, regt er sich sehr auf, sagt von sich selber: „Ich werde kaum lange leben.“ Folgsam und still, passiv, fängt nichts selbständig an.

Schweift ziellos umher, benimmt sich manchmal läppisch, stellt an die umgebenden Menschen eine Menge absurder Fragen. Wiederholt mehrmals ein und dasselbe und beruhigt sich nur in dem Falle, wenn er eine erschöpfende Antwort erhält. Appetit herabgesetzt, unruhiger Schlaf, nächtliches Aufschreien, ängstigt sich vor der Dunkelheit und vor den „Gespenstern“. Als er sechs Jahre alt war, wurde er einmal zufällig allein im Zimmer gelassen, worauf er mit heftigem Schreck und Schrei reagierte. Seit dieser Zeit hat er Furcht vor der Einsamkeit und vor geschlossenen Türen. Gleichzeitig wurde intensives Onanieren beobachtet. Mit sieben Jahren fängt er an, im ABC und in der Musik (Geige) unterrichtet zu werden.

Er lernte zu Hause mit Hilfe eines Lehrers, war zerstreut und wenig ausdauernd, hatte Schwierigkeiten im Rechnen; in der Musik machte er dagegen rasch Fortschritte, arbeitete jedoch ohne besondere Lust. 1920 wurde er bei dem Konservatorium (Abteilung für Violone) aufgenommen,

wo er seitdem als ein guter Schüler betrachtet wird; das Vorwärtkommen wird bei ihm durch die Unfähigkeit zu systematischer Arbeit aufgehalten.

1923 kam er auf die Heilschule der psychoneurologischen Kinderklinik. Die Klagen der Eltern bezogen sich auf die Zwangszustände des Knaben und auf seine geringe Arbeitsfähigkeit. Der Anfang aller dieser Erscheinungen ist, nach den Worten seiner Mutter, in der frühen Kindheit zu suchen. Eine Verschlimmerung der krankhaften Erscheinungen im Verlaufe des weiteren Lebens konnte nicht verzeichnet werden, im Gegenteil geht der Gesamteindruck dahin, daß der Knabe mit den Jahren immer gleichmäßiger wurde.

Status: Nach der Körperlänge und dem Körpergewicht übertrifft er sein Alter; Körperbau regelmäßig, wohlproportioniert; Typus asthenisch dolichomorph; langer, schmaler Brustkorb; längliches Gesicht mit kleinen Gesichtszügen; das Muskelsystem und das subkutane Fettgewebe mäßig entwickelt; die Gesichtshaut matt, ungleichmäßig gefärbt, stellenweise etwas intensivere rote Flecken; die Haut am Rumpfe ist derber, elastisch, weder trocken noch übermäßig schwitzend; Hände zyanotisch, feucht und kalt; Kopfhaare dunkel, dicht, niedrig wachsend; die sekundären Haare am Mons pubis stark ausgesprochen. Polyadenitis. Schilddrüse — N; Geschlechtsorgane sind stärker, als es der Norm entsprechen würde, entwickelt. Innere Organe: Lungenausatmung in der rechten Spitze; Herz leicht erregbar, reine Töne; Appetit herabgesetzt, zuweilen Durchfall.

Nervensystem: Gehirnnerven-N; Pupillen gleichmäßig, Reaktion lebhaft; Sehnenreflexe normal; träge Hautreflexe, Rachenreflex herabgesetzt; Sensibilität auf allen Gebieten normal; kraß ausgesprochen roter Dermographismus. Plumpe, ungeschickte Bewegungen, grobe Muskelkraft genügend. Dynamometrie: D. 50 S 40. Zurückgebliebenheit nach der Stufenleiter von Dr. *Oseretzky*: — vier Jahre. Plumper, etwas ungeschickter Gang; schlafe Mimik; Sprache nicht genügend moduliert. Blutuntersuchung: Hämoglobin 80⁰/₁₀₀, Erythrozyten 4 700 000, Leukozyten 7 200; die Leukozytenformel weist keine Abweichungen von der Norm auf, abgesehen von einer geringen Lymphozytose. Die Untersuchung des vegetativen Nervensystems erwies eine Labilität beider Systeme. Wassermannsche Reaktion negativ; Abderhaldensche Reaktion mit Testes und Thyreoidea negativ.

Status psychicus: Bei der Untersuchung ist er freundlich und höflich. Schüchternheit und Unsicherheit in der Haltung. Unruhig, eine Menge überflüssiger Bewegungen, manchmal tickähnliche Zuckungen des Gesichts. Faßt die Fragen sofort auf und antwortet willig. Sprache eilend, unbestimmt. Ist nur äußerlich zugänglich. Verbirgt seine Gedanken unter einer Menge von Worten und verschiedenen Redensarten. Auf die Frage, wie es ihm gehe, gibt er folgende Antwort: „Ich weiß nicht, vielleicht gut, vielleicht schlechter, überhaupt geht es den Menschen verschieden.“ Auf die Frage, ob ihm das durchgelesene Buch gefalle, erfolgt die Antwort: „Es scheint mir, daß das Buch mir gefallen hat, aber ich weiß es eigentlich nicht bestimmt, das Prinzip des Lesens ist schon so, daß man eingenommen wird.“ Beim Formulieren irgendeines Gedankens

macht er einen langen Umweg, räsioniert dabei und lenkt nach der Seite des Abstrakten ab, jedoch ist eine Zerfahrenheit und Verwirrtheit des Denkens nicht zu verzeichnen.

Was die Assoziationen anbetrifft, so herrschen darunter die inneren und die koordinierten vor. Die logischen Prozesse verlaufen vollkommen befriedigend. Das Schließen bleibt intakt. Bei der Feststellung von Ähnlichkeiten und Unterscheiden wird das Wesentliche erfaßt, Definitionen gelingen ihm treffend, auch wenn es sich um abstrakte Begriffe handelt (z. B. Schönheit — „das Aussehen eines Gegenstandes in einer für das Auge angenehmen Form“, Unterschied zwischen dem Eigensinn und der Beharrlichkeit — „der Eigensinnige handelt ohne jeden Grund, der Beharrliche aus einem Prinzip“).

Resultate der Untersuchung im psychologischen Laboratorium: nach der Binetschen Skala ergibt er + zwei Jahre, nach der Methode von Rossolimo beträgt die mittlere Profilhöhe 8,6.

Sagt über sich selbst, daß er nicht so ist wie alle die anderen Knaben, „sie sind in den Spielen sehr geübt, nehmen mich nicht mit; der Charakter der Kinder ist ein solcher, daß sie den Stärkeren wählen“. Ist zur Selbstanalyse und zur Kritik befähigt; hält sich selbst für nervös: „Ich konnte niemals ohne Angst sein, früher hatte ich Angst vor den Wölfen und Gespenstern, jetzt ängstige ich mich, daß man mich im Zimmer einsperren wird, besonders wenn es engräumig ist; oft liege ich und denke mir, daß vielleicht zu Hause etwas geschehen sein konnte, z. B. eine Feuersbrunst; eine besondere Angst habe ich, wenn ich im Schlafzimmer bin.“ Stellt bei sich die Erscheinungen des Zwanges und des Automatismus fest: „Oft kommt es vor, daß bei mir im Kopfe sich ein Wort dreht, so daß ich von ihm auf keine Weise los werden kann; oder es fällt mir ein, daß, wenn ich das und das nicht tue, mir irgendwas passiert. Es fällt mir schwer, irgend etwas anzufangen, ich muß mich lange vorbereiten, nachher aber ist es mir schwer, mich davon zu trennen.“

In die Anstalt tritt er willig ein, fügt sich leicht in die Hausordnung der Schule, geht auf alle Vorschläge zur Arbeit ein, macht aber alles ungeschickt; ist äußerst saumselig und plump. Rief von vornherein im Kindermilieu ein höhnisches Verhalten sich gegenüber hervor, hält sich mehr in der Gesellschaft der kleineren Kinder auf; die Stimmung ist bald eine gleichgültig-erhöhte: plaudert ohne Ende, reimt Worte, grimassiert, spielt einen Possenreißer; es wurden Perioden eines noch stärkeren Erregungszustandes beobachtet, in welchen er viel gesprungen, Fratzen geschnitten hat usw. Er ist stets albern und zudringlich, belästigt die Kinder, langweilt die Erwachsenen mit seinen unendlichen Fragen. Während des ganzen Winters begegnete er allen mit der Frage: „Wo ist Ihr Rock?“ oder „Warum sind Sie ohne Rock?“ Seine Witze sind meistens gereimt, es kamen Perseverationen vor, oft wiederholte er mehrmals ein und dasselbe Wort. Das affektive Leben ist, von außen her betrachtet, arm; er interessiert sich für nichts, schweift während der Mußstunden ziellos und träge umher. Seine einzelnen feinen Bemerkungen dagegen, die so kraß mit seiner üblichen Albernheit kontrastieren, seine Feinfühligkeit allem Schönen gegenüber „Welt der Träume“, welche in seinen

Gedichten oft ermahnt wird, — dies alles läßt uns denken, daß hinter seiner äußeren Indolenz sich ein reicherer innerer Inhalt verbirgt.

Musikalisch begabt; während des Spiels verändert er sich vollkommen und macht den Eindruck eines sicheren und feinfühlenden Kenners. Ist auch malerisch befähigt. Der Lehrer für das Zeichnen (ein Künstler) rechnet ihn zu der Gruppe der hochbegabten Kinder. Macht Verse, die inhaltlich unoriginell, jedoch klangvoll sind.

Ausgesprochene Sexualität, onanierte eine Zeitlang intensiv, hat eine Vorliebe zu zynischen Unarten und zweideutigen Scherzen.

In der Klasse bleibt er zurück in der Arbeit. Seine Produktivität ist gering; er wird dabei gestört 1. durch die krasse Saumseligkeit, den Automatismus, das Haftenbleiben bei irgendeinem Thema und 2. durch die Unfähigkeit zu derjenigen Anstrengung und Anspannung, die für die systematische Arbeit erforderlich ist.

Während des zweijährigen Aufenthaltes in der Heilschule wurde er körperlich stärker, fing an, mehr Freude an den körperlichen Übungen, am Turnen und Rhythmik, zu finden. Psychischerseits ließen sich keine bedeutenden Veränderungen beobachten: er ist etwas schlichter und ruhiger geworden, jedoch ist er auch jetzt, wie früher, periodenweise läppisch und albern. In der Schularbeit sind jedoch gewisse Leistungen nicht zu leugnen: stellte einige selbständig ausgeführte Aufgaben vor. Macht gute Fortschritte in der Malerei und in der Musik.

Zusammenfassung: Eine minderwertige, dysharmonische Persönlichkeit; eine Mischung von Feinheit und läppischer Albernheit in der Psyche. Hohe künstlerische Begabung bei einer Minderwertigkeit in toto. Symptomatologie: Neigung zum Automatismus und zu Zwangszuständen nebst einer Schwäche des zielbewußten Willens. Neigung zu autistischen Reaktionen. Intellekt normal, Denken geordnet, jedoch Rasonnieren, Saumseligkeit, Haftenbleiben. Aus dem körperlichen Status: asthenischer Körperbau. Labiles vegetatives Nervensystem. Motorische Unzulänglichkeit, Ungeschicktheit und Eckigkeit der Bewegungen, schlaife Mimik. *Verlauf:* stationär ohne krasse Schwankungen mit einer geringen Besserung. *Diagnose:* psychopathische Persönlichkeit. Schizoid. (Verschroben).

Fall 2. M. R., 10 $\frac{1}{2}$ Jahre, jüdisch, aus intelligenter Familie. Heredität: *Vater* Arzt, ein befähigter Wissenschaftler, körperlich gesund, zerstreut, reizbar, etwas sonderbar, „hatte immer etwas an sich, was schwer zu verstehen war“ (wie seine Frau über ihn geäußert hat). *Großvater* väterlicherseits an Vitium cordis gestorben. *Onkel* von der väterlichen Seite Epileptiker, ein anderer *Onkel* eine hitzige Persönlichkeit mit etwas sonderbarer Denkweise und öfters impulsiven Handlungen. *Mutter* 34jährig, gesund. Der Großvater von der mütterlichen Seite wurde mit 35 Jahren geisteskrank (Schizophrenie?). in der Seitenlinie des Großvaters ein Selbstmordfall. *Großmutter* litt an einer Herzkrankheit und starb an Apoplexie. In der Seitenlinie der Großmutter ein Fall psychischer

Erkrankung (Schizophrenie?) und zwei Selbstmordfälle. Ein Onkel von der mütterlichen Seite leidet von 35 Jahren an an einer seelischen Erkrankung, die als Zykllothymie diagnostiziert wurde; in freien Intervallen ist er ein weicher, charakterloser, durchaus arbeitsfähiger Mann, welcher jedoch bei der Notwendigkeit, irgendeinen Entschluß zu fassen, in eine außerordentliche Unruhe gerät.

Der Knabe ist das erste Kind in der Familie; Schwangerschaft und Geburt normal; körperliche Entwicklung regelmäßig. Überstandene Krankheiten: Diphtherie, Masern, Pneumonie. Die ökonomischen Verhältnisse waren befriedigend. Ist als Kind gesund und verständig gewesen. Lernte mit fünf Jahren lesen, las gerne alles, was ihm nur in die Hände fiel. Mit acht Jahren wurde er in die Waldschule abgegeben, wo er sich als ein schwer erziehbares Kind erwies: fügte sich nicht in die Hausordnung, störte die Arbeit der ganzen Klasse, beging alberne impulsive Handlungen. Einst nahm er einem Knaben irgend etwas übel und stieß ihn daraufhin in den Teich hinunter. Man konnte mit ihm in der Schule nicht fertig werden und überwies ihn 1922 in die Heilschule unserer Klinik. Die Mutter charakterisierte ihn damals als träge, apathisch, leicht durch fremden Willen beeinflusßbar und zur systematischen Arbeit unfähig.

Status: Übertrifft hinsichtlich Körperlänge und -gewicht sein Alter; Ernährungszustand befriedigend. Körperbau dem asthenischen Typus nahestehend. Dysplastisch — lange, dünne, ungeschickt hängende Arme, flacher, langer Brustkorb, hält sich gebückt, längliches Gesicht mit hervorstehender dicker und breiter Nase und großem Mund. Ein geringer oberer Prognatismus. Schlaffe Muskulatur. Die Umrisse der Muskeln sind unausgesprochen; feine, glatte Haut. Hände und Füße zyanotisch, feucht und kalt; oft schwitzend. Kopfhare dunkel, hart, dicht; Terminalhaare nicht vorhanden. Vergrößerte Hals- und Submaxillarlymphdrüsen, Schilddrüse normal. — Das Geschlechtsorgan normal. Seitens der inneren Organe keine Abweichungen von der Norm. Nervensystem: Gehirnnerven normal; Pupillen gleichmäßig, Lichtreaktion etwas träge. Sehnenreflexe etwas gesteigert, Hautreflexe lebhaft, Schleimhautreflexe normal. Pathologische Reflexe fehlen. Aschners Symptom positiv. Sensibilität normal; das Gehör etwas herabgesetzt, das Gesicht normal. Aktive Bewegungen eckig, ungeschickt, heftig; feine und differenzierte Bewegungen gelingen ihm schlecht, schreibt schlecht, macht keine Fortschritte im Zeichnen. Zurückgebliebenheit nach der Stufenleiter von Dr. *Oseretzky*: — 2½ Jahre. Viel überflüssige Bewegungen (Synkinesien). Schlaffer, ungeschickter, loser Gang — macht bald zu große, bald zu kleine Schritte. Haltung schlaff, eine gewisse Hypotonie der Gelenke. Schlaffe, fast maskenhafte Mimik, die nicht immer den emotionellen Regungen entspricht. Eine gewisse Paramimie. Beim Lachen ist der Gesichtsausdruck nicht lustig, sondern traurig ergeben. Stimme mit nälendem Beiklang. Laboratoriumsuntersuchungen: Wassermannsche Reaktion — negativ, Abderhalden mit Testes und Thyreoidea negativ. Die Untersuchung des vegetativen Nervensystems ergab eine schwach ausgesprochene Vagotonie. Blutuntersuchung: das Blutbild stellt keine Abweichungen von der Norm dar.

Status psychicus: Fällt bei der Aufnahme durch seine Ungeschicktheit und Plumpheit auf und wird im Kindermilieu sofort zum Gegenstand des allgemeinen Spottes. Benimmt sich albern, grimassiert, stößt verschiedene Schimpfworte aus; betitelt sich selbst als einen Ziegenbock und andere Kinder als Kühe und Schafsböcke und benahm sich in entsprechender Weise, schüttelte mit dem Kopfe, tat, als ob er mit den Hörnern stieße usw. Impulsiv in den Handlungen: tritt irgendeinen Kameraden und fängt an zu schlagen; es wurden auch ganz absurde Handlungen beobachtet: bestieg das Fenster des im oberen Stocke befindlichen Abortes und urinierte von da aus auf den draußen unten stehenden Speisetisch. Als er über die Motive seiner Handlung befragt wurde, antwortete er: „Ich weiß nicht, ich bekam einen so starken Wunsch, daß ich darüber nicht nachgedacht habe“. Räsontiert sehr viel, ist stereotyp in seinem vielen Reden, erzählt immer dasselbe vom Kriege im Jahre 1812. In dem Prozesse der Erzählung ist ein Element des Zwanges vorhanden: wenn er unterbrochen wird, so kommt er nicht zur Ruhe, wartet bis auf einen bequemen Augenblick ab und fängt seinen Bericht von neuem mit den geringsten Einzelheiten wieder an. Die Stimmung ist vorherrschend apathisch: interessiert sich für nichts, ist passiv in den Spielen, unterordnet sich den anderen, spielt „ohne Seele“, ohne affektive Ladung. In der Klasse arbeitet er ungern, hat weder Interesse für die Arbeit noch für ihre Resultate. Eine angefangene Arbeit bringt er nicht zu Ende, ihre Ausführung geht träge, ruckweise und ungeordnet vonstatten.

Bei der Untersuchung ist er wenig zugänglich. Träge, apathisch. Mit einer monotonen Stimme erzählt er über sich selbst: „Ich bin immer etwas ungeschickt gewesen; an den Spielen im Freien habe ich nicht teilgenommen, ich spielte nur solche Spiele, die man ohne Kameraden spielen kann.“ Mit derselben Ruhe, ohne den Tonfall der Stimme zu wechseln, erzählt er weiter, daß er aus der Schule ausgeschlossen war. „Ich war mehr als alle anderen albern, trieb Possen, lachte viel, nannte die Lehrerin eine ‚Stute‘“. — Über Phobien weiß er nichts zu berichten, in bezug auf Zwangserrscheinungen sagt er nur, daß bei ihm oft irgendein Wort sich im Kopfe dreht und keine Ruhe gibt. Auf die Frage, was ihn am meisten interessiert, antwortet er sofort: „Am meisten habe ich Bücher gern.“ — In der Unterhaltung ergreift er sofort das Wesen der aufgeworfenen Frage. Seine Gedanken formuliert er richtig, die logischen Operationen gelingen ihm leicht. Es ist eine Fähigkeit zum abstrakten Denken vorhanden; es kann aber auch eine Neigung zu Grübeleien und Räsonnements verzeichnet werden. Assoziationen folgerichtig, koordiniert. Nach der Untersuchung im psychologischen Laboratorium übertrifft sein Intellekt die Norm: nach Binet + vier Jahre, nach der Methode von *Rossolimo* ergibt er überall Plusleistungen.

Der Verlauf dieses Falles gestaltet sich den Tagesprotokollen zufolge folgendermaßen: die ersten zwei, drei Monate ohne merkliche Änderungen. Paßt sich sehr langsam an die Umgebung an und fügt sich nur allmählich in das gemeinsame Kinderleben hinein. Gegen das Ende des ersten Jahres des Schulaufenthaltes wird er ruhiger, fängt an, sich in die Hausordnung zu fügen, Benimmt sich diszipliniert während der Klassenarbeit, interes-

siert sich für die Arbeit und macht gute Fortschritte; viel weniger unerwartete Auftritte während der freien Zeit. Ist wie früher wenig gesellig, hält sich abseits von den Kindern. Wurde jedoch bedeutend lebhafter. Beteiligt sich am Kindertheater; fügt sich in die Hausordnung der Anstalt; ist manchmal reizbar, bemüht sich aber offensichtlich, sich zu beherrschen. Ist weniger plump geworden, nimmt an Turnübungen und an Handarbeiten teil.

Zusammenfassung: Von der frühen Kindheit an ein träges ungeschicktes „ungeschlechtes“ Kind. Einsam im Kindermilieu. Albernes Benehmen, läppisches Wesen, sonderbare impulsive Handlungen. Intellekt überrnormal mit einer Neigung zu abstraktem Denken. Gute Produktivität in den Schularbeiten, ein intensives Interesse für Bücher. Somatische Besonderheiten: Körperbau: asthenisch mit dysplastischen Eigentümlichkeiten. Nervensystem: kraß ausgesprochene motorische Unzulänglichkeit, plumper Gang, schlaffe Haltung, Hypotonie der Gelenke, schlaffe, fast maskenhafte Mimik, nieselnde Sprache.

Verlauf: die letzten zwei Jahre ist eine krasse Besserung eingetreten.

Diagnose: psychopathische Persönlichkeit, Schizoid (verschroben).

Fall 3: A. D., zwölf Jahre, aus intelligenter Familie, Vater — Jude, Mutter — Russin.

Heredität: Vater — ein Musiker, verschlossen, zweifelsüchtig, äußerst scheu, nur in einem kleinen intimen Kreise gesellig, charakterlos, erhöht suggestibel, wenig an das Leben angepaßt, häufiges Stottern. Großvater väterlicherseits an Krebs gestorben. Großmutter verschlossen, machthaberisch, unverträglich, argwöhnisch, geizig. Onkel enthusiastisch, prahlerisch, ein Abenteurer. Mutter gesund. Großvater mütterlicherseits an progressiver Paralyse gestorben; Onkel verschlossen grämlich, sonderbar, pathologisch geizig; ein anderer Onkel ein begabter Musiker und Mathematiker, ungleichmäßig, in seinem Benehmen bald exaltiert, bald indolent.

Der Knabe ist das erste und das einzige Kind in der Familie; körperliche Entwicklung regelmäßig. Ist als ein gesundes intelligentes Kind aufgewachsen. Lernte mit fünf Jahren lesen. Hatte ein gutes Gedächtnis. Schon mit fünf Jahren fiel es den Eltern auf, daß er ein „wunderliches“ Kind ist. Es fielen auf seine Zerstreutheit, sein rasches Hinüberspringen von einem Gegenstand zum anderen, seine manchmal unmotivierten Handlungen (wo er z. B. plötzlich Gegenstände aus dem Fenster herauswarf). Begeisterte sich periodisch für etwas und befaßte sich ausschließlich damit. Mit sechs Jahren fing er plötzlich an, lange arithmetische Rechnungen auszusinnen, ließ nach drei Monaten davon ab; mit sieben Jahren fing er an, kleine Lieder zu dichten. Mit zehn Jahren kam er zum ersten Male zur Schule, spielte hier die Rolle eines Spaßmachers und war Gegenstand des allgemeinen Spottes unter den Kameraden, obgleich er

besser als die anderen lernte. Mit elf Jahren werden zwangsmäßige Thematata in den Gesprächen bemerkbar; er räsonniert, belästigt alle, gibt allen Spitznamen. 1923 wurde er in der Heilschule unserer Klinik untergebracht. Die Mutter, die über den Knaben Auskunft gab, betont, daß in seinem Benehmen von der Kindheit an bis auf die Gegenwart keine Verschlimmerung beobachtet werden konnte, eher wird der Knabe besser, fängt an, ein größeres Interesse für das praktische Leben zu zeigen.

Status: Nach der Körperlänge, dem Körpergewicht, dem Thorax- und dem Kopfumfange übertrifft er sein Alter um zwei Jahre. Asthenischer Körperbautypus, das Verhältnis der Extremitäten zu der Körperlänge ist größer als in der Norm, nähert sich dem eunuchoiden Typus. Langer, feiner Hals, magere Extremitäten, herabhängende Schultern, flacher Brustkorb; die Muskulatur und das subkutane Fettgewebe schwach entwickelt; glatte elastische Haut; Kopfhaare hart, dicht, wellig, stellenweise Büschel ergrauter Haare; terminale Haare fehlen. Geschlechtsorgane dem Alter entsprechend; innere Organe normal; Nervensystem: Gehirnnerven normal; Sehnenreflexe — Kniesehnen und Achillesreflex — etwas gesteigert; Hautreflexe lebhaft, pathologische Reflexe fehlen; Rachen und Bindehautreflexe lebhaft. Sensibilität normal. Gutes Gehör und Gesicht; gleichmäßige Pupillen, lebhaft Reaktion; idiomuskuläre Erregbarkeit etwas gesteigert; weißer Dermographismus. Reichliche unruhige in vielem überflüssige Bewegungen. Zurückgebliebenheit nach der Skala von Dr. Oseretzky: — 2,8 Jahre. Ungeschickter eckiger Gang; schlaife Mimik.

Laboratoriumsuntersuchungen: Wassermann-Reaktion negativ. Die Untersuchung des vegetativen Nervensystems ergab eine Labilität beider Systeme, eine paradoxe Reaktion mit Pilokarpin. Das Blutbild stellt keine Abweichungen von der Norm dar.

Status psychicus. Weist bei der Untersuchung einen großen Vorrat an Kenntnissen und gute mathematische Fähigkeiten auf. Nach dem allgemeinen Niveau übertrifft er sein Alter. Nach Binet entspricht er 15 Jahren. Gutes, jedoch ungleichmäßiges Gedächtnis, gute Einprägungsfähigkeit für Zahlen und Worte, verwechselt dagegen Personen. Rasche Assoziationen, keine Sperrungen; viele äußere Assoziationen; manchmal Automatismus, ein Haftenbleiben bei einem und demselben Thema. Keine Zerfahrenheit des Denkens. Die logischen Prozesse verlaufen regelrecht. Konstatiert gut Ähnlichkeiten und Unterschiede, zieht richtige Schlußfolgerungen. Es ist eine Neigung zum zwangsmäßigen Grübeln vorhanden. „Warum sind so wenig Kinder in der Schule, warum ist die Zahl der Mädchen geringer“ usw. belästigt mit diesen Fragen bis ins Unendliche, bis er eine erschöpfende Antwort erhält.

Äußerst geschwätzig und zu gleicher Zeit verschlossen und verschwiegen, spricht ungern von seinen Erlebnissen. Kommt das Gespräch auf ihn persönlich, so übergeht er es mit Schweigen oder schlägt ein neues Thema an. In der Schule spielt er die Rolle eines Possenreißers, benimmt sich albern, erdenkt den Kindern verschiedene Spitznamen. An irgendwelchen gemeinsamen Spielen nimmt er jedoch keinen Anteil. Erhöht suggestibel, ahmt alle nach. Die Stimmung ist stets etwas erhöht. Das affektive Leben ist abgeflacht, sein Verhalten allem gegenüber erscheint oberflächlich, nichts berührt ihn tief, weder Kummer noch Freude, alles geht sehr bald

vorbei. Grobe egoistische Gefühle fehlen, er ist weder habsüchtig noch boshaft. Seinen Eltern ist er zugetan. Großer Schwärmer, lebt in seiner Phantasiewelt und vergißt oft die Wirklichkeit. Es konnten Zwangszustände, Zwangszählen — beobachtet werden. Es fällt ihm z. B. ein, die im Theater vorhandenen Zuschauer auszuzählen. Erdenkt besonders dazugeeignete Methoden, zählt die Zuschauer nach dem Schließen der Tür und eilt in der Zwischenpause, die zu spät gekommenen hinzuzuaddieren, indem er sie an den Fingern aufzählt. Es kamen auch Phobien vor (hatte Angst vor den Fliegen). In der Klasse fällt es ihm schwer, die Aufmerksamkeit auf die Arbeit zu konzentrieren. Es fehlt die Fähigkeit zu einer zielbewußten Anstrengung. Entweder fügt er sich automatisch den anderen oder stört ganz unwillkürlich die Disziplin, indem er Fragen stellt, die zur Sache nicht gehören.

Hat musikalische Fähigkeiten, gutes musikalisches Gehör. Mit den Turnübungen, der Rhythmik und der manuellen Arbeit geht es dagegen schlecht. In den letzten zwei Jahren sind keine besonderen Veränderungen eingetreten. 1924 trat er in ein Musiktechnikum ein, wo er gut vorwärtskommt.

Zusammenfassung: Als charakteristische Besonderheiten dieses Falles können folgende Erscheinungen aufgezählt werden: eine etwas erhöhte läppische Stimmung, Neigung zu Stereotypen und absurden Grübeleien, erhöhte Suggestibilität, Automatismus, Zwangsrechnen, Phobien, eine gewisse Flachheit der Emotionen. Nach der Untersuchung im psychologischen Laboratorium ist sein Intellekt übernormal. Somatische Besonderheiten: asthenischer Körperbautypus, eunuchoide Eigentümlichkeiten, hoher Wuchs, ausgesprochene motorische Unzulänglichkeit.

Verlauf: stationär ohne krasse Schwankungen.

Diagnose: Psychopathische Persönlichkeit. (Verschroben.)

Fall 4. J. D., 12 Jahre, Russe, aus intelligenter Familie. Heredität. *Vater* leidet an Zwangszuständen, ein schwerer Charakter, eigensinnig, urverträglich. *Großmutter* nervös, litt an Zwangszuständen, war stets in ärztlicher Behandlung. Tante pathologisch argwöhnisch, egozentrisch.

Mutter weichlich, charakterlos, leidet an neuralgischen Schmerzen. Der Knabe wurde rechtzeitig, jedoch asphyktisch geboren. Die körperliche Entwicklung ging regelmäßig. Überstandene Krankheiten: Variicellae, Pertussis, Tuberkulose-Intoxikation. Als Kind war er träge, hielt sich mehr unter den Erwachsenen auf, mied die Gesellschaft der Kinder, motivierte es damit, daß es ihm mit ihnen uninteressant sei; hatte keine Liebe für Spielzeug. War stets verschlossen, lebte in seiner eigenen Innenwelt, hatte schon sehr früh seine eigene Weltanschauung. Die intellektuelle Entwicklung ging gut: mit fünf Jahren lernte er selbständig lesen, das Schreiben fiel ihm schwerer. Liebte Witze zu machen, sich über andere zu belustigen. Fiel durch seine Reizbarkeit und Launenhaftigkeit auf; hatte unruhigen Schlaf, oft Pavor nocturnus. Mit zehn Jahren kam er auf die Schule, fand keinen Anschluß an die Kameraden, haßte und ver-

achtete ganz besonders die Mädchen. Mit den Eltern war er freundlich und zärtlich. Sonst erbittert und unverträglich; hatte keine Liebe zu den Menschen, kritisierte alle. Seit 1923 entstehen bei ihm Zwangszustände und Phobien, äußert oft Befürchtungen, daß etwas Schlechtes geschehen könnte. Ist um die Mutter besorgt, wenn sie ausgeht. 1924 in die Heilschule unserer Klinik aufgenommen.

Status: Körperlänge dem Alter entsprechend; Ernährungszustand unter dem Durchschnitt. Schwächerer Körperbau von ausgesprochen asthenischem Typus. Lange, feine Knochen. Flacher langer Brustkorb; hängende Schultern; längliches Gesicht mit kleinen Gesichtszügen. Schlanke Muskulatur. Spärliche Fettschicht; glatte blasse Haut. Hände und Füße feucht, etwas zyanotisch. Dunkelbraunes, weiches Haupthaar, terminale Haare fehlen. Lymphdrüsen vergrößert: Polyadenitis. Schilddrüse normal, die Hoden befinden sich im Hodensack, Penis dem Alter entsprechend. Innere Organe: Atmung über dem rechten Apex herabgesetzt. Herztöne rein; Herz leicht erregbar. Verdauungsorgane: Appetit herabgesetzt, oft Colitis. Nervensystem: Gehirnnerven normal; erhöhte Sehnenreflexe an den oberen und unteren Extremitäten; Abdominalreflexe schlaff; Cremasterreflexe normal. Pupillen mittelweit, lebhaft Reaktion. Sensibilität jeder Art normal. Gesicht und Gehör normal. Roter Dermographismus. Langsame, plumpe Bewegungen. Schlanke Haltung, hält sich gebückt, Gang etwas plump. Mimik lebhaft, den Erlebnissen adäquat. Hohe winselnde Stimme.

Status psychicus. Wenig zugänglich, mißtrauisch und argwöhnisch bei der Untersuchung. Gespannt ernster Gesichtsausdruck, manchmal ein schiefes Lächeln; Tonfall eines Erwachsenen. Weist in der Unterhaltung eine gute Orientierung in der Umgebung auf. Großer Vorrat an Kenntnissen. Seine Kenntnisse sind jedoch oberflächlich und fragmentarisch. Seine Rede ist fließend, keine Schwierigkeiten bei der Wortfindung. Die logischen Operationen verlaufen regelrecht; die Antworten sind immer gelungen. Ergreift sofort das Wesentliche bei dem Konstatieren der Ähnlichkeiten und der Unterschiede. Gibt gute Definitionen abstrakter Begriffe, läßt sich gerne in Erörterungen ein und spricht gerne über „ernste Dinge“. Die experimentell-psychologische Untersuchung ergab bei ihm einen hohen Intellekt. Nach der Binetschen Skala übertrifft er um zwei Jahre sein Alter. Nach der Methode von *Rossolimo* gibt er ein hohes Profil, 8,5. Bei gut entwickelten Denkprozessen kann bei ihm ein gewisses Zwangselement vermerkt werden: bleibt oft auf der Stelle stocken; haftet an irgendeinem Thema. Assoziative Prozesse geordnet.

Ließ sich willig in die Heilschule aufnehmen, paßt sich aber schlecht und langsam an die neue Umgebung an. Findet keinen Anschluß an die Kinder, nimmt keinen Anteil an ihren Spielen. Stimmung apathisch, manchmal etwas deprimiert, mit einem Stich ins Erbitterte. Es herrscht bei ihm ein negativer Gefühlston dem Leben und den Menschen gegenüber vor: „Nichts gefällt mir, alle beleidigen mich.“ Den Beleidigern gegenüber empfindet er längere Zeit Haß und Feindseligkeit. Liebt dagegen selbst, andere auszuspotten; stößt die Kinder im stillen an. Unbeliebt von den Kameraden, da er viel über Gerechtigkeit redet, selbst aber kraß egozen-

trisch ist und überall seine eigenen Interessen verteidigt. Ehe er an eine Arbeit herantritt, muß er sich längere Zeit alles überlegen; handelt ungerne. Hat eine Neigung zu übertriebener Selbstanalyse. Es fällt seine außerordentliche Saumseligkeit beim Essen, beim Sichankleiden auf; wird mit jeder Arbeit als letzter fertig. Trotz seines genügenden Intellektes ist die Produktivität in den Schularbeiten wegen des schwachen seelischen Tonus und der Unfähigkeit zur Anstrengung eine geringe; auch die Saumseligkeit, der Automatismus, die Zwangsmäßigkeit des Denkens wirken störend dabei. In Arbeiten, die mit körperlichen Übungen und mit manueller Fertigkeit zusammenhängen, bleibt er hinter den anderen Kindern zurück (manuelle Arbeiten, Zeichnen). Während der ganzen Beobachtungszeit wurden keine krassen Veränderungen in der Psyche des Knaben beobachtet.

Zusammenfassung: Intravertierter Typus; autistische, nach innen gekehrte Einstellung. Abstrakter Typus des Denkens. Neigung zum Rasonnieren. Bei gutem Intellekt eine (wegen des schwachen seelischen Tonus) herabgesetzte Produktivität. Egozentrisch. Erhöhte Selbstschätzung, ein sehr leicht verwundbares Selbstgefühl. Eine reizbar grämliche allgemeine Färbung des Gefühlslebens. Neigung zu Zwangszuständen. Somatischerseits: schwächlicher Körperbau, asthenischer Typus. Tuberkulöse Intoxikationserscheinungen. Nervensystem: Steigerung der Sehnenreflexe, motorische Unzulänglichkeit.

Diagnose: Psychopathische Persönlichkeit, Schizoid (verschroben). Ein Teil der psychoasthenischen Züge könnte durch die tuberkulöse Intoxikation erklärt werden.

Fall 5. K. A., 13 Jahre, Russe, aus intelligentem Milieu. Heredität: *Vater* mit 43 Jahren unter Erscheinungen der miliaren Tuberkulose gestorben. Ist ein begabter Mensch gewesen, schrieb Verse, ein schwerer Charakter, verschlossen, nachtragend, reizbar, unbeständig, ein Hazardspieler. *Großvater* väterlicherseits — haltlos, prinzipienlos, machthaberisch, despotisch; *Großmutter* — exaltiert, launisch, ließ sich von ihrem Manne scheiden, als sie 13 Kinder hatte. *Onkel* — faul, bilderisch, Hazardspieler. *Tante* — sonderbar, exzentrisch. Mutter, 40jährig, hält sich für gesund. Onkel mütterlicherseits epileptisch.

Der Knabe war gesund geboren; mit 1½ Monaten bekam er ein Ekzem, welches bis zu vier Jahren vorhanden war und eine Trockenheit der Haut hinter sich ließ. Die frühe Kindheit hatte einen schweren Verlauf, hatte oft Darmstörungen, litt an Rachitis.

Die körperliche Entwicklung ging regelmäßig. Überstandene Krankheiten: Masern, Pleuritis. Enuresis nocturna von der frühen Kindheit bis zu zwölf Jahren. Wuchs als ein schwaches empfindsames Kind auf, war stets unter Erwachsenen, hatte kein Interesse für Kameradschaften, spielte allein, erdachte sich selbst seine Spiele. Reizbar, launisch, hartnäckig in seinen Forderungen, oft unmotiviert eigensinnig. Sehr geschwätzig, fing mit drei Jahren an, in Reimen zu sprechen.

Lernete mit fünf Jahren lesen und las alles, was er nur fand. Der Schul-

unterricht begann mit acht Jahren, kam gut vorwärts. Von der Kindheit an pavor nocturnus. Seit 1921 wurde er, im Zusammenhange mit dem Familienzwise zwischen seinen Eltern, viel reizbarer, frecher und eigensinniger. 1922 in die Heilschule aufgenommen.

Status: Der Körperlänge nach entspricht er einem 15jährigen, nach dem Körpergewicht dagegen seinem Alter. Langbeinig, engschulterig, engbrüstig. Schwächlicher, asthenischer Körperbau. Großes, längliches Gesicht; unregelmäßige Gesichtszüge; langer feiner Hals; schmale, emporgezogene Schultern, Hühnerbrust; rechtsseitige Skoliose; schlaffe, wenig subkutane Fettschicht. Gräuliche, blasse äußerst trockene, dicke, grobe, sich scheefernde Haut; blasse Schleimhäute. Bronchiale Drüsen vergrößert. Schilddrüse normal; Geschlechtsorgane dem Alter entsprechend; die sekundären Geschlechtsmerkmale fehlen. Innere Organe: Ausatmung in der rechten Spitze, anämische Geräusche in den Venen, im übrigen normal.

Nervensystem: gesteigerte Sehnenreflexe, pathologische Reflexe fehlen; Haut- und Schleimhautreflexe in der Norm. Pupillen gleichmäßig, lebhafte Reaktion, Gehirnnerven normal. Schwaches, schlaffes rosafarbenes Nachröten. Aschners Symptom positiv. Gang etwas hüpfend. Bewegungen eckig, manchmal ausladend, manchmal gleichsam gehemmt und zurückhaltend. Zurückgebliebenheit nach der Stufenleiter von Dr. Oseretzky — 2½ Jahre. Lebhaft, etwas schlaffe Mimik. Stimme tief, heiser. Gehör und Gesicht normal. Ruhiger Schlaf.

Ergebnisse der Laboratoriumsuntersuchungen. Blut: Hämoglobin 75%, Erythrozyten 4570000, Leukozyten 7600. Die Leukozytenformel ergibt, abgesehen von der Lymphozytose, keine Abweichungen von der Norm. Die Abderhaldensche Reaktion mit Schilddrüse und Hoden negativ. Wassermann negativ. Die Untersuchung des vegetativen Nervensystems ergab eine gewisse Sympathikotonie. Die röntgenologische Untersuchung des Schädels ergab keine Abweichungen von der Norm. Was die Trockenheit der Haut anbetrifft, so wurde diesbezüglich eine Konsultation mit der dermatologischen Klinik vorgenommen, wobei eine Ichthyosis levis degenerativer Herkunft diagnostiziert wurde.

Status psychicus: Läßt sich gern untersuchen. Tonfall und Manieren eines erwachsenen Menschen. Höflich, zurückhaltend in Bewegungen, übertrieben gesellschaftliche Umgangsformen. Sprache ungewöhnlich literarisch und gesucht. Oft Aphorismen und Wortspielereien. Charakterisiert sich selbst als ruhig und ausgeglichen. „Ich bin sehr zurückhaltend,“ sagt er über sich selbst „früher bin ich nervös gewesen,“ Es waren irgendwelche Phobien vorhanden, deren er sich nicht mehr erinnert. Erzählt eingehend über seine frühe Kindheit, erinnert sich, daß er nicht gern mit Kameraden spielte, daß er sich seine Spiele selbst komponierte. Am meisten liebte er es, zu phantasieren: „im Kamin wohnten besondere Geschöpfe, die sich in drei Gruppen teilten, wobei jede einen besondere Namen hatte.“ Während mehrerer Jahre betrachtete er sich selbst als mit irgendeinem Geschöpfe verbunden, zuerst war es eine Fliege, später ein Mensch: „Ich erinnere mich sehr gut an das Haus und an die Wohnung, wo sie lebten. Einst bekam dieses Geschöpf einen Sohn, und seit der Zeit habe ich jedes Jahr den Geburtstag dieses Sohnes gefeiert.“ — Im

Anfang der Untersuchung ist er redselig und leicht zugänglich, wird aber, sobald die Rede auf seine intimen Erlebnisse kommt, sofort verschlossen, mißtrauisch, verschwiegen und wortkarg. Bekundet in der Unterhaltung eine große Belesenheit. Ist intellektuell gut entwickelt. Großer Vorrat an Kenntnissen auf dem Gebiete der sozialpolitischen Fragen; seine Überzeugungen sind für ihn, wie er sagt, „heilig“ — „wenn die Tatsachen gegen meine Überzeugungen sprechen, so muß ich mich bemühen einen Fehler in diesen Tatsachen aufzufinden.“

Geordnetes, genügend exaktes und klares Denken vom ausgesprochen abstrakten Typus. Operiert viel besser mit abstrakten Begriffen und Schemata als mit konkreten Bildern. Die Antworten sind allzu weit-schweifig. Es läßt sich eine Neigung zum Rasonnieren, Grübeln und zu überflüssigem Detail konstatieren. Auf die Frage, z. B., was eine Tasse sei, folgt die Antwort: „Eine Tasse ist ein Gegenstand, welcher aus Glas oder Ton gemacht ist, eine Aushöhlung besitzt und zum Trinken verwendet wird“ oder „Tisch — ein Stück Holz, welcher nur im Haushalt verwendet wird und unbedingt aus einer Fläche besteht.“

Nach der experimentell-psychologischen Untersuchung ist sein Intellekt als übernormal zu bezeichnen.

In der Schule hält er sich abseits. Sein Verhalten den Kindern gegenüber ist entweder ein herablassendes oder spöttisches, hat bei ihnen gar keine Autorität. Hat von ihnen den Spitznamen „Sprechmaschine“ bekommen; nimmt keinen Anteil an den Spielen der Kinder. Stimmung ruhig, ohne intensive Schwankungen und affektive Explosionen, oft indolent und apathisch. Es konnten auch periodische Erregungszustände beobachtet werden, in welchen er beweglicher als sonst ist, Possen reißt, alle belästigt. Er selbst beschreibt diese Zustände folgendermaßen: „Es kommen manchmal solche Minuten, wo ich zu plaudern und Dummheiten zu reden anfangen; nachher muß ich selbst dergleichen tadeln, kann mich aber in dieser Zeit nicht immer beherrschen; es kommt etwas über mich dabei.“

Einen krassen Kontrast zu seiner ruhigen Stimmung und einer gewissen affektiven Indolenz bildet seine leidenschaftliche Zuneigung zu seiner Mutter; er ist mit ihr stürmisch zärtlich, überhäuft sie mit Liebkosungen, begegnet ihr und trennt sich von ihr stets mit Tränen in den Augen. Fügt sich im ganzen in die Hausordnung. Ab und zu kommen Anfälle von Eigensinn vor — eine unmotivierte Hartnäckigkeit in Kleinigkeiten. Der Erzieher bittet ihn beim Mittagstisch, etwas weiter zu rücken; er antwortet: „Ich bin prinzipiell und pedantisch und werde es deswegen nicht tun.“

Arbeitet fleißig in der Klasse. Pedantisch, ordentlich; da, wo manuelle Fertigkeit erforderlich ist, ist er hilflos. In den Mußestunden geht er ziellos herum, falls er nicht mit Lesen beschäftigt ist. Fängt selbständig keine Beschäftigung an; ist zudringlich und lästig, langweilt alle mit unendlich sich wiederholenden Fragen. Stellt allen mehrmals Fragen, wie etwa die folgenden: „Wieviel Stimmen erhielten die verschiedenen Parteien bei den Wahlen in England?, „Welche Rassen der Kaninchen sind die besten? usw. Schreibt an die Ärzte und die Erzieher Zettel absurden Inhalts, legte einem Arzt in die Tasche ein Billett mit der Aufschrift

„Ehrenmitglied der Gesellschaft gebratener Hunde“; in einem anderen Zettel teilt er mit, daß er eine „Vorlesung über die Menge von Nährstoffen, die in der Watte enthalten sind“ lesen will. Nebenbei schreibt er gute Vorträge auf politische Themata, gibt inhaltvolle Artikel für die Kinderzeitschrift, unter welchen einige sogar für seine gute literarische Begabung sprechen (publizistischer Stil mit einem Stich ins Humoristische).

Während des Aufenthaltes in der Heilschule vollzieht sich eine bedeutende Besserung: er wurde ruhiger und arbeitsfähiger, weniger ungeschickt, arbeitet in der Tischlerwerkstatt, beteiligt sich sogar manchmal an dem Unterricht im Turnen und in der Rhythmik.

Zusammenfassung: Intellekt übernormal; es kann sogar von einer gewissen literarischen Begabung gesprochen werden. Daneben noch der Eindruck von etwas Bizarrem und Sonderlinghaftem. Dieser Eindruck wird durch die Neigung zu absurden Grübeleien durch die häufigen Anfälle von Albernheit hervorgerufen. Auf dem Gebiet der Thymopsyche ein ruhiger allgemeiner Gefühlston und nebenbei eine große Zärtlichkeit wenigen nahestehenden Personen gegenüber.

Somatischerseits: hoher Wuchs; Körperbau: asthenisch-eunuchoid; Trockenheit der Haut (Ichthyosis levis), tuberkulöse Intoxikationserscheinungen. Nervensystem: gesteigerte Sehnenreflexe; manierterter hüpfender Gang; schlaffe Mimik; motorische Unzulänglichkeit.

Verlauf: bedeutende Besserung während des Aufenthaltes in der Klinik.

Diagnose: psychopathische Persönlichkeit; Schizoid (Verschroben).

Fall 6. P. P., 12 Jahre, Russe, aus intelligenter Familie. Heredität: *Vater* pathologisch zerstreut, ehrlich, wahrheitsliebend, begabt, schrieb Verse und Erzählungen, mathematisch befähigt. *Großvater* väterlicherseits — ein eingebildeter Mensch. Despotisch, schlechter Familienvater. *Großmutter* launisch, eigenwillig. *Onkel* begabter Mathematiker. *Mutter* egoistisch, zanksüchtig, Hazardspielerin, interessierte sich gar nicht für die Kinder. Wies im Alter von 30 Jahren „kleptomanische“ Handlungen auf: entwand Sachen bei Bekannten, hat in Kaufläden gestohlen. Musikalisch begabt, beteiligte sich an Konzerten. Improvisiert.

Der Knabe wurde rechtzeitig geboren, die körperliche Entwicklung ging regelrecht. Überstandene Erkrankungen: Scharlach, Masern. Ist in den frühen Jahren ein stilles Kind gewesen: saß allein in Winkeln, meidete andere Kinder. War ungeschickt, „ein kleiner Bär“, hält sich gebückt, konnte schlecht laufen, war sehr selten ausgelassen. Zeichnete sich von früh auf durch seine Zerstreutheit aus, versank oft in Gedanken, richtete die Augen auf einen Punkt. War immer taktvoll, weich und wahrheitsliebend; ist im allgemeinen folgsam, manchmal kommen jedoch Anfälle unmotivierten Eigensinns vor, wo mit ihm nichts zu machen ist.

Intellektuelle Fähigkeiten befriedigend, der Schulunterricht begann mit acht Jahren. Lernte ohne Lust, hatte keine besonderen Interessen, war als Schüler unter den mittleren. Zeichnete sich durch große Beharrlichkeit bei der Arbeit aus: wenn er irgendeine Beschäftigung unternahm, so war es schwer, ihn davon abzulenken. Bis zu sechs Jahren lebte er in guten materiellen Verhältnissen. Die moralische Atmosphäre war dagegen eine schwere, war von seiner Mutter vernachlässigt. Mit sechs Jahren kam er zu seiner Schwester in Erziehung, bei welcher er bis 1922 blieb. Schon sehr früh zeigte sich seine musikalische Begabung, seine besondere Eindrucksfähigkeit den Tönen gegenüber. Mit drei Jahren imitierte er selbstständig verschiedene Melodien auf dem Klavier. Hatte keinen systematischen Musikunterricht bis 1922 genossen, in welchem Jahre er in die Heilschule unserer Klinik aufgenommen wurde.

Status: Körperlänge dem Alter entsprechend. Ernährungszustand unter dem Durchschnitt. Körperbau: unausgesprochener, dem asthenischen näherstehender Typus — mager, langbeinig. Breite, gerade Schultern, abstehende Schulterblätter, gebückt. Unbedeutende, rechtsseitige Skoliose. Flacher, langer Brustkorb. Die subkutane Fettschicht und die Muskulatur genügend entwickelt. Polyadenitis. Geschlechtsorgane dem Alter entsprechend, die sekundären Geschlechtsmerkmale fehlen. Innere Organe: krasse Ausatmung in der rechten Spitze. Pulsus frequens. Nervensystem: Gehirnnerven in der Norm; lebhaftere Pupillenreaktion; Sehnenreflexe lebhaft, insbesondere die Patellarreflexe; Haut und Schleimhautreflexe normal. Roter Dermographismus. Aschners Symptom positiv. Sensibilität aller Arten normal, Gehör und Gesicht normal. Etwas langsame, zurückhaltende Bewegungen. Schaukelnder Gang; schlaffe Mimik.

Laboratoriumsuntersuchungen: Blutbild: Hämoglobin 70%, Erythrozyten 4350000, Leukozyten 7400. Leukozytäre Formel: bedeutende Lymphozytose. Wassermannsche Reaktion negativ. Abderhaldensche Reaktion mit Schilddrüse und Hoden negativ. Die Untersuchung des vegetativen Nervensystems ergab die Labilität beider Systeme.

Status psychicus: Paßt sich sehr langsam an die neue Umgebung an, meidet die Gesellschaft der Kinder und motiviert es damit, daß „die Kinder zu viel lärmten und ihn beim Denken stören“. Bei der Untersuchung hält er sich gespannt, sein Gesichtsausdruck ist ernst und aufmerksam; wenn er einen fremden Blick auf sich empfindet, so ist er noch mehr auf der Hut; wenig zugänglich, wortkarg; hat große Schwierigkeiten bei dem Finden passender Ausdrücke. Ist genügend in der Umgebung orientiert. Seine Assoziationen sind geordnet, es herrschen die sinnesmäßigen Assoziationen vor. Die logischen Operationen verlaufen befriedigend: seine Verallgemeinerungen sind gut, seine Schlüsse richtig; es kann nur eine gewisse Saumseligkeit verzeichnet werden. Nach der Binetschen Skala entspricht er einem 15jährigen. Bei der Untersuchung nach der Methode der psychologischen Profile ergab er eine gute Aufmerksamkeit, ein genügendes Gedächtnis und durchaus zureichende höhere Prozesse: Auffassung und Kombinationsfähigkeit.

In der Klasse ist er beharrlich und eifrig, arbeitet mit Geduld und Ausdauer, paßt gespannt und konzentriert auf die Worte des Lehrers auf. Arbeitet ungleichmäßig, manchmal sitzt er sehr lange, mehrere Stunden

nacheinander bei der Arbeit, manchmal versinkt er, trotz seinem anscheinend aufmerksamen Blick, in sich selbst und hört nicht auf die an ihn gerichteten Fragen. Pathologisch zerstreut. Die Aufmerksamkeit wird nicht durch äußere, sondern durch irgendwelche innere Momente abgelenkt. Außerhalb der Schulstunden geht er einsam und gebückt herum, ohne irgendwelche Annäherungsversuche an die Kinder zu machen; sein Blick ist dabei zerstreut.

Schweigsam, teilt mit niemandem seine Gedanken. Im Umgang mit anderen ist er weich und feinfühlig. Bei der äußeren Indolenz ist er doch innerlich hypermotiv und taktvoll. Hat ein tiefes Gefühl für die Schönheit der Natur. Empfindet äußerst intensiv die geringste Kränkung, bricht sofort in Tränen aus und sucht die Einsamkeit auf. Bewacht längere Zeit die Erinnerung über überstandene Unannehmlichkeiten. Seine Emotionen sind tief; hängt an seiner Schwester. Bekommt er von ihr einen Brief, so versteckt er sich in einem abgelegenen Winkel, um ihn in Einsamkeit zu lesen, meidet das Lesen unter Zeugen vorzunehmen, wartet geduldig ab, bis man ihn allein läßt. Wahrheitsliebend, pedantisch, steht stets auf einem prinzipiellen Standpunkt. Bei Reibungen mit Kameraden ist er niemals nachgiebig; hat kein Verständnis für Zufälligkeiten und Mißverständnisse. Fügt sich in die Hausordnung der Anstalt. Ein ausgesprochener Negativismus sowie auch eine Befehlsautomatie konnten nicht beobachtet werden. In der Schularbeit kann eine Neigung zum Automatismus vermerkt werden: hat er eine Arbeit (z. B. Abschreiben) angefangen, so kann er sie nicht lassen. Musikalisch begabt, hat ein musikalisches Gehör, ein reiches musikalisches Gedächtnis, ganz gute pianistische Fähigkeiten.

Während des 2½-jährigen Aufenthaltes in der Schule hat er sich an das gemeinsame Kinderleben gewöhnt, beteiligt sich an den Kinderorganisationen, ist viel lebhafter und beweglicher geworden. Spielt oft mit den Kindern, macht gerne Turnübungen. Während des Spiels wird er viel lebhafter; hat dabei ein frisches, munteres Aussehen. Ist, wie früher, verschlossen und schweigsam; das Verhalten den Kameraden gegenüber ist ein gleichmäßiges und ruhiges, ist jedoch mit niemandem intim, Seine Leistungen in der Schularbeit und in der Musik sind sehr gut.

Zusammenfassung: Ein verschlossener, schweigsamer, „kleiner Greis“. Ein Drang nach Einsamkeit und Stille, um in seine innere Welt sich versenken zu können. Äußerlich indolent und apathisch, ist er zu gleicher Zeit sehr empfindlich, feinfühlig und zu tiefem Erleben neigend. Normaler Intellekt. Die Produktivität der intellektuellen Arbeit wird durch die pathologische Zerstretheit und die Neigung zum Automatismus etwas herabgesetzt. Musikalisch begabt. Schwächlicher Körperbau; tuberkulöse Intoxikationserscheinungen. Motorische Unzulänglichkeit, die sich in der letzten Zeit etwas ausgeglichen hat.

Verlauf: Bedeutende Besserung während des Aufenthaltes in der Heilschule.

Diagnose: Psychopathische Persönlichkeit, Schizoid (verschroben).

Ungeachtet der Verschiedenheit des klinischen Bildes der von uns angeführten Fälle halten wir es für möglich, das Gemeinsame, was diese ganze Gruppe schizoider Psychopathien charakterisiert, herauszuheben. Dies besteht in folgendem:

I. Ein eigenartiger Typus des Denkens:

- a) Neigung zu Abstraktem und Schematischem (das Einführen des Konkreten erhöht nicht die Denkprozesse, sondern erschwert sie);
- b) Diese Besonderheit der Denkprozesse kombiniert sich oft mit einer Neigung zum Räsonnieren und absurden Grübeln (s. Fälle 1, 2, 3, 4, 5). Letzteres drückt der Persönlichkeit oft den Stempel des Sonderlinghaften auf.

II. Autistische Einstellung. Alle Kinder dieser Gruppe halten sich abseits in dem Kindermilieu, passen sich nur schwer an dieses Milieu an und gehen in ihm niemals vollständig auf. Die Fälle 1, 2 und 3 werden nach der Aufnahme in die Schule sofort zum Gegenstande des allgemeinen Spottes unter den anderen Kindern. Fälle 4 und 5 haben keine Autorität unter den Kameraden und führen den Spitznamen „Sprechmaschine“, obgleich sie ihrem allgemeinen Niveau nach sich bedeutend über der übrigen Masse der Kinder erheben. Fall 6 meidet selbst die Gesellschaft der Kinder, welche ihn traumatisiert.

Die Neigung zur Einsamkeit, die Menschenscheu beobachtet man bei allen diesen Kindern von der frühen Kindheit an; sie halten sich abseits von den anderen, meiden gemeinsame Spiele, ziehen ihnen phantastische Erzählungen und Märchen vor.

III. Auf dem Gebiete der Thymopsyche eine gewisse *Abgeplachtheit und Oberflächlichkeit der Gefühle* (Fall 2, 3, 5). Diese letzte kombiniert sich oft damit, was *Kretschmer* äußerst treffend als *psychästhetische Proportion der Stimmung* bezeichnet hat.

Diese Mischung der anästhetischen und hyperästhetischen Elemente kann in allen unseren Fällen wahrgenommen werden.

Im Falle 1 haben wir zu gleicher Zeit eine affektive Indolenz und eine übertriebene Empfindlichkeit, im Falle 2 eine bis zu starken Affektexplosionen erhöhte Reizbarkeit, die sich mit einer ausgesprochenen affektiven Indolenz vergesellschaftet — das eben, was *Bleuler* den Affektkrampf und die Affektlahmheit genannt hat. Fall 5 — ruhiger allgemeiner Gefühlston, affektive Trägheit und zu gleicher Zeit eine exaltierte Zärtlichkeit einigen

nahestehenden Personen gegenüber. Fall 4 — grämlicher, mürischer Menschenfeind und zärtlich liebender Sohn.

IV. Es folgen weitere Besonderheiten, wie:

- a) die *Neigung zum Automatismus* (Fälle 1, 2, 3, 4 und 6), welche sich in dem Haften bei der angefangenen Arbeit in der Steifheit der Psyche, die sich schwer an das Neue anpaßt, äußert,
- b) die *impulsiven absurden Handlungen* (Fälle 1, 2, 3),
- c) das *läppische Benehmen, die Neigung zum Reimen*, zu stereotypen Wortneubildungen (Fälle 1, 2, 3, 5),
- d) die *Neigung zu Zwangszuständen* (Fälle 1, 2, 3, 4) und
- e) die *erhöhte Suggestibilität* (Fälle 1, 3 und 6).

Einen ausgesprochenen Negativismus haben wir nicht beobachtet. Unmotivierter Eigensinn war in zwei Fällen vorhanden (Fälle 5 und 6).

V. In allen unseren Fällen konnte eine ausgesprochene *motorische Unzulänglichkeit* beobachtet werden: Ungeschicktheit, Plumpheit, Eckigkeit der Bewegungen, viele überflüssige Bewegungen, Synkinesien (Fälle 1, 2, 3 und 4). Unzulänglichkeit der Mimik und der Ausdrucksbewegungen (Maniriertheit [Fälle 1, 4 und 5]). schlaffe Haltung (Fälle 2, 4, 6), sprachliche Eigentümlichkeiten, ungenügend modulierte Sprache (Fälle 1, 2, 3).

Was die Frage über den Zusammenhang zwischen dem Körperbau und der seelischen Struktur anbetrifft, so scheinen unsere Beobachtungen das von *Kretschmer* festgestellte somatopsychische Syndrom zu bestätigen: alle unsere Schizoiden sind dem Körperbau nach Astheniker. Ziehen wir aber in Betracht, daß unser Material zumeist zu dem Vorpubertäts- und Pubertätsalter gehört, wo auch in der Norm asthenisch dysplastische Typen prävalieren, so können wir unseren Beobachtungen in dieser Hinsicht kaum irgendeine Bedeutung zuschreiben. Dasselbe muß auch über die bei uns oft vorkommende Kombination der schizoiden Konstitution und der tuberkulösen Intoxikation gesagt werden; diese Kombination ist keinesfalls demonstrativ, da auch unter den anderen Kindern ein hoher Prozentsatz Tuberkulöser zu finden ist.

Die von uns *beschriebene Symptomatologie der schizoiden Psychopathien* nähert sich derjenigen, die *Kraepelin* für den von ihm aufgestellten Typus der Verschrobeneu und *Kretschmer* für die Gruppe bei Schizoiden gegeben haben. Die Grundmerkmale der Schizoide, die *Kretschmer* angibt — Autismus und psychästhe-

tische Proportion —, sind auch in allen unseren Fällen ausnahmslos vorhanden. Dasjenige aber, was bei uns am meisten charakteristisch ist und was uns stets als Stützpunkt bei der differentiellen Diagnose diente, sind die Besonderheiten des motorischen Gebiets und die deutlich ausgesprochene motorische Unzulänglichkeit. Sollten sich diese Beobachtungen an einem großen klinischen Material bestätigen, so könnten sie für die Lösung der Frage von dem biologisch-pathogenetischen Substrat der schizoiden Psychopathie von Belang erscheinen. Die motorische Unzulänglichkeit, die von einer ganzen Reihe anderer Symptome, wie eine gewisse Schwäche der Mimik und der Ausdrucksbewegungen, wie gewisse Besonderheiten der Sprache und der Stimme, begleitet wird, könnte als eine Anomalie der Entwicklung bestimmter Hirnsysteme betrachtet werden. Somit würde es gelingen, auf Grund klinischer Tatsachen ein biologisch-pathogenetisches Fundament unter den Begriff der „Schizoide“ aufzubauen. Unsere Beobachtungen sind zu wenig zahlreich, um zu irgendwelchen Schlüssen führen zu können, aber sie genügen dazu, um eine derartige Fragestellung zu begründen.

Die differentielle Diagnostik der Fälle schizoider Psychopathie muß in mehreren Richtungen geführt werden.

Die leichteren von den angeführten Fällen müssen von der Norm abgegrenzt werden.

Einzelne schizoide Eigentümlichkeiten bilden eine nicht seltene Erscheinung auch bei normalen Kindern. Die Kinder pflegen oft zu grimassieren, stereotyp ein und dasselbe Wort zu wiederholen, neue Worte zu ersinnen usw.

Viele Autoren weisen auf das Vorkommen katatonischer Eigentümlichkeiten bei Kindern hin: Neigung zur Perseveration, Echolalie, Stereotypie in den Zeichnungen usw. *Wildermuth* zieht eine Parallele zwischen der schizophreneren Persönlichkeitspaltung und demjenigen Zustand der affektiven Spaltung, welcher beim normalen Kinde während des Spiels sich beobachten läßt. Die Symptome des Negativismus und der gesteigerten Suggestibilität kommen in dem Kindesalter öfter als andere vor.

Besonders hervorstehend und reichlich sind die schizoiden Eigentümlichkeiten während der sogenannten kritischen Perioden der Kindheit. Als solche sind das Alter von 3—4 Jahren und insbesondere das Pubertätsalter anzusprechen.

Das klinische Bild der Pubertätsveränderungen erinnert sehr an die oben beschriebene Symptomatologie der schizoiden

Psychopathien. Das Pubertätsalter charakterisiert sich durch eine Abkehr von der Realität, erhöhte Phantastik, Hang zu allem Abstrakten, zum Philosophieren und Grübeln (die Periode der „philosophischen Intoxikation“ nach Ziehen). *Ziehen, Lange, K. Schneider* u. a. Autoren weisen auf eine Reihe im Pubertätsalter vorkommender katatonischen Symptome hin: auf die Neigung zur Stereotypie, zur Geziertheit und Schwülstigkeit des Stiles, zu einer sonderbaren Konstruktion der Sätze. *Lange* weist bei den Mädchen auf das läppische Benehmen, die Maniertheit, die Schüchternheit hin, bei den Knaben auf die Grobheit, den Verzicht auf alle üblichen Traditionen, die Neigung, sich mit hohen Problemen zu beschäftigen usw.

Den somatischen Eigentümlichkeiten nach nähert sich die Pubertätsperiode demjenigen, was bei den schizoiden Psychopathen geschrieben wurde: asthenischer Körperbau, dysplastische Besonderheiten, ungleichmäßige Entwicklung einzelner Gliedmaßen, Vorherrschen der Unterlänge usw. Eine charakteristische Besonderheit dieser Periode bildet außerdem die Störung des motorischen Gebiets; die Bewegungen sind ungeschickt, eckig, die Kinder lassen während dieser Zeit alles fallen, kippen alles um, stolpern oft usw.

Eine eingehende Besprechung dieser Frage der „motorischen Krise“ finden wir bei *Homburger*. Er bemerkt, daß alle diese Störungen demjenigen, was wir bei den Schizophrenen vor uns haben, sehr ähneln, und betrachtet sie als Störungen des extrapyramidalen Systems. In der Pubertätsperiode ist diese Störung eine temporäre, bei der Schizophrenie dagegen eine dauernde.

Aus der angeführten Übersicht der Pubertätsveränderungen erhellt, daß man sie leicht mit den schizoiden Psychopathien verwechseln kann. In allen unseren Fällen beginnen die schizoiden Eigentümlichkeiten von der frühen Kindheit an und können nicht als psychophysische Besonderheiten der Pubertätsperiode interpretiert werden.

Weiter muß bei der differentiellen Diagnose der schizoiden Psychopathien in Betracht gezogen werden, daß einzelne schizoide Symptome auch auf dem Wege der Exogenie entstehen können. Hierher gehören in erster Linie die psychopathischen Charakterveränderungen unter dem Einfluß der Enzephalitis und anderer Hirnerkrankungen und Intoxikationen (Narkomanien).

In der Kinderpraxis kann man sehr oft krasse Charakteralterationen im Sinne des schizoiden Symptomenkomplexes,

welche unter dem Einflusse von andauernd wirkenden psychogenen Faktoren (Einfluß des schlechten Milieus oder der schlechten Erziehung) entstehen, beobachten. Zu dieser Gruppe gehören Kinder, die von frühen Jahren an in schlecht organisierten Kinderheimen gelebt haben und eine liebevolle Pflege entbehren mußten. Bei ihnen können oft emotionelle Stumpfheit und negativistische Auftritte beobachtet werden.

In der Mehrzahl unserer Fälle kann das exogene Moment auf Grund eines eingehenden Studiums der Anamnese ausgeschlossen werden:

Beim Fehlen pathogener Faktoren in der Form von Hirnerkrankungen, Vergiftungen und der Einwirkungen eines schlechten Milieus— stationärer Zustand der Symptome, welche alle von der frühen Kindheit an vorhanden sind.

In schwereren Fällen mit reichlichen schizoiden Symptomen entsteht die Frage über ihre Abgrenzung von der Schizophrenie. Den schizophrenen Krankheitsprozeß haben wir auf Grund des Fehlens des Progredienzmerkmals ausgeschlossen. In allen unseren Fällen hatten die schizoiden Symptome ihren Anfang in der frühen Kindheit. Ihre weitere Entwicklung erfolgte dem Wachstum der Persönlichkeit parallel und gab keinen Anlaß zur Diagnostik eines schizophrenen Schubes. In keinem von unseren Fällen hatten wir es mit einer Intellektherabsetzung zu tun, welche uns den Verdacht einer schizophrenen Degradation einflößen konnte. Alle unsere Fälle befanden sich während einiger Jahre in unserer Beobachtung, und es konnten überall bedeutende Fortschritte konstatiert werden. Im Falle 1 sind große Leistungen auf dem Gebiete der Musik und der Malerei vorhanden. Fall 2 hat gute Schulleistungen und gleicht sich bedeutend hinsichtlich des Charakters aus. Fall 3 macht trotz seiner ganzen Sonderlinghaftigkeit und Verschrobenheit gute Fortschritte bei dem Musiktechnikum.

In der die kindlichen Psychopathien betreffenden Literatur wurden die Typen der Schizoiden bisher noch nicht beschrieben.

Rinderknecht beschreibt einige Fälle aus der Klinik *Bleulers*, welche einige Züge mit den schizoiden Psychopathen gemeinsam haben (alle diese Fälle sind im Alter von über 16 Jahren).

Es sind alles Subjekte, bei denen schon in der frühen Kindheit Autismus, Neigung zu negativistischen Handlungen, häufige hebefrene. oder katatonische Erregungszustände beobachtet werden konnten. Nach der Pubertätsperiode machen sich anti-

soziale Tendenzen geltend. Der Autor bezeichnet diese Fälle als „kriminelle Heboide“ und rechnet sie zu einer besonderen Schizophreniegruppe, bei welcher die Tendenz zum progredienten Verlaufe und zu dem Ausgang in Verblödung fehlt.

Den *Rinderknechtschen* Fällen nähert sich auch der von *Meggendorfer* unter der Bezeichnung der „Parathymie“ beschriebene Typus von antisozialen Subjekten. Auch hier hält der Verfasser diese Fälle für eine besondere Unterart der Schizophrenie. In dieser letzten Arbeit wird der Schizophreniebegriff auch wie bei *Rinderknecht* in einem sehr weiten Sinne genommen,

Wenn man von einer solchen erweiterten Auffassung der Schizophrenie ausgehen wollte, so könnten auch unsere Fälle seitens einiger Autoren zu den latenten und leichten Schizophrenien gerechnet werden.

Es drängt sich aber die Frage auf, ob eine derartige erweiterte Auffassung der Schizophrenie der klinischen Psychiatrie überhaupt was geben würde, ob sie die psychiatrische Diagnostik leichter machen oder zu noch größerer Verwirrung und Verwechslung der Begriffe führen würde. In der letzten Zeit wird von neuem die Frage über die Umgrenzung der Schizophrenie aufgeworfen, da aus dem Schizophreniebegriff eine Alltagsmünze wird (*Ewald*).

Bei der Analyse unserer Fälle gingen wir von derjenigen Auffassung der Schizophrenie aus, welche in ihr einem Krankheitsvorgang mit einer bestimmten Tendenz zur Zerstörung der Persönlichkeit erblickt. Unsere Kranken wiesen keine Züge auf, welche ihre Einreibung in diese Gruppe berechtigt hätten.

Für die die schizoiden Psychopathien betreffende Streitfrage erscheint unser Kindermaterial sehr bezeichnend. Die Vorgänge der schizophrenen Degradation sind bei dem Kinde viel demonstrativer; der schizophrene Krankheitsprozeß ergibt hier eine viel größere Benachteiligung, da hier neben der Zerstörung der reifen Psyche außerdem auch mangelhafte Entwicklung der Anlagen statt hat. Desto lehrreicher sind die Fälle, in denen, wie in den von uns angeführten, bei einem frühen Aufkommen der schizoiden Symptome und ihrem stationären Zustand nicht nur keine Zeichen des Persönlichkeitsverfalls auftreten, sondern sogar ein ständiges Fortschreiten und Wachsen der Persönlichkeit sich beobachten läßt.

Die von uns beobachteten Fälle zwingen uns zu der Schlußfolgerung, daß eine Psychopathiengruppe existiert, deren klini-

sches Bild gewisse gemeinsame Züge mit der Schizophrenie aufweist, welche jedoch ihrer Pathogenese nach, sich wesentlich von der Schizophrenie unterscheiden. Die Frage über das biologisch-pathogenetische Substrat dieser Formen geht gegenwärtig nicht über einige Hypothesen hinaus. Den klinischen Tatsachen wird aber am meisten diejenige Vermutung gerecht, welche annimmt, daß die schizoiden Psychopathien auf dem Boden einer angeborenen Unzulänglichkeit derjenigen Systeme entstehen, welche auch bei der Schizophrenie (hier aber unter dem Einflusse anderer Faktoren) affiziert werden.

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- b. "Die Besonderheiten der schizoiden Psychopathien bei den Mädchen." by G. E. Sukhareva

III.

(Aus der Sanatoriumschule der psycho-neurologischen Kinderklinik zu Moskau [Direktor: Prof. Dr. M. O. Gurewitsch].)

Die Besonderheiten der schizoiden Psychopathien bei den Mädchen.

Von

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wiss. Assistent.

Diese Mitteilung bildet eine Ergänzung unserer Arbeit „Über die schizoiden Psychopathien im Kindesalter“¹⁾ und kann als ihre Fortsetzung betrachtet werden. Unseren Ausgangspunkt bildet hier die Hauptschlußfolgerung der erwähnten Arbeit, daß es nämlich eine Gruppe von Psychopathien gibt, bei welchen sich einige äußere Züge der schizophrenen Psyche beobachten lassen (schizoide Psychopathien). Symptomatologisch steht diese Gruppe der von Kraepelin unter der Bezeichnung „die Verschrobene“ beschriebenen Gruppe am nächsten. In der oben erwähnten Arbeit machten wir auf diejenige mißbräuchliche Anwendung des Terminus Schizoid, welche in der letzten Zeit sich geltend machte, aufmerksam und schlugen vor, diesen Terminus nur für eine kleine Gruppe von Psychopathien mit bestimmter Symptomatologie beizubehalten. An der Hand des von uns dargelegten Materials waren wir imstande, einige Anhaltspunkte zur Differenzierung dieser Gruppe auszuarbeiten, und zwar sowohl von denjenigen Eigentümlichkeiten schizoider Psyche, welche im Pubertätsalter auch in der Norm vorkommen, als auch von den Schizophrenien und denjenigen schizoiden Reaktionen, welche auf exogenem Wege entstehen.

Bei der Auswahl unseres klinischen Materials hatten wir absichtlich vorläufig nur die Fälle bei den Knaben beschrieben.

¹⁾ Siehe „Die schizoiden Psychopathien im Kindesalter“. Monatschrift für Psychiatrie und Neurologie Bd. 60 (1925).

Indem wir den Fällen bei den Mädchen eine besondere Arbeit widmen, haben wir die Absicht, diejenigen unterscheidenden Besonderheiten herauszuheben, welche das Geschlechtsmerkmal in das Bild der schizoiden Psychopathien hineinträgt.

Das Problem des Einflusses der Geschlechtsdifferenzen auf die Symptomatologie und den Verlauf verschiedener klinischer Formen verdient viel mehr Aufmerksamkeit, als ihm gewöhnlich gewidmet wird. Die Verschiedenheit der funktionellen evolutiven und involutiven Besonderheiten beider Geschlechter hat in der Psychiatrie eine große Bedeutung, nicht so sehr im Sinne der Pathogenese als im Sinne der Pathoplastik verschiedener Geisteskrankheiten. Eine ganze Reihe Psychiater weist darauf hin, daß verschiedene psychische Krankheitsformen bei Männern und Frauen nicht gleich oft vorkommen und verschieden verlaufen. Die Frauen scheinen für das manisch-depressive Irresein besonders veranlagt zu sein. Nach den Angaben *Kraepelins* bilden die Frauen 70% aller Fälle des manisch-depressiven Irreseins. Die psycho-physiologischen Besonderheiten der Geschlechter bleiben nicht ohne Einfluß auf den Verlauf und das klinische Bild der Psychose. Bei Männern haben wir es viel häufiger mit reinen (depressiven und manischen) Formen zu tun, für Frauen sind dagegen Depressionen mit abenteuerlichen Wahnideen und Angst und kompliziertere manische Zustände mit Stupor und Verwirrtheitsperioden charakteristisch (*Kraepelin*). Unter den an Schizophrenie Erkrankten ist der männliche Anteil etwas größer. Nach den Angaben *Kraepelins* fielen unter 1054 Fällen von *Dementia praecox* 57,40% auf Männer. Nimmt man aber die Verteilung der Kranken nach Altersgruppen, so werden die Differenzen der Anteile beider Geschlechter viel bedeutender. Im Alter von 20 bis 25 Jahren, in dem die Mehrzahl der Schizophrenien beginnt, finden wir ein bedeutendes Vorwiegen der Männer (57,9—65,8%); gegen das 35. Jahr erreicht der weibliche Anteil den männlichen und überholt ihn bedeutend für das Alter von 45 und 55 Jahren. Die Fälle der Spätschizophrenie beziehen sich hauptsächlich auf Frauen. Bei *Schroeder* handelte es sich in 16 Fällen von Spätkatatonien um 13 Frauen und drei Männer. Was die Häufigkeit einzelner Formen anbetrifft, so hat das Geschlecht eine noch größere Bedeutung. Die Frauen neigen besonders zu periodischen Formen. Nach *Kraepelin* fallen zwei Drittel aller dieser Fälle auf Frauen; er erklärt diese

Tatsache durch den Einfluß menstrueller Perioden. Bei den hebephrenen und katatonen Formen überwiegen die Männer — (63⁰/₀ und 59⁰/₀ nach den Angaben von *Kraepelin*). Bei den paranoiden Formen haben wir ein geringes Überwiegen der Frauen.

Im Bereiche der konstitutionellen psychopathischen Zustände steht es schon seit langem fest, daß die Hysterie besonders für das weibliche Geschlecht charakteristisch ist, daß die Neurasthenie dagegen häufiger bei Männern vorkommt. Über die Verschiedenheiten der psychopathischen Manifestationen bei Kindern beider Geschlechter finden wir Angaben in den Arbeiten von *Voigtländer* und *Gregor*. Die Autoren beschreiben eine Reihe Differenzen in der Psyche der schwer erziehbaren Knaben und Mädchen. Bei den Mädchen dominieren die Züge der Unstetigkeit, Unordentlichkeit, Herrschsucht und Lügenhaftigkeit; bei den Knaben kommen dagegen folgende Eigenschaften in Betracht: eine bis zum Gefühlsstumpfsinn gehende Gleichgültigkeit; deprimierte oder gereizte Stimmung, Verslossenheit, Grobheit, Reizbarkeit. Für die männliche Hälfte dominieren somit Angaben über emotionelle Stumpfheit, für die weibliche über Labilität und Unbeständigkeit. Der Autor bespricht außerdem eingehend die Besonderheiten der antisozialen Handlung bei Männern und Frauen. Das Verbrechen der Frau soll stets subjektiv und emotionell gefärbt sein, ein Element des Sentimentalen ist bei der Frau selbst in der antisozialen Handlung zu finden. Große Rollen spielen bei den Frauen ihre emotionellen Erlebnisse; Männer handeln dagegen viel gerader und sachlicher.

Die Feststellung der differenziellen Besonderheiten beider Geschlechter am Kindermaterial hat den Vorzug, daß hier viel leichter der Einfluß der sozialökonomischen Faktoren (Beruf, Bildung, Milieu usw.) zu eliminieren ist. Deswegen glaubten wir, daß eine Parallele zwischen Fällen schizoider Psychopathie bei Knaben und Mädchen ein gewisses Interesse beanspruchen dürfte. Als Ergänzung zu den von uns beschriebenen Fällen schizoider Knaben führen wir hier einige Fälle schizoider Psychopathien bei Mädchen an. Das Alter ist dasselbe wie bei den Knaben: 12—14 Jahre. Drei dieser Fälle wurden in der psychoneurologischen Kinderklinik behandelt, zwei in der Anstalt für schwer erziehbare Mädchen. Wie in der vorhergehenden Arbeit befassen wir uns auch hier nur

mit solchen Fällen, welche längere Zeit (2 bis 4 Jahre) verfolgt wurden und diagnostisch geklärt erscheinen.

Fall 1. P. L., 1913 geboren. Heredität. Vater, 45jährig, Russe. Lebhafter, aktiver Mensch. Sehr nervös, heftig. Großvater väterlicherseits starb an Kehlkopfkrebs; ist stets nervös und reizbar gewesen; ein tatkräftiger und lustiger Mensch; Großmutter — vom 60. Jahre an senil dement; früher körperlich und geistig gesund. Ein Onkel litt an hysterischen Anfällen, ein zweiter Onkel konstitutionell-neurasthenisch, stets hypochondrisch eingestellt. Mutter — 43jährig, Lettin; hält sich für gesund; verschlossen, schweigsam, zurückhaltend; Großvater (Lette), bäuerlicher Landwirt, starb mit 81 Jahren an Herzschwäche; war finster, schweigsam und grämlich. Großmutter, eine Deutsche, starb mit 65 Jahren an Myelitis. Die Familie des Großvaters bestand aus zehn Kindern. Alle sind am Leben. Darunter zwei Tuberkulosekranke. Keine Geistes- und Nervenkrankheiten. Charakterologisch sind es meist Leute grämlichen Schlages.

Persönliche Anamnese. Schwangerschaft und Partus — N. Körperliche Entwicklung regelrecht. Von den Infektionskrankheiten überstand sie Masern, Keuchhusten und eine Lungenentzündung. Wuchs als ein gesundes und ruhiges Kind auf, zeigte sich jedoch schon sehr früh als eigensinnig und hartnäckig. Schon mit zwei Jahren kam es vor, daß man mit ihr manchmal nicht fertig werden konnte, blieb z. B. beim Spaziergehen plötzlich stehen, wollte nicht weitergehen, setzte sich auf dem Bürgersteig am Boden hin, und alles Zureden blieb vergeblich. Bis zu vier Jahren lebte sie in Finnland in guten ökonomischen Verhältnissen, hatte genügend Pflege und Obhut. Mit vier Jahren wurde sie mit anderen Kindern aus Leningrad nach der Tschechoslowakei evakuiert. Als sie von dort heimkehrte, war sie noch gröber und ungehorsamer geworden. Mit fünf Jahren wurde sie in einen Kindergarten aufgenommen, wo sie, als ein Mädchen mit Begabung, mit einer „ausgesprochenen Individualität“ betrachtet wurde. Nach einem Jahre wurde sie in einen anderen Kindergarten versetzt; diese Anstalt war schlechter organisiert; hier nahm ihre Entwicklung einen weniger günstigen Verlauf und sie galt hier als schwer erziehbar. Schon jetzt fiel das Mädchen durch ihre Grämlichkeit auf. „Ihr fehlte das lustige Gesicht eines Kindes,“ sagte ihre Mutter, „ihr Lachen machte bange, so unnatürlich, so unkindlich war es.“ Größere Kindergesellschaften mied sie, aber zu einzelnen Kindern pflegte sie sehr tiefe und starke Neigungen, die jedoch des öfteren plötzlich ganz unvermittelt abbrachen. Ihre Spiele mit den Kindern endeten oft mit Zusammenstößen, da sie immer und überall auf eine besondere Aufmerksamkeit ihr gegenüber Anspruch erhob. Sie war stets mißtrauisch, mürrisch; immer kam es ihr vor, daß man sie schlechter als andere Kinder behandelt; immer beklagte sie sich, daß man sie nicht liebe, daß die Mutter ihr gegenüber ungerecht wäre, usw. Mit den Geschwistern war sie oft grob, mit den kleineren manchmal sogar grausam, schlug sie zuweilen. Dessenungeachtet sehnte sie sich nach ihnen in ihrer Abwesenheit, war um sie besorgt, als sie krank waren, und äußerte ihnen gegenüber zu solchen Zeiten eine große Aufmerk-

samkeit und Feingefühl. „Zu Zeiten, wo ich krank war oder mich verstimmt fühlte,“ sagte die Mutter „war keines von meinen Kindern so zärtlich und aufmerksam mir gegenüber wie L.“ Über sich selbst sprach das Mädchen stets sehr ungerne und wenig. Sie war verschlossen und verschwiegen sogar der Mutter und dem Vater gegenüber. Diese Verschlossenheit und die Kontraste ihrer Gefühlsstruktur machten sie für ihre Eltern zu einem Rätsel. „Sie ist krank“, meinte die Mutter; „sie ist eine schlafende Prinzessin“, sagte der Vater. Von der Kindheit an beunruhigte sie ihre Eltern mit ihrer Neigung zu Erfindungen und zur Lüge. Als sie sieben Jahre alt war, verirrte sie sich einmal in den Straßen der Stadt, kam spät abends nach Hause und erzählte, daß sie den Vater getroffen habe, welcher auf einem Pferde ritt, sie zu sich nahm und nach Hause brachte (alles erwies sich später als erfunden). Oft fabulierte sie, daß sie im Kindergarten ganz besonders feine Speisen zu essen bekam, wobei dies alles mit ausführlichen Details erzählt wurde und sie selbst an ihre Erfindungen zu glauben schien. Während dieser Zeit hatte sie oft unruhig geschlafen, hatte oft nachts große Angst gehabt, weckte die Tante und ließ sie mit ihr zusammen wach bleiben. Äußerte stets eine große Liebe für Selbständigkeit, duldete keine Widersprüche, wenn sie etwas wünschte. Mit neun Jahren entließ sie aus der Kolonie (40 km von Moskau) mit der Motivierung: „Man hat mich da ungerne, ich kann da nicht mehr leben.“ Der Schulunterricht begann mit neun Jahren. Besuchte die Schule während zwei Jahren. Lernete befriedigend; gegen das Ende des Schuljahres mußte ihr jedoch zu Hause nachgeholfen werden, da sie merklich müde wurde. Die Mußstunden verbrachte sie ziellos, hatte kein Interesse für Lektüre, keine Vorliebe für Spiele; die Hausarbeiten machte sie ungewandt, alles tat sie plump: ließ alles fallen, war stolperig. Hatte wenig Interesse für ihre Kleidung, war oft unordentlich gekleidet, wenig ordnungsliebend ihren Sachen gegenüber. Liebte nicht, sich so wie alle zu kleiden; ging im Winter ohne Überzieher oder zog sich verschiedene Strümpfe an. 1924 machte sich bei dem Mädchen eine motorische Unruhe bemerkbar, manchmal auch Tremor der Hände bei der Arbeit. Nach dem Rate der Ärzte wurde sie im Sommer auf das Land geschickt und im Herbst in die Heilschule aufgenommen.

Status physicus. Ihrer Körperlänge nach entspricht sie 15 Jahren. Körperbautypus: Asthenisch mit athletischen Zügen. Die gebeugte Haltung, die unproportioniert geringe Größe des Schädels und die breiten Schultern bewirken den Eindruck des Dysplastischen. Ovale, sich nach oben verjüngende Kopfform. Langes Gesicht, blaue Augen mit spärlichen, hellen Wimpern. Hohe Stirn; Oberkiefer etwas prognatisch. Steiler Gaumen, unregelmäßig gestellte Zähne, langer Hals, Schultern im Verhältnis zum Becken sehr breit. Langer Brustkorb. Große Hände und Füße. Ziemlich blasse Haut, ausgesprochene Zyanose der Hände und Füße. Die subkutane Fettschicht genügend entwickelt. Kopffaare blond, gerade. Urogenitaler Apparat — N. Die Anzeichen der Geschlechtsreife sind vorhanden. Menses — abs. Innere Organe: Lungen — rechts verlängerte Ausatmung; Herz — systolisches Geräusch am Apex cordis; linke Grenze lateralwärts von der L. mamillaris. Magendarmtraktus in Ordnung. *Nervensystem:* Die Bewegungen sind genügend kräftig,

etwas verlangsamt und ungeschickt. Nach der Skala von Dr. *Oseretzky* entspricht die Motorik dem Alter. Schläffe Haltung, langsamer Gang, geht etwas buckelig. Mimik schlaff, jedoch dem Erleben adäquat. Hirnnerven: schwache Asymmetrie der N. N. faciales; Pupillen gleichmäßig; Reaktionen (Licht, Akkomodation, Konvergenz) wohl erhalten; psychische Reaktion ebenfalls vorhanden. Sehnenreflexe etwas gesteigert. Schleimhautreflexe: Conjunctiva, Cornea — N. Pathologische Reflexe fehlen. Sinnesorgane — N. Schläft in der letzten Zeit ruhig. Laboratoriumsuntersuchungen: Blut: Hb — 65%, Erythrocyten — 4620000, Leukozyten — 8000. Leukozytäre Formel — keine Abweichungen von der Norm. Negativer Wassermann im Blute.

Status psychicus. Wenig zugänglich. Spricht sehr ungerne über ihre Vergangenheit. Macht nur sehr oberflächliche und unzusammenhängende Angaben. Bei Fragen, welche ihre intimen Erlebnisse betreffen, wird sie noch verschlossener, zieht sich noch mehr zurück. Hält sich für gesund, stellt alles in Abrede: Stimmungsschwankungen, Phobien, erhöhte Reizbarkeit. Bei längerer und vorsichtiger Exploration gelingt es, zu erfahren, daß sie oft traurig gestimmt ist. Auf die Frage: „Weshalb“ — antwortet sie: „Das sage ich nicht, es ist mein Geheimnis.“ Während der weiteren Unterhaltung antwortet sie stereotyp: „Fragen Sie nicht, ich werde ja sowieso nicht sagen, es ist mein Geheimnis.“ In ihrer Art zu sprechen fällt der unzufriedene, finstere Tonfall auf. Sie ist bestrebt, möglichst bald wegzugehen, ist unruhig, macht viele überflüssige Bewegungen. Sprache arm: die Wortfindung fällt ihr sehr schwer. Der Vorrat an Kenntnissen ist ebenfalls ein geringer. Die logischen Operationen gelingen ihr gut nur in den Grenzen des Konkreten. Da, wo Abstraktionen erforderlich sind, sind die Antworten viel schlechter. Denkprozesse etwas verlangsamt und steif; qualitativ in Grenzen der Norm, quantitativ (funktionell) jedoch bedeutend herabgesetzt — wegen Unfähigkeit zur intellektuellen Anstrengung. Hat kein Interesse an intellektueller Arbeit; da, wo eine Überlegung erforderlich ist, gibt sie sofort eine negativistische Reaktion; — „ich weiß nicht“. Bei ständigem Ermuntern und einiger Unterstützung gibt sie bedeutend bessere Antworten. Bei der Untersuchung im Laboratorium nach der *Binetschen* Skala gab sie + 1 Jahr.

In der Schule blieb sie ungerne, wiederholte stets: „ich bin hier nur für kurze Zeit, ich gehe ja sowieso, bald weg.“ Gewöhnte sich sehr langsam an die neuen Verhältnisse; äußerte allem gegenüber ein mißtrauisches, skeptisches Verhalten: „Hier ist alles schlecht, auch die Kinder sind schlecht, in der anderen Schule war es besser.“ Hält sich abseits von dem gemeinsamen Leben der Kinder, ist jedoch nicht teilnahmslos. Ist beobachtungsfähig; benimmt sich so, als ob sie alles studiert und kritisiert. Die dominierende Stimmung ist eine ruhige; heitere Erregungen oder erhöhte Reizbarkeit ließen sich nicht beobachten. Ist zurückhaltend und gleichmäßig, immer hat man von ihr den Eindruck einer gewissen Kühle. Ausgesprochene affektive Färbung läßt sich nur überall da wahrnehmen, wo ihr Selbstgefühl berührt wird. Hier kann sogar von einer erhöhten Sensibilität gesprochen werden. Der beständige Wunsch, besser zu sein, bewirkt im Zusammenhange mit ihrem Minderwertigkeits-

gefühl einen unruhigen Grundton der Affektivität und eine mißtrauische argwöhnische Einstellung zu den Menschen. Sie apperzipiert sehr fein das Verhalten der Menschen ihr gegenüber; auch die Fähigkeit zu lebendigem, mitfühlendem Verstehen fremder Erlebnisse ist bei ihr vorhanden. Sie ist nicht boshaft, teilt ihre Geschenke gern mit den Freundinnen, alle affektiven Bewegungen bleiben aber äußerlich kalt und schwach gefärbt. Ein Kameradschaftsgefühl ist bei ihr vorhanden, es äußert sich in beständigem Streben, Beleidigte zu beschützen; aber auch hier handelt es sich um ein eigenartiges, starres und übertriebenes Gerechtigkeitsgefühl. Scheint ihren Eltern sehr zugetan zu sein, insbesondere dem Vater gegenüber, welcher bei ihr eine unerschütterliche Autorität genießt. Irgendwelche ästhetischen Fähigkeiten konnten nicht vermerkt werden. Die Leistungsfähigkeit in der Schule war eine genügende.

Während des Aufenthaltes in der Schule konnten keine krassen Veränderungen beobachtet werden; wurde körperlich kräftiger, in der letzten Zeit fing sie außerdem an, sich aktiver an dem sozialen Leben der Schule zu beteiligen. Die Mutter bemerkt eine bedeutende Besserung. Zu Hause ist das Mädchen viel ruhiger, hat weniger Konflikte mit den Angehörigen, wurde ordentlicher, schläft gut.

Zusammenfassung. Die Erbkomponenten verhalten sich hier folgendermaßen: auf der Seite des Vaters sthenische, aktive Naturen mit einer Reihe neurotischer Züge; mütterlicherseits herrschen schizoide Züge vor: kühle, finstere, schweigsame Menschen. Das Mädchen entwickelte sich regelrecht. Von früh an eigensinnig, hartnäckig, ausgesprochen „individualistisch“, Daneben einzelne neurotische Züge: unruhiger Schlaf, Alpträume, hyperphantastisches Lügen. Mit den Jahren werden ihre Eigentümlichkeiten immer markanter: einerseits — ihre Neigung zu autistischen Reaktionen: Verschlossenheit, Verschwiegenheit, geringe Geselligkeit; andererseits — die Kontrastmäßigkeit ihrer emotionellen Persönlichkeit. Bei der emotionellen Kühle und Trägheit der affektiven Reaktionen eine große Sensitivität und Feingefühl im Verstehen fremder Erlebnisse. Erhöhte Eindrucksfähigkeit bei der Bewertung des Verhaltens der Umgebung ihr gegenüber. Das Bewußtsein der eigenen Minderwertigkeit bewirkt bei dem erhöhten Selbstgefühl oft einen ängstlichen emotionellen Grundton.

Rudimente des paranoiden Symptomenkomplexes: mißtrauisches, argwöhnisches Verhalten zu den Mitmenschen, beständiges Suchen der Gerechtigkeit. Intellekt gering, aber in der Normbreite. Leistungsfähigkeit befriedigend. Somatisch: asthenischer Körperbautypus, eine gewisse Eckigkeit der Bewegungen. Innere Organe: Myokarditis, tuberkulöse Intoxikations-

erscheinungen. Eine gewisse Besserung während des Aufenthaltes in der Heilschule.

Diagnose: Psychopathische Persönlichkeit. — Schizoid
Verlauf: stationär mit einer geringen Besserung.

Fall 2. 1. W., 14 Jahre, 1912 geboren, Mädchen aus einer ungebildeten Arbeiterfamilie.

Heredität: Mutter mit 44 Jahren an Magenkrebs gestorben; war nervös, reizbar und boshaft. Großvater mütterlicherseits — Alkoholiker, starb als alter Mann. Großmutter war körperlich gesund, ruhig und gleichmäßig. Onkel mütterlicherseits — Alkoholiker, ein Mensch mit schwerem Charakter. Vater — im Kriege gefallen; körperlich und geistig gesund. Über seine Verwandtschaft ist nichts Näheres bekannt.

Persönliche Anamnese. Schwangerschaft und Geburt — N. War als gesundes Kind geboren. Überstand Scharlach und Masern. Wuchs als ein sehr stilles Kind auf, spielte wenig mit Kindern, fiel den Verwandten durch ihre Ruhe auf. War zeitweise launisch, ungehorsam und eigensinnig. Nach dem Tode des Vaters wurde das Mädchen mit sechs Jahren in ein Kinderheim untergebracht, wo sie ein Jahr verbrachte und alsdann in ein anderes Kinderheim versetzt wurde; mit zehn Jahren wurde sie der ärztlichen Beobachtungsstelle mit folgenden Beschwerden überwiesen: „meidet die größere Kindergesellschaft, verkehrt nur mit zwei bis drei Freundinnen, sucht sich dabei besonders schwache und stille Mädchen heraus. Ist in intellektueller Hinsicht normal, aber für die Schularbeiten ist ihr Interesse sehr schwer zu fesseln“. Bei der Untersuchung in der Ambulanz der ärztlichen Beobachtungsstelle (Mai 1922) ergab sich ein normaler Intellekt; sie machte den Eindruck eines sehr verschlossenen Mädchens. Die Aufnahme bei der stationären Abteilung der Beobachtungsstelle nahm sie ruhig hin; hier war sie ebenfalls sehr verschlossen und wenig zugänglich. (In der Beobachtungsstelle befand sie sich unter unserer Beobachtung.) Die Arbeiten in der Klasse besuchte sie selten; war sie zugegen, so weigerte sie sich, ihre Hefte der Lehrerin zu zeigen. Die dominierende Stimmung war eine gleichgültige und schlaffe, zeitweise eine etwas gehobene, läppische — lief im ganzen Hause herum, grimassierte, machte Faxen. Auf die Bemerkungen der Erwachsenen reagierte sie mit einer noch größeren Erregung, war negativistisch; beruhigte sich jedoch spontan, wenn sie unbeachtet blieb. Fügte sich schlecht in die Hausordnung der Anstalt. Wies alle Vorschläge, irgendeine Arbeit zu leisten, zurück, tat jedoch gerne das, was verboten war. Äußerlich war sie emotionell-oberflächlich, erinnerte sich niemals an ihre Verwandten; wollte an Feiertagen niemals nach Hause. Hatte unter den Mitschülerinnen keine einzige Freundin; ihr Verhalten den Erwachsenen gegenüber war ein gleichgültiges, manchmal sogar feindseliges. Über die Schulleistungen konnte kein Urteil gebildet werden, da das Mädchen auf der Schule nichts getan hatte. Von den ästhetischen Fähigkeiten konnte bei ihr eine graphische Begabung vermerkt werden. Die Lehrerin hielt sie nicht nur für technisch, sondern auch künstlerisch-schöpferisch begabt. In ihren Zeichnungen fiel das Dominieren der finsternen Farben auf. In der Anstalt blieb sie zwei Jahre lang; irgendwelche merklichen Ver-

änderungen ihrer Psyche ließen sich während dieser Zeit nicht beobachten. Im März 1924 wurde sie in eine Anstalt für schwer erziehbare Mädchen versetzt, wo sie auch jetzt sich unter unserer Beobachtung befindet.

Status physicus. Nach der Körperlänge übertrifft sie ihr Alter. Körperbau: regelmäßig, asthenisch (unausgesprochen). Kleines Gesicht, regelmäßige Gesichtszüge. Geringer Prognatismus des Oberkiefers. Kopf im Verhältnis zum Rumpfe wohlproportioniert; Hals dünn und lang; flacher Brustkorb. Rechtsseitige, unscharf ausgesprochene Skoliose. Fettschicht genügend entwickelt, Muskulatur schlaff. Haut dünn, elastisch; rosige Wangen. Haare dunkelblond, hart. Schilddrüse normal. Die sekundären Geschlechtsmerkmale machen sich bemerkbar. Menses — abs. Innere Organe: Herz und Lungen — N. Tractus gastro-intestinalis — Neigung zu Verstopfungen.

Nervensystem. Bewegungen genügend kräftig, koordiniert, heftig, ausladend, viel überflüssige Bewegungen. Mimik lebhaft, während der Erregungszustände intensives Grimassieren. Hirnnerven — N; Pupillen — N; psychische Pupillenreaktion vorhanden. Etwas erhöhte Patellarreflexe. Haut- und Schleimhautreflexe normal. Eine gewisse Hyperästhesie der Hautsensibilität. Roter, schlaffer Dermographismus; Hände etwas zyanotisch. W. R. im Blute negativ.

Status psychicus. Wenig zugänglich bei der Untersuchung. Unzufriedenes, finsternes Aussehen. Versteckt ihren Blick vor dem Untersucher. Gibt kurze, einsilbige Antworten; bei Fragen über ihre Person und ihre Vergangenheit verweigert sie hartnäckig die Antworten und teilt nur einige äußere Tatsachen mit: „Wozu wollen Sie das wissen, ich werde ihnen nichts erzählen.“ In dem unmittelbaren Milieu ist sie genügend orientiert. Das Niveau der allgemeinen Bildung ist kein hohes, aber für ein Mädchen ihrer Herkunft genügendes. Ihre Kenntnisse sind gering, Sprache arm, weswegen ihre Antworten viel verlieren. Logische Operationen befriedigend; es besteht bei ihr eine gewisse Neigung zum Schematisieren: auf die Frage „Was ist eine Gabel“ gibt sie z. B. folgende Antwort: „ein Gegenstand, welcher aus irgend etwas, wie Eisen, gemacht ist und mehrere Fortsätze hat“; „was ist ein Tisch?“ — „ein Holzdeckel mit vier Beinen“. Die Definitionen abstrakter Begriffe gelingen gar nicht, weil ihr die nötigen Worte fehlen. Auffassung richtig: alle vorgelegten Bilder hat sie richtig verstanden und erklärt. Es ist interessant, daß bei allen Bildern mit anschaulichen Unmöglichkeiten sie, obgleich sie das Bild richtig verstanden hatte, doch hartnäckig bestrebt war, ihre Richtigkeit nachzuweisen: „Macht nichts; so was kommt vor; ich tue auch gerne alles umgekehrt; dieser Onkel ist im Sommer sehr warm gekleidet; ich tue auch so: im Sommer trage ich einen Mantel, im Winter aber nicht.“

Assoziationen koordiniert (oft negativistische Reaktionen: „Ach wo, langweilig, will nicht mehr.“ Es kommen Kontrastassoziationen vor: viele Negationen. Gedächtnis befriedigend, vorwiegend mechanischen Typus. Bei der Untersuchung nach der Methode von Prof. Rossolimo ergibt sie hohe Suggestibilität und Automatismus, geringe Aufmerksamkeit und genügende höhere Prozesse. Gute Leistungsfähigkeit in der

Schule. Vorgeschlagene Aufgaben faßt sie gut auf, zieht aber mechanisch-automatische Arbeiten vor. Äußert oft einen hartnäckigen Negativismus: wenn man sie bittet, irgend etwas aufzuschreiben, antwortet sie: „Ich will nicht, ich tue es nicht.“ Alles Zureden und alles Bestrafen bleibt erfolglos. Läßt man sie unbeobachtet, so setzt sie sich hin und geht allmählich an die Arbeit; weigert sich immer, wenn sie irgend etwas laut vorlesen muß. Sie ist sehr schüchtern, eigenliebend und selbstunsicher — wird deswegen sehr verlegen und errötet, wenn sie antworten muß. Sie bemüht sich, ihre Verlegenheit durch Lachen, Grimassen und überflüssige Bewegungen zu maskieren. In der Klasse ist sie sehr unruhig, bewegt sich auf der Schulbank hin und her, springt auf, zupft an den Heften. Die freie Zeit verbringt sie allein oder in Gesellschaft einer einzigen Freundin. Verliert sich in der Gesamtmasse der Kinder; ist verschlossen, verschwiegen, läßt niemanden in ihre innere Welt hinein. Die Stimmung ist vorwiegend eine apathische. Die Zustände erhöhter Erregbarkeit und läppischen Wesens sind bedeutend seltener als während des Aufenthaltes bei der ärztlichen Beobachtungsstelle; in den letzten Jahren wurde dagegen der finstere mißtrauische emotionelle Grundton viel ausgesprochen. Alles sei ihr hier unangenehm, alles an ihr werde hier getadelt. Auf die Frage „Was ist dir angenehm?“ — antwortete sie: „Nichts, nichts habe ich gern.“ Auf die Frage: „Was ist dir zuwider?“ gab sie die Antwort: „Alles ist mir zuwider und alle Hiesigen sind schlecht.“ Eine Zeitlang wurde sie mit einem Mädchen sehr befreundet, geriet in Verlegenheit, wenn man über diese Freundschaft sprach, ließ sie aber sofort fallen, als das Mädchen ihr ein Band, das sie ihr geschenkt hatte, zurückgab; sie fühlte sich dermaßen beleidigt und war so böse, daß sie dieses Band sofort in der Gegenwart des Mädchens zerriß. Trotz ihrer ausgesprochenen äußeren emotionalen Flachheit ist sie sehr sensitiv, insbesondere ist ihr Selbstgefühl verwundbar. Sie hat ein feines Verständnis für verschiedene gefühlsmäßige Erlebnisse. Nach der Meinung der Lehrerin war sie das feinfühligste und intelligenteste Mädchen ihrer ganzen Gruppe. Zeichnet gern, weigert sich aber, nach einer Vorlage zu zeichnen. Arbeitet in der Buchbinderei, leistet Gutes. Im Laufe des letzten Jahres wurde das Mädchen etwas weicher und ruhiger; den Verlust der Mutter (welche vor einigen Monaten gestorben war), erlebte sie sehr schwer. Nach ihren Worten weinte sie viel des Nachts, wo sie niemand sehen konnte.

Zusammenfassung. Erbliche Belastung mütterlicherseits. Regelmäßige körperliche Entwicklung. Von frühen Jahren an wenig gesellig, unkindlich ruhig. Zeitweise finster und launisch. Von sechs Jahren an lebt sie in Kinderheimen und ist hier schwer zu erziehen wegen ihrer geringen Zugänglichkeit, ausgesprochenen Negativismus und Neigung zu läppischen Unarten. Ein emotionell flaches Mädchen: empfindet keine Sehnsucht nach Verwandten, hat keine intimen Freundinnen. Ist zu gleicher Zeit sehr sensitiv und gegen Verletzungen ihres Selbstgefühls sehr empfindlich. Intellekt normal, gute Schul-

leistungen, äußert eine zeichnerische Begabung. Körperlicherseits: asthenischer Körperbau (unausgesprochen); motorische Zurückgebliebenheit, Plumpheit, viele überflüssige Bewegungen. Während der Beobachtung konnte eine gewisse Besserung konstatiert werden: das Mädchen wurde weicher und ruhiger.

Diagnose: Psychopathische Persönlichkeit: „Schizoid“. Verlauf: stationär mit einer geringen Besserung in den letzten Jahren.

Fall 3. W. P., geboren 1909.

Heredität: Vater mit 42 Jahren an Typhus gestorben; war ein finsterner, boshafter Mensch, welcher für die Familie und die Kinder kein Interesse hatte. Hat oft getrunken. Lues wird in Abrede gestellt. Über seine Verwandtschaft liegen keine Kenntnisse vor. Mutter, 47 Jahre, arbeitet als Wärterin in einem Krankenhaus, macht den Eindruck einer Debilen; dem Charakter nach ist sie weich und willensschwach. Großvater und Großmutter mütterlicherseits starben im vorgeschrittenen Alter — nähere Angaben fehlen. Die Mutter hatte drei Schwangerschaften. 1. Der ältere Sohn, 20jährig, Psychopath; unordentlich, unet, grob, frech, kann sich nirgends zurechtfinden; 2. unsere Patientin; 3. ein 14jähriges Mädchen: ruhig, still, oligophren.

Persönliche Anamnese. Schwangerschaft und Partus verliefen normal. Wurde als gesundes Kind geboren. Die körperliche Entwicklung ging mit einer gewissen Verspätung. Sprechen und Laufen fing sie mit zwei Jahren an. Überstand Varicellen, Masern und Keuchhusten. Wuchs als ein schwächliches Mädchen auf, hatte oft Bronchialkatarrh. Die ökonomischen Verhältnisse waren stets sehr schwierig. Die Erziehung des Mädchens lag in den Händen der Mutter, welche mit ihr nicht fertig wurde. Das launische, kapriziöse und eigenartige Mädchen war von der frühesten Kindheit an sehr schwer zu behandeln. Für gewöhnlich war sie der Mutter gegenüber gütig, aufmerksam und zärtlich, zeitweise aber wurde sie auf einmal, anscheinend ohne jede Ursache, grob, frech und höhnisch, schlug sogar die Mutter in diesen Zeiten. War immer sehr eigensinnig und ungehorsam, machte immer das Gegenteil von dem Erforderlichen. Sagte man ihr „Geh spazieren!“ so war die Antwort: „Nein, ich gehe nicht“, „Leg dich dann hin und ruhe aus“ — daraufhin zog sie sich rasch an und saß stundenlang am Tore. Mit den Kindern spielte sie wenig und kam mit ihnen schlecht aus. Mit neun Jahren wurde das Mädchen in eine Kolonie nach der Ukraine gebracht, wo sie bis zu zwölf Jahren verblieb. Nach der Rückkehr von dort wurde sie von der Mutter der ärztlichen Beobachtungsstelle in Moskau überwiesen (Februar 1922), wo sie sich unter unserer Beobachtung befand.

Status physicus Anno 1923. Entspricht der Körperlänge und dem Gewichte nach ihrem Alter; ist schwächlich und dysplastisch gebaut. Körperbautypus eher asthenisch. Kopf groß, der Form nach annähernd viereckig, Gesicht breit, Stirn eng mit tief wachsenden Haaren; große graue Augen; breite Nase, kleiner Mund, breit gestellte Zähne. Hals kurz, breit, enge Schultern. Etwas buckelig. Scapulae alatae. Flacher

Brustkorb. Rachitisresiduen. Die oberflächlichen Lymphdrüsen vergrößert. Mandeln hypertrophisch. Subkutane Fettschicht schwach entwickelt; Muskulatur schlaff. Schilddrüse — Norm. Urogenitaler Apparat — Norm. Menses abs. Innere Organe: chronischer Spitzenkatarrh. Gefäßsystem: anämische Venengeräusche. Herz — Norm.

Nervensystem. Schlaaffe Haltung, eckige Bewegungen, plumper Gang; viele Grimassen, viele überflüssige Bewegungen; Mimik dem Erleben adäquat. Hirnnerven — N; Pupillen — D = S, reagieren lebhaft. Patellarreflexe erhöht. Rachenreflex — abs. Sensibilität — N. Gesicht kraß herabgesetzt — kurzsichtig.

Status psychicus. Intellekt gering, jedoch in der Normbreite. Kenntnissevorrat gering. Schulkenntnisse noch unzureichender. Logische Operationen in den Grenzen des Konkreten regelrecht. Nach den Methoden von *Binet-Simon* und *Rossolimo* zeigt sie eine gewisse Zurückgebliebenheit. Bei der Untersuchung ist sie negativistisch, viele Fragen will sie überhaupt nicht beantworten. Diese negativistische Einstellung erschwert die Bewertung ihrer intellektuellen Fähigkeiten, da es nicht zu entscheiden ist, was auf Kosten ihrer intellektuellen Unzulänglichkeit zu setzen ist und was von ihrem Nichtantwortenwollen abhängt. Auch auf der stationären Abteilung der Beobachtungsstelle ist sie negativistisch, fügt sich nicht in die Hausordnung, ist dem Lehrpersonal gegenüber grob. Während ihres zweijährigen Aufenthaltes bei der Abteilung hatte sie ihre Hefte niemals den Lehrern gezeigt; bei Versuchen, ihre Arbeit anzusehen, gab sie immer krasse, affektive Explosionen, konnte ihr Heft zerreißen, dem Lehrer etwas ins Gesicht werfen usw. Ihre Grobheit und Frechheit, ihr Negativismus äußern sich dabei gewissermaßen periodisch. Zeitweise ist sie ruhiger und arbeitet dann in der Klasse oder in der Nähwerkstatt. Zu diesen Zeiten macht sie nicht den Eindruck einer Zurückgebliebenen, gibt gescheite Antworten, findet sich sehr gut in der Umgebung zurecht. Trotzdem ist sie unfähig zur intellektuellen Anspannung. Sie hält sich immer an automatische Arbeiten; es macht sich eine gewisse Gehemmtheit bemerkbar, eine Langsamkeit des Denkens, etwas Steifes in ihrer Psyche, eine mangelnde Anpassung. In den erregten Zeiten macht sie abgeschmackte Streiche, spielt die Rolle eines Possenreißers, kleidet sich in seltsame auffällige Kostüme, grimassiert. Zu diesen Zeiten ist sie argwöhnisch und mißtrauisch, wähnt überall etwas Beleidigendes und bemüht sich, den Mitmenschen möglichst viel Unangenehmes zu machen. Diese groben Äußerungen passen schlecht zu dem Grundton ihrer emotionellen Persönlichkeit. Das Mädchen ist im ganzen sehr emotiv, feinfühlig, zart und gütig. Diese Kombination zarter Feinfühligkeit und Grobheit macht die Psyche des Mädchens zu einer fremdartigen und schwerverständlichen. Einen bizarren Eindruck macht auch ihre Stimmungs labilität: für gewöhnlich ist sie freundlich und zärtlich, manchmal aber wird sie plötzlich, ohne jeden Anlaß, mißtrauisch und grob. Diese Ambivalenz ist allen ihren affektiven Reaktionen eigentümlich. Stets erlebt sie zu gleicher Zeit ein „ich will“ und daneben ein „ich will nicht“. Leidenschaftlich wünscht sie etwas und stemmt sich gleichzeitig impulsiv gegen diese Wünsche. Fröhlich begegnet sie dem Arzte; macht aber der letzte einen Schritt auf sie zu, so versteckt sie sich

momentan oder läuft weg, hinterher aber geht sie längere Zeit hinter dem Arzte und beschwert sich, daß sie nicht genügend beachtet wurde. Mehrfach wollte sie den Arzt in seiner Wohnung besuchen, aber sobald die Tür auf ihr Anklingen geöffnet wurde, lief sie schleunigst weg. Im Kindermilieu hält sie sich abseits, an den gemeinsamen Spielen beteiligt sie sich nicht, schämt sich ihrer plumpen Bewegungen. Hat unter den Mädchen keine intimen Freundinnen, ist verschwiegen. Gegen das Ende des zweiten Jahres ihres Aufenthaltes bei der Beobachtungsstelle wurde sie etwas gleichmäßiger. 1924 wurde sie in die Anstalt für schwer erziehbare Mädchen versetzt. Hier blieb sie fast ein Jahr lang. Wurde bei einer Fabrik angestellt, hielt sich aber dort nicht lange. Nach den letzten Nachrichten lebt sie jetzt bei ihrer Mutter, ist als Laufbote angestellt und wird mit ihrer Arbeit fertig. Wurde etwas ruhiger.

Zusammenfassung. Erbliche Belastung: pathologischer Charakter und Alkoholismus des Vaters, Debilitas bei der Mutter. Körperliche Entwicklung mit einer gewissen Verspätung. Viele Krankheiten im Kindesalter (oft Bronchialkatarrh). Pathologische Charakteranomalien von der frühesten Kindheit an: Negativismus, ausgesprochene Ambivalenz der Thymopsyché, inadäquate emotionelle Reaktionen. Alle diese Besonderheiten werden noch markanter nach der Aufnahme in das Kinderheim. Hier ist sie dem pädagogischen Einflusse sehr schwer zugänglich, weigert sich, ihre Arbeiten zu zeigen, ist zeitweise grob und frech. Intellekt gering, aber in der Normbreite. Ausgesprochene motorische Unzulänglichkeit: Plumpheit und Eckigkeit der Bewegungen, Synkinesien. Innere Organe: chronischer Katarrh der Lungenspitzen. In den letzten Jahren eine gewisse Besserung. Wurde ruhiger und gleichmäßiger.

Diagnose: Psychopathische Persönlichkeit: „Schizoid“. *Verlauf:* stationär, eine gewisse Besserung nach dem Ablauf der Pubertät.

Fall 4. L. K., 13jährig (Januar 1913 geboren).

Heredität: Vater starb mit 76 Jahren an Erschöpfung (während der Hungersnotzeit). War stets gesund, gesellig und lustig. Musiker: spielte Violine. Großvater und Großmutter starben aus unbekanntem Ursachen. Beide waren robust und gesund. Weitere Kenntnisse liegen nicht vor. Urgroßvater väterlicherseits — ein nach Rußland übergesiedelter Franzose. Musiker: Komponist. Die Verwandtschaft des Vaters musikalisch begabt. Mutter, 47jährig, hält sich für nervenkrank, wird bei dem psycho-neurologischem Dispensaire behandelt (wo die Diagnose auf „Schizophrenie“ lautet). Macht den Eindruck einer sonderlinghaften, exaltierten, wenig an das Leben angepaßten Person. Gibt Musikstunden. Großvater mütterlicherseits starb mit 63 Jahren an Sklerose, war ein lustiger und witziger Mensch. Hatte manchmal getrunken. Großmutter starb mit 25 Jahren, während einer Entbindung: war musikalisch begabt,

Schauspielerin. In der Familie der Mutter viele Neurastheniker und viele musikalisch begabte Leute.

Die Mutter hatte drei Schwangerschaften. 1. — spontane Fehlgeburt. 2. — Tochter aus der ersten Ehe, 24jährig; befindet sich ebenfalls bei dem psycho-neurologischen Dispensaire in Behandlung (Diagnose: psychopathische Persönlichkeit). 3. — unsere Patientin.

Persönliche Anamnese: Als das Mädchen zur Welt kam, war der Vater 64 Jahre alt, die Mutter 33jährig. Die Schwangerschaft verlief bei hoher körperlicher Schwäche der Mutter. Partus rechtzeitig, lange dauernd, ohne operative Eingriffe. Körperliche Entwicklung regelrecht. Von den Krankheiten nur Parotitis und oft Influenza. Von der Kindheit an bis jetzt unruhiger Schlaf, oft automatische Bewegungen im Schlafe (pendelnde Bewegungen des Rumpfes). Schon von drei Jahren an machten sich die schwierigen Eigenschaften ihres Charakters bemerkbar: sie war ungehorsam, launisch, oft unüberwindbar eigensinnig. Die intellektuelle Entwicklung ging gut. Lernte mit fünf Jahren selbständig lesen; früh zeigte sich bei ihr eine musikalische Begabung: (Fähigkeit zu Improvisationen). Hand in Hand damit wurde mit jedem Jahr eine gewisse Zerstreuung des Mädchens immer deutlicher. Intelligent und verständig, wurde sie jedoch mit den einfachsten Aufträgen nicht fertig. Wurde sie nach irgendwas in den Laden geschickt, so vergaß sie unterwegs, was sie zu bringen hatte. Man beobachtete an ihr eine große Saumseligkeit: sie aß sehr langsam, zog sich eine ganze Stunde lang an, legte sich irgendein Kleidungsstück an und versank in Gedanken. Bevor sie etwas tat, mußte sie sich sehr lange Vorsätze machen, machte alles mit Verspätung, ließ sich oft ablenken und brachte das Angefangene nicht zu Ende. Dem Charakter nach war sie nicht boshaft, hatte aber wenig kindliche Freundlichkeit und Zärtlichkeit in ihrem Wesen. Mit Kindern spielte sie gerne, zog aber die Gesellschaft der Erwachsenen vor; besonders gern hörte sie phantastische Erzählungen und Märchen. Sie liebte lärmende Bewegungsspiele und spielte selten mit Puppen. Bis zu sieben Jahren lebte sie in guten ökonomischen Verhältnissen. Die Eltern verhielten sich dem Kinde gegenüber weich und zärtlich. Mit sechs Jahren wurde das Mädchen in einen Kindergarten geschickt, wo sie nur zwei Monate lang bleiben konnte, da sie sich nicht anpassen konnte, die Froebelschen Spiele nicht leiden wollte und sich die Spiele selbst erfand. Die Pädagogen fanden ihr weiteres Bleiben in dem Garten nutzlos, hielten sie für begabt, aber sehr zerstreut. Mit sieben Jahren wurde das Mädchen zur Volksschule für Musik geschickt. Trotz der guten musikalischen Anlagen kam sie schlecht vorwärts, beschäftigte sich ungern mit der „Theorie“ und mit allem, wo Anstrengung und Ausdauer erforderlich waren. Die Periode von sieben bis zehn Jahren war für das Mädchen eine besonders schwierige, die ökonomischen Verhältnisse änderten sich kraß nach der schlechten Seite hin (schlechte Nahrung, häufiges Übersiedeln von einer Stadt zur anderen); gleichzeitig ließ sich die Mutter vom Vater scheiden und verliebte sich in einen psychisch-kranken Menschen. Das Mädchen lebte bei der Mutter und wurde beständig körperlich und geistig traumatisiert, da der Stiefvater sie oft geschlagen und überhaupt schlecht behandelt hatte. Bis zu zehn Jahren

hatte sie keinen systematischen Schulunterricht gehabt. Es wurden Hauslehrer eingeladen, welche alle guten Fähigkeiten konstatierten, sie aber für eine sehr schwer zu behandelnde Schülerin hielten. Sie faßte alles sehr rasch auf, vergaß aber alles ebenso rasch. Mit zehn Jahren übersiedelte das Mädchen mit der Mutter nach Moskau und gelangte hier in eine sogenannte experimentelle Musterschule. Wurde von vornherein in die vierte Gruppe aufgenommen und schon nach zwei Monaten in die fünfte Gruppe versetzt. In der Schule wurde sie für sehr begabt und gut entwickelt gehalten; hier wurden zum erstenmal ihre literarischen Fähigkeiten entdeckt. Ein Jahr ging sie zur Schule und wurde darauf nach der Vorschrift des Tuberkulosearztes für das nächste Jahr nach dem Lande geschickt. Während des Aufenthaltes auf dem Lande wurde ihre Gesundheit hergestellt. Anfang 1924 kehrte das Mädchen nach Moskau zurück, wo sie wieder in schweren Verhältnissen einer schlechten und mangelhaften Ernährung zu leben hatte. Die pathologischen Besonderheiten des Mädchens kamen diesmal noch intensiver zur Geltung: ihre Zerstretheit, Passivität und Saumseligkeit machten sie zu jeder selbständigen Arbeit unfähig. In erzieherischer Hinsicht wurde sie noch schwieriger: sie wurde immer gröber, frecher, negativistischer. Dies alles veranlaßte die Mutter, sich an einen Psychiater zu wenden, welcher das Mädchen im März 1925 unserer Klinik überwies.

Status physicus. Nach der Körperlänge und dem Gewicht übertrifft sie ihr Alter um zwei Jahre. Körperbautypus nähert sich dem Athletischen. Dysplastische Besonderheiten: unproportioniert große Hände und Füße. Kopf dem Rumpfe proportional. Schädel: brachyzephaler Typus. Breites Gesicht, gut ausgesprochene Jochbeinknochen. Kleine Gesichtszüge, unscharfes Profil. Zähne: breit, unregelmäßig sitzend. Hals stark, mittellang, breite Schultern. Brustkorb hoch, von regelmäßiger zylindrischer Form. Haut etwas blaß, glatt, elastisch, weder trocken noch übermäßig schwitzend. Blasse Schleimhäute. Subkutane Fettschicht genügend entwickelt, gleichmäßig verteilt. Muskulatur gut entwickelt. Breite Knochen. Rachenmandeln etwas vergrößert. Schilddrüse normal. Brustdrüsen entsprechen (palpatorisch) dem Alter. Sekundäre Geschlechtsmerkmale sind vorhanden. Seit September 1925 Menses, regelrecht, wenig schmerzhaft. Innere Organe: Atmungsorgane: Ausatmung in der rechten Spitze, Neigung zu häufigem Schnupfen; Kreislauf: reine Herztöne, pulsus 72.

Nervensystem: Bewegungen — kräftig, genügend koordiniert, aber etwas eckig und kraß. Geht mit ausladenden großen Schritten. Bei der Untersuchung nach der Skala von Dr. *Oseretsky* gibt sie + zwei Jahre. Tremor der geschlossenen Lider und der Finger bei ausgestreckten Armen. Mimik wenig ausdrucksvoll. Stimme ziemlich grob. Sensibilität erhalten. Hirnnerven — N, Pupillen — D = S, reagieren etwas träge; psychische Reaktion vorhanden. Reflexe — Patellar — R. und Achilles — R. — lebhaft. Sehnenreflexe der oberen Extremitäten träge. Hautreflexe — N. Schleimhautreflexe: herabgesetzt. Pathologische Reflexe fehlen. Vegetative Symptome: weiße Dermographie, positiver *Aschner*. Schlaf — schläft schwer ein. Beim Einschlafen oft rhythmische Bewegungen des Rumpfes (erklärt, daß sie auf diese Weise sich einschlä-

fert). Dieselben Bewegungen lassen sich auch im Schlafe beobachten. Onanie wurde nicht beobachtet. Laboratoriumuntersuchungen: *Wassermann* im Blute negativ; die Blutuntersuchung ergibt Anämie und geringe Leukozytose. Leukozytäre Formel — keine Abweichungen von der Norm. Harnuntersuchung: nichts Pathologisches.

Status psychicus. Ruhig, orientiert, hat sich ziemlich bald in der neuen Umgebung und unter den neuen Menschen zurechtgefunden. Steht ihrem Zustande vollkommen kritisch gegenüber. Es besteht ein ausgesprochenes, mit ängstlicher Unruhe verbundenes Gefühl der eigenen Minderwertigkeit. Bei der Untersuchung fragt sie immer: „Bin ich normal?“ „Ich habe so große Hände — kommt so was vor oder ist es eine Krankheit?“ usw. Klagt über die eigene Zerstretheit, sie könne nichts tun, da sie alles rasch vergesse. Wird ihr eine Arbeit vorgeschlagen, so schlägt sie lange ab: „Ich werde ja damit nicht fertig, es wird mir nicht gelingen.“ Geht ungern an die Arbeit, ist dabei ängstlich aufgeregt. In der Arbeit ist sie hilflos, unschlüssig, erwartet von außen eine Unterstützung. Wurde mit einer sehr einfachen Aufgabe nicht fertig, was jedoch nicht aus Geistesschwäche geschah. Intellekt gut (übernormal); hohe allgemeine Entwicklung. Wahrnehmung gut, exakt; gute Auffassung. Versteht sofort die an sie gerichteten Fragen, gibt aber oft anstatt einer Antwort mehrere Varianten, schwankt und ist unschlüssig, welche von ihnen die am besten gelungene ist. Ihre Antworten sind oft sehr lang, detailliert, rasonnierend, aber der Gedanke ist immer richtig. Logische Prozesse koordiniert, keine Zerfahrenheiten, keine Denksperren. Es ist eine Fähigkeit zum abstrakten Denken vorhanden. Gibt gute Unterscheidungen abstrakter Begriffe (Unterschied zwischen Liebe und Freundschaft? — „Liebe ist ein menschliches Gefühl; Freundschaft — ist ein Verhältnis menschlicher Gesinnungen“; besonders gelungen erscheinen die Antworten auf dem Gebiete der emotionalen Erlebnisse: hier kommt ein ganz bestimmtes Verständnis menschlicher Gefühle und Verhältnisse zum Vorschein. Andere Antworten, bei denen es weniger auf Gefühlsmomente ankommt, erscheinen nicht so gut. Gedächtnis unter dem Durchschnitt. Nach der *Binet-Simonschen* Skala ist sie eine 15jährige (+ 1½ Jahre).

Über ihre Vergangenheit erzählt sie ungern: „Ich liebe keine Vertraulichkeiten“, sagt sie, „und habe keine Achtung für solche, welche von sich selbst alles erzählen.“ „Ich bin eher kaltblütig als nervös“, sagt sie von sich selbst. „Ich hatte niemals starke Neigungen“, „nichts berührt mich besonders stark“, „ich habe keine intimen Freundinnen“. Von einer affektiven Stumpfheit kann hier jedoch keine Rede sein. Das Mädchen hat ein bestimmtes Interesse für die Umgebung. Beschäftigt sich sehr gern in der Klasse, liebt Musik, Körperübungen und Spiele — spielt mit großer Hingebung und Hazard. Ausgesprochen erhöhte Sensibilität des „Ich-Komplexes“. Sie ist egozentrisch, möchte immer besser als die anderen sein und regt sich darüber auf, daß es ihr nicht gelingt. In der Bewertung ihrer eigenen Persönlichkeit ist ebenfalls eine Ambivalenz vorhanden. Bei hoher Einschätzung ihrer selbst und ihrer Fähigkeiten, bei einem Streben, besser als die anderen zu sein — eine ständige Unruhe und Unsicherheit in den eigenen Kräften. Mit den

Schulkindern verkehrt sie leicht, ist aber mit niemandem intim. Schreibt allen Mädchen zum Andenken immer dieselben Worte in ihre Stammbücher: „Ich fange an, mich allmählich an Dich zu gewöhnen.“ Im Verkehr mit den Mitmenschen ist sie weder gütig noch boshaft zu nennen. Sie ist egoistisch und um die eigenen Vorteile besorgt, bemüht sich aber häufig auch für die Kameraden und steht ihnen bei. Spricht gerne über Prinzipien und Gerechtigkeit. In allen ihren emotionellen Bewegungen besteht eine gewisse Heftigkeit und Eckigkeit, dagegen wenig seelische Wärme. In ihrem Benehmen ist sie oft belästigend und zudringlich. Sie belästigt mit ihren endlosen Fragen und Bitten; ist sehr hartnäckig, wenn sie etwas wünscht. Sie fügt sich im allgemeinen gut in die Hausordnung der Anstalt; ist aber manchmal sehr eigensinnig und grob. Ausgesprochener Negativismus ließ sich nicht beobachten. In der Selbstbedienung ist sie sehr saumselig, verrichtet alles sehr unbeholfen. Die Aufträge, welche ihr gegeben werden, erfüllt sie mangelhaft, ist dabei vergeßlich und unaufmerksam, übersieht manchmal die Hauptsache. In den Schularbeiten ist sie genügend produktiv; ihre Leistungsfähigkeit wird immer höher. Spezielle Begabungen: sie ist musikalisch begabt (Fähigkeit zum Komponieren) und zeigt literarische Fähigkeiten (schreibt Erzählungen für die Kinderzeitschrift der Schule). Die Turn- und Rhythmusübungen macht sie gut.

Verlauf. Während des Aufenthaltes in der Heilschule entwickelte sie sich körperlich und wurde robuster. Seit September 1925 stellten sich Menses ein. Der Schlaf wurde ruhiger. In der letzten Zeit verschwanden auch die pendelnden Bewegungen während des Schlafes. Auch seitens der Psyche sind bedeutende Veränderungen zu verzeichnen. Während des ersten Monats wurden ihre psychasthenischen Züge allmählich blasser, sie wurde sicherer, lernte selbständig arbeiten. Verfolgte mit Ausdauer die gestellten Ziele. In der letzten Zeit wurden die entgegengesetzten Züge des erhöhten Selbstgefühles immer deutlicher. Oft ist ihr Tonfall grob, oft prahlt sie gern mit ihrer körperlichen Kraft, schreit auf die Kinder, welche sie ein wenig fürchten. Der affektive Grundton ist, wie früher, ein ruhiger. Ausgesprochene affektive Entladungen kommen nicht vor. Sie bleibt wie früher verschlossen und wenig zugänglich. Mit dem Kindermilieu steht sie nunmehr auf besserem Fuße, beteiligt sich an den sozialen Organisationen der Schule.

Zusammenfassung. Heredität: Erhebliche erbliche Belastung (Mutter geisteskrank, Schwester psychopathisch) und musikalische Begabung (viele begabte Musiker in der Familie). Ökonomische Verhältnisse: befriedigend bis zu sieben Jahren, später krasse Veränderung nach der schlechten Seite hin. Regelrechte körperliche Entwicklung. Gute geistige Entwicklung. Sie war ein intelligentes, begabtes, musikalisches Mädchen gewesen. Schon früh fielen aber ihre große Zerstreuung, Insuffizienz der aktiven Impulse und Saumseligkeit in der Arbeit auf. Im Kindergarten konnte sich das Mädchen nicht einleben, liebte die Kinderspiele und die Froebelschen Beschäftigungen

nicht, erfand sich selbst ihre Spiele und lebte mehr in einer eigenen Phantasiewelt. Die Lehrer, die sich mit ihr beschäftigten, hielten sie wegen ihrer hohen Zerstreuung für ein begabtes, jedoch pädagogisch schwieriges Mädchen. Den Charaktereigenschaften nach war sie verschlossen, verschwiegen, hatte keine starken Zuneigungen, war zeitweise grob und eigensinnig. In der Vorpubertätszeit spitzten sich alle diese pathologischen Besonderheiten zu, weswegen die Mutter sich an die Heilschule wenden mußte. Bei der Aufnahme zeigte sie ein kraß ausgesprochenes psychasthenisches Syndrom: Unfähigkeit zu Anstrengung, Selbstunsicherheit in Verbindung mit ängstlicher Unruhe. Intellekt gut, übernormal. Neigung zu Räsonnements und überflüssigem Grübeln. Während des Aufenthaltes in der Heilschule bedeutende Änderungen nach der guten Seite. Sie lernte selbständig arbeiten, zeigte eine hohe Produktivität in den Schularbeiten und im Musikunterricht. Von den somatischen Eigentümlichkeiten läßt sich folgendes verzeichnen: Athletischer Körperbautypus mit einzelnen dysplastischen Merkmalen, Anämie und tuberkulöse Intoxikationserscheinungen.

Diagnose: Psychopathische Persönlichkeit: „Schizoid“. Verlauf: stationär. Zuspitzung in der Vorpubertätsperiode. Es ist möglich, daß die Zuspitzung auch durch die ungünstigen Lebensverhältnisse (häufige Umzüge, schlechte Nahrung, Familienzwistigkeiten) hervorgerufen wurde. In der Heilschule bedeutende Besserung.

Fall 5. N. W. (geboren 1913).

Heredität. *Vater*, Arzt, starb mit 61 Jahren an Flecktyphus. Nach dem japanischen Kriege, als er 45 Jahre alt war, entwickelten sich bei ihm Größenideen — er befaßte sich mit Projekten, bei welchen es sich um eigentümliche Erfindungen handelte. Er blieb jedoch im Berufe, war als Chefarzt in verschiedenen Spitälern tätig. Über seine Verwandtschaft ist Näheres nicht bekannt. *Mutter* starb mit 46 Jahren an Dysenterie; war herzkrank; dem Charakter nach war sie reizbar und nervös, litt an hysterischen Anfällen. *Großmutter* mütterlicherseits ebenfalls sehr ungleichmäßig, hysterisch. Über die übrigen Verwandten ist nichts bekannt.

Die Mutter hatte nur eine Schwangerschaft: unsere Patientin.

Persönliche Anamnese. Bei der Geburt des Mädchens war der Vater 55jährig, die Mutter 36jährig; über den Verlauf der Schwangerschaft und der Entbindung ist nichts bekannt. Die körperliche Entwicklung ging regelmäßig. Überstand Masern und Lungenentzündung. Die ersten drei Jahre wurde sie bei ihrer Großmutter erzogen, später bei den Eltern.

Die ökonomischen Verhältnisse waren bis zum Tode des Vaters befriedigend (er starb, als das Mädchen sechs Jahre alt war), weiter haben sie sich bedeutend verschlechtert — die Mutter arbeitete als Lehrerin in Kinderheimen, das Mädchen lebte bei der Mutter. Die Mutter verhätschelte das Mädchen, reizte sie aber gleichzeitig durch ihre Nervosität. Sie wuchs als ein kränkliches, schwächliches Mädchen auf und machte in erzieherischer Hinsicht, schon von der frühen Kindheit an, große Schwierigkeiten. War stets undiszipliniert und frech. Sie liebte ihre Mutter sehr, quälte sie aber fortwährend, beschimpfte sie und erlaubte sich sogar, die Mutter zu schlagen. Einst nahm sie ihrer Mutter etwas sehr übel, verschloß sich in dem Zimmer der Landwohnung und ließ die Mutter stundenlang im Hofe warten. In den Kinderheimen, wo sie zusammen mit ihrer Mutter lebte, hatte sie beständig Zwistigkeiten mit den Kindern, so daß der Mutter mehrmals ihre Stellung gekündigt wurde. Die intellektuelle Entwicklung des Mädchens verlief regelmäßig. Mit sechs Jahren lernte sie lesen, war ein gescheites Mädchen, las viel. Mit neun Jahren ging sie zur Schule und leistete Gutes. Als das Mädchen zehn Jahre alt wurde, starb ihre Mutter. Sie blieb der Fürsorge einer Freundin ihrer Mutter überlassen, welche sie im August 1923 der ärztlichen Beobachtungsstelle überwies.

Bei der Untersuchung in der Ambulanz zeigte sie eine gute Entwicklung: hohes Profil nach der Methode von Prof. *Rossolimo*. Sie wurde auf die stationäre Abteilung der Beobachtungsstelle gebracht und erwies sich da sofort als schwer erziehbar. Sehr negativistisch, grob, frech. Fügte sich nicht in die Hausordnung der Anstalt und wurde nach einigen Monaten in die Heilstätte für Psychopathen versetzt. Dort verblieb sie etwa ein Jahr und wurde daraufhin der Anstalt für schwer erziehbare Mädchen überwiesen. (Hier befand sie sich in unserer Beobachtung.) Auch hier konnte sich das Mädchen nicht einleben: Ihre Grobheit, ihr krasser Negativismus und beständige Albernheiten stören die Arbeit der ganzen Klasse. Dem pädagogischen Personal gegenüber verhält sie sich verächtlich und boshaft. Verschlossen, verschwiegen. Immer scheint es ihr, daß die Lehrer die Kinder beleidigen und ungerecht behandeln.

Im März 1926 wurde sie in die Heilschule der Psychoneurologischen Kinderklinik aufgenommen.

Status physicus. Der Körperlänge nach übertrifft sie das Alter von 16 Jahren, dem Thoraxumfange nach entspricht sie 13 Jahren, dem Schädelumfange nach 14 Jahren. Dem Verhältnisse zwischen der Unterlänge zur Oberlänge nach nähert sie sich etwas dem eunuchoiden Typus. Körperbautypus: Asthenisch-dysplastisch. Hoch, mager, etwas buckelig. Hoher, unregelmäßig geformter, fast turmförmiger Schädel. Langes, schmales, eiförmiges Gesicht. Kleine Gesichtszüge. Langer, dünner Hals; schmale einwärts rotierte Schultern; langer, schmaler Brustkorb; rechtsseitige Scoliose. Muskulatur befriedigend, subkutane Fettschicht spärlich entwickelt. Schilddrüse — Norm. Brustdrüsen gut palpierbar. Innere Organe: Lungenausatmung in der rechten Spitze. Herz reine Töne. Pulsus — 82. Anämische Venengeräusche. Magendarmkanal

— Norm. Urogenitalsystem — N. Sekundäre Geschlechtsmerkmale machen sich bemerkbar. Menses — abs.

Nervensystem. Bewegungen genügend kräftig, rasch, heftig, etwas eckig. Viele überflüssige Bewegungen, wenn sie sich aufregt. Manchmal Zwangsbewegungen: Nägelkauen. Plumper Gang. Mimik entspricht dem Erleben. Stimme laut, schneidend. Hirnnerven: Nn. faciales etwas asymmetrisch. Im übrigen — N. Pupillen D = S, Reaktion erhalten. Psychische Pupillenreaktion vorhanden. Patellar — R. etwas erhöht; geringer Tremor der Lider bei geschlossenen Augen. Sensibilität erhalten. Gesicht herabgesetzt — Myopie. Gehör — N. Schlaf ruhig, schläft früh ein. Laboratoriumsuntersuchungen: *Wassermann* im Blute negativ. Leukozytäre Formel: geringe Leukozytose. Harn: nichts Pathologisches.

Status psychicus. Wenig zugänglich. Finster, mißtrauisch. Ein emotioneller Kontakt mit ihr ist nicht sofort und nur mit Schwierigkeiten herzustellen. Macht eingehende autoanamnestische Angaben. Die ersten Erinnerungen stammen aus dem vierten Lebensjahre. Es ging ihr damals gut, doch hatte sie eine böse Wärterin, welche sie in der Abwesenheit der Mutter schlug. Puppen liebte sie nicht und zerschlug sie, um zu erfahren, was drinnen steckt; zog Bewegungsspiele mit Knaben vor. Sie sei weder krank noch nervös. „Niemals habe ich vor irgend etwas Angst gehabt. Ich kletterte auf die Dachkammer und auf die Dächer. Immer bin ich eigensinnig gewesen und machte gerne alles zum Trotz.“

Fragt man sie über etwas, was ihr intimes Leben berührt, so macht sie ein unzufriedenes Gesicht und antwortet: „Fragen sie mich nicht aus.“ Spricht ungern über das Leben in den Kinderheimen. „Ja, ich bin defekt; ich trieb Unfug und beschimpfte die Lehrerinnen, weil ich böse war; ich konnte mich stets beherrschen, aber ich war rasend böse; einer neuen Lehrerin machte ich immer eine Probe: regte sie sich auf, so fuhr ich fort, sie rasend zu machen — war sie ruhig, so hörte ich auf“. Intimere Freundinnen habe sie nicht gehabt: „Manchmal gefällt mir diese oder jene, aber ich liebe sie nicht. Ich habe niemanden besonders lieb, Menschen gegenüber bin ich meistens gleichgültig.“ Ihre Sprache ist abgerissen, arm an Wortschatz, viele spezifische Ausdrücke aus dem Kinderheimjargon.

Experimentell-psychologische Untersuchung: Intellekt — N. Assoziative Prozesse koordiniert: sinnesmäßige Assoziationen vorherrschend. Denken geordnet; die Definitionen abstrakter Begriffe gelingen ihr jedoch schwer (wegen Mangels an Worten). Gutes Gedächtnis. Kombinationsvorgänge gut: alle zehn Tests nach *Rossolimo* führte sie richtig aus. Aufmerksamkeit: genügende Tenazität. Nach Binet: + ein Jahr.

Mit der Versetzung in die Heilschule war sie sehr zufrieden, gab aber ihre Freude äußerlich gar nicht kund und redete in demselben unzufrieden-mürrischem Tonfall: „Alle sind hier so artig, man wird mich sehr bald herauschmeißen.“ Die erste Zeit sah sie sich um. Hielt sich abseits von allen, knüpfte mit den Kindern keine Gespräche an, antwortete wenig auf Fragen. Gab sich Mühe, um unauffällig zu bleiben, wollte keine Turnübungen machen und kein Solo beim Gesangunterricht singen. Den größten Teil der Zeit verbrachte sie in der Klasse, las oder

arbeitete an den Klassenaufgaben. Nach ein bis zwei Monaten wurde sie in der Schule dermaßen heimisch, daß sie sich schon an den Schulfestlichkeiten öffentlich beteiligen konnte. Wurde mit den Kindern etwas intimer, etwas freundlicher den Lehrern gegenüber, weicher und zugänglicher. Stimmung ruhig. Keine einzige affektive Explosion während dieser Zeit. Auch keine heitere Erregung oder erhöhte Reizbarkeit. Sie war immer gleichmäßig, beherrscht und weinte niemals. Ambivalenz ist für alle ihre affektiven Erlebnisse charakteristisch. Sie ist finster, etwas boshaft und doch sehr feinfühlig. Auf der Bühne zeigt sie eine sehr feine Widergabe der emotionellen Erlebnisse; sie hat ein feines Empfinden für das Schöne in der Natur und in Büchern. Intensive intellektuelle Interessen, welche sie mit Hilfe der Lektüre befriedigt. Egozentrisch und äußerst eigenliebend. Gestand einmal einer Erzieherin: „Ich möchte, daß alles in der Welt nur für mich da wäre.“ Sie hat es sehr gern, wenn man sie lobt, wird aber dabei sehr verlegen; äußert oft die Befürchtung, daß man sie auslacht und verspottet. „Tadeln Sie mich lieber anstatt zu loben.“

Sthenisch, sehr hartnäckig in ihren Unternehmungen, alles Begonnene führt sie stets zum Ende: „Wenn ich etwas will, so tue ich es.“ Wegen dieser Ausdauer zeigt sie eine sehr große Produktivität bei der Schularbeit.

In künstlerischer Hinsicht ist sie ein begabtes Mädchen. Musikalisch, singt gut. Szenische Begabung. Zeichnet gut.

Zusammenfassung. Heredität: Vater geisteskrank, von der mütterlichen Seite — Hysterie. Regelmäßige körperliche und geistige Entwicklung. Schwer erziehbar von der frühesten Kindheit an. Eigensinnig, launisch, reizbar. Kraß ausgesprochene Ambivalenz der affektiven Reaktionen: liebt die Mutter und mißhandelt sie gleichzeitig. Äußerlich emotionell flach. Die empfindlichste Stelle — der Komplex des eigenen Ich, krankhaft erhöhtes und verwundbares Selbstgefühl. Von 10 bis 13 Jahren lebte sie in mehreren Kinderanstalten. Überall war sie sehr schwierig, pädagogisch schwer beeinflussbar. Es ließen sich folgende Erscheinungen beobachten: Verschlossenheit, geringe Zugänglichkeit, Erbostheit, mißtrauisches Verhalten den Lehrern gegenüber, hartnäckiger Negativismus, zeitweise Neigung zu läppischem Wesen. Nach der Aufnahme in die Heilschule ausgesprochene Veränderung nach der besseren Seite: sie wurde ruhiger, kein Negativismus, kein läppisches Wesen (bleibt jedoch immer noch verschlossen und wenig gesellig). Große Fortschritte in den Schularbeiten. Äußerte musikalische und szenische Befähigung. Somatische Eigentümlichkeiten: asthenischer Körperbautypus mit dysplastischen Besonderheiten: eunchoide Proportionen im Verhältnis der unteren Extremitäten

zum Rumpfe; eckige Bewegungen. Motorische Unruhe, Zwangsbewegungen (Nägelkauen).

Diagnose: Psychopathische Persönlichkeit (Schizoid). *Verlauf* stationär. Zuspitzung aller pathologischen Besonderheiten des Mädchens während des Aufenthaltes in den Kinderanstalten. (Letztere kann als eine psychogene Reaktion auf die plötzlich verschlechterten Lebensbedingungen bei einem Mädchen von schizoider Konstitution betrachtet werden.) In günstiger Umgebung rasche Besserung.

Auf Grund der schon angeführten Fälle und des weiteren Studiums der schizoiden Psychopathien bei Knaben (das wir im verflossenen Jahre fortgesetzt hatten) halten wir es für möglich, die Symptomatologie der schizoiden Psychopathien exakter zu beschreiben, und zwar indem wir die beobachteten Symptome in zwei Gruppen einteilen: 1. in Grundsymptome, welche die charakteristischen Eigentümlichkeiten der Psyche der schizoiden Psychopathen bilden, und 2. in akzessorische Symptome, welche oft, aber doch nicht immer, vorkommen.

Zu den Grundsymptomen zählen wir: 1. die autistische Einstellung, 2. die Ambivalenz der Thymopsyche, 3. die Besonderheiten des Denkens: Neigung zum Abstrakten, Formalen; Automatismus, 4. die Erscheinungen der motorischen Unzulänglichkeit: Eckigkeit, Plumpheit der Bewegungen. Zu den akzessorischen Symptomen: 1. den paranoiden Symptomenkomplex — die mißtrauische, argwöhnische Einstellung zu der Umgebung (das beständige Gefühl des Verletztseins, die unrichtige Deutung des Verhaltens der Mitmenschen), 2. das psychasthenische Syndrom: Selbstunsicherheit, Gefühl der eigenen Minderwertigkeit, Neigung zu Zwangszuständen und 3. Symptome, welche man „katatonoid“ Symptome nennen könnte —, erhöhte Suggestibilität, ausgesprochener Negativismus, manchmal beides gleichzeitig, 4. dieser letzten Gruppe nahestehend sind die psychomotorischen Störungen — Neigung zu Stereotypien, läppischem Wesen; Automatismus; Impulsivität.

Die Symptomatologie der angeführten Fälle schizoider Psychopathien bei Mädchen wiederholt in ihren Grundzügen das von uns beschriebene Bild. Bei der Analyse der einzelnen Symptome läßt sich jedoch eine Reihe spezifischer Eigentümlichkeiten aussondern, die an das Geschlecht gebunden erscheinen.

1. Der Hauptunterschied besteht darin, daß bei den Mädchen in dem Bilde schizoider Psychopathien die *Störungen des Gefühlslebens* stets im Vordergrund stehen. Es sind eben diese emotionellen Defekte, welche den Schizoiden den Stempel des Abgeschmackten, des Sonderbaren und Verschrobenen aufdrücken. Bei den schizoiden Knaben setzt sich das Bild der Verschrobenheit aus den Neigungen zur überflüssigen Abstraktion, absurdem Grübeln, Stereotypien und motorische Unzulänglichkeit zusammen; bei den Mädchen haben wir dagegen eine, wenn man so sagen darf, emotionelle Verschrobenheit, welche durch ein kompliziertes Spiel der seltsamsten emotionellen Kombinationen entsteht. Die Ambivalenz des Gefühlslebens, das beständige Vorhandensein sich widersprechender Emotionen — hat, als Folgeerscheinungen, solche Handlungen, welche abgeschmackt, widerspruchsvoll und unverständlich erscheinen. *Bleuler* erklärt diese Ambivalenz durch die Störung der Einheitlichkeit des dominierenden Affekts, die dazu führt, daß gleichzeitig eine ganze Reihe Strebungen aufkommen, wobei keine einzige von ihnen Überhand gewinnt. Eine unterschiedliche Besonderheit der Mädchen bildet außerdem die größere Beweglichkeit der Stimmung, wobei dieser Stimmungswechsel der schizoiden Mädchen sich sehr stark von der hysterischen Stimmungslabilität und von den zyklischen endogenen Stimmungsphasen unterscheidet. Dieser Stimmungswechsel erscheint bizarr und widerspruchsvoll (siehe Fall Nr. 3). Die Elemente der psychästhetischen Proportion sind bei den Mädchen noch ausgesprochener als bei den Knaben. Die beständige Kombination der Sensitivität und der emotionellen Stumpfheit — die innere Spannung bei äußerer Kälte — ist hier noch greller und ausgesprochener. Es entsteht das Bild isolierter empfindlicher Stellen auf dem Hintergrund einer allgemeinen emotionellen Abgeflachtheit. Solche besonders empfindlichen Stellen, affektiv gefärbte Komplexe, lagen in unseren Fällen im Bereiche des „Ich“-Komplexes. Alle diese Kinder sind sehr egozentrisch, streben, etwas Höheres zu sein, und erleben jede Verletzung ihres Selbstgefühls äußerst schmerzhaft. Das Vorhandensein der Ambivalenz drückt auch hier seinen Stempel auf: ein hohes Selbstgefühl, eine erhöhte Selbsteinschätzung geht bei ihnen mit dem Gefühl eigener Minderwertigkeit einher, es entsteht dadurch ein beständiges Gefühl einer inneren Spannung, das sich in unverständlich erscheinenden Launen und Albernheiten entlädt.

Die beschriebenen Eigentümlichkeiten haben wir auch bei schizoiden Knaben beobachtet, bei letzteren erreichen sie aber nie einen so starken Grad. Das Vorherrschen der affektiven Störungen im Bilde schizoider Psychopathien bei den Mädchen findet vielleicht in den spezifischen Besonderheiten der weiblichen Psyche — in der größeren emotionellen Erregbarkeit und in der Vielseitigkeit der weiblichen Affektivität — seine Erklärung.

Daß die Frauen in ihrer Mehrzahl eindrucksfähiger und an emotionellem Erleben reicher erscheinen, ist ja eine Tatsache, die niemand bestreitet. Die Gesamtstimmung spielt bei den Frauen eine entscheidendere Rolle. Die Gefühle beeinflussen bei ihnen die Handlungen und das Denken in hohem Maße; das Gedächtnis, die Aufmerksamkeit und die Urteilsfähigkeit sind bei dem Weibe ebenfalls intensiver affektiv gefärbt. Auch die Beweglichkeit der Stimmung ist bei den Frauen eine viel höhere als bei den Männern.

2. Die Besonderheiten des schizoiden Denkens sind bei den Mädchen weniger scharf ausgesprochen. Wir beobachteten solche schizoiden Symptome wie einen ausgesprochenen Automatismus des Denkens (Fälle 1, 2, 3), manchmal eine wenig plastische, etwas gehemmte Psyche und einen gewissen Autismus des Denkens, welcher sich in der Entfremdung von der realen Welt äußerte (Abschwächung des Gefühls der realen Wirklichkeit). Die Neigung zum Abstrakten, schematischen und formellen Denken, welche für die schizoiden Knaben charakteristisch ist, beobachtet man dagegen bei den Mädchen viel seltener (wir sahen sie nur in einem Falle).

Es ist möglich, daß auch diese Beobachtung keine zufällige ist und ebenfalls durch die spezifischen Eigentümlichkeiten der weiblichen Psyche erklärt werden kann. Neben einer größeren Emotivität der Frau ist ihr Denken viel greller, gefühlsmäßiger und bildhafter; dies erschwert die Operationen, bei denen die Abstraktion erforderlich ist. Das Weib empfindet die Welt in konkreten Bildern und ist zu dem Abstrakten und Schematischen weniger befähigt.

3. Das Symptom der autistischen Einstellung ist für beide Geschlechter gleich charakteristisch. In drei beschriebenen Fällen handelte es sich um einen scharf ausgesprochenen Autismus, in zwei anderen um geringe oder elektive Geselligkeit. Alle diese Mädchen erscheinen verschlossen, verschwiegen, we-

nig zugänglich. Alle waren von früher Kindheit an „einsam“ und sprechen selbst davon. „Ich hatte niemals Freundinnen, Vertraulichkeit habe ich ungern.“ (Fall 4.) „Ich habe niemand lieb, und ich hasse niemanden, alle sind mir gleichgültig.“ (Fall 5.) „Alle Mädchen sind mir unangenehm, ich liebe niemand.“ (Fall 2.) „Ich habe nur eine einzige Freundin, außer ihr habe ich niemanden lieb.“ (Fall 1.) Der Stempel der Ambivalenz liegt auch auf ihrem Verhalten zu der Umwelt, ihre emotionalen Verhältnisse werden oft ganz plötzlich abgebrochen, ihre Gefühle sind oft ihrem Wesen nach widerspruchsvoll — sie lieben und hassen gleichzeitig (Fälle 1, 2, 3, 5).

Im Kindermilieu stehen sie abseits, manchmal erwecken sie feindseliges Verhalten (Fälle 1, 3, 5), manchmal sind sie einfach unauffällig. Es existiert eine Ansicht, nach welcher diese autistische Einstellung der Schizoiden sich durch ihre motorische Unzulänglichkeit erklärt: die Ungewandtheit ihrer Bewegungen macht sie ängstlich und schüchtern, zwingt sie, den Verkehr mit den Menschen zu meiden. So schreibt z. B. *Oetli*, daß die krankhaften Veränderungen der Motorik (insbesondere auf dem Gebiete der Ausdrucksbewegungen) die Einstellung der sozialen Gefühle beeinflussen. Die schizophreneren Kranken mit motorischen Störungen werden menschenscheu, ziehen sich allmählich immer mehr zurück und empfinden die Außenwelt als etwas Feindseliges. Dem Autor kann hier vieles entgegnet werden: die Postenzephalitiker mit motorischen Störungen z. B. zeigen keine autistische Einstellung.

Bei schizoiden Psychopathien, wo die motorische Unzulänglichkeit eine angeborene ist, könnte sie dagegen für die soziale Einstellung eine größere Bedeutung haben; aber auch hier ist die motorische Störung kein erschöpfender Faktor.

4. Das nächste Symptom — die motorische Unzulänglichkeit — beobachteten wir in allen unseren Fällen. Die motorische Störung äußert sich in der Form einer allgemeinen Eckigkeit und Plumpheit der Bewegungen bei genügender Muskelkraft und guter Handfertigkeit. In drei Fällen hatten wir außerdem eine motorische Unruhe, viele überflüssige Bewegungen, Synkinesien. Bei der Zusammenstellung dieser Beobachtungen mit denen des vorigen Jahres (bei Knaben) kann gesagt werden, daß bei den Knaben die motorische Unzulänglichkeit schärfer ausgesprochen ist. Nach der Skala von Dr. *Oseretzky* beträgt die mittlere Zurückgebliebenheit der schizo-

iden Knaben = 2 bis 3 Jahre; die Mädchen ergaben meist ihr eigenes Alter (in einem Falle + zwei Jahre). Weiter hatten wir bei den Knaben eine krasse Zurückgebliebenheit in Handarbeiten, Körperkultur, Unfähigkeit zum Zeichnen, Schreiben usw. beobachtet, während wir bei den Mädchen in dreien unserer Fälle gute Fähigkeit für Turnen und Handarbeit gefunden haben.

Auch auf dem Gebiete der Ausdrucksbewegungen, der Mimik, Stimme und Sprache finden wir bei den Mädchen keine so ausgesprochenen Störungen wie bei den schizoiden Knaben. Es kann sein, daß diese Überlegenheit der Mädchen auf dem Gebiete der Ausdrucksbewegungen ebenfalls auf Rechnung der spezifischen Geschlechtsbesonderheiten gesetzt werden kann. (Es muß hier außerdem hinzugefügt werden, daß auch die anderen mit der Motorik verbundenen Störungen — verschiedene Sprachstörungen, Enuresis, Linkshändigkeit — bei den Mädchen seltener als bei den Knaben verzeichnet werden.)

Was die somatischen Besonderheiten und den Körperbau anbetrifft, so nähern sich hier unsere Feststellungen demjenigen, was wir bei den Knaben gefunden haben¹⁾. Nach den Körperbautypen verteilen sich unsere Fälle folgendermaßen: Athletische — 1, Asthenische — 2, Asthenisch-Dysplastische — 2 (es muß bemerkt werden, daß alle unsere Fälle dem Pubertätsalter angehören, bei denen in der Norm die asthenischen und die dysplastischen Typen vorherrschen, was unsere letzten Angaben wenig demonstrativ erscheinen läßt).

Was die Symptome anbetrifft, die wir als akzessorische beschrieben haben, so beobachteten wir in zwei Fällen das psychasthenische Syndrom und in drei Fällen Symptome, die den paranoiden nahe waren: eine mißtrauische Einstellung zu der Umgebung, mürrischen, grämlichen Tonfall, eine unrichtige Deutung des Verhaltens der Umgebung ihnen gegenüber: überall sehen sie Beleidigungen und Ungerechtigkeiten. Daneben besteht bei ihnen ein eigenartiges starres Gerechtigkeitsgefühl, das mit einer Neigung, überall Bedrückte zu sehen, die sie beschützen müssen, verbunden ist — eine pedantische Prinzipienreiterei. Die *psychomotorischen* Störungen (Neigungen zu Stereotypen und läppischem Wesen, Impulsivität) sahen

¹⁾ Es ist hier zu bemerken, daß Körperbautypen bei Mädchen noch weniger scharf ausgesprochen sind als bei den Knaben.

wir auch bei Mädchen, wenn auch in einer weniger scharf ausgesprochenen Form als bei Knaben. Die *negativischen Symptome* konnten bei den Mädchen häufiger als bei den Knaben beobachtet werden. Negativismus häufig mit hysteroidem Einschlag, maniriertes Wesen, ein Bestreben, beachtet zu werden. Läßt man sie unbeachtet, so verschwinden die negativischen Erscheinungen sehr bald.

Wir müssen außerdem bemerken, daß ein gewisser hysteroider Einschlag bei den schizoiden Mädchen stets zu finden ist; ihre Überspanntheit, ihre Launenhaftigkeit und Seltsamkeit machen anfänglich stets den Eindruck des Hysterischen.

Bei der *differenziellen Diagnose* der schizoiden Psychopathien bei den Mädchen muß deswegen stets mit Hysterie angefangen werden. Folgende Eigentümlichkeiten sprechen in unseren Fällen für schizoide Psychopathie und gegen Hysterie: 1. Autistische Einstellung; alle diese Mädchen sind von ihrer Kindheit an einsam, wenig gesellig, verschlossen, während die Hysteriker zumeist die Gesellschaft, wo sie sich produzieren können, sehr lieben. 2. In unseren Fällen fehlt die charakteristische, reaktive Labilität und Suggestibilität der Hysterischen; unsere Mädchen sind viel selbständiger, viel fester in ihren Absichten, sie sind schwer beeinflussbar, da ihnen die dazu erforderliche emotionelle Empfänglichkeit abgeht. 3. Die für die Hysteriker charakteristische lebhaft, grelle Affektivität war in unseren Fällen nicht vorhanden. Bei aller Seltsamkeit der emotionellen Kombinationen, welche unseren schizoiden Mädchen eigentümlich ist, zeichnen sie sich alle durch eine gewisse Kälte aus; es ist deswegen schwierig, einen emotionellen Kontakt mit ihnen herzustellen. 4. Gegen Hysterie spricht zuletzt das Fehlen der somatischen Stigmen dieser Krankheitsform (Sensibilitätsstörungen, Anfälle usw.).

Wie alle Fälle schizoider Psychopathien müssen auch unsere Fälle erstens mit *Schizophrenie* und zweitens mit den *Pubertätsveränderungen* der Psyche differenziert werden. Die Abgrenzung kann hier nur auf Grund der Beobachtung und der Anamnese erfolgen; mit der psychopathologischen Analyse des Status praesens können wir hier nicht auskommen.

Die Schizophrenie läßt sich in unseren Fällen ausschließen, da die Progrediens fehlt: den anamnestischen Angaben zufolge bestehen die schizoiden Symptome von der Kindheit an und zeigen keine Tendenz zur Verschlimmerung. Der Verlauf ist

in unseren Fällen ein durchaus günstiger, was ebenfalls für die Schizophrenie nicht charakteristisch ist (in drei Fällen von den beschriebenen haben wir im Laufe der Jahre eine bedeutende Besserung gesehen). Dieselben Angaben sprechen gegen die Möglichkeit, die Erklärung des ganzen klinischen Bildes nur in den Pubertätsveränderungen der Psyche sehen zu wollen. Alle diese seelischen Eigentümlichkeiten existierten in unseren Fällen schon von der Kindheit an und erlitten in einigen Fällen in der Pubertät nur eine Zuspitzung (Fälle 4 und 5).

Nicht weniger wichtig erscheint die Abgrenzung unserer Fälle von den schizoiden Reaktionen exogenen Ursprungs (welche unter dem Einflusse psychogener Momente, Hirnerkrankungen, Narkotika, chronischer Infektionen, wie Tuberkulose u. a. entstehen).

Den Einfluß irgendeines exogenen Faktors (seelische Traumata, Tuberkulose usw.) konnten wir in keinem unserer Fälle ausschließen, aber in keinem dieser Fälle würde dieser exogene Faktor das ganze Bild der schizoiden Psychopathie restlos erklären können. Die beschriebenen Besonderheiten zeigen sich alle so früh, erscheinen so hartnäckig und während des ganzen Lebens des Kindes so wenig veränderlich, daß sie eher zu den konstitutionellen Besonderheiten des Kindes gerechnet werden können. In der letzten Zeit erschienen Arbeiten, in welchen die schizoiden Psychopathien, als Exogenien als psychische Reaktionen auf tuberkulöse Intoxikation betrachtet werden. Bei der Durchsicht eines größeren Kindermaterials leuchtet die Unrichtigkeit eines derartigen Standpunktes sofort ein. Fälle schizoider Psychopathien sind im Kindesalter ziemlich selten, während die Erscheinungen der tuberkulösen Intoxikation die große Mehrzahl der kindlichen Bevölkerung umfassen. Die Entstehung eines derartigen Standpunktes läßt sich durch terminologische Unklarheiten erklären: bei der Anwendung des Terminus „Schizoid“ im weiten Sinne gibt jede neurotische Manifestation des Kindes, jede Neigung zur Intra-version schon das Recht auf die Diagnose der „Schizoidie“.

In der Literatur finden wir keine Angaben über die Besonderheiten der weiblichen Psyche bei verschiedenen konstitutionellen Typen. *Kretschmer*, *Bleuler* u. a., die auf diesem Gebiete gearbeitet haben, halten hauptsächlich die männliche Psyche im Auge. Eine gewisse Bestätigung unserer Beobach-

tungen fanden wir bei *Kraepelin*: in seiner Beschreibung der präpsychotischen Persönlichkeit der Schizophrenen.

Er bemerkt, daß die Mädchen folgende präpsychotischen Besonderheiten (zum Unterschiede von den Knaben) zeigen: erhöhte Empfindlichkeit, Überspanntheit, Nervosität, Eigensinn. Dieselben präpsychotischen Eigentümlichkeiten findet an seinem Material (103 Schizophreniefälle) auch *Voigt. Schultze* schreibt ebenfalls über die erhöhte Eindrucksfähigkeit und Launenhaftigkeit der Frauen, die später an Schizophrenie erkrankt waren.

Bevor wir die Zusammenfassung unserer Beobachtungen geben, sei noch auf die folgende Tatsache aufmerksam gemacht: das Gesamtbild der schizoiden Psychopathien ist bei den Mädchen blasser als bei den Knaben, die schizoiden Besonderheiten der Mädchen erscheinen weniger hervortretend. Auch scheint der Prozentsatz der schizoiden Psychopathien bei den Mädchen (wenn wir unserem wenig umfangreichen Material Glauben schenken wollen) geringer zu sein als bei den Knaben. Diese Beobachtungen bestätigen die Ansicht *Bleulers*, welcher die schizoiden Züge als vorwiegend männliche betrachtet. Seiner Ansicht nach sind die Frauen viel syntonier; ausgesprochene schizoide Züge sprechen für einen männlichen Charakter und sind für die Frauen imponierend.

Dieses sind die unterschiedlichen Besonderheiten der schizoiden Psychopathien, welche wir bei den Mädchen verzeichnen konnten.

Zusammenfassend läßt sich das Wesentliche in folgenden Sätzen formulieren:

1. Das klinische Bild der schizoiden Psychopathien bei den Mädchen fällt in seinen Hauptzügen mit dem bei schizoiden Knaben beschriebenen zusammen. Wie dort, so handelt es sich auch hier um eine ungenügende Einheitlichkeit und Folgerichtigkeit der psychischen Mechanismen, wodurch äußerlich eine Ähnlichkeit mit der schizophrenen Zerfahrenheit entsteht.

Die differentiellen Besonderheiten der schizoiden Psychopathien der Mädchen bestehen in folgendem: a) Im klinischen Bilde treten die affektiven Störungen in den Vordergrund: Ambivalenz der Gefühle, das Inadäquate der affektiven Reaktionen, das Vorhandensein komplizierter und sich widersprechender emotioneller Kombinationen (diese Besonderheiten

finden in der stärkeren und beweglicheren Affektivität der weiblichen Psyche ihre Erklärung). b) Der schizoide Charakter des Denkens ist bei den Mädchen weniger scharf ausgesprochen; die Neigung zum abstrakten, schematischen Denken und absurden Grübeln findet sich bei ihnen seltener. Auch diese Besonderheiten lassen sich durch die spezifischen Eigentümlichkeiten des weiblichen Denkens erklären: Es ist bildhafter, praktischer und stärker affektiv gefärbt, c) die Erscheinungen der motorischen Unzulänglichkeit (insbesondere auf dem Gebiete der Ausdrucksbewegungen: Mimik, Stimme, Sprache) sind bei den Mädchen weniger stark ausgesprochen. d) Der Negativismus ließ sich bei den Mädchen häufiger und stets mit einem hysteroiden Einschlag beobachten, e) die hysterischen Symptome sind bei den schizoiden Mädchen viel häufiger als bei den Knaben, weswegen die schizoiden Psychoopathien bei den Mädchen am häufigsten mit Hysterien verwechselt werden.

- c. "Grouping of Psychiatric Disorders", Soviet classification translated by Nancy Rollins based on material by G. E. Sukhareva

Appendix III

Grouping of Psychiatric Disorders

(After G. E. Sukhareva, *Clinical Lectures in Child Psychiatry*.)

VOLUME I, MAJOR PSYCHIATRY

I. Symptomatic psychoses: infectious or postinfectious

- A. Malaria
- B. Virus grippe
- C. Diphtheria
- D. Measles
- E. Scarlet fever
- F. Enteritis
- G. Typhoid, paratyphoid
- H. Pneumonia

II. Acute infections of the brain and meninges

- A. Meningitis
 - 1. Serious meningitis—typhoid fever, pneumonia, grippe, parotitis, etc.
 - 2. Tuberculous meningitis
- B. Encephalitis
 - 1. Encephalitis

Grouping of
Psychiatric Disorders

- a. Poliomyelitis
- b. Japanese form
- c. Rabies
- d. Epidemic
- e. Virus
- 2. Secondary encephalitis
 - a. Infectious
 - b. Choreiform
 - c. Pertussis
- C. Atypical forms, abortive forms (virus)
- D. Residuals
 - 1. Dementia
 - 2. Epileptiform seizures
 - 3. Psychopathic-like syndromes
 - 4. Cerebrasthenia

III. "Rheumatism" of the central nervous system

- A. Rheumatic cerebrasthenia
- B. Epileptic seizures
- C. Rheumatic cerebropathia with dementia
- D. Rheumatic psychoses
 - 1. Depressive form
 - 2. Oneiroid form
- E. Neurotic-like syndromes
- F. Rheumatic chorea

IV. Syphilis of central nervous system

- A. Congenital central nervous system syphilis
 - 1. Progressive form
 - a. Pseudoparesis
 - b. Epileptiform
 - c. Apoplectiform (vascular)
 - d. Meningoencephalitis
 - 2. Stationary form
- B. Juvenile progressive paresis

V. Brain trauma

- A. Psychic disturbances accompanying acute brain trauma
 - 1. Open trauma
 - 2. Closed trauma
- B. Residual encephalopathy after brain trauma
 - 1. Traumatic cerebrasthenia

Appendix III

2. Motor disturbances
 - a. Apathy, underactivity syndrome
 - b. Hyperkinetic syndrome
3. Psychopathic-like behavior
4. Traumatic intellectual defects
 - a. Disturbances of memory, attention
 - b. Aphasia, other speech disturbances
5. Traumatic epilepsy

VI. Epilepsy

- A. True epilepsy (endogenous)
Hereditary predisposition
- B. Symptomatic (exogenous)
 1. Traumatic
 2. Syphilitic
 3. Associated with encephalitis, meningitis
 4. Rheumatic
- C. Epileptic illness caused by brain damage (mixed)
with characteristic features of "true epilepsy"

VII. Schizophrenia

- A. Forms
 1. Childhood form
 2. Adolescent form
- B. Classification by type of onset and course
 1. Insidious, progressive
 2. Acute onset with intermittent course and no residual
 3. Mixed: intermittent with progression

VIII. Manic-Depressive Psychoses

- A. Manic form
- B. Depressive form
- C. Mixed form

IX. Periodic psychoses (nosological status still questionable)

- A. Disturbances of affect
 1. Depressive form
 2. Manic form
- B. Motor disturbances—without negativism
 1. Inhibition
 2. Excitement
- C. Sensory disturbances
- D. Disturbances of consciousness

VOLUME II, MINOR PSYCHIATRY: BORDERLINE STATES

- I. Reactive states—neuroses and psychoses
 - A. Acute shock and subshock reactions
 - 1. Fear with motor excitement
 - 2. Twilight states
 - 3. Stupor
 - 4. Monosymptomatic forms
 - a. Speech disturbances—stuttering mutism
 - b. Paralysis, paresis
 - c. Hyperkinesis
 - d. Functional disturbances of the internal organs
 - e. Sleep disturbances
 - B. Subacute psychogenic reactions
 - 1. Depression
 - 2. Paranoia
 - 3. Asthenia-neurasthenia
 - a. Increased fatigability
 - b. Increased excitability
 - 4. Anxiety neurosis
 - a. Panic state
 - b. Twilight state
 - c. Phobic state
 - 5. Hysterical neurosis
 - 6. Reaction of protest
 - a. Passive form
 - 1. Elective mutism
 - 2. Suicidal attempts
 - 3. Vegetative-somatic disturbances
 - b. Active form
 - 1. Aggressive acts
 - 2. Tantrums
 - 7. Vegetative-somatic disturbances (organ neuroses)
 - a. Psychogenic anorexia
 - b. Habitual vomiting
 - c. Enuresis, encopresis
 - d. Nervous cough
 - 8. Speech and motor disturbances—monosymptomatic neuroses
 - a. Sleep disturbances, night fears
 - b. Stuttering
 - c. Tics
 - 9. Pathological reactions at transitional growth periods
 - C. Chronic reactive states (Myasishchev: Neurosis of development)
 - 1. Obsessional neurosis
 - 2. Hypochondriacal, asthenic, and hysterical development

Appendix III

3. Distorted character formation (changes of character)
—unfavorable conditions of upbringing
 - a. Aggressive-defensive type
 - b. Passive-defensive type
 - c. Infantile type

II. Neuropathy (nervousness, nervous predisposition)

- A. Congenital
- B. Acquired

III. Psychopathy (pathological development of the personality)

- A. Infantilism: inhibitions of development
 1. Instability
 2. Excitement
 3. Hysteroid
 4. Pseudologia
- B. Disproportional (distorted) development—genetically determined
 1. Cyclothymic personality
 2. Schizoid (autistic) personality
 3. Psychasthenic personality
 4. Paranoid personality
 5. Epileptoid personality
- C. Damaged development—intrauterine or postnatal brain damage
 1. Failure of inhibitory controls
 2. Impulsive excitement

VOLUME III, OLIGOPHRENIA

I. Levels of retardation

- A. Idiot
- B. Imbecile
- C. Moron

II. Etiological grouping

- A. Endogenous—genetic
 1. Langdon-Down disease
 2. True microcephaly
 3. Enzymopathic forms with hereditary disturbances of lipid, carbohydrate, and albumen metabolism
 - a. Phenylpyruvic oligophrenia
 - b. Oligophrenia with galactosemia, sucrosuria
 - c. Other enzymopathics

Grouping of
Psychiatric Disorders

4. Oligophrenia with diseases of the bones and skin
 - a. Dysostosis
 - b. Ichthyosis
 - c. Angiomatosis
- B. Oligophrenia acquired in embryonal or fetal period
 1. Viruses: German measles, grippc, parotitis, infectious hepatitis, infectious mononucleosis
 2. Toxoplasmosis, histoplasmosis
 3. Congenital syphilis
 4. Hormonal and toxic agents
 5. Hemolytic disease of the newborn
- C. Exogenous oligophrenia—acquired by damage at birth or early in life
 1. Birth trauma and asphyxia
 2. Brain trauma in early childhood
 3. Encephalitis and meningitis in early childhood
- D. Atypical forms of oligophrenia
 1. Progressive hydrocephalus
 2. Localized defects in the development of the brain
 3. Endocrine disturbances