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ORIGINAL CONTRIBUTION

The first account of the syndrome Asperger described? Part 2: the girls

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Abstract
Translation of G. E. Sukhareva's "Die Besonderheiten der schizoiden Psychopathien bei den Mädchen", which appeared in 1927 in Monatsschrift für Psychiatrie und Neurologie as a continuation of "Die schizoiden Psychopathien", previously translated by Sula Wolff. This second paper comprises five case studies of girls and a discussion of the sex differences in the presentation of schizoid psychopathy, potentially what we would now consider part of the autism spectrum.

Keywords Asperger · Sukhareva · Autism/history · Women/girls · Translations · Schizoid/history

The first account of the syndrome Asperger described? Part 2: the girls

Translation of G. E. Sukhareva's "Die Besonderheiten der schizoiden Psychopathien bei den Mädchen"

Charlotte Simmonds.

Introductory comments

In 1996, Sula Wolff's translation of Soviet psychiatrist and neurologist G. E. Sukhareva's 1926 paper "Die schizoiden Psychopathien im Kindesalter" appeared in European Child & Adolescent Psychiatry under the query "The first account of the syndrome Asperger described?" (Walter Spiel had also equated Sukhareva's syndrome with Asperger's in 1961.) Wolff's translation has gradually been entering the popular history of autism research, with Sukhareva and Wolff becoming more widely known among lay people. However, the paper Wolff translated was merely part one of a two-part series. The second paper, containing five case studies of girls with a concluding discussion of what Sukhareva and her colleagues felt were sex differences in the way the syndrome presents, has been missed. It appeared in the same journal, Monatsschrift für Psychiatrie und Neurologie, in 1927, the year after the first paper of case studies on boys. Not only did Sukhareva describe something quite similar to the syndrome described by Asperger as autistic psychopathy 10 or 20 years later (depending on which paper of his we take as our reference point), she also described the syndrome in girls and sex differences, something which neither Asperger, nor others like Vedder, van Krevelen, and Bosch who made comparisons of Kanner's and Asperger's autisms, engaged with in much detail. Throughout the 20th century, prominent European researchers, among them van Krevelen and Asperger, were certain Asperger's syndrome presented almost exclusively in boys, with Asperger attributing female autistic traits to postencephalitic conditions, while Kanner's early infantile autism was thought to have a lower sex discrepancy. In the 21st century, more and more English-language books and articles are now appearing on "invisible" autistic women and girls, many claiming the syndrome looks different in females. The syndrome Sukhareva described also appeared in far fewer girls than boys (1959), yet she and her colleagues still felt sex differences were worth investigating.

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, were laid out by Sukhareva in 1927. Among traits not usually attributed to ASDs in the Anglosphere, Sukhareva includes extreme ambivalence and negativism. 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

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emotional cognition, Bermond's alexithymia type II. The latter is described by Sukhareva as an accessory (in German) or secondary (in Russian) symptom, one brought on by adverse life circumstances. An as yet untranslated 1930 Russian paper further outlines the prognosis and life course for such individuals, and establishes the following triad of impairments considered the core "biological insufficiency" of the syndrome: (1) psychomotor impairment—awkwardness, angular movements, bipolarity between excitation and lethargy, automatism, and 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.

Lecture 19 in Sukhareva's 1959 textbook deals further with the syndrome, explicitly renaming it autistic psychopathy, the term used by Asperger. Ironically, only the year before, van Krevelen (in Stutte) had proposed renaming Asperger's autistic psychopathy schizoid psychopathy to resolve the confusion between Kanner's and Asperger's autisms and avoid eponyms. It is also worth noting that the work of T. P. Simson, specifically her chapter "[Autistic Children (Schizoid Psychopathy Group)]" in her 1929 book [*Neuropathy, Psychopathy and Reactive Conditions in Childhood*], was affirmed as a description of autism by Leo Kanner in 1971. In 1959, Sukhareva highlights Simson as another author on the topic. While female autistic syndromes with unimpaired intelligence have only begun receiving close attention in English literature in recent years, the schizoid/autistic psychopathy diagnosis, considered synonymous in the Russophone world with Asperger syndrome or the ICD-10 category F84.5 (Mnukhin & Isaev. Goriunov, Sorokin), existed within Russian child psychiatry for most of the last century.

Autistic syndromes were repeatedly described independently till roughly the 1950s. The search for the 'first' describer is a vain enterprise, one which ignores that all new work builds on an existing body of knowledge. Yet, this translation is still a timely reminder of the crucial importance of continuing to share research across languages, borders, and political affiliations.

Translation notes and methodology

I am a professional commercial German-to-English translator with an extra qualification in medical terminology, and I am also a literary author and literary translator (my MA was in Literary Translation Studies). I am a native speaker of New Zealand English. I have Asperger syndrome (or ASD level 1) and in the course of my PhD study on the history of research into ASDs or ASD-like conditions, read almost every text remotely related to autistic or autism-like syndromes from the 1800s till around the time of Sula Wolff in multiple languages. After that, the quantity of texts becomes too great to keep on top of. I completed this translation as part of my PhD thesis under the supervision of Prof. Bart Ellenbroek, a clinical psychologist who lived and worked in Germany for 20 years. I also had extensive assistance from Dr Richard Millington, another translator and academic who works with both German and Russian. Dr Millington assisted me in comparing the English, German, and Russian texts, and identifying Russianisms in Sukhareva's German.

As I come 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. In Wolff's translation, for example, *Rock* is translated with the modern meaning skirt, rather than the older coat, making the boy in Case 1 sound far stranger and less logical than he was. The Russian here is халат, in this context, most likely a doctor's coat. My approach is more cautious than Wolff's, probably also more pedantic.

The source text is not a modern German text and was not written by a native German speaker but by a Russian who learned medicine from even older German textbooks. Modernising the language completely becomes, from a translator's perspective, contentious and fraught. 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 1926? 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 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 certainly do not want the text to be unintelligible, but it should be reflective of the original. With a text like this, I wanted to avoid imposing modern interpretations 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.

To give examples of some translation decisions, my choice of the archaic "anamnesis" over the modern "case history" might be questioned. Yet, these are not the same thing—a case history is the doctor's record, while an anamnesis is derived from patient's self-reporting and/or their relatives' reporting. Personal anamnesis is tautological—but the tautology was present in Sukhareva's German, which, again, it is my task to document and not to improve. Similarly, some readers might expect "family history" where I have "heredity". The word Sukhareva uses is *Heredität* rather than, for example, *Erblichkeit*. Heredity is not an obscure word in English, so it seemed acceptable to keep this. Sukhareva also uses *erbliche Belastung* which I have translated as "hereditary burden".

References

1. Wolff S (1996) The first account of the syndrome Asperger described? Eur Child Adolesc Psychiat 5:119–132 https://doi.org/10.1007/BF00571671.
2. Sukhareva G as Ssucharewa G (1926) Die schizoiden Psychopathien im Kindesalter. Monatsschr Psychiat Neurol 60:235–261 https://doi.org/10.1159/000190478.
3. Spiel W (1961) Die endogenen Psychosen des Kindes- und Jugendalters. Karger, Basel.
4. Spiel W (1927) Die Besonderheiten der schizoiden Psychopathien bei den Mädchen. Monatsschr Psychiat Neurol 62:171–200 https://doi.org/10.1159/000190478.
5. Asperger H (1938) Das psychisch abnorme Kind. Wien klin Wochenschr 51:1314–1317.
6. Asperger H (1938) (1944) Die „Autistischen Psychopathen" im Kindesalter. Archiv Psychiatr Nervenkrankheit 117:76–136.
7. Vedder R (1962) Kinderen met leer- en gedragsmoeilijkheden. J. B. Wolters, Groningen.
8. van Krevelen D (1962) Autismus infantum and autistic personality. Two clinical syndromes. Jap J Child Psychiat 3:135–146.
9. Bosch G (1970) Infantile Autism. Springer, Berlin.
10. Asperger H (1960) Autistisches Verhalten im Kindesalter. Jahrb Jugendpsychiatr Grenzgeb 2:53–67.
11. Bargiela S, Steward R, Mandy W (2016) The experiences of late-diagnosed women with autism spectrum conditions. J Autism Dev Disord 46:3281–3294 https://doi.org/10.1007/s10803-016-2872-8.
12. Sukhareva G. (1959) Klinicheskie lektsii po psikhiatrii detskogo vozrasta. Vol. II. Medgiz, Moscow.
13. Hill E, Berthoz S (2006) Response to ''Letter to the Editor: The Overlap Between Alexithymia and Asperger's Syndrome''. J Autism Dev Disord 36:1143–1145 https://doig.org/10.1007/s10803-006-0287-7.
14. Stutte H (1958/59) Deutsche Vereinigung für Jugendpsychiatrie e. V. Zentralbl gesamt Neurol Psychiatr 148:12–24.
15. Sukhareva G (1930) K probleme struktury i dinamiki detskikh konstitutsionnykh psikhopatiĭ (shizoidnye formy). Zh nevrol psikhiatr 6:64–74.
16. Simson T (1929) Nevropatii, psikhopatii i reaktivnye sostoianiia mladencheskogo vozrasta. Medgiz, Moscow.
17. Kanner L (1971) Abstracts Soviet Serials J Autism Dev Disord 1:106–114 https://doi.org/10.1007/BF01537748.
18. Mnukhin S, Isaev D (1975) On the organic nature of some forms of schizoid or autistic psychopathy. J Autism Dev Disord 5:99–108 https://doi.org/10.1007/BF01537927.
19. Goriunov A (2012) G.E. Sukhareva: zhiznennyĭ put′ i nauchno-pedagogicheskoe nasledie (k 125-letiiu so dnia rozhdeniia). Zh nevrol psikhiatr 112:67–71.
20. Sorokin A (2015) Russia and Autism. Encyclopedia of Autism Spectrum Disorders. Springer, New York. https://doi.org/10.1007/978-1-4614-6435-8_102022-3.

Translation

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The Particular Features of Schizoid Psychopathies in Girls

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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). Symptomatologically, 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 20–25, 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 3 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 *out*number 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 (2–4 years) and which appear diagnostically explained.

Case 1

P. L, born 1913. Heredity. *Father*, 45 years old, Russian. Lively, active person. Very nervous, violent. Paternal introverted, reticent 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 2, 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 4, she lived in Finland in good economic conditions, had enough care and shelter. At age 4, 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 5, she entered a kindergarten where she was considered a talented girl with "strong individuality". After 1 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 9, 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 9 years of age. She went to school for 2 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—4,620,000, 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 gives a negativistic response;—"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 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

I. 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 6-year-old girl was taken to a children's home where she spent 1 year before being placed in another; at the age of 10, 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 2 years; no kind of noticeable 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 dermatographism; 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 6 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 9, 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 2-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 inhibitedness 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 years 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 years 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 5; showed talent for music early on: (ability to improvise). At the same time, a marked absentmindedness 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 7, she lived in good economic conditions. Her parents were gentle and tender towards her. At the age of 6, the girl was sent to a kindergarten where she was only able to stay for 2 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 7, 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 7–10 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 10, 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 2 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 2 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 + 2 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 15 years old (+ 1½ 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 7, 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 War,[1] 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

[1] Translator's note: Russo-Japanese War, 8 February 1904-5 September 1905.

was normal. Survived measles and a lung infection. She was raised by her grandmother for the first 3 years, later by her parents. The economic conditions were satisfactory until the death of the father (he died when the girl was 6 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 6, was a bright girl, read a lot. At the age of nine, she went to school and performed well. When the girl was 10 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, and 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 that 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: + 1 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 1–2 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 10–13. 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. basic symptoms that form the characteristics of the psyche of schizoid psychopaths, and 2. accessory symptoms that appear frequently but not always.

We count among the basic symptoms: 1. the autistic attitude, 2. the ambivalence of the thymopsyche, 3. the idiosyncratic thought processes: tendency towards the abstract and formal; automatism, and 4. symptoms of motor skill deficiency: angularity, clumsy movements. Among the accessory 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 that 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 simul-

taneously 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, and 5), and 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, synkin-

eses. 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 = 2–3 years; the girls usually resulted in their own age (+ 2 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 boys.[2] 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 do not demonstratively show).

As far as the symptoms we have termed secondary 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) 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, and 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 jitteriness, moodiness, and oddness always give the initial impression of hysteria.

[2] It must be noted here that body types are less strongly pronounced in girls than in boys.

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 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 "schizoidy".

We find no details in the literature on the particular features of the female psyche for different constitutional types. Kretschmer, 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 syntonic; 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.

Compliance with ethical standards

Conflict of interest On behalf of all authors, the corresponding author states that there is no conflict of interest.