

THE UNIVERSITY OF CHICAGO

SCIENTIFIC PSYCHIATRY IN STALIN'S SOVIET UNION:  
THE POLITICS OF MODERN MEDICINE AND THE  
STRUGGLE TO DEFINE 'PAVLOVIAN' PSYCHIATRY, 1939-1953

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## INTRODUCTION

In 1937 Aubrey Lewis, a rising star in British psychiatry, went on tour of all the major psychiatric institutions in Europe, including those in Moscow and Leningrad.<sup>1</sup> Having read Soviet claims about the creation of a new society, Lewis expected to find something unique. “I had supposed I might find in Soviet psychiatry great license of speculation and experiment, original points of view, and enormous development of the social side of the subject,” he wrote. Instead he found that “the work was mostly along familiar lines.”<sup>2</sup> Probably Lewis should not have been so surprised. After all, virtually every professor of psychiatry and every director of a psychiatric institute in Moscow and Leningrad had spent time studying in Germany and France, most of them before the Bolshevik Revolution. Throughout the 1920s they had continued to engage in many of the same debates and polemics as their western colleagues. Even in the isolationist 1930s, the main Soviet psychiatric journal continued to publish abstracts of new

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<sup>1</sup> Lewis went on to become director of the famous Maudsley Hospital. In this position, according to Edgar Jones, Lewis was “the most influential post-war psychiatrist in the UK,” and “exercised a profound influence on clinical practice, training and academic research.” Edgar Jones, “Aubrey Lewis, Edward Mapother and the Maudsley, in *European Psychiatry on the Eve of War: Aubrey Lewis, the Maudsley Hospital and the Rockefeller Foundation in the 1930s*, Katherine Angel, Edgar Jones, and Michael Neve, eds., Medical History, Supplement no. 22 (London: The Wellcome Trust Centre for the History of Medicine, 2003), 3.

<sup>2</sup> Katherine Angel, Edgar Jones, and Michael Neve, eds., *European Psychiatry on the Eve of War: Aubrey Lewis, the Maudsley Hospital and the Rockefeller Foundation in the 1930s*, Medical History, Supplement no. 22 (London: The Wellcome Trust Centre for the History of Medicine, 2003), 129.



Western research.<sup>3</sup> Soviet psychiatrists may have become cut off from their peers, but they were still recognizably part of the continental tradition of European psychiatry.

Still, Lewis was not alone in his assumption that Soviet psychiatry would be different from psychiatry in the West. Soviet psychiatrists themselves assumed that psychiatry in the USSR would be different from psychiatry in the West: more humane, profoundly materialist, daringly experimental, and focused on the interaction between society and the individual. Without the corrupting and distorting influence of capitalism, it was thought, psychiatrists would be free to develop a better and more truly scientific approach to psychiatric medicine. The need for a distinctly Soviet psychiatry only increased in significance as time went on, in part because of the significance that Bolshevik leaders placed on “consciousness” in class conflict. It was understandable that the bad social environment under tsarist rule would produce disturbed psyches, but why then did mental illness and socially harmful behavior continue under socialism? What psychiatrists were doing, they claimed, was providing the Soviet state with the scientific tools that could identify people who had not adjusted to socialist conditions and with the tools for curing them or isolating them from the rest of society. As one prominent Moscow psychiatrist summarized this achievement in an essay written for the fifteenth anniversary of the revolution: “By shifting the center of attention to... to that which is external [as opposed to

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<sup>3</sup> The two Soviet journals of psychiatry and neurology that continued to publish in the 1930s regularly featured reviews of foreign literature. *Nevropatologiia i psikhiiatriia* featured a section called “*Retsentsii*” (Reviews) and *Sovetskaia psikhonevrologiia* included a section called Referaty” (Abstracts). Both were primarily devoted to abstracts of foreign monographs and articles published in foreign periodicals. Edited volumes were also a venue where information about European psychiatry could be published. In 1934, for instance, Nikolai Brukhanskii added a 65 page long digest of the third edition of Karl Jasper’s landmark two-volume work, *General Psychopathology* to an edited volume of papers on schizophrenia. N. P. Brukhanskii, “Referaty: Iaspers Karl, Obshchaia psikhopatologiia Allgemeine Psychopathologie, 3-e izd. Berlin 1923 g.,” in *Skhizofrenii*, ed. N. P. Brukhanskii (Smolensk: Smolenskii meditsinskii institut, 1934), 205-269.

hereditary],” he wrote, “the [psychiatrists’] relationship to treatment has been completely changed, filled with a healthy optimism.”<sup>4</sup>

In 1936, however, Soviet psychiatrists were dealt a harsh rebuke by Soviet authorities. Some of the country’s leading psychiatrists had been criticized by authorities going back to 1931 for publishing studies that suggested that long hours and hard working conditions could lead to neurosis.<sup>5</sup> Then in 1936 the Party’s Central Committee banned the use of psychological testing in education and industry. This ban on “pedology” and “psychotechnics” did not mention psychiatry by name, but it did condemn “the so-called ‘scientific’ bio-sociological point of view.”<sup>6</sup> Biomedical scientists, in short, were warned away from claiming special expertise in detecting and treating social problems.

This called into question the main body of work being done by the USSR’s leading psychiatrists. From 1927-1935, psychiatric policy in the USSR was overseen by The Institute of Neuropsychiatric Prophylaxis, the brainchild of a psychiatrist named Lev Rozenshtein.<sup>7</sup> Under socialism, Rozenshtein believed, psychiatrists could come to play an important role in helping create a harmonious society. Instead of working behind the walls of giant asylums, his

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<sup>4</sup> V. A. Giliarovskii, "Dostizheniia sovetskoi psikhatrii za poslednie 15 let i ee blizhaishie perspektivy," *Sovetskaia nevropatologiiia, psikhatriia i psikhogigiiena* 2, no. 1 (1933): 10.

<sup>5</sup> "Ot redaktsii," *Zhurnal nevropatologii i psikhatrii*, no. 1 (1931): 3.

<sup>6</sup> "O pedologicheskikh izvrashcheniiaakh v sisteme narkomprosov (4 iulia 1936 goda)," in *KPSS v rezoliutsiakh i resheniakh s'ezdov, konferentsii i plenumov TsK*, vol. 6 (Moscow: Politizdat, 1985), 364-367. Translated as "On Pedological Distortions in the Commissariats of Education. A Resolution of the Central Committee of the Communist Party of the Soviet Union July 4, 1936," in Joseph Wortis, *Soviet Psychiatry*, (Baltimore: Williams & Wilkins, 1950), 242-245.

<sup>7</sup> The Institute of Neuropsychiatric Prophylaxis officially became the “leading” institute for psychiatric policy within Narkomzdrav RSFSR in 1930. In addition to heading the institute, Rozenshtein chaired Narkomzdrav RSFSR’s “committee on the reconstruction of psychiatry” and was the director of the psychiatry department at the Central Institute for Advanced Medical Training (Ts. Institut usov. vrachei). *Zhurnal nevropatologii i psikhatrii*, no. 1 (1931): 147; L. Rozenshtein and G. Karanovich to M. F. Vladimirkii (NKZ RSFSR), “O rekonstruktsii nevro-psikhiatricheskogo dela v RSFSR,” (undated, 1931), GARF f. a-482, op. 24, d. 3, l. 304; Savenko, "120-letie L'va Markovicha Rozenshteina (1884-1934)."

psychiatrists were to be stationed in small neuropsychiatric dispensaries spread throughout the country. These institutions would do detailed surveys of local housing, working conditions, and schools and assess the “neuro-psychic health” of the population. They would be given broad authority to “participate in changing the very conditions of and daily life [byt’] of the dispensarized population.” They would use scientific knowledge of how healthy minds were created to examine the conditions of everyday life, and they would intervene to improve people’s “family situation,” diet, and profession, to council juvenile delinquents, to screen the mental state of criminals, and to rationalize industrial labor. They would prescribe psychotherapy or even hospitalization for disturbed citizens.<sup>8</sup> Psychiatrists, in short, would cease to be “psychiatrists” in the old sense and become experts in “mental hygiene.”<sup>9</sup> At an international conference on mental hygiene in 1930, Rozenshtein declared that “The whole mental-hygiene movement in Russia has

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<sup>8</sup> L. M. Rozenshtein, "O nevro-psikhiatricheskoi dispanserizatsii," in *Sovetskaia meditsina v bor'be za zdorovyie nery: Trudy I vsesoiuznogo soveshchaniia po psikhiatrii i nevrologii i gosudarstvennogo nevro-psikhiatricheskogo dispansera*, ed. A. I. Miskinov, L. A. Prozorov and L. M. Rozenshtein (Samara: Izd. Ul'ianovskogo kombinata PPP, 1926), 23-24, 31.

<sup>9</sup> The Russian mental hygiene movement was clearly rooted in the broader social medicine movement in Russia in the 1920s and, prior to that, in the community medicine movement that was developed by *zemstvo* physicians beginning in the 1880s. It also had clear similarities to the social prophylaxis movement that had been prominent in German psychiatry in the 1890s. In his own work, however, Rozenshtein made very clear that he intended “psikhogigiena” to be a direct translation of the American term “mental hygiene.” On a 1913 trip to England, Rozenshtein had seen a talk given by Swiss-American psychiatrists Adolf Meyer, one of the leading proponents of mental hygiene in America. It was after his return from this trip that Rozenshtein began to adapt Meyer’s ideas to the Russian context. Irina Sirotkina, *Diagnosing Literary Genius: A Cultural History of Psychiatry in Russia, 1880-1930* (Baltimore and London: Johns Hopkins University Press, 2002), 152-153; idem., Irina Sirotkina, "Psikhopatologiya i politika: Stanovlenie iedei i praktiki psikhogigieny v Rossii," *Voprosy istorii estestvoznaniia i tekhniki*, no. 1 (2000): 154-177. On Adolf Meyer and mental hygiene see Jack D. Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge: Cambridge University Press, 1998), chapter 1; and Hans Pols, “Managing the Mind: The Culture of American Mental Hygiene, 1910-1950” (Ph.D. diss., University of Pennsylvania, 1997). On social-prophylaxis in German psychiatry, see Eric J. Engstrom, *Clinical Psychiatry in Imperial Germany: A History of Psychiatric Practice* (Ithaca: Cornell University Press, 2003), ch 7.

completely revolutionized the concept of psychiatry in the direction of medical, biological, and social-hygiene discipline.”<sup>10</sup>

In light of the Party’s ban on the so-called ‘scientific’ bio-sociological point of view, Rozenshtein’s approach was repudiated and declared unscientific and positively harmful. At an important congress in December 1936, the Chairman of the All-Union Society of Neuropathologists and Psychiatrists declared that psychiatrists were to stop using “simplistic tests and forms” to make their diagnoses and to abandon approaches that blurred the lines between mental health and madness. They should treat major psychoses like schizophrenia as distinct diseases, not as extreme examples of “inadequate reaction to stimuli.” Psychiatrists’ proper role was to treat severely ill patients in a medical setting, not to search out soviet citizens who were having trouble adjusting to the demands of citizenship in the socialist utopia.<sup>11</sup> Speaking at the opening session of the congress, the USSR Commissar of Public Health called psychiatry “the most backward area [of public health]” and described 1936 as a “critical moment” for the discipline.<sup>12</sup>

These high-profile interventions into psychiatry, psychology, and related fields in 1936 were followed up in 1937 by further demonstrations of the consequences of crossing ideological lines. Rozenshtein himself had died of natural causes in 1934, but his wife and daughter were arrested by the NKVD in 1937. Another leading proponent of phenomenology in psychiatry,

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<sup>10</sup> L. M. Rozenshtein, "The Development of Mental Hygiene in the Soviet Union as a Public-Health Measure," in *Proceedings of the First International Congress on Mental Hygiene*, vol. 1, ed. Frankwood E. Williams (New York: International Committee for Mental Hygiene, 1932), 148.

<sup>11</sup> M. B. Krol’, “Zakliuchitel’naia rech’,” in *Trudy 2-go vsesoiuznogo s"ezda nevropatologov i psikhiatrov. 25-29 dekabria 1936 g.*, vol. 1, ed. M. B. Krol' and A. O. Edel'shtein (Moscow: 1937), 691-692.

<sup>12</sup> G. Kaminskii (Narkom Zdrav. SSSR), in "Stenogramma s"ezda psikhiatrov i nevropatologov,” 25 December 1936, GARF, f. r-8009, op. 1, d. 47, l. 17.

Nikolai Brukhanskii, was arrested and shot.<sup>13</sup> The phrase “mental hygiene” was dropped from the title of the field’s primary journal: *Neuropathology, Psychiatry, and Mental Hygiene*, was renamed simply “*Neuropathology and Psychiatry*.”<sup>14</sup> And the Institute of Neuropsychiatric Prophylaxis was completely reorganized, given a new name, a new director and deputy director, and a new charter. In its new incarnation as “The RSFSR Central Institute of Psychiatry” it was tasked with refocusing Soviet psychiatry on major psychoses and diseases of the central nervous system. Instead of diagnosing schizophrenia everywhere they looked, psychiatrists were to focus on a core population of patients who were clearly suffering from full-blown psychosis.<sup>15</sup>

Psychiatrists were on notice. They needed to reconsider the institutional scope of their discipline, the proper object of analysis of their science, and their *bona fides* as good dialectical-materialist scientists.

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<sup>13</sup> Iu. S. Savenko, "'1937' 70-letie bol'shogo terrora i psikhiiatriia," *Nezavisimyi psikhiatricheskii zhurnal*, no. 3 (2007). I strongly suspect that Rozenshtein's successor at the Institute of Neuropsychiatric Prophylaxis was also arrested in 1937. Vol'f Abramovich Vnukov had been among the activist psychiatrists who took over the Moscow Society of Neuropathologists and Psychiatrists in 1930, and he became an editor of the society's journal in 1931. In 1933 he succeeded his mentor, Pavel Gannushkin, as chairman of the psychiatry department at 1 MMI, and in 1934 he became the director of the Institute of Neuropsychiatric Prophylaxis. Vnukov's fate is unclear: no obituary or profile was published then or later in *Nevropatologii i psikhiiatriia*, and Vnukov does not appear in Iudin's 1951 *Ocherki istorii otechestvennoi psikhiiatrii*. It seems probable that Vnukov was arrested in the terror in 1937. The Memorial Society does not list him among the Muscovites who were shot during the terror, but six other people who lived in his central Moscow apartment building at No. 22 *Skaternyi pereulok* were shot. "Moskovskoe obshchestvo nevropatologov i psikhiiatrov im. Kozhevnikova pri 1 MGU: Reorganizatsiia obshchestva," *Zhurnal nevropatologii i psikhiiatrii*, no. 3 (1930): 103; M. Rozentsveig, "Itogi rabot patologo-klinicheskoi sektiis 1 Vsesiounzno go povedencheskogo s"ezda," *Zhurnal nevropatologii i psikhiiatrii* 23, no. 5 (1930): 13; M.O. Gurevich, in *Trudy pervogo ukrainskogo s"ezda nevropatologov i psikhiiatrov*, ed. L. L. Rokhlin and O. I. Vol'fovskii (Khar'kov: Ukrainskaia psikhonevrologichesaia akademiia, 1935), 558; *Nauchnye rabotniki Moskvyy*, ed. V. P. Volgina, S. F. Ol'denburg and E. F. Karskii, *Nauka i nauchnye rabotniki SSSR*, vol. 4 (Leningrad: AN SSSR, 1930), 51; "Rasstrely v Moskve," online database, available at <http://mos.memo.ru/> (accessed 10 August 2008).

<sup>14</sup> This change was made at the time of the December 1936 Congress. The last issue titled *Nevropatologii i psikhiiatriia, i psikhogigiena* was volume 5, no. 12 (1936). Until mid-1935, the journal had been titled *Sovetskaia nevropatologii i psikhiiatriia, i psikhogigiena*. The word “Sovetskaia” was dropped after volume 4, no. 8 (1935).

<sup>15</sup> “Polozhenie o Tsentral'nom nauchno-issledovatel'skom institute psikhiiatrii NKZ RSFSR (proekt),” 1937, GARF f. a-482, op. 24, d. 868, ll. 2-5; G. G. Karanovich (Chairman), “Stenogramma zasedaniia kollegii NKZ RSFSR,” 26 September 1938, GARF f. a-482, op. 24, d. 985, l. 101; P. B. Posvianskii, "Itogi deiatel'nosti Tsentral'nogo instituta psikhiiatrii za 25 let i perspektivy ee dal'neishego razvitiia," in *Trudy tsentral'nogo instituta psikhiiatrii MZ RSFSR*, ed. P. B. Posvianskii and A. S. Shmar'ian (Moscow: 1947), 11. See also David Joravsky, "The Construction of the Stalinist Psyche," in *Cultural Revolution in Russia, 1928-1931*, ed. Sheila Fitzpatrick (Bloomington: Indiana University Press, 1978), 115-116.

The period under consideration in this dissertation begins roughly in 1939 when psychiatrists were beginning to sort out what their discipline should be in the aftermath of 1936-1937. The dissertation ends with the aftermath of another major intervention by the Party, the “Pavlov Session” for psychiatry held in 1951. These two interventions by Party authorities demonstrated the regime’s ability to assert control over the psychiatric profession. In practice such direct interventions and sanctions were infrequent, but when they did intervene they could have a profound impact on fields like psychiatry. Interventions by the central committee of the party, however, were by no means the only outstanding events that mark these years as a distinct period in the history of Soviet psychiatry. It was also a period of major institutional and technological change, and both of these factors played fundamentally important roles in structuring the challenges and possibilities that faced psychiatrists.

Technological changes in how psychiatry was practiced were driven by the introduction of shock therapy. Beginning in the early twentieth century, some psychiatrists had begun to experiment with fever and sleep as methods of treatment for psychosis. The invention of insulin shock therapy in 1933 led to a period of enthusiastic experimentation that lasted until the early 1950s when the first effective anti-psychotic drugs went into use. Along with the new “shock therapies” came a host of other experimental forms of “active therapy,” including long-term sleep and lobotomy.<sup>16</sup> These “great and desperate cures,” as historian Elliot Valenstein has evocatively dubbed them, were controversial from the beginning. They were often self-evidently

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<sup>16</sup> Benoit Majerus, "Revisiting Psychiatry in Twentieth-Century Europe," *European Review of History* 15, no. 1 (February 2008): 57; Max Fink, "The Origins of Convulsive Therapy," in *A Century of Psychiatry*, ed. Hugh Freeman (London: Harcourt, 1999), 96-98; Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley, 1997), chapter 6.

brutal, dangerous, and hard to manage.<sup>17</sup> With the exception of electroshock therapy, all these methods of treatment have long since been abandoned, and many of them have become synonymous with medical barbarism.<sup>18</sup> And yet, at the time many psychiatrists embraced these new methods as first steps toward truly effective treatments for serious mental illness, treatments that targeted the fundamental causes of mental illness in the body. For Soviet psychiatrists who were under intense ideological pressure and caught up in rapid institutional change, the new biological therapies were adopted gratefully. Here, finally, was proof that psychiatrists were truly medical doctors – and materialist to boot. And yet for some psychiatrists initial enthusiasm gave way to doubts, and the biological therapies themselves became the focus of intense debate about the basic rationale of psychiatry.

Changes in the bureaucratic system that psychiatry was a part of began in 1937, when Soviet government created the USSR Commissariat of Public Health. By 1953 this organization had grown to become a massive state bureaucracy. The creation for the first time of a centralized, All-Union medical bureaucracy upset the existing hierarchy of medical research institutes, policy making committees, and patronage networks, and set off a scramble among psychiatrists to determine who would set policy, who get funding, and what type of psychiatric medicine they would favor. While some scholars have described the Second World War as a fundamental break in Soviet history,<sup>19</sup> I argue that, at least from the perspective Soviet psychiatry, the war did not

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<sup>17</sup> Elliot S. Valenstein, *Great and Desperate Cures: The Rise and Decline of Psychosurgery and Other Radical Treatments for Mental Illness* (New York: Basic Books, 1986). On early controversies, see Shorter, *A History of Psychiatry*, 210-211; and Pressman, *Last Resort*, 157-160.

<sup>18</sup> Edward Shorter and David Healy, *Shock Therapy: A History of Electroconvulsive Treatment in Mental Illness* (New Brunswick, New Jersey, & London: Rutgers University Press, 2007).

<sup>19</sup> This argument has been made most forcefully by Amir Weiner. "The Making of a Dominant Myth: The Second World War and the Construction of Political Identities within the Soviet Polity," *Russian Review* 55, no. 4 (1996): 638-660; and idem., Amir Weiner, *Making Sense of War: The Second World War and the Fate of the Bolshevik Revolution* (Princeton: Princeton University Press, 2001).

represent a new beginning. What the war did, at least at the level of elite psychiatric research institutions, was accelerate a process of institutional and technological change that was already underway in the 1930s.

At the same time, of course, the war left ordinary psychiatric hospitals in a terrible state of deprivation. In territories occupied by the German army, hospitals were destroyed and patients murdered. Those hospitals that survived the war were left without medicine or basic amenities. Resources had always been scarce in the Soviet Union, and psychiatric hospitals were low priority institutions. To save their patients and staff from malnutrition and starvation the hospitals had to become virtually self-sufficient. Researchers and professors felt the pinch too: funding for psychiatric clinics was hard to come by and paper was rationed grudgingly. So while elite psychiatrists had new-found ability to impose standardized practices on psychiatrists throughout the USSR, in practice they were often unable to do so. Tensions between rationalizing elites and resource-starved rank and file provided another source of incipient conflict within Soviet psychiatry.

Finally, the war accelerated generational change in Soviet psychiatry. During the war several young psychiatrists were brought into the USSR Commissariat of Public Health as senior administrators, and after the war they became quite important in the public health bureaucracy. One, Sergei Kurashov, went on to become USSR Minister of Public Health under Khrushchev.<sup>20</sup> These young psychiatrists came from positions as the directors of provincial psychiatric hospitals, and thus saw psychiatric policy from a different perspective than senior researchers

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<sup>20</sup> N. A. Vinogradov, *S. V. Kursahov* (Moscow: Meditsina, 1967); *BME* 2<sup>nd</sup> ed., s.v. "Kurashov, Sergei Vladimirovich." Dmitrii Fedotov was the other senior level Narkomzdrav member who started as a psychiatric hospital director.



who had worked for decades in Moscow. Finally, these young psychiatrists were part of a team that was assembled at Narkomzdrav USSR by the new Commissar, Efim Smirnov, who came to Narkomzdrav from running the Red Army's health system. One of Smirnov's main goals at Narkomzdrav was to rationalize an organization that had developed rapidly and somewhat randomly during the war.<sup>21</sup> It would be accurate to say, then, that these young psychiatrists at Narkomzdrav personified the key tensions in their discipline: institutional change, generational change, and center-periphery/elite-hospital.

### **Psychiatry in the Soviet Union: Historiography**

Little has been written about the history of psychiatry in the Soviet Union. Historians who have attempted to write general histories of modern psychiatry have either excluded the Soviet Union altogether, or have relegated it to a footnote about the persecution of political dissidents.<sup>22</sup> Specialists in Soviet History have treated psychiatry in much the same way, leaving the study of Soviet psychiatry to medical ethicists, human rights activists, and political scientists.<sup>23</sup> (The political abuse of psychiatry also produced a substantial memoir literature

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<sup>21</sup> Burton, "Medical Welfare During Late Stalinism," 97. In his memoirs, Smirnov described his task as "breaking the psychology of a significant part of the leadership of medical organs and institutions." Efim Smirnov, *Medsina i organizatsiia zdravookhraneniia, 1947-1953* (Moscow: Meditsina, 1989), 92.

<sup>22</sup> Roy Porter and Mark S. Micale, "Reflections on Psychiatry and Its Histories," in *Discovering the History of Psychiatry*, ed. Mark S. Micale and Roy Porter (New York: Oxford University Press, 1994); Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley, 1997). See also Hugh Freeman, ed., *A Century of Psychiatry* (London: Harcourt, 1999). Older histories of psychiatry mention Pavlov if they mention the USSR at all. Franz Alexander and Sheldon T. Selesnick, *The History of Psychiatry: An Evaluation of Psychiatric Thought and Practice from Prehistoric Times to the Present* (New York: Harper & Row, 1966); Gregory Zilboorg and George W. Henry, *A History of Medical Psychology* (New York: Norton, 1941).

<sup>23</sup> For the most current understanding of psychiatric abuse in the USSR, see Vladimir Bukovskii, "Psikhiatricheskii GULAG," in *Moskovskii protsess* (Paris & Moscow: Russkaia mysl', 1996), 144-161; A. S. Prokopenko, *Bezumnaiia psikhiatriia: Sekretnye materialy o primenenii v SSSR psikhiatrii v karatel'nykh tseliakh* (Moscow: Sovershenno sekretno, 1997); and Theresa C. Smith and Thomas A. Oleszczuk, *No Asylum: State Psychiatric Repression in the Former USSR* (New York: New York University Press, 1996). See also V. Bukovskii, "Repressivnaia psikhiatriia," in *Sovetskii Arkhiv sobran Vladimirov Bukovskim*, online document repository,

written by Soviet dissidents.<sup>24</sup>) Those historians who have studied psychiatry in the USSR have primarily focused on psychiatry in the tsarist period and during the revolution itself.<sup>25</sup> Since 1991 this situation has changed somewhat with the publication of several important histories of psychoanalysis in the Soviet Union,<sup>26</sup> but we still know surprisingly little about Soviet

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available at <http://psi.ece.jhu.edu/~kaplan/IRUSS/BUK/GBARC/pdfs/psychiat/psy-rus.html> (accessed 7 August 2008). The literature on Soviet psychiatric abuse from the 1960s through the 1980s is very large. Among the key texts are Sidney Bloch and Peter Reddaway, *Psychiatric Terror: How Soviet Psychiatry Is Used to Suppress Dissent* (New York: Basic Books, 1977); idem., *Soviet Psychiatric Abuse: The Shadow over World Psychiatry* (Boulder, CO: Westview Press, 1985); Sidney Bloch, "Psychiatry as Ideology in the USSR," *Journal of Medical Ethics* 4, no. 3 (1978): 126-131; idem., "The Political Misuse of Psychiatry in the Soviet Union," in *Psychiatric Ethics*, ed. Sidney Bloch and Paul Chodoff (Oxford: Oxford University Press, 1981), 322-342; Zhores Medvedev and Roy A. Medvedev, *A Question of Madness* (New York: 1971); Aleksandr Podrabinek, *Punative Medicine*, trans. Alexander Lehrman (Ann Arbor: Karoma, 1980); Walter Reich, "Diagnosing Soviet Dissidents," *Harper's* 257, no. 1539 (August 1978): 31-37; idem., "The World of Soviet Psychiatry," *New York Times Magazine*, 30 January 1983.

<sup>24</sup> An important outlet for information about Soviet psychiatric abuse was the samizdat journal *The Chronicle of Current Events*. For first person accounts and memoirs, see: *Abuse of Psychiatry for Political Repression in the Soviet Union: Testimony of Dr. Alexander Sergeyovich Yesenin-Volpin*, Subcommittee to Investigate the Administration of the Internal Security Act and Other Internal Security Laws of the Committee on the Judiciary, United States Senate, Ninety-Second Congress (Washington, D. C.: U.S. GPO, 1972); *Abuse of Psychiatry for Political Repression in the Soviet Union: Testimony of Dr. Norman B. Hirt*, Subcommittee to Investigate the Administration of the Internal Security Act and Other Internal Security Laws of the Committee on the Judiciary, United States Senate, Ninety-Fourth Congress (Washington, D. C.: U.S. GPO, 1975); P. Grigorenko, *The Grigorenko Papers* (London: Hurst, 1976); L. Plyushch, *History's Carnival* (London: Collins and Harvill, 1979); Victor Nekipelov, *Institute of Fools: Notes From the Serbsky*, trans. Marco Carynyk and Marta Horban (New York: Farrar Straus Giroux, 1980).

<sup>25</sup> A particularly important recent work is Jacqueline Lee Friedlander, "Psychiatrists and Crisis in Russia, 1880-1917" (PhD, University of California, Berkeley, 2007). The most prolific American scholar of Russian psychiatry has been sociologist Julie Vail Brown, who wrote a path breaking thesis on the topic. Julie Vail Brown, "The Professionalization of Russian Psychiatry: 1857-1911" (PhD, University of Pennsylvania, 1981). Among her other works are Julie Vail Brown, "Psychiatrists and the State in Tsarist Russia," in *Social Control and the State*, ed. Andrew Scull and S. Cohen (New York: 1983), 267-287; idem., "Revolution and Psychosis: The Mixing of Science and Politics in Russian Psychiatric Medicine, 1905-13," *Russian Review* 46, no. 3 (July 1987): 283-302; idem., "Social Influences on Psychiatric Theory and Practice in Late Imperial Russia," in *Health and Society in Revolutionary Russia*, ed. Susan Gross Solomon and John F. Hutchinson (Bloomington: Indiana University Press, 1990), 27-44; and idem., "Heroes and Non-Heroes: Recurring Themes in the Historiography of Russian-Soviet Psychiatry," in *Discovering the History of Psychiatry*, ed. Mark S. Micale and Roy Porter (New York: Oxford University Press, 1994), 297-307.

<sup>26</sup> Alexandr Etkind, *Eros nevozmozhnogo: istoriia psikhoanaliza v Rossii* (Sankt-Peterburg: Meduza, 1993), translated as Alexander Etkind, *Eros of the Impossible: The History of Psychoanalysis in Russia*, trans. Noah and Maria Rubins (Boulder, Colorado: Westview Press, 1997); Martin A. Miller, *Freud and the Bolsheviks: Psychoanalysis in Imperial Russia and the Soviet Union* (New Haven: Yale University Press, 1998). See also Alberto Angelini, "History of the Unconscious in Soviet Russia: From its Origins to the Fall of the Soviet Union," *International Journal of Psychoanalysis* 89, no. 2 (April 2008): 369-88.

psychiatrists or psychiatric practice.<sup>27</sup> Several scholars have written about the Russian experience of psychological trauma in World War Two, but they have either claimed (mistakenly) that Soviet psychiatrists had no concept of psychological trauma,<sup>28</sup> or they have chosen to ignore the Soviet psychiatric discourse as irrelevant to Soviet society more broadly.<sup>29</sup> The one bright spot has been a growing literature on madness as a theme in Russian culture and studies of how psychiatrists shaped Soviet attitudes toward sex and deviance. With only a few exceptions, however, these studies have focused on imperial Russian history and the Soviet Union in the 1920s.<sup>30</sup> The history of psychiatry as a medical specialty during the Stalin years largely remains a gap in the historiography.<sup>31</sup>

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<sup>27</sup> The classic work on Soviet psychiatry remains Joseph Wortis's *Soviet Psychiatry* (Baltimore: Williams & Wilkins, 1950). Wortis made headlines in 1953 when he was brought before the Senate Internal Security subcommittee to answer questions about his loyalties. "Ex:-Bellevue Aide Linked to Red Line: Brooklynite's Book on Russian Psychiatry Held Propaganda in Senate Group's Report," *New York Times*, 24 September 1953, 22. Other American psychiatrists were also fascinated by Soviet psychiatry, and wrote extensively about it in psychiatric journals in the 1950s. See Gary S. Belkin, "Writing About Their Science: American Interest in Soviet Psychiatry During the Post-Stalin Cold War," *Perspectives in Biology and Medicine* 43, no. 1 (Autumn 1999): 31-46.

<sup>28</sup> Anna Krylova, "'Healers of Wounded Souls': The Crisis of Private Life in Soviet Literature and Society, 1944-46," *Journal of Modern History* 73, no. 2 (June 2001): 317-318. On the Soviet psychiatric debate about "mental trauma" [*psikhicheskaiia travmatizatsiia*] see chapters 2 and 3 of this dissertation.

<sup>29</sup> Catherine Merridale, "The Collective Mind: Trauma and Shell-Shock in Twentieth-Century Russia," *Journal of Contemporary History* 35, no. 1 (2000): 39-55; Catherine Merridale, *Ivan's War: Life and Death in the Red Army, 1939-1945* (New York: Metropolitan Books, 2006), 268-269. For an overview of Russian military psychiatry, see Paul Wanke, *Russian/Soviet Military Psychiatry, 1904-1945* (London: Frank Cass, 2005). The best study of Russian military psychiatry and concepts of war trauma is Friedlander, "Psychiatrists and Crisis in Russia," which focuses on the Russo-Japanese war and WWI.

<sup>30</sup> Laura Engelstein, *The Keys to Happiness: Sex and the Search for Modernity in fin-de-siècle Russia* (Ithaca: Cornell University Press, 1992); and idem, Laura Engelstein, *Castration and the Heavenly Kingdom: A Russian Folktale* (Ithaca, N.Y.: Cornell University Press, 1999); Eric Naiman, *Sex in Public: The Incarnation of Early Soviet Ideology* (Princeton: Princeton University Press, 1997); Kenneth Pinnow, "Making Suicide Soviet: Medicine, Moral Statistics, and the Politics of Social Science in Bolshevik Russia, 1920-1930" (PhD, Columbia University, 1998); Dan Healy, *Homosexual Desire in Revolutionary Russia: The Regulation of Sexual and Gender Dissent* (Chicago: University of Chicago Press, 2001); Irina Sirotkina, *Diagnosing Literary Genius: A Cultural History of Psychiatry in Russia, 1880-1930* (Baltimore and London: Johns Hopkins University Press, 2002); Frances Lee Bernstein, *The Dictatorship of Sex: Lifestyle Advice for the Soviet Masses* (DeKalb: Northern Illinois University Press, 2007); Daniel Beer, *Renovating Russia: The Human Sciences and the Fate of Liberal Modernity, 1880-1930* (Ithaca: Cornell University Press, 2008); Angela Brintlinger and Ilya Vinitsky, eds., *Madness and the Mad in Russian Culture* (Toronto: Toronto University Press, 2007).

<sup>31</sup> The exception to this lack of work on psychiatry in the Stalin period is the work done by David Joravsky, discussed below. See also Martin A. Miller, "The Theory and Practice of Psychiatry in the Soviet Union,"

If one turns to the pages of Russian medical journals, of course, one finds a great deal about the history of Soviet psychiatry. Several full scale histories of Russian psychiatry were written during the Soviet period<sup>32</sup> and psychiatrists have continued to produce a steady stream of biographies, institutional histories, and studies of the origins of specific ideas and treatments.<sup>33</sup> These “internalist” histories can be excellent sources of information, and they also offer important insights into the values and ideals of their authors. As a group, however, they suffer from a lack of historical context or critical distance. At their worst, they preserve a tone of Russian exceptionalism, angry at not being taken seriously by their peers in the West while at the same time being defiantly proud of their allegedly unique Russian approach to the subject.<sup>34</sup>

While many of the historical essays found in Russian psychiatric journals advance a narrative of ongoing progress, others narrate the twentieth century as the story of science betrayed, a deviation from the path of progress.<sup>35</sup> This division remains strong despite the fact

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*Psychiatry* 48, no. 1 (1985): 13-24; idem., *Soviet Psychiatry: The Historical and Cultural Context* (The National Council for Soviet and East European Research, 1986); and George Windholz, "Soviet Psychiatrists under Stalinist Duress: The Design for a 'New Soviet Psychiatry' and Its Demise," *History of Psychiatry* 10, no. 3 (1999): 329-347.

<sup>32</sup> The two major surveys of the history of Russian psychiatry were written in the 1920s and the 1940s, and both end with chapters on the early soviet period. Iu. Kannabikh, *Istoriia psikhiiatrii* (Moscow: TsTR MGP VOS, 1994 [1928]), and T. I. Iudin, *Ocherki istorii otechestvennoi psikhiiatrii* (Moscow: Medgiz, 1951). See also Edward Babayan and Yu. G. Shashina, *The Structure of Psychiatry in the Soviet Union*, trans. Vladimir Brobov and Boris Meerovich (New York: International Universities Press, 1985); V. M. Banshchikov, *Vsesoiuznoe nauchnoe meditsinskoe obshchestvo nevropatologov i psikhiiatrov (Materialy k istorii nauchnogo obshchestva, 1878-1967 gg.)* (Moscow: 1967); and L. L. Rokhlin, *Ocherki psikhiiatrii* (Moscow: Medgiz, 1967).

<sup>33</sup> Biographies, obituaries, and institutional histories have been regularly published in the Korsakov Journal of Neuropathology and Psychiatry (ZhNiP). More recently, most Russian psychiatric research institutes and many psychiatric hospitals have published institutional histories on the internet, some of which include photographs and historical texts as well as biographical materials about staff members. A partial index of Russian psychiatric internet resources can be found at <http://psychiatry.ru/stat.php?num=164> (accessed 26 October 2008).

<sup>34</sup> In the first issue of a journal which he began to publish in 2003, Aleksandr Tiganov writes of the fundamentally new approach to psychiatry developed by Andrei Snezhnevskii in the 1950s and 1960s. He berates Snezhnevskii's critics for their failure to understand his unique contributions to Russian psychiatry and he decries the psychiatric standards set in America and Europe (the DSM-IV and European ICD-10) for ignoring Russian contributions. A. S. Tiganov, "Zhurnal 'Psikhiiatriia,' Ot glavnogo redaktora," available at <http://www.psychiatry.ru/stat.php?num=69> (accessed 6 May 2006).

<sup>35</sup> Voices critical of how psychiatry was practiced in the USSR most frequently find a voice in the *Nezavisimyi psikhiiatricheskii zhurnal*, the journal of the Russian Independent Psychiatric Association (NPAR). The NPAR was

that eighteen years have past since the collapse of the Soviet Union.<sup>36</sup> Of course, institutions change very slowly: the psychiatrists who now control university departments and editorial boards in Russia were themselves trained in the Soviet period and in some cases would potentially have much to lose from a thorough going discussion of the past.<sup>37</sup> Meanwhile, other psychiatrists continue to hold grudges over mistreatment and indignities that in some cases date back to the 1940s. Careers set back, mentors humiliated and demoted: a long history of personal, intellectual, and political relationships continues to make the past a very sore subject. Critics within Russian psychiatry differ on just why things went wrong, but the moment that most single out is the 1951 “Pavlov Session,” a public meeting held in the waning years of Stalin’s regime. Looking back from the perspective of 1991, two participants in the 1951 Session recalled it as “the precursor of later abuses in psychiatry in the USSR,” the moment when “an unseen border had been crossed and the ‘sin taken into one’s soul.’ ....”<sup>38</sup> Soviet psychiatrists, in this reading, were corrupted by totalitarianism, and the Soviet period should be understood as an extended period in which Soviet psychiatry was cut off from the universal norms of psychiatric science.

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organized in the early 1990s to advocate for the reform of Soviet psychiatry and for the separation of psychiatric expertise from state authorities. Their journal regularly publishes excellent biographical pieces, and the journal is available through the internet at <http://www.npar.ru/journal>.

<sup>36</sup> Psychiatry in the Russian Republic since 1991, see Julie Vail Brown, "Afterword," in *Madness and the Mad in Russian Culture*, ed. Angela Brintlinger and Ilya Vinitsky (Toronto: Toronto University Press, 2007), 283-299.

<sup>37</sup> Vladimir Snezhnevskii, the man who delivered the main speech at the 1951 Session, remained the leader of Soviet psychiatry and the editor of its main journal until his death in 1987, and was the chief proponent of the concept of “sluggish schizophrenia,” the regime’s diagnosis of choice for troublesome intellectuals. One of Snezhnevskii’s students, Aleksandr Tiganov, now serves as the director of the Scientific Center for Mental Health of the Russian Academy of Medical Sciences, the successor to the Institute of Psychiatry of the USSR Academy of Medical Sciences, the institute that Snezhnevskii directed for many decades. On the continuing influence of Snezhnevskii and his apologists in post-Soviet Russia, see Theresa C. Smith and Thomas A. Oleszczuk, *No Asylum: State Psychiatric Repression in the Former USSR* (New York: New York University Press, 1996), 27.

<sup>38</sup> Y. V Popov and A. E. Lichko, "A Somber Page in the History of the All-Union Psychiatric Association," *Bekhterev Review of Psychiatry and Medical Psychology*, no. 3 (1991): 90.

This notion that normal psychiatric science was corrupted by Stalinist totalitarianism can be found in Western commentary on Soviet psychiatry as well. The Cold War made Soviet science a particularly sensitive subject, and in the popular mind the phrases “soviet science” or “Stalinist science” became virtually synonymous with science corrupted by power and used cynically for political ends. The implication was that good science was only really possible in democratic societies. As historian Alexei Kojevnikov writes, “Anticommunist ideologues denounced the Soviet system as the very opposite of democracy, and, by implication, also accused it of being harmful to science. To maintain the latter claim and to see science as suffering rather than prospering at the hands of communists, they had to turn their attention away from the achievements to the weaknesses and failures of Soviet science.” The classic example of the failure of Soviet science was the “Lysenko episode,” which, Kojevnikov points out, “acquired symbolic status as the first, and sometimes the only, event that many a general reader and professional historian in the West considered worth knowing from the history of Soviet science.”<sup>39</sup>

It was not hard for Western scholars to place Soviet psychiatry into this framework. For evidence they had to look no further than the writings of Soviet psychiatrists themselves. At a 1930 address to the First International Mental Hygiene Congress, Rozenshtein began by stating simply that “The development of mental hygiene or psycho-hygiene in the Soviet Union is closely bound up with the special conditions of public-health service.”<sup>40</sup> The entry for “psychiatry” in the Great Soviet Encyclopedia concurred: “Soviet Psychiatry changed the whole

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<sup>39</sup> Alexei Kojevnikov, *Stalin's Great Science: The Times and Adventures of Soviet Physicists* (London: Imperial College Press, 2004), xii.

<sup>40</sup> L. M. Rozenshtein, "The Development of Mental Hygiene in the Soviet Union as a Public-Health Measure," in *Proceedings of the First International Congress on Mental Hygiene*, vol. 1, ed. Frankwood E. Williams (New York: International Committee for Mental Hygiene, 1932), 145-148.

system of psychiatric treatment,” it claimed, creating approaches that were “in essence unknown in the West.”<sup>41</sup> Furthermore, Soviet psychiatrists explicitly drew a strong contrast between the “idealist” approaches to the psyche used by bourgeois scientists, and the dialectical-materialist approach used in the Soviet Union.<sup>42</sup> If Soviet psychiatrists rejected commonly accepted theories and standards of evidence, observers assumed that the Soviet approach itself must be pseudoscientific.<sup>43</sup> In its most reduced form, the assumption was that Soviet psychiatrists must use the theories dictated to them by the regime, not those “dictated” by science.

In his classic book *The New Man in Soviet Psychology* (1952), Raymond Bauer concluded that Bolshevik ideology and the needs of the Stalinist regime dictated the content of psychological theory. The regime wanted workers with a new type of socialist consciousness, and psychologists were expected to give them a theory of the mind that would support this effort.<sup>44</sup> Robert Tucker extended Bauer’s argument to the post-WWII period, arguing that Stalin abandoned efforts to create the “New Man” through psychological theory and hoped instead to

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<sup>41</sup> V.A. Giliarovskii, "Psikhiatriia," in *Bol'shaia sovetskaia entsiklopediia*, ed. Otto Schmidt (Moscow: OGIZ, 1940).

<sup>42</sup> A. N. Leont'iev, "Psikhika," in *Bol'shaia sovetskaia entsiklopediia*, ed. Otto Schmidt (Moscow: OGIZ, 1940).

<sup>43</sup> One prominent American psychiatrist, Doctor Leopold Bellak, wrote a particularly direct statement of this belief in a 1969 letter to the editors of the *American Journal of Psychiatry*. Bellak speculated that the difference between Soviet and American psychiatry lay in the ban on psychoanalysis. “Somehow,” he wrote, “psychoanalysis was never rehabilitated in Russian ideology and no systematic personality theory or psychotherapy seems to have been found as substitute....In fact, much of Russian psychiatry still seems to be of a Kraepelinian nature. Could it be that indeed German influences still persist?...It must be fervently hoped that this scientific isolation of Russian psychiatry, unparalleled in other fields of Russian science, will be lifted before too long.” Leopold Bellak, "Soviet Psychiatric Lag," *American Journal of Psychiatry* 125, no. 9 (1969): 1267.

<sup>44</sup> In the 1930s, according to Bauer, Soviet psychologists began to stress the importance of individual psychology as opposed to social environment. Environment and heredity provided a starting point, but individuals were responsible for their own socially disruptive behavior and failures to fulfill the plan. If there were problems in the implementation of Party decrees, it was because individuals were mentally ill and/or enemies of the state. Social deviants were guilty of not having tried hard enough to remake themselves into “new Soviet people.” Raymond Bauer, *The New Man in Soviet Psychology* (Cambridge, Mass.: Harvard University Press, 1952).

use Pavlov's conditioned reflexes to directly control the individual mind.<sup>45</sup> Tucker's analysis provided the general framework that informed how other scholars evaluated what happened to Soviet psychiatrists in the last years of Stalin's life.<sup>46</sup>

These neat narratives of politicians dictating science to experts fit well with many preconceptions of what the practice of science was like under the Bolsheviks. In his far more ambitious study of Soviet psychology, however, historian David Joravsky argues that the reality was more complex and confusing. Psychological theories did not map neatly onto Bolshevik ideology, according to Joravsky. It was convenient for Soviet scientists to claim that their approaches *did* support the Party's general line (and that their opponents' theories supported its ideological opposite), but Western historians should be very cautious in accepting such simplistic conclusions.<sup>47</sup>

Joravsky himself has written a short but excellent account of psychiatry during the Stalin period. He does not think that Soviet psychiatry was corrupted by totalitarianism, nor does he think that it deviated from the scientific norms of Western psychiatry. With few exceptions, he finds, psychiatrists were able to operate more or less without interference from political authorities. Indeed, Joravsky argues that the political abuse of psychiatry in the USSR, while

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<sup>45</sup> After the war, according to Tucker, the Soviet population was unwilling to resume the grueling industrialization drive of the 1930s. In order to rouse them from their apathy, Stalin launched a massive propaganda campaign (the so-called *zhdanovshchina*) and when this failed he was forced to conclude that the pre-war effort to create a "New Man" had been unsuccessful. In the late 1940s, therefore, Stalin looked to Soviet biology and psychology to provide him with new tools to create people who would unfailingly follow his lead. By combining Pavlov's conditioned reflexes with Lysenko's theory of acquired hereditary traits, Stalin hoped to literally engineer a new type of human being. Robert Tucker, "Stalin and the Uses of Psychology," in *The Soviet Political Mind: Studies in Stalinism and Post-Stalin Change* (New York: Praeger, 1963), 91-121.

<sup>46</sup> George Windholz explicitly bases his analysis of the 1951 Pavlov Session on the work of Tucker and Bauer. George Windholz, "Soviet Psychiatrists under Stalinist Duress: The Design for a 'New Soviet Psychiatry' and Its Demise," *History of Psychiatry* 10, no. 3 (1999): 329-347.

<sup>47</sup> "Such correlations appeal to the desire for governable order, whether bureaucratic or ideological," Joravsky writes, "but they hardly fit the historical facts." Joravsky, *Russian Psychology*, 231.



abhorrent, did not define the essence of Soviet psychiatry. (In most cases, according to Joravsky, psychiatrists found dissidents sane and sent them back to the courts). This does not mean, however, that Joravsky thinks that all was well. He concludes that by its very nature, psychiatry is a “cultural project.” Psychiatrists still do not understand what causes mental illness, despite decades of research and claims to the contrary. They can see that some people suffer from mental disturbances and that their behavior is anomalous, and they genuinely want to help. But they have no real means that would enable them to understand what goes on in someone else’s mind, particularly when that person’s mind is so utterly different as to be labeled “insane.” Without such understanding, psychiatrists who want to do something to help their patients must simply do what they think is best. But in the absence of any real understanding, Joravsky thinks, such action is fundamentally based on the psychiatrist’s own judgment and imposed on the patient. The patient is made to conform to the psychiatrists’ ideal of how a person should be, and this ideal is inherently a “cultural project.” Of course, to maintain their authority, psychiatrists must not admit their uncertainty. “In short,” Joravsky writes, “severe mental disorder puts the psychiatrist under pressure not only to act with insufficient knowledge but also to repress awareness of his ignorance, to become a ‘clinical dogmatist.’” This tendency to act for the sake of acting, to do what one believes is right while all the while claiming complete objective certainty, is, according to Joravsky, the essence of “the Stalinist mentality.” He implies that this “Stalinist mentality” can be found anywhere psychiatry is practiced. Soviet psychiatry was part of Western psychiatry, and the whole lot were at best guilty of self-delusion.<sup>48</sup>

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<sup>48</sup> David Joravsky, *Russian Psychology: A Critical History* (Oxford: Basil Blackwell, 1989), 415-442. Joravsky is ultimately pessimistic about the whole idea of scientific understanding of the mind. We would be better off, he implies, if we looked to great literature like Dostoevsky instead of psychologists like Freud. *Ibid.*, 455-456, 464.

In his own study of Soviet psychiatry, philosopher and psychiatrist K.W.M Fulford comes to a conclusion that is similar to Joravsky’s. Both Soviet and Western psychiatrists, he argues, were involved in an activity that always

Joravsky's conclusions share much in common with the school of thought associated with Michel Foucault (discussed below) that sees the human sciences as key agents of normalization in the modern world. In this reading, psychiatrists acting in good faith impose a particularly narrow notion of what it means to be a good modern citizen. I find much that is useful in this approach, but in my own study I do not take the "cultural project" of psychiatry as my primary object of study. Historians of any such "cultural project" must ultimately show how this process worked in practice through empirical case studies. To do this we must go beyond the ideals found in the world of published scientific literature and examine how psychiatry in the Soviet Union actually worked.

Rather than trying to identify a dominant ethos of Soviet psychiatry, then, I have attempted to use both archival and published sources to show how psychiatric theory was generated, how psychiatric hospitals worked, and how psychiatric practice and psychiatric theory interacted with one another in the broader social domain of government institutions, "intellectual schools," academic journals, and the communist party. Whenever possible I have tried to avoid generalizations like "the state" and "society" because I do not find these concepts particularly useful.<sup>49</sup> The field of action that psychiatrists operated in was made up of a wide range of state and non-state institutions, most of which had their own distinct interests. Power was not diffused

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required subjective evaluation. Unlike Joravsky, though, Fulford is not ready to abandon psychiatry altogether. He concludes that the solution is for psychiatrists – and all other medical specialists - to openly admit that they do make such evaluations. There will always be a danger of Soviet-style political abuse as long as psychiatrists insist that what they are doing is objective science and thus beyond reproach. K. W. M. Fulford, A. Y. Smirnov, and E. Snow, "Concepts of Disease and The Abuse Of Psychiatry in the USSR," *British Journal of Psychiatry* 162 (June 1993): 801-10. See also K. W. M. Fulford, "Values in Psychiatric Diagnosis: Executive Summary of a Report to the Chair of the ICD-12/DSM-VI Coordination Task Force (Dateline 2010)," *Psychopathology* 35, no. 2 (2002): 7.

<sup>49</sup> On the state and society problem in Soviet history, see Mark Edele, "Soviet Society, Social Structure, and Everyday Life: Major Frameworks Reconsidered," *Kritika: Explorations in Russian and Eurasian History* 8, no. 2 (Spring 2007): 361-634; Kiril Tomoff, *Creative Union: The Professional Organization of Soviet Composers, 1939-1953* (Ithaca, N.Y.: Cornell University Press, 2006), 5.

evenly throughout “the state” – some institutional agents were more able to get their way than others.<sup>50</sup> Nor was “the state” the only organization that created social solidarities among psychiatrists. Though government organizations like university departments, research institutes, and psychiatric hospitals certainly created powerful basis of solidarity and action, there were other sources of social solidarity. Many psychiatrists, for instance, were linked to one another through “schools” established by shared academic advisors. These relationships persisted even when there was no common institutional relationship between their members, and some of these affiliations had their roots in the pre-1917 period.<sup>51</sup>

It should not be surprising that when we examine the archival records of Soviet psychiatry that we find disarray and conflict. The same, to one degree or another, can be expected from the archives of most any sprawling bureaucracy, particularly in the Soviet Union.<sup>52</sup> What this confusion and infighting suggests, however, is a far greater degree of complexity. If we can understand this complexity and how it contributed to the outcomes that we observe in publications, clinical practice, and high politics, we can hopefully emerge not only with a better understanding of the Soviet system, but also with a better understanding of how psychiatry developed in the twentieth century.

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<sup>50</sup> The concept of power that I use throughout the dissertation follows the classical Weberian definition of power as “the probability that one actor within a social relationship will be in a position to carry out his will despite resistances.” Weber, cited in Mark Anthony Wenman, “Power,” in *Political Concepts: A Reader and Guide*, ed. Iain MacKenzie (2005), 372.

<sup>51</sup> D. A. Alexandrov, “Istoricheskaia antropologiia nauki v rossii,” *Voprosy istorii estestvoznaniia i tekhniki*, no. 4 (1994): 3-22. On the long-lasting rivalry between “Moscow” and “Petersburg” schools in psychiatry, see Julie Vail Brown, “Heroes and Non-Heroes: Recurring Themes in the Historiography of Russian-Soviet Psychiatry,” in *Discovering the History of Psychiatry*, ed. Mark S. Micale and Roy Porter (New York: Oxford University Press, 1994), 297-307.

<sup>52</sup> Terry Martin, “Interpreting the New Archival Signals: Nationalities Policy and the Nature of the Soviet Bureaucracy,” *Cahiers du Monde russe* 40, no. 1-2 (1999): 113-24.

## War, Society, and Soviet Medicine

In their work on the Soviet government, Yoram Gorlizki and Oleg Khlevniuk have noted that Soviet government institutions in general increased in scope and became more subject to “bureaucratic rationality” in a Weberian sense in the period that followed World War Two.<sup>53</sup> Max Weber particularly associated increasingly centralized and rational government administration with “modernity.” In this Weberian view, modernity is understood in terms of social relations. Roger Cooter and Steve Sturdy summarize the characteristics of Weberian modernity as “the growth, differentiation and integration of bureaucracy and other organizational and managerial systems; the standardization and routinization of administrative action; and the employment of experts to define and order such systems.”<sup>54</sup> Closely associated with the development of industrial capitalism, such “modern” institutions push for increasing uniformity of practices in all spheres of life, in part to increase efficiency and productivity, but also as an end in itself. Weberian modernity is not just new ways of organizing labor, in other words, but also new ways of thinking about how the world should be organized.

In the Soviet case, the growth of the size and scope of government bureaucracies was connected to the Bolshevik’s ideological sense of revolutionary time.<sup>55</sup> As Chris Burton has noted, “the Leninist penchant to think and plan in terms of rigid historical phases” had a major impact on the resources that were devoted to public health and the ways that those resources

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<sup>53</sup> Yoram Gorlizki and O. V. Khlevniuk, *Cold Peace: Stalin and the Soviet Ruling Circle, 1945-1953* (New York: Oxford University Press, 2003).

<sup>54</sup> Roger Cooter and Steve Sturdy, "Of War, Medicine and Modernity: Introduction," in *War, Medicine and Modernity*, ed. Roger Cooter, Mark Harrison and Steve Sturdy (Stroud, Gloucestershire England: Sutton Publishing, 1998), 2

<sup>55</sup> On the Bolshevik’s teleological concept of time see Amir Weiner, "Nature, Nurture, and Memory in a Socialist Utopia: Delineating the Soviet Socio-Ethnic Body in the Age of Socialism," *The American Historical Review* 104, no. 4 (Oct. 1999): 1119; Igal Halfin, *From Darkness to Light: Class, Consciousness, and Salvation in Revolutionary Russia* (Pittsburgh: University of Pittsburgh Press, 2000), ch. 1.

were used. During the “building of socialism” in the First-Five Year Plan, industrial workers in high-priority sectors of the economy were given priority. Universal access to preventive medicine and clinical care were severely deemphasized. The end of the First Five Year Plan, however, marked the beginning of a new historical era, a transition that was “formalized in 1936 by the adoption of the Stalin Constitution.” In this new era, the regime adopted a new framework for the scope and purpose of government. Under the new constitution, the concept of citizenship “shifted from the exclusion of class enemies to inclusiveness.” This shift from away from explicitly class based government was accompanied by a shift “not only away from classism but also more toward statism.” The creation of centralized organs of government like Narkomzdrav USSR, Burton argues, reflected an important shift in the development of the Soviet Union as a welfare state.<sup>56</sup>

The creation of this new bureaucracy changed the relationship between leading psychiatrists and their institutions: committees and research institutions that were attached to the Russian Republic’s Commissariat of Public Health, Narkomzdrav RSFSR, had previously enjoyed a preeminent position, effectively setting psychiatric policy for the whole profession. These institutions were now forced to subordinate themselves to the committees and research institutes that were part of the new Narkomzdrav USSR. Not only did this entail a loss of status, it also meant that there was more competition for already very scarce resources. Narkomzdrav USSR was established in 1937, but it was only in 1938 and 1939 that its offices were staffed with real people and began the task of creating a functioning bureaucracy. The war intervened, leading to rapid development of some of Narkomzdrav USSR’s divisions, but this development

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<sup>56</sup> Chris Burton, “Medical Welfare During Late Stalinism: A Study of Doctors and the Soviet Health System, 1945-1953” (Ph.D., University of Chicago, 2000), 43-44.

was often ad hoc. By 1945 Narkomzdrav USSR had become a sprawling bureaucracy, but one in which some divisions were woefully underdeveloped while others were no longer needed. For Soviet public health, then, postwar reconstruction meant not only literally rebuilding hospitals and clinics, but also centralizing and rationalizing the national public health bureaucracy. From 1945 to 1953, the number of doctors in the Soviet Union doubled and the range of public health services expanded rapidly.<sup>57</sup>

The development of a centralized public health bureaucracy in Russia did not begin in the 1930s, of course. In tsarist Russia there had been two basic types of health providers, those that were run individually by private or government institutions and those that were part of the rural zemstvo health system. Most urban medicine was thus fragmented into many jurisdictions, while the “community physicians” who worked for the zemstvos developed a framework for a centralized public health bureaucracy. Their basic concept, which dated back to the 1880s, called for rural districts to be blanketed with small clinics which would provide free care to all citizens. The tsarist Ministry of Interior Affairs proposed an alternative plan relatively late, in 1910. The Rein Plan, named after its author, G.E. Rein, called for a “unified ministry of health” and “would have appropriated many of the zemstvo initiatives for the state by gathering together many public health responsibilities in a single, central organ.” This plan was never realized under the old regime, but in 1918 it was revived by the Bolsheviks.<sup>58</sup>

Modern war, historians have found, has often played an important role in accelerating the centralization and rationalization of both state and non-state organizations. Total war requires

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<sup>57</sup> Burton, “Medical Welfare During Late Stalinism,” 2.

<sup>58</sup> Ibid., 41-42. See also John F. Hutchinson, *Politics and Public Health in Revolutionary Russia, 1890-1918* (Baltimore & London: Johns Hopkins University Press, 1990) and Nancy M. Frieden, *Russian Physicians in an Era of Reform and Revolution, 1856-1905* (Princeton: Princeton University Press, 1981).

efficient use of human and material resources, and so, not surprisingly, medicine has been a key part of modern warfare.<sup>59</sup> In the First World War doctors, nurses and ambulance drivers were systematically brought together to enhance the efficiency of the military. Through physical and psychological examination of recruits they were able to “standardize men” in the new mass armies, and by calculating dietary requirements and need for rest they could hope to standardize the physical experience of war and maximize the effectiveness of their soldiers and civilians.<sup>60</sup> In the Soviet case creating a single centralized commissariat of public health was imperative particularly because epidemic disease was a serious threat to the Bolsheviks and their hold on power. Between 1913 and 1928 the number of doctors tripled and the regime succeeded in increasing the number of urban hospital beds from 93,000 to 168,500.<sup>61</sup>

The RSFSR Commissariat of Public Health, Narkomzdrav RSFSR became the template for other soviet republics’ public health commissariats. In principle, the republics were in charge of their own public health policy because there was no single all-union commissariat in Moscow coordinating these commissariats. In practice, most republic level commissariat’s looked to Narkomzdrav RSFSR a model to be emulated, and medical research institutes affiliated with Narkomzdrav RSFSR, like its Central Institute of Psychiatry, officially played a “leading role” in setting standards for their specialty.

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<sup>59</sup> Cooter and Sturdy, “Of War, Medicine, and Modernity,” 3-5. On the way in which WWI led to an expansion of government in Russia, as well as to an increasingly “governmental” ethos, see Peter Holquist, *Making War, Forging Revolution: Russia's Continuum of Crisis, 1914-1921* (Cambridge, Mass.: Harvard University Press, 2002); and idem., “Information is the Alpha and Omega of Our Work’: Bolshevik Surveillance in its Pan-European Context,” *Journal of Modern History* 69, no. 3 (September 1997): 415-450.

<sup>60</sup> Christopher Lawrence, “Continuity in Crisis: Medicine, 1914-1945,” in *The Western Medical Tradition, 1800 to 2000* ed. W. F. Bynum, Stephen Jacyna, Christopher Lawrence and E. M. Tansey (Cambridge: Cambridge University Press, 2006), 250-252.

<sup>61</sup> Field, *Doctor and Patient*, 23.

In 1934 the government took a first step toward creating a nation-wide medical administration when it established the All-Union Institute for Experimental Medicine. Usually referred to by its Russian acronym, VIEM, the “institute” was in fact an umbrella organization for a wide range of biomedical research institutes and clinics. For a short time it was tasked with setting Union-wide priorities for medical research. Then, in 1936-1937, the new All-Union Commissariat of Public Health was created. Narkomzdrav USSR had a standards committee that, like VIEM, was tasked with overseeing medical research. Serious friction between the two organizations was prevented because they were chaired by the same men.<sup>62</sup> For elite psychiatrists, this all meant new opportunities for funding, influence, and prestige, and conflicts quickly broke out over which psychiatrists would benefit most. The creation of Narkomzdrav USSR upset the existing hierarchy of authority within the medical establishment, and the resulting clashes between different medical institutions and powerful individuals were not resolved into the late 1940s, and in some cases the 1950s. The destabilizing effects of this change led to 15 years of discord within Soviet psychiatry as leaders in the field fought and negotiated to reestablish a stable professional hierarchy.

The Soviet Union was not alone in increasingly the level of centralization and standardization in its health system in the 1920s and 1930s. Elsewhere in Europe, the governments began to see public health as a crucial tool for increasing the productivity of their citizens, and ordinary people began to conceptualize their citizenship rights as including a right to certain social goods, including education and health care. Such rights were enshrined in the 1936 Constitution as a fundamental right to access to medical care, work, old age care, etc. This

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<sup>62</sup> N. I. Grashchenkov (Chairman), "Stenogramma Rasshirennogo zsedaniia Prezidiuma UMS MZ SSSR," 4 December 1956, GARF f. r-8009, op. 2, d. 2254, l. 9.



ideal of “social citizenship” was one of the values promulgated by the Soviet regime that resonated most strongly with the Soviet people.<sup>63</sup> Indeed, the researchers who conducted the Harvard Interview Project in the late 1940s found that the Soviet government had so well inculcating these “social citizenship” values that the regime's failure to live up to these ideals had become a source of discontent in the society. Even after refusing to return to the Soviet Union after WWII, the displaced persons that the researchers interviewed thought that the Soviet principles of health care were superior to those that they found in the west.<sup>64</sup>

Like medical systems in Europe and America, in the 1920s elite Soviet hospitals began to intensively introduce laboratory technologies to ordinary hospital practice. Laboratory technologies like the microscope had been used for generations, of course, but the scale of their use in actual clinical work was new.<sup>65</sup> Together with increasingly intense use of laboratory-produced medicines like insulin, the technological shift in hospital practice introduced new problems, but also new opportunities for the standardization and centralization of medical practice. In both Europe and America, the controversy over medical practice reached a point in the 1930s where governmental and quasi-governmental, and professional institutions were created to monitor and regulate the procedures used in developing and approving new medical treatments and technologies. Britain established a “Therapeutic Trials Committee” in 1931, while the United States established the Food and Drug Administration in 1938.<sup>66</sup> In the Soviet Union, a similar organization was created in 1937 as part of the new All-Union Commissariat of Public Health (Narkomzdrav USSR). The new “Scientific Medical Council” of Narkomzdrav

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<sup>63</sup> On “social citizenship,” see Burton, “Medical Welfare during Late Stalinism,” 15.

<sup>64</sup> Alex Inkeles and Raymond Bauer, *The Soviet Citizen: Daily Life in a Totalitarian Society* (Cambridge, Mass: Harvard University Press, 1959), 236-237.

<sup>65</sup> Lawrence, “Continuity in Crisis,” 274-278.

<sup>66</sup> *Ibid.*, 292-293.

USSR approved research proposals, issued instructions on how medicines, medical equipment, and therapeutic techniques should be used, and so forth. An official charter defining its role was issued on 22 May 1941 and gave the council “methodological leadership” over medical research and approval of new methods of diagnosis, prevention, and treatment.<sup>67</sup>

The creation of government institutions to regulate medical technology led to more rigorous standards, but it also led to acute debates over what constituted acceptable “scientific” evidence in medical tests. In the USSR, the Scientific Medical Council asked experts in each medical specialty to propose guidelines about what constituted acceptable practice, and in most cases the Scientific Medical Council seems to have been happy to delegate decisions about specific technologies and drugs to the executive councils of professional medical societies. In the postwar period, however, it became clear that in certain key instances psychiatrists could not agree about what constituted scientific evidence of therapeutic efficacy. Lobotomy, electroshock, and long-term sleep therapy all came in for criticism, and both proponents and detractors of each method appealed to the Scientific Medical Council to resolve the conflict. In the USSR, then, as in other modern societies, government regulatory bodies played crucial roles as mediators between conflicting groups of medical professionals.

### **Shock Therapy, Lobotomy, and the Promise of the New Biological Psychiatry**

Compared to the large literature on the history of psychiatry in the nineteenth century, historians have written comparatively little about the development of psychiatry in the twentieth century, particularly the period that followed the Second World War.<sup>68</sup> In the twentieth century,

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<sup>67</sup> G. Miterev, (Narkom Zdrav. SSSR), "Polozhenie o UMS SSSR," 22 May 1941, GARF, f. r-8009, op. 2, d. 739, l. 9; N. I. Grashchenkov (Chairman), "Stenogramma Rasshirenogo zsedaniia Prezidiuma UMS MZ SSSR," 4 December 1956, GARF f. r-8009, op. 2, d. 2254, l. 9.

<sup>68</sup> Shorter, *History of Psychiatry*; Freeman, ed., *A Century of Psychiatry*; Roy W. Menninger and John C. Nemiah, eds., *American Psychiatry After World War II (1944-1994)* (Washington, D. C.: American Psychiatric

however, the practice of psychiatry underwent some very significant changes, especially in terms of the tools that psychiatrists used to treat their patients.<sup>69</sup> The great hope of psychiatrists in the nineteenth century had been “moral therapy,” the psychological influence exercised by a rationally organized institution.<sup>70</sup> By the 1870s, however, psychiatrists and alienists who worked in asylums had become disillusioned with moral therapy and had begun to look for interventions in the body that could cure mental illness.<sup>71</sup> Medicines of all sorts were given to patients, as were long-lasting hot baths and other bodily treatments. The dominant ideology of the time, however, suggested that in the absence of firm knowledge about what caused mental illness, psychiatrists should refrain from treatment. This “therapeutic nihilism” was promoted in America by William Osler, and in Russia by Botkin. Both men stressed the latent powers of the body to heal itself, and saw the role of the physician as a facilitator of these natural in-born healing processes.<sup>72</sup>

Therapeutic nihilism in psychiatry was challenged in the 1920s by Julius von Wagner-Jauregg (1857-1940), a Viennese psychiatrist who had developed a cure for people suffering from progressive paralysis of the insane. Progressive paralysis was a debilitating form of neurosyphilis that filled early twentieth century asylums with patients.<sup>73</sup> Having observed cases

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Press, 2000); Mark S. Micale, "The Psychiatric Body," in *Medicine in the Twentieth Century*, ed. Roger Cooter and John V. Pickstone (Amsterdam: Harwood Academic Publishers, 2000), 323-346.

<sup>69</sup> Elliot S. Valenstein, *Great and Desperate Cures: The Rise and Decline of Psychosurgery and Other Radical Treatments for Mental Illness* (New York: Basic Books, 1986); Andrew Scull, "Somatic Treatments and the Historiography of Psychiatry," *History of Psychiatry* 5, no. 1 (1994): 1-12; Joel Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley: University of California Press, 1997).

<sup>70</sup> Shorter, *A History of Psychiatry*, 18-32; Erwin H. Ackerknecht, *A Short History of Psychiatry*, trans. Sulammith Wolff (New York: Hafner, 1959), 36-46; Jan Goldstein, *Console and Classify: The French Psychiatric Profession in the Nineteenth Century*, 2nd ed. (Cambridge: Cambridge UP, 2001), ch. 3.

<sup>71</sup> Shorter, *A History of Psychiatry*, 79-87.

<sup>72</sup> Edwin R. Wallace and John Gach, eds., *History of Psychiatry and Medical Psychology* (New York: Springer, 2008), 148-149; Stewart Wolf, "Sergei Petrovich Botkin: A Russian William Osler," *Integrative Physiological & Behavioral Science* 29, no. 2 (April-June 1994): 189-190.

<sup>73</sup> Shorter, *A History of Psychiatry*, 53-59.

of remission in patients with high fever, Wagner-Jauregg intentionally infected his patients with malaria, and their malarial fevers seemed to produce dramatic improvements.<sup>74</sup> The technique was highly dangerous: 10-15% of Wagner-Jauregg's patients died.<sup>75</sup> Still, according to Magda Whitrow, "the success rate was about 30% full remission and 20% partial remission; until then, improvement had been virtually impossible."<sup>76</sup> In the USSR, as in other parts of Europe, fever therapy was used widely by psychiatric hospitals in the 1920s and 1930s.<sup>77</sup> The possibility of actually curing their patients appealed deeply to psychiatrists. They also were attracted by the tools of the laboratory, which they hoped would transform their discipline into a respectable branch of medical science. Wagner-Jauregg won a Nobel Prize for his discovery in 1927.<sup>78</sup>

Working in an insane asylum was not a high prestige profession in the early twentieth century.<sup>79</sup> It was common for people to think of psychiatric asylums as places of horror. Even other physicians tended to look down on those who worked with the insane, seeing them as more a type of jailor than as healers. Advances in nineteenth century medicine had come from first from the hospital, and then after 1848 from laboratory, and these new approaches to general medicine established new models that psychiatrists adopted in their own approaches to medical science.<sup>80</sup> The ideal of medical science that emerged was one which idealized controlled

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<sup>74</sup> Ibid., 194. Valenstein, *Great and Desperate Cures*, ch. 3.

<sup>75</sup> Benoit Majerus, "Revisiting Psychiatry in Twentieth-Century Europe," *European Review of History* 15, no. 1 (February 2008): 57.

<sup>76</sup> Magda Whitrow, "Julius Wagner-Jauregg (1857-1940)," in *A Century of Psychiatry*, ed. Hugh Freeman (London: Mosby-Wolfe, 1999), 74-75.

<sup>77</sup> Shorter, *A History of Psychiatry*, 194-195; "Meditsinskii otchet psikhiatricheskoi bol'nitsi im. Kashchenko za 1925," TsAGM f. r-389, op. 1, d. 5, l. 30.

<sup>78</sup> "The Nobel Prize in Physiology or Medicine 1927," [http://nobelprize.org/nobel\\_prizes/medicine/laureates/1927/](http://nobelprize.org/nobel_prizes/medicine/laureates/1927/) (accessed 24 July 2009).

<sup>79</sup> Shorter, *A History of Psychiatry*, 65-68; Andrew Scull, "The Insanity of Place," *History of Psychiatry* 15, no. 4 (2004): 427-428.

<sup>80</sup> Bynum, *Science and the Practice of Medicine*, 92.

experimentation and inductive reasoning. “In leaving the hospital,” Claude Bernard wrote, “a physician, jealous of the title in its scientific sense, must go into his laboratory; and there, by experiments on animals, he will seek to account for what he has observed in his patients, whether about the action of drugs or about the origin of morbid lesions in organs or tissues. There, in a word, he will achieve true medical science.”<sup>81</sup>

The success of the laboratory in establishing priority over the hospital was particularly aided by bacteriology. The bacteriologist was not even a physician: he was a laboratory professional, someone who used microscopes and stains and experimental animals to discover the fundamental underlying causes of killer diseases like tuberculosis and cholera. In this model, the medical scientist was someone who established the specific germ that caused the disease (its etiology), the way in which that germ upset the normal function of the body (its pathology), and the observable changes caused by these underlying changes (its symptoms). By discovering this chain of cause and effect, the medical scientist enabled practitioners to properly diagnose disease and then rationally set about curing it by targeting its underlying causes.<sup>82</sup> This had a major impact on how physicians went about their work. Whereas before diseases like plague had been defined by their symptoms, now they were defined by the laboratory detection of microbes.<sup>83</sup> Doctors treated or did not treat their patients based on very different circumstances.

In the 1920s and 1930s, Soviet psychiatrists who were enthusiastic about Wagner-Jauregg’s fever therapy optimistically predicted that other psychiatric illnesses would be

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<sup>81</sup> Claude Bernard, *Introduction to the Study of Experimental Medicine*, trans. Henry Copley Greene (New York, 1957; original French ed, 1865), 146-147, quoted in in Andrew Cunningham and Perry Williams, eds., *The Laboratory Revolution in Medicine* (Cambridge: Cambridge University Press, 1992), 3.

<sup>82</sup> Bynum, *Science and the Practice of Medicine*, 127-132.

<sup>83</sup> Andrew Cunningham and Perry Williams, eds., *The Laboratory Revolution in Medicine* (Cambridge: Cambridge University Press, 1992), 9.

understood and treated in the same terms, their etiology discovered and targeted. In an address to new students in 1935, a professor told incoming students at Moscow's First Medical Institute that Wagner-Jauregg's accomplishment was "one of the most important achievements not only in psychiatry, but in general medicine." The lesson to be learned was this: "In order to treat, one must understand what to treat. That is why for us, as for any clinician, the task is to correctly establish the essence of the disease, the essence of its dynamics, and to predict what will happen to the patient."<sup>84</sup> Scientific psychiatry meant psychiatry directed by the laboratory.

By bringing the laboratory's cognitive and technological toolkit to the psychiatric hospital, psychiatrists hoped to transform these institutions from houses of incarceration into houses of emancipation. "Until very recently," one prominent psychiatrist wrote in 1935, "our psychiatric hospitals primarily worked to confine [*rabotali po prizreniiu*] the chronic mentally ill, to isolate from society those who were agitated or partially agitated, the weak, the homeless, those who were difficult for the population; the medical side was low priority." These priorities had now been reversed: "... from the confinement of the chronic mentally ill, the number of which even now has reached 70-80% in many hospitals," psychiatrists were now transitioning to "the active treatment of the newly ill." New methods of treatment were bringing about psychiatry's own "Great Break."<sup>85</sup> Often referred to as "active therapy," these methods of treatment were described as quintessentially soviet, never mind that they had been invented abroad and were widely used there as well. What made them "soviet" in the eyes of Soviet psychiatrists and medical administrators was the way that they corresponded to the dominant

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<sup>84</sup> V. A. Vnukov, "Psikhiatriia v sisteme sovremennoi meditsiny (Vstupitel'naia lektsiia, pročitannaia 5.IX.1934 na kafedra psikhiatriia 1 MMI," *Sovetskaia nevropatologiia, psikhiatriia i psikhogigiena* 4, no. 1 (1935): 6.

<sup>85</sup> L. A. Prozorov, "Tekhnicheskoe osnashchenie psikhiatricheskikh bol'nits i aktivnaia terapiia," *Nevropatologiia, psikhiatriia, psikhogigiena* 4, no. 12 (1935): 23-28.

paradigm of scientific medicine. Modern treatment was treatment that targeted biological causes, and Soviet citizens had a right to be given these treatments if they needed it.<sup>86</sup>

In 1935 fever therapy was eclipsed by the introduction of an important new method of biological treatment, shock therapy. The introduction of metrazol shock therapy in 1935 inaugurated an intense period of experimentation in European psychiatry, a period that lasted from roughly 1935 to 1952, when the first antipsychotic drugs were introduced.<sup>87</sup> The term “shock therapy” is really a misnomer. Metrazol was a drug similar to camphor that was injected into patients to produce convulsions similar to those seen in people with epilepsy.<sup>88</sup> (Its inventor, Hungarian psychiatrist Ladislav Meduna (1896-1964), believed that patients with schizophrenia recovered if they developed epilepsy.) In the USSR the drug was called “korazol,” and was introduced in 1938.<sup>89</sup> Italian psychiatrists began inducing seizures by applying electricity to the brain in 1938. Along the way, psychiatrists experimented with almost every other imaginable substance that could be injected into the body to induce seizures. (In the Soviet Union, for instance, psychiatrists sometimes intentionally injected their patients with blood of an incompatible type.<sup>90</sup>) Finally, in the midst of this experimentation with shock therapy, Portuguese psychiatrist Egaz Moniz (1874-1955) announced that he had found a way to cure some forms of insanity by operating directly on the brain. The “prefrontal leucotomy” and its more common

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<sup>86</sup> See, for instance, the discussion of psychiatry in the Minzdrav RSFSR collegium in January 1951, where “active therapy” was explicitly contrasted to a pre-soviet psychiatry that was devoted to incarceration instead of treatment. M. D. Kovrigina (Chairman), “Zasedanie kollegii MZ RSFSR,” 4 January 1951, GARF f. a-482, op. 49, d. 3041, l. 34.

<sup>87</sup> Psychiatrists had been experimenting with insulin coma therapy since 1933, but were not using it to induce seizures. Shorter, *A History of Psychiatry*, 209-210. On periodization, see Majerus, “Revisiting Psychiatry in Twentieth-Century Europe,” 57.

<sup>88</sup> Shorter, *A History of Psychiatry*, 214-215.

<sup>89</sup> M. Ia. Sereiskii, “Sudorozhnaia terapiia shizofrenii,” *Nevropatologiya i psikiatriia* 7, no. 12 (1938): 3-25.

<sup>90</sup> I. Iu. Lifshits, “Perelivanie krovi,” in *Metodika i tekhnika aktivnoi terapii psikhicheskikh zabolovaniy*, ed. V. A. Giliarovskii and P. B. Posvianskii (Moscow: 1939), 54-61.

American cousin, the lobotomy, arguably became the most notorious method of medical treatment in the twentieth century.<sup>91</sup> Moniz went on to win the Nobel Prize in medicine for his achievement in 1949.<sup>92</sup>

The biological therapies that were used in the 1930s and 1940s were often dangerous or even deadly for patients, and, in retrospect, have been seen by most psychiatrists as mistakes at best, criminal malpractice at worst.<sup>93</sup> (Electroshock therapy is the exception here: it is still used and considered highly effective in some cases, though its mechanism is still not understood.<sup>94</sup>) The temptation for historians is to pass judgment on these past practitioners, to expose them as charlatans and frauds. As Joel Braslow points out, however, this approach fails to “identify the means by which the ‘bizarre’ was made therapeutic and efficacious for the many physicians who readily deployed these remedies.”<sup>95</sup> In his own work, Braslow has attempted to show how the psychiatrists who used biological therapies like lobotomy and insulin shock genuinely believed that they worked. They were not deluded, he argues. In the particular social context in which they were used, these therapies really did have significant effects. They were not therapeutic effects that could be reproduced in a controlled environment, but in the context of the psychiatric hospital they produced results that *signified* improvement in the condition of the insane. The

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<sup>91</sup> Jack D. Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge: Cambridge University Press, 1998), introduction; Gretchen J. Diefenbach, *et al*, "Portrayal of Lobotomy in the Popular Press: 1935-1960," *Journal of the History of Neuroscience* 8, no. 1 (1999): 60-69; Jack El-Hai, *The Lobotomist: A Maverick Medical Genius and His Tragic Quest to Rid the World of Mental Illness* (Wiley, 2005).

<sup>92</sup> Moniz shared his prize with Swiss physiologist Walter Rudolf Hess (1881-1973). "The Nobel Prize in Physiology or Medicine 1949," [http://nobelprize.org/nobel\\_prizes/medicine/laureates/1949/](http://nobelprize.org/nobel_prizes/medicine/laureates/1949/) (accessed 24 July 2009).

<sup>93</sup> Elliot S. Valenstein, *Great and Desperate Cures: The Rise and Decline of Psychosurgery and Other Radical Treatments for Mental Illness* (New York: Basic Books, 1986), ch. 2.

<sup>94</sup> Edward Shorter and David Healy, *Shock Therapy: A History of Electroconvulsive Treatment in Mental Illness* (New Brunswick, New Jersey, & London: Rutgers University Press, 2007).

<sup>95</sup> Joel Braslow, "Therapeutics and the History of Psychiatry," *Bulletin of the History of Medicine* 74, no. 4 (2000): 800.



approach that Braslow suggests, then, is for the historian to try to understand the contextual ways in which psychiatrists interpreted the results of their actions.<sup>96</sup>

Taking a similar approach in his landmark study of lobotomy in America, Jack Pressman argues that, “Any connections made between what a treatment *really* does and its subsequent life course must be proven, not assumed. . . . medical treatments do *not* possess an inherent clinical attractiveness in the way that physical objects possess mass” [emphasis original].<sup>97</sup> The problem, Pressman says, is that in an era of evidence-based medicine, people assume that treatments are adopted simply because they “really work,” that is, because of objective results that they produce self-evidently tell us whether these treatments are useful or not. Studies of “failed medical technologies” are thus particularly useful, Pressman argues, because “they test comfortable assumptions concerning the introduction, evaluation, and diffusion of therapeutic innovation.”<sup>98</sup> By studying why technologies like lobotomy were first embraced by the medical establishment only later to be rejected, we help can contextualize clinical decision making in a way that helps us understand the value systems that were operating in specific times and places.

Soviet psychiatrists read about these new methods of treatment in European journals and talked about them with the few European psychiatrists who came to the Soviet Union.<sup>99</sup> Detailed knowledge of insulin therapy was brought to the USSR in 1936 by Arthur Kronfeld, a well-regarded German psychiatrist who had been forced to flee when the Nazi Party came to power.

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<sup>96</sup> Joel Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley: University of California Press, 1997), esp. 4-5.

<sup>97</sup> Pressman, *Last Resort*, 7-8.

<sup>98</sup> *Ibid.*

<sup>99</sup> See, for instance, S. I. Konstorum, "Inostrannaia literatura po shizofrenii za 1934 g.," *Nevropatologiia, psikhiaetriia, psikhogigiena* 5, no. 5 (1936): 865-873; K. Skvortsov, "Vozmozhnosti i popytki terapii (Obzory: Vie Tacques, Lechenie shizofrenii, Gazette des hopitaux, 1936, 8, s. 129-136, 10, 141-168)," *Nevropatologiia, psikhiaetriia, psikhogigiena* 5, no. 6 (1936): 1035-1040.

(Kronfeld had spent time in Switzerland before coming to the Soviet Union, and there he had seen the early tests being done on insulin therapy.<sup>100</sup>) By December 1936, a leading Soviet researcher reported that there were over 70 different treatments in use for schizophrenia alone. The field of psychiatric treatment, he told a major gathering of Soviet psychiatrists, was “in chaos.”<sup>101</sup>

This “chaos” was by no means limited to the Soviet Union. Insulin therapy and shock therapy were being quickly taken up and experimented with in America, and psychiatrists throughout Europe were vigorously injecting their patients with anything they could think of that might induce fever, seizures, shock, or any other sort of reaction.<sup>102</sup> A 1935 review article of the current state of French psychiatry informed Soviet readers of a broad range of methods, none of which seemed to be any good for treating patients suffering from chronic schizophrenia.<sup>103</sup> The period that ran from around 1936 to the introduction of psychoactive drugs in the early 1950s, then, was a particularly intense period of ferment in Western psychiatry in general. What made this period particularly interesting in the USSR was that this period of change in psychiatry coincided with rapid institutional changes in the Soviet system of public health, and with political and ideological pressure put on psychiatrists to define themselves and their role in Soviet society. The result was an intense politicization of debates surrounding the new biological

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<sup>100</sup> A. S. Kronfel'd and E. Ia. Shternberg, "Lechenie shizofrenii insulinovym shokom," in *Trudy 2-go vsesoiuznogo s"ezda nevropatologov i psikhiatrov. 25-29 dekabria 1936 g.*, ed. M. B. Krol' and A. O. Edel'shtein (Moscow: 1937), 603-608; Iu. S. Savenko, "120-Letie Artura Kronfel'da (1886-1941). Tragediia zhizni i tvorchestva artura Kronfel'da - klassika i vse eshche sovremennika," *Nezavisimyi psikhiatricheskii zhurnal*, no. 1 (2007).

<sup>101</sup> M. Ia. Sereiskii, "Sovremennye problemy lecheniia shizofrenii," in *Trudy 2-go vsesoiuznogo s"ezda nevropatologov i psikhiatrov. 25-29 dekabria 1936 g.*, ed. M. B. Krol' and A. O. Edel'shtein (Moscow: 1937), 570.

<sup>102</sup> Among the more surprising substances used to induce fever was the *Spirillum minus*, a bacterium found in rats which produces an illness known in English as “rat bite fever.” P. B. Posvianskii and M. A. Vunder, "Metodika primeneniia privivok sodoku v terapii progressivnogo paralicha," in *Metodika i tekhnika aktivnoi terapii psikhicheskikh zabolevanii*, ed. V. A. Giliarovskii and P. B. Posvianskii (Moscow: 1939), 62-66.

<sup>103</sup> K. Skvortsov, "Vozmozhnosti i popytki terrapii," *Nevropatologiya, psikhiatriia, psikhogigiiena* 5, no. 6 (1936): 1035-1040.

therapies, debates that had much in common with debates going on in Europe and America, but which were carried out in particularly Soviet ways and brought in uniquely Soviet themes.

### **Foucault and Soviet Psychiatry**

Since the 1970s, studies of psychiatry and the human sciences have been heavily influenced by the work of Michel Foucault. The implications of his work for the study of Soviet professions are quite interesting, as are the possibilities opened by his work for understanding the construction of identity and knowledge. Of course, Foucault himself was far from consistent in his approaches to these subjects, which makes any attempt at a concise précis of his ideas risky. In the brief discussion that follows, therefore, I do not pretend to any sort of comprehensive survey of Foucault's thought. Instead I focus particularly on the ideas that historians have drawn from Foucault's work and which they have found particularly useful for understanding the role of psychiatry and disciplinary power and for understanding the Soviet Union.

According to Foucault, scholars cannot understand how power functions in modern states simply by reading law codes or studying how governments use their monopoly on physical violence. These sorts of "political power," according to Foucault, are quite insufficient to keep order in modern societies. Political power, however, is just one "modality" among many, and Foucault contrasts it with other "modalities" of power that he refers to variously as "disciplinary" or "pastoral." These sorts of power are not codified in laws, nor are they applied equally to all. The analogy here is to a shepherd looking after a herd of sheep: each sheep is treated as the shepherd sees best according to its needs, with the ultimate goal being the well-

being of both the individual and the herd.<sup>104</sup> To quote Jan Goldstein's apt paraphrase, "Unable to constrain behavior on the huge demographic scale characteristic of modern societies, [the law] needs external support in what... is the necessarily 'corporal' matter of exercising power."<sup>105</sup>

It is this realm of discipline where Foucault sees psychiatry and the human sciences playing a particularly significant role. In the aftermath of the French Revolution, Foucault argues, people were taught to believe that everyone should be free to do as they pleased within the limits of the law, and that the law should be applied equally to all citizens. Such political autonomy, however, ignored or obscured the role of disciplinary power. Far from being free to act as they pleased, citizens were in fact subjected to hidden and unequal discipline exercised by experts like psychiatrists. These experts claimed to be acting according to objective laws of science: they were simply helping the individual to overcome his or her particular biological or psychological nature. Certainly they were not making normative judgments about what was right or wrong. In fact, they were managing individuals according to normative criteria that were arrived at through cultural process rooted in discourse.<sup>106</sup>

Historians have used Foucault's framework to help them explore the role of medical experts in Russia and the Soviet Union.<sup>107</sup> In a particularly interesting study of the human sciences, Daniel Beer has highlighted the role of early twentieth century psychiatrists in creating "the intellectual categories, assumptions, and theories" that the Bolsheviks used to understand

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<sup>104</sup> Michel Foucault, "Omnes et Singulatim: Toward a Critique of Political Reason," in *Power*, vol. 3, trans. Robert Hurley, ed. James D. Faubion, Essential Works of Foucault 1954-1984 (New York: The New Press, 2000), 298-325; idem., "Governmentality," in *The Foucault Effect: Studies in Governmentality*, trans. Pasquale Pasquino, ed. Graham Burchell, Colin Gordon, and Peter Miller (Chicago: University of Chicago Press, 1991), 87-104.

<sup>105</sup> Jan Goldstein, "Framing Discipline with Law: Problems and Promises of the Liberal State," *American Historical Review* 98, no. 2 (April 1993): 367.

<sup>106</sup> Michel Foucault, *Discipline & Punish: The Birth of the Prison*, trans. Alan Sheridan, 2nd ed. (New York: Vintage Books, 1995), 136-139.

<sup>107</sup> See note 28, above.

their world and develop their policies, including the policies that led to the Great Terror.<sup>108</sup> In the late tsarist period, Beer argues, Russian psychiatrists and other practitioners of the “human sciences” generally hoped that Russia would become a country where social order was based on equality under the law, respect for private property, and the gradual increase in human freedom through rationality.<sup>109</sup> The problem, as they saw it, was that the vast majority of Russians would have to be educated and acculturated before they could help build this stable society governed by law. Psychiatrists operating in this milieu judged the capacities of their patients in relation to their own standards of rationality and morality. People who were judged to be backward or unfit were in some cases curable through medical treatment, psychotherapy, or improved living conditions. Others were not: hereditary biological flaws could render some people unredeemable threats to the creation of a stable and harmonious modern society. They would have to be sent to live out their lives in psychiatric colonies separated from the rest of society. The psychiatrists, in short, were making judgments that were “as much cultural as [they were] medical.”<sup>110</sup> They were applying power to bodies in ways that the law could not.

Psychiatrists continued to pursue this “cultural project” (as Joravsky would call it) well into the Soviet period. Practitioners of mental hygiene, pedology, and other “bio-social” disciplines were quite open about their goals of changing what they saw as backward habits, figuring out the best profession for every individual, and weeding out people who were deemed “defective.”<sup>111</sup> They aimed to use science to create a type of person who would conform to their

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<sup>108</sup> Beer, *Renovating Russia*, 1

<sup>109</sup> *Ibid.*, 2.

<sup>110</sup> *Ibid.*, 20. Beer is paraphrasing Christine Worobec, *Possessed: Women, Witches, and Demons in Imperial Russia* (DeKalb, Ill.: Northern Illinois University Press, 2001), 150-151.

<sup>111</sup> “Defectology” [*defektologiia*] was the name of the discipline that provided care to disabled children in the USSR. In the 1920s defectology was a thriving field, but the field was severely curtailed during the First Five Year

vision of what an ideal person should be. They believed, in short, that practitioners of the bio-social sciences should play an integral role in shaping the “new soviet man.” By the early 1930s, however, it had become quite clear that the Bolsheviks would not allow the biomedical professions to play this role in Soviet society, and this prohibition was formalized by the 1936 ban on pedology and psychotechnics.<sup>112</sup> This exclusion raises important questions about the status of the human sciences in the Soviet system and the relationship in the USSR between political and disciplinary power. Why, in short, did the Bolsheviks not give biomedical experts free reign to “landscape the human garden”?<sup>113</sup>

One possible answer is that this was a predictable outcome of institutional politics. Sheila Fitzpatrick has pointed out that in the day-to-day tussle over scarce resources, state institutions with a “soft-line” profile, that is, those that focused on culture or social welfare, almost always lost out to those with “hard-line” portfolios, like the industrial ministries or the organs of state security.<sup>114</sup> It is not hard to see disciplines like educational testing (pedology) or mental health

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Plan. Children from defectology institutions who were considered juvenile delinquents were transferred to NKVD jurisdiction, while children with severe mental retardation (“oligophrenia”) and epilepsy remained within Commissariat of Health institutions. Iudin attributed the decline of defectology to the end of the problem of child homelessness [*besprizornost*'] and the remarkable general improvement in living conditions in the Soviet Union. Iudin, *Ocherki istorii otechestvennoi psikhiiatrii*, 389.

<sup>112</sup> Beer sees this shift as the product of institutional politics, with the Communist Academy becoming dominant to the exclusion of other approaches, rather than a rejection of disciplinary power per se. Beer, *Renovating Russia*, 167.

<sup>113</sup> The phrase comes from Amir Weiner, *Landscaping the Human Garden: Twentieth-Century Population Management in a Comparative Framework* (Stanford: Stanford University Press, 2003).

<sup>114</sup> In Fitzpatrick’s formulation, issues of social policy in the USSR were often overseen by both soft-line and hard-line institutions. The soft-line institutions promoted policy of reconciliation and accommodation with people who were potential class allies. They used the metaphorical “carrot” to convince people that they should ally themselves with soviet socialism and the Soviet government. Hard-line institutions carried the stick. Instead of coddling potential class enemies, they treated them harshly as the enemies that they could become. Soft-line institutions offered benefits, but had little power to follow through on their promises. Hard-line institutions inflicted penalties, and had the muscle to turn them into reality. Sheila Fitzpatrick, “The Soft Line on Culture and Its Enemies,” in *The Cultural Front: Power and Culture in Revolutionary Russia* (Ithaca and New York: Cornell University Press, 1992), 91-114. Terry Martin has developed this idea in his work on Soviet nationalities. See Terry Martin, “Interpreting the New Archival Signals: Nationalities Policy and the Nature of the Soviet Bureaucracy,” *Cahiers du Monde russe* 40, no. 1-2 (1999): 113-24.

services (mental hygiene) in this light. Perhaps in an ideal world all of these projects would be well funded, but in the Soviet Union's military-style campaign to industrialize the country and prepare it for war, managers could hardly justify giving resources to dubious tests or family counseling. What is more, "experts" who told factory bosses to let their workers have lighter hours or more healthful conditions were clearly not contributing to the fulfillment of the Five-Year Plan, much less to its over-fulfillment in 4 years. As one activist wrote in 1931, "So-called 'Soviet exhaustion [*iznoshennost*']' does not exist in reality. What exists is merely a reactionary mania [*bred*], by which they are trying to pit the proletariat against its revolutionary tempos, and by sowing fear of non-existent difficulties to hold back our movement forward. This whole theory of Professor Giliarovskii is a theory of bourgeois restoration."<sup>115</sup>

This soft-line/hard-line dichotomy is an important feature of the Soviet system and certainly played a role in structuring the possibilities that were open to psychiatrists. It is probably not the whole story, however. Psychiatrists, after all, had their own "hard-line" functions in their capacity as forensic experts. They even had their own hard-line institution, the Serbsky Institute of Forensic Psychiatry, which even in the 1930s was working closely with the security organs to create psychiatric prison hospitals.<sup>116</sup> By sidelining psychiatric experts, were the Bolshevik leaders not casting off a potentially very useful source of control in their society?

One way of thinking about this problem is provided by Laura Engelstein in her 1993 essay on the applicability of Foucault's ideas to the Russian case. Engelstein argues that in the Soviet Union, disciplinary power was operating within a different set of structural constraints

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<sup>115</sup> S. I. Subotnik, "Za bol'shevistskoe nastuplenie na teoreticheskom fronte psikhonevrologii," *Zhurnal nevropatologii i psikhatrii*, no. 2 (1931): 14, quoted in David Joravsky, "The Construction of the Stalinist Psyche," in *Cultural Revolution in Russia, 1928-1931*, ed. Sheila Fitzpatrick (Bloomington: Indiana University Press, 1978), 116.

<sup>116</sup> Prokopenko, *Bezumnoia psikhiaatriia*, 24-26.

than those in the societies that Foucault studied. In Foucault's post-revolutionary nation-state, according to Engelstein, professionals worked in an environment where they were legally autonomous from the sovereign. Disciplinary power and political power were formally separated from one another, and the tension between the two was important for preserving legal authority and disciplinary authority as distinct spheres.<sup>117</sup> According to Engelstein, however, these spheres were not distinctly separated in the Soviet Union. In the USSR, she argues, law was not used to create a framework for autonomous subjects enjoying universal rights. Instead, fundamental laws like the 1936 Constitution were used as tools of "pastoral" power.<sup>118</sup> Under this arrangement, experts like psychiatrists no longer played a distinct role in society by applying a type of power that was unavailable to the constitutionally established authorities.<sup>119</sup> They continued to act independently to some degree, though their autonomy as professionals was not always recognized even in principle.<sup>120</sup> But their role was essentially the same as other actors in the soviet system: making bodies docile.

One of the implications of Engelstein's argument is that biomedical expertise could potentially have played a much *larger* role in the Soviet Union. After all, in Foucault's post-revolutionary regime in the West, the actions of psychiatrists were significantly constrained by the constitutionally established rights of citizens.<sup>121</sup> Psychiatrists in such a society exercised great influence through their power to "discipline bodies" and produce the knowledge-power that

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<sup>117</sup> Laura Engelstein, "Combined Underdevelopment: Discipline and Law in Imperial and Soviet Russia," *American Historical Review* (April 1993): 343-344.

<sup>118</sup> Laura Engelstein, "Framing Discipline with Law: Problems and Promises of the Liberal State: Reply," *American Historical Review* 98, no. 2 (April 1993): 378.

<sup>119</sup> Idem., "Combined Underdevelopment," 353.

<sup>120</sup> Idem., "Framing Discipline with Law," 377-378.

<sup>121</sup> Idem., "Combined Underdevelopment," 353.



constitutes liberal subjectivity (on which more below), but the division between disciplinary power and political power remained socially important. These barriers to psychiatric expertise would not exist in a different sort of society, one without constitutionally enshrined rights to personal sovereignty. If Engelstein is right and law in the Soviet Union was essentially just another tool of disciplinary/pastoral power, then it is conceivable that a powerful bio-social discipline might have been able to take on a much larger role in managing Soviet society than would have been possible in a rights-based system. Put in a slightly different way, the Communist Party was right to see “bourgeois experts” as a threat to their authority.<sup>122</sup> The Party justified its vanguard role in the proletarian dictatorship on the grounds that its members possessed a specific type of social-scientific expertise, their superior understanding of Marxist-Leninist theory. Biosocial scientists like those in the mental hygiene movement were advocating a comprehensive science of population management that, if shown to be empirically grounded, might have been seen as a rival to Marxism-Leninism. The psychiatrists, of course, claimed that they were working within a Marxist-Leninist paradigm.<sup>123</sup> From the perspective of actual Party cadres, however, they looked like outsiders making a bid for disciplinary jurisdiction on the basis of their superior scientific knowledge.

For Soviet psychiatrists in the aftermath of 1936, therefore, part of the task was finding a role for themselves that would signal to the Party that they were not a threat to the pastoral power that was used to dominate Soviet society. Thus discussion of “mental hygiene” fell to a minimum

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<sup>122</sup> This fits well with Joravsky’s that factory bosses read the Cultural Revolution as meaning that “that specialists must be on tap, not on top,” Joravsky, “The Construction of the Stalinist Psyche,” 120.

<sup>123</sup> L. M. Rozenshtein, “Sotsial'no-profilakticheskoe napravlenie v psikhii,” *Zhurnal nevropatologii i psikhatrii*, no. 4 (1930): 19-20. When mental hygiene came under attack in 1932, Party activists demanded that mental hygiene be retheorized to cleanse it of the influence of American mental hygiene movement. D. E. Stolbun and A. S. Shmar'ian, “Pis'mo t. Stalina i zadachi nevropsikhiatricheskogo fronta,” *Sovetskaia nevropatologiya, psikhii i psikhogigiena* 1, no. 1-2 (1932): 19.

in the late 1930s as psychiatrists adopted a mode of discourse that was determinedly circumscribed by discussion of biological facts.<sup>124</sup> Significantly, all mention of “the new Soviet Man” vanished from psychiatric journals, monographs, textbooks and conference reports. Psychiatrists were keen to demonstrate that they were no longer in the business of creating a totalizing theory of population management.

### *Psychiatry and Soviet Subjectivity?*

So far my discussion of Foucault’s approach to power has evaded the issue of subjectivity. It is precisely in the realm of subjectivity, however, that Foucault’s approach is particularly radical. The concept of power that has conventionally been used by political scientists and sociologists can be traced back to Thomas Hobbes. Despite a wide range of disagreements, scholars working in this tradition have generally understood power to be the capacity of an agent to achieve his own desires despite resistance on the part of other agents. Power, in this definition, is the ability to do things that others do not want you to do, and this ability, this power, is something that one possesses.<sup>125</sup> Within this basic definition, scholars often speak of “three dimensions” of power. These are, roughly speaking, the power to prevail in a direct contest, the power to determine what issues will be contested, and, finally, the power to shape how people evaluate what is good and bad, and thus determine their choices about what should and should not change.<sup>126</sup> Foucault’s concept of “governmentality” and Gramsci’s concept of hegemony both share much in common with this “third dimension” of power, dealing as they

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<sup>124</sup> A few lone voices continued to speak up for mental hygiene, but they were the exception. "V Moskovskom obshchestve nevropatologov i psikiatrov," *Nevropatologiya i psikiatriia* 7, no. 3 (1938): 150.

<sup>125</sup> Barry Hindess, *Discourses of Power: From Hobbes to Foucault* (Oxford: Wiley-Blackwell, 1996), 1-22.

<sup>126</sup> Steven Lukes, *Power: A Radical View, Second Edition* (Palgrave Macmillan, 2005).

do with the practices and categories that shape how people understand themselves and their world.<sup>127</sup>

Unlike most scholars, however, Foucault does not conceptualize power as something that can be possessed by one agent and imposed on another. His key point is that disciplinary power cannot be adequately represented by the image of the armed sovereign striking down a lawbreaker. The actual operation of disciplinary power is something that is not only punitive or “negative,” it is also “productive” or “positive” in the sense that they give people an ordered way of seeing the world and themselves. Such structure is “a prerequisite for new knowledge, for effective therapy, for informed judgments, and for structured lifestyles.” Disciplinary practices, in short, are essential parts of how we make sense of our world.<sup>128</sup> In Foucault’s view, then, “to impose” is the wrong verb altogether. Disciplinary power resides in practices and techniques, not in coherent agents who have definite goals. Individuals develop a sense of what it means to be an agent, to be a “self,” only through the process of acting out and responding to these disciplinary practices.<sup>129</sup> The practices themselves shape what people want, what their goals are, what they want to make other people do. The question of “Who has power?” is therefore “unanswerable.”<sup>130</sup>

In her 1993 article, Engelstein suggests that the disciplinary regime under Stalinism produced a distinctly Soviet subject that was quite different to the subjectivity that was produced by liberal, post-revolutionary regimes on the continent. There, individuals developed a sense of self that was embedded in a specific set of power relations. On the one hand, the individual

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<sup>127</sup> Wenman, "Power," 374.

<sup>128</sup> Eric J. Engstrom, *Clinical Psychiatry in Imperial Germany: A History of Psychiatric Practice* (Ithaca: Cornell University Press, 2003), 5.

<sup>129</sup> Greg Eghigian, Andreas Killen, and Christine Leuenberger, "The Self as Project: Politics and the Human Sciences in the Twentieth Century," *Osiris* 22 (2007): 1-25.

<sup>130</sup> Michel Foucault, *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977*, ed. Colin Gordon, 1st American ed. (New York: Pantheon Books, 1980), 97, quoted in Wenman, "Power," 376.

believed that he or she was truly an autonomous, sovereign individual bounded only by the law. On the other hand there was the lived experience of being subjected to disciplinary power outside the law, one's life chances shaped and limited by all the "microphysics" of everyday life.<sup>131</sup> In the Soviet Union, Engelstein suggests, individuals simply did not share this experience of the self, because, in Russia, "there has historically been no tension between subjectivity and submission."<sup>132</sup> The soviet experience of the insecurities and aspirations of the self, the Soviet subject's sense of what he or she ought to be feeling or doing – this experience was different than the experience of subjectivity in the liberal West.

In the past decade several scholars have taken up the challenge of showing what "subjectivity" might have meant in the Soviet context.<sup>133</sup> Empirically, of course, this is an extraordinarily difficult task, not least because it requires access to a sort of interior experience which few if any sources can actually give. Scholars attempting to write this type of history have relied on Party discipline proceedings, diaries, letters, and oral histories. Other historians have chosen to focus on advice literature and other normative texts that helped people develop a sense of self.<sup>134</sup> The crucial insight of this literature is that "Stalinist subjectivity" was not something that was imposed on the individual from outside. Instead individuals were active and enthusiastic agents in the construction of their own "Stalinist selfhood." Caught up in the multiple and

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<sup>131</sup> Anna Krylova, "The Tenacious Liberal Subject in Soviet Studies," *Kritika: Explorations in Russian and Eurasian History* 1, no. 1 (2000): 119-46.

<sup>132</sup> Engelstein, "Combined Underdevelopment," 353.

<sup>133</sup> See particularly Stephen Kotkin, *Magnetic Mountain: Stalinism as a Civilization* (Berkeley: University of California Press, 1995); Igal Halfin and Jochen Hellbeck, "Rethinking the Stalinist Subject," *Jahrbücher für Geschichte Osteuropas* 44 (1996): 456-463; Jochen Hellbeck, "Fashioning the Stalinist Soul: The Diary of Stepan Podlubnyi, 1931-9," in *Stalinism: New Directions*, ed. Sheila Fitzpatrick (London and New York: Routledge, 2000), 77-116; Igal Halfin, *Language and Revolution: Making Modern Political Identities* (London: F. Cass, 2002).

<sup>134</sup> For party discipline and diaries, see works by Halfin and Helbeck, cited above. Advice literature has been used to particularly good effect by Oleg Kharkhordin, *The Collective and the Individual in Russia: A Study of Practices* (Berkeley: University of California Press, 1999).

sometimes contradictory discourses of selfhood, Soviet people often seem to have felt inadequate and alone, to have longed to shape themselves into a “self” that would feel accepted as a full and adequate member of the Soviet polity.<sup>135</sup>

Medical records potentially constitute a major source base for scholars of Soviet subjectivity. Illness and the body, after all, are a large part of how people experience themselves and thus important sites to look for “modalities” of power. The temptation for scholars is to look only at what doctors wrote and said about illness rather what actually happened when their patients were in the room with them. Studies of professional discourse are important, and this dissertation engages in it wholeheartedly, but we should not mistake professional discourse for the experience of being a person with an illness. By empirically studying patient and physician records, correspondence, diaries, and oral histories, historians could make major contributions to our understanding of how Soviets experienced themselves and how their sense of self was affected or structured by their experiences of illness and their interactions with medical experts.

When I began this dissertation I hoped to make use of hospital records, patient letters, court documents, and other sources that would give us insight into how Soviet subjectivity was affected by the experience of illness and the process of being examined and treated by medical experts. This is not that dissertation. The archives of the Ministries of Health and local psychiatric hospitals did hold some patient records, but they were few and far between, and did not provide the source base necessary for robust analysis. Court records were another matter. I made a decision early on in my research to focus on the psychiatric hospital system rather than psychiatric expertise in the courts. I reasoned that in order to adequately understand the world of

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<sup>135</sup>Hellbeck, “Fashioning the Stalinist Soul,” and idem., *Revolution on My Mind: Writing a Diary under Stalin* (Cambridge, Mass.: Harvard University Press, 2006). See also Stephen Kotkin, “The State - Is It Us? Memoirs, Archives, and Kremlinologists,” *Russian Review* 61 (January 2002): 35-51.

psychiatric expertise, it was first necessary to develop a solid empirical understanding of how psychiatric knowledge was generated and contested within the party-state system. The question of how psychiatric experts actually worked in the soviet judicial system is very important, not only to our understanding of the relationship between disciplinary power and administrative power in the USSR, but also to help contextualize the political abuse of psychiatry that became prominent under Khrushchev and Brezhnev. That, however, is a project for another time.

### *Disciplinary Knowledge and Technology in the Clinic*

For Soviet psychiatrists in the late 1930s, it was clear that to be accepted as properly “soviet,” psychiatry would have to prove that it had become truly “scientific.” This posed both conceptual and epistemological problems. New biological treatments like insulin shock and lobotomy were dramatic and exciting, but how should they be used? How should their results be evaluated? Soviet psychiatrists could not seem to agree on a standard set of criteria. And though they started their discussions by debating their empirical findings, they quickly moved to disputing the methodologies and assumptions that their rivals had used to collect their facts. It is in this domain of how medical facts are created that Foucault’s concept of “productive power” is most important to this dissertation.

Knowledge, Foucault would have us understand, is the product of distinct disciplinary practices. This is particularly easy to grasp when studying the use of technology in the medical clinic. As historian Eric Engstrom has lucidly explained in his study of psychiatry in imperial Germany, you can't simply look through a microscope and see structure *x*, and you *certainly* can't look through the microscope and understand the relationship of structure *x* to structure *y*, much less to disease state *z*. In order to make any sense of what you see through the microscope, you

need to know what tissue counts as an important structure and what does not, and you need to memorize the names of the structures in the organism. You need to know how to prepare your specimens using special dyes and stains to make detail visible. And so on, and so forth. Looking at a blurry image, in other words, is not sufficient to produce knowledge. Useful knowledge is not just lying around waiting to be found. To produce knowledge, the scientist has to be taught how to *see*, how to collect, how to interpret.<sup>136</sup> All of these techniques can be understood as “disciplinary” in Foucault’s sense of the word. They are “negative,” in the sense that they teach the observer *not* to do certain things. But they are also enormously “productive” in that, by structuring the way he watches, they enable him to fit what he sees into a framework in relation to other observations. In this sense, knowledge is a function of disciplinary power.<sup>137</sup>

Following Andrew Abbott, I see knowledge as particularly important to professionals because they use their mastery of knowledge to assert claims to jurisdiction over work.<sup>138</sup> If one professional wants to contest the results obtained by another, the most powerful type of critique that can be made is a challenge to the disciplinary practices that his rival used to produce his facts. Disciplinary practices that are based in the clinic or the laboratory can thus have a major impact on the rhetoric of scientific disputes. Furthermore, as theories, methods, and technologies change, new ways of seeing come into existence.<sup>139</sup> This produces new knowledge, and this new knowledge enables its producers to reassert their own authority within the profession or to contest the authority of others.

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<sup>136</sup> Eric J. Engstrom, *Clinical Psychiatry in Imperial Germany: A History of Psychiatric Practice* (Ithaca: Cornell University Press, 2003), 6-7.

<sup>137</sup> Foucault, *Discipline and Punish*, 170-194.

<sup>138</sup> Andrew Abbott, *The System of Professions: An Essay on the Expert Division of Labor* (Chicago: University of Chicago Press, 1988).

<sup>139</sup> Engstrom , 5-7, 94-96.

Since the 1850s, medical science has been dominated by the criteria set by scientists working in the laboratory.<sup>140</sup> New technologies developed for the laboratory gradually found their way into hospitals in the late nineteenth century, but it was in the early twentieth century that the “laboratory revolution” really came to the hospital.<sup>141</sup>

Soviet psychiatric hospitals were relatively late to adopt these new tools. In part this was a function of conservatism. Most psychiatric hospitals were very large and located in rural districts. The people who ran them were reluctant to change long-established systems, particularly since the buildings themselves would in many cases have to be adapted to the new methods and tools. Academic psychiatrists and public health administrators, however, were very keen to see laboratory technologies brought to the psychiatric hospital. Their efforts were given a major boost when the “shock therapies” were introduced because these new biological methods of treatment required large-scale restructuring of the daily routines and procedures in psychiatric hospitals. These changes began in some places in the late 1930s, but most hospitals began adopting them in earnest only after the war. In order to properly deliver treatments like insulin shock therapy or lobotomy, the hospital staff had to adhere to strict routines and standards of cleanliness and accuracy. Psychiatric hospital administrators and academic psychiatrists had long tried to get nurses and doctors to observe similar standards. In a sense, then, disciplinary practices associated with the new biological therapies helped to modernize and “civilize” Soviet psychiatric hospitals.

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<sup>140</sup> Andrew Cunningham and Perry Williams, eds., *The Laboratory Revolution in Medicine* (Cambridge: Cambridge University Press, 1992).

<sup>141</sup> Joel D. Howell, *Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century* (Baltimore: Johns Hopkins University Press, 1995), 52.



At the same time, I argue, these new disciplinary practices also produced new ways of understanding what it meant for psychiatry to be “scientific.” Narkomzdrav’s experts were constantly counting and reporting the number of psychiatric hospitals with laboratories, the number of x-ray machines, the number of Wasserman tests, the number of urine analyses. They pressured psychiatric hospital directors to “re-profile” their wards, sorting patients in ways that would make “active therapy” more easy to conduct. These metrics were used to track the progress of modernization within the psychiatric system. Furthermore, new ways of seeing produced new forms of knowledge. The shift in disciplinary practices in the hospital, therefore, was closely connected to the higher level debates about the future of psychiatric science.

### **Science and Psychiatry, and Pavlov’s Theory of Higher Nervous Activity**

From 1939 to 1951, Soviet psychiatrists advanced a wide range of solutions to the problem of what it meant for psychiatry to be scientific. What they had in common was that they articulated their claims using quotations and ideas taken from the work of Ivan Pavlov, the Russian physiologist who had won the Nobel Prize in Physiology in 1904.<sup>142</sup> In his later years Pavlov himself had been interested in psychiatry and he had written a number of articles speculating about the implications of his conditioned reflex for human psychology. Some Soviet psychiatrists had even tried to apply his ideas to human patients in the 1920s and 1930s. In some cases these efforts failed, or failed to gain a following. Others were denounced publicly by party activists as “mechanicism.”<sup>143</sup> When Pavlov died in 1936, he was eulogized in the journal *Neuropathology and Psychiatry*, his contribution to psychiatry was summarized as having been

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<sup>142</sup> “The Nobel Prize in Physiology or Medicine 1904,” [http://nobelprize.org/nobel\\_prizes/medicine/laureates/1904/pavlov-bio.html](http://nobelprize.org/nobel_prizes/medicine/laureates/1904/pavlov-bio.html) (accessed 25 July 2009).

<sup>143</sup> D. E. Stolbun and A. S. Shmar'ian, "Pis'mo t. Stalina i zadachi nevropsikhiatricheskogo fronta," *Sovetskaia nevropatologiia, psikhiaetriia i psikhogigiiena* 1, no. 1-2 (1932): 15.

to “indicate the exact path along which we must travel further ... on the basis of complete mastery of more general physiological propositions.”<sup>144</sup> Pavlov’s work, in other words, was taken as a starting point, not a dogmatic system, and certainly not a general theory of psychiatry. This was the spirit in which Pavlov’s ideas were employed by Soviet psychiatrists in the decade that followed.

There is a temptation when studying the history of these disciplinary debates to assume that the participants were acting cynically, advancing medical concepts for their own political, economic, or social gain. In the Soviet context, the suspicion that psychiatrists might have been cynical (if not outright charlatans) is sometimes heightened by their ritualized use of authoritative texts by the likes of Marx, Lenin, and Pavlov. By pressing their ideas into officially approved forms, after all, psychiatrists and other Soviet professionals were quite obviously manipulating their ideas, often using them to impugn the patriotism and ideological purity of their intellectual opponents. Nevertheless, I believe it is important to approach these debates with the assumption that the protagonists genuinely believed their ideas were correct and that patients would be better off if their ideas were put into practice.

John Harley Warner points out the difficulty of this stance. “If asked,” he writes, “most historians would certainly agree that any given scientific concept in medicine might simultaneously be useful for furthering research and practice and in advancing socioeconomic and political goals, but in their work many tend to act as if they must choose between functions.”<sup>145</sup> In the history of medicine, pursuit of social and political power and pursuit of

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<sup>144</sup> V. A. Giliarovskii, "I. P. Pavlov i psikhiaetriia," *Nevropatologiia, psikhiaetriia, psikhogigiiena* 5, no. 6 (1936): 908. In his obituary, Giliarovskii claimed that Pavlov had rejected the mechanistic views of his more zealous followers and had always believed in the importance of “the role of the personality, and its activity and other qualities.” *Ibid.*, 907.

<sup>145</sup> John Harley Warner, "Science in Medicine," *Osiris* 1, no. 1 (1985): 49.

better knowledge and the public good cannot be neatly disentangled.<sup>146</sup> Realistically, there probably were times when some Soviet psychiatrists used their ideas for political gain without really believing in them. Cynicism, after all, was not unknown to Soviet society. The point is that we should not start from assumption that the ideas being discussed were bad science or that their authors were insincere. (Though, of course, we should be open to the possibility that both were true, should evidence support that conclusion.)

Historians of Soviet science like Nikolai Kremmentsov and Alexei Kojevnikov have shown that Soviet scientists *could* advance scientific knowledge even working within the confines of what seems at first and second glance to be empty phraseology. Just because the Party imposed the language which scientists had to use to discuss their ideas does not mean that the Party also imposed a pre-decided approach to individual scientific disciplines. Soviet scientists were able to pursue their own agendas within the “rules of the game,” as Kojevnikov puts it. That is, they were able to express a surprisingly wide range of ideas and needs all the while using the “ritualized” practices that had developed as part of Bolshevik political culture. In order to understand the outcome of events like scientific meetings and discussions, then, it is not enough to study what the Party said the correct ideological line should be. We must also understand how the participants used that rhetoric and the formalized social settings where they performed that rhetoric.<sup>147</sup>

Psychiatrists continued to use Pavlov’s theories to help them articulate their ideas both because the Bolshevik regime had elevated him to the status of a “safe,” canonical thinker, but

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<sup>146</sup> Warner reiterates this theme in idem., "The History of Science and the Sciences of Medicine," *Osiris* 10, no. 1 (1995): 174.

<sup>147</sup> Alexei Kojevnikov, *Stalin's Great Science: The Times and Adventures of Soviet Physicists* (London: Imperial College Press, 2004), xv; Nikolai Kremmentsov, *Stalinist Science* (Princeton: Princeton University Press, 1997), ch. 7.

also because Pavlov's ideas conformed closely to the expectations that Soviet government officials had for psychiatric research.<sup>148</sup> This conventional wisdom about what to expect from research into the mind had been firmly established for most Russian intellectuals going back all the way to the 1860s. In the '60s, members of the more radical fringe of the Russian intelligentsia had embraced the radical idea that science could "explain" the soul, a position that implicitly undermined any claim the Tsar might have to divine right to rule. A particularly influential text had been an 1863 book by physiologist Ivan Sechenov. The book, "Reflexes of the Brain," "created a sensation because [of] the author's schema for explaining higher mental functions on the basis of reflex physiology," writes historian Daniel Todes. According to Sechenov, human thought was the product of physiological processes and was subject to physical, scientifically explainable laws.<sup>149</sup> By the turn of the twentieth century, Sechenov's once radical-sounding views had come to seem common-sense and value neutral to scientists and physicians of all political persuasions.<sup>150</sup> It was in this context that Pavlov introduced his idea that the conditioned reflex was the fundamental unit of the mind.<sup>151</sup> "For these professionals," Todes writes, "... it was neither radical nor uncommon to assert that what Pavlov termed *psychic secretion* might be explicable as a reflex."<sup>152</sup> Having been raised in this intellectual milieu, Bolshevik leaders, educated government officials, and Soviet psychiatrists themselves all understood the assumption that the idea of "reflexes of the brain" would ultimately help

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<sup>148</sup> Joravsky, *Russian Psychology*, 387, 399.

<sup>149</sup> Daniel P. Todes, *Pavlov's Physiology Factory: Experiment, Interpretation, Laboratory Enterprise* (Baltimore: Johns Hopkins University Press, 2002), 229-230. See also idem., "From Radicalism to Scientific Convention: Biological Psychology in Russia from Sechenov to Pavlov" (PhD, University of Pennsylvania, 1981), 239-240; Joravsky, *Russian Psychology*, 126-134; and Mary A. B. Brazier, *A History of Neurophysiology in the 19th Century* (New York: Raven, 1988), 212-215.

<sup>150</sup> Todes, *Pavlov's Physiology Factory*, 229-230.

<sup>151</sup> Joravsky, *Russian Psychology*, 138 -145.

<sup>152</sup> Todes, *Pavlov's Physiology Factory*, 229-230.

articulate whatever conceptualizations of the mind might be advanced. Just what a “reflex” meant was left a bit fuzzy, as was the mechanism by which these “reflexes” produced thought.<sup>153</sup> But never mind: whether used literally or metaphorically, “reflexes of the brain” became a shorthand way of stating the truism that thought is produced by the biological processes of the brain.

Virtually all educated people know the basic idea of Pavlov’s “conditioned reflex.” When a dog sees food it naturally salivates. Pavlov called these inborn responses “unconditioned reflexes.” But when a researcher consistently rings a bell before bringing out the food, the dog will begin to salivate to the sound of the bell. There was nothing naturally salubrious about the bell or its ring, but the dog salivated as if it were smelling meat. Pavlov called this a “conditioned reflex.”<sup>154</sup> He believed that the reflex was the basic unit of thought and behavior, in humans as well as in animals. Furthermore, he believed that this was a strictly deterministic process. The dog salivated because of past events (the bell ringing at the same time that an unconditioned reflex was triggered). This temporal sequence was important to Pavlov: the dog did not salivate because it consciously knew food was coming. It did not choose to salivate. Its salivation was predetermined by its experiences in the past.<sup>155</sup>

Pavlov’s enthusiasm for the conditioned reflex lay in his belief that it could be used as tool to objectively uncover the basic procedural rules that govern human thought at the physical

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<sup>153</sup> Joravsky, *Russian Psychology*, 98.

<sup>154</sup> “Conditioned reflex” is a mistranslation of the Russian “*uslovnyi reflex*.” As David Joravsky points out, “*Uslovnyi* should be translated as ‘conditional’, but endless repetition of ‘conditioned’ has made that mistranslation stick.” By “conditional,” Pavlov and his colleagues had in mind “a certain kind of salivation [that] was conditional on past experience – if associated with acid on the tongue, the sight of the bottle caused salivation; if not, not – but also that the hypothesis was conditional: the scientists were not sure that the correlation of experience and salivation was reducing psychic secretion to a newly discovered type of reflex.” Joravsky, *Russian Psychology*, 137-138.

<sup>155</sup> Joravsky, *Russian Psychology*, 155-156.

level. The basic idea was simple. Conditioned reflexes did not last forever. If stimuli were not repeated, the conditioned reflex faded away, or was “extinguished.” Establishing a second conditioned reflex could hasten the speed at which a previously established conditioned reflex was extinguished; ringing the original bell again could quickly re-establish the conditioned reflex. The amount of time that these processes took could be precisely measured and predicated. Conditioned reflexes, in other words, were not simply a curious phenomenon: they could be used as laboratory tools to painstakingly work out the objective rules that underpin all human thought. Pavlov called his work “the theory of higher nervous activity.”<sup>156</sup>

Psychiatrists and psychologists found Pavlov’s work highly suggestive, and they were particularly struck by his work on “experimental neuroses.” Essentially, Pavlov used conditioning to put a dog into a situation where it was conflicted between contradictory impulses. Eventually, this produced behaviors that looked very much like the phobias and hysterias sometimes seen in humans. Pavlov speculated that “Different conditions productive of extreme excitation, such as intense grief or bitter insults, often lead, when the natural reactions are inhibited by the necessary restraint, to profound and prolonged loss of balance in nervous and psychic activity.”<sup>157</sup> The implication was that reflexes served as mechanisms that helped people adjust to the circumstances they found themselves in. Neuroses, according to this view, were the outcome of extreme conditions or maladaptive responses.

Russian psychiatrists and psychologists were not the only ones to see the potential in this idea. In America, psychiatrists used Pavlov’s concept to argue that “the mad” were actually located on a spectrum of mental health that ran from high-functioning people through mild

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<sup>156</sup> Ibid., 138 –145, 277, 293-297.

<sup>157</sup> Quoted in *ibid.*, 203.

neurotics and all the way to the insane. The difference between them was how well they had adjusted to their place in society. Biology clearly played a role here: some people were simply biologically more capable of doing some things than others. But upbringing, socioeconomic status, and education all played a role as well. The psychiatrists' role should not be limited to biology, then. Instead "psychiatry" should be understood broadly reframed as "psychobiology," the science of maladjustment. Within this framework "psychiatry" could include people trained in psychology, neurology, physiology, psychiatry, social work, and any other discipline that might help people to find a place in society where they could live happy lives well suited to their own abilities and aptitudes. Pavlov's conditioned reflex could be used to help ground this multidisciplinary framework in the contemporary standards of laboratory science.<sup>158</sup>

This bio-social science of "adaptation" was, of course, precisely the sort of thing that the Central Committee had placed out of bounds when they banned pedology and psychotechnics in 1936. (Soviet mental hygiene specialists were explicitly criticized for their ties to the American mental hygiene movement and its concept of adjustment.<sup>159</sup>) But Pavlov's work was broad enough that Soviet scientists could reject these broad readings without rejecting his work on "higher nervous activity." The question, then, was just what this theory should mean in psychiatry.

The polemics and discussions that went on within Soviet psychiatry in the 1940s can be boiled down to two basic debates. The first was essentially a conflict over whether psychiatry should be governed by the laboratory or the hospital. In a sense, this argument recapitulated the nineteenth century argument about whether medical science could be done by observing large

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<sup>158</sup> Pressman, *Last Resort*, 36-38.

<sup>159</sup> Stolbun and Shmar'ian, "Pis'mo t. Stalina i zadachi nevro-psikhiatricheskogo fronta," 19.

numbers of patients in hospitals, or whether to be “scientific” medical experts needed to do experiments under the controlled conditions of the laboratory. Proponents of a laboratory approach to psychiatry were working from the natural sciences paradigm that came out of the bacteriological revolution. According to this model, a psychiatric illness was only truly understood if the causes and effects of its etiology and pathology could be revealed in the laboratory. Psychiatrists could be said to be acting rationally only when they treated patients with full knowledge of what they were doing and why.

Not all proponents of laboratory-based psychiatry agreed on what laboratory techniques should be used or which institutes should be in charge of deciding. At the extreme were psychiatrists who argued that all psychiatric classification based on clinical symptoms should be abandoned. Instead, psychiatric illnesses should be re-classified based on the underlying processes of higher nervous activity. These would be determined using the strictly objective methods developed in Pavlov’s physiological laboratory. The criteria governing psychiatric knowledge and practice would, in this approach, be set entirely by people working in a laboratory setting. Without the aid of Pavlovian methods of observation and analysis, no true psychiatric knowledge could be generated.

At the other end of this spectrum were psychiatrists who used the tools of modern science, but who did not believe that medical knowledge was produced in the laboratory. These psychiatrists continued to work within a nosological tradition that was particularly associated with German psychiatrist Emil Kraepelin. Rather than sitting in a laboratory looking at tissue under a microscope, these clinical psychiatrists primarily worked in psychiatric hospitals carefully recording patient symptoms and attempting to derive medical knowledge from them. Kraepelin’s basic procedure had been to keep elaborate card files for all his patients. He used his



cards to find correlations between typical groupings of symptoms and typical ways in which those symptom-complexes changed over time. On this basis of these findings he tentatively sketched out a picture of what symptoms belong to each disease entity and how those disease entities develop over time. This knowledge was scientific, they argued, in the sense that it gave insight into real aspects of the disease process. What is more, the knowledge was potentially very useful. With the aid of diagnostic criteria derived from this type of knowledge, the clinician could hope to accurately predict the future course of the patient's disease. This knowledge could then be used to design treatment and care. Proponents of this type of clinical nosology did reject the possibility of knowledge coming from the laboratory. The point, rather, was to defend the possibility of scientific medical knowledge coming from the clinic.

The second axis of debate within Soviet psychiatry concerned how "disease" should be defined. The tendency within modern medicine has been to conceptualize diseases as entities that are essentially similar in each patient that they afflict, an approach referred to as the ontological theory of disease. When seen in this way, disease itself becomes the primary unit that the physician studies as well as the primary target of treatment. The goal of the specialist is to thoroughly understand the etiology, pathology, and symptoms of a specific type of disease. This approach to disease can be said to be reductionist in that it implies that causes of disease can be found in discrete parts of the body.<sup>160</sup> The assumption here is that the body is like a mechanism

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<sup>160</sup> Owsei Temkin, "The Scientific Approach to Disease: Specific Entity and Individual Sickness," in *The Double Face of Janus and Other Essays in the History of Medicine* (Baltimore: Johns Hopkins Press, 1977), 441-455; W. F. Bynum, "Nosology," in *Companion Encyclopedia of the History of Medicine*, vol. 1, ed. W. F. Bynum and Roy Porter (London: Routledge, 1993), 338-342.

where the disease is caused by “broken parts” and the role of the physician is to find and fix the broken or malfunctioning component.<sup>161</sup>

This “disease entity” approach to medical problems had been relatively common in European medicine since the early modern period, but it had only become predominant in the late eighteenth and early nineteenth century.<sup>162</sup> Prior to that, disease had been conceptualized within a holistic, neo-Hippocratic tradition that had predominated for centuries. Within this older tradition, disease was thought to be unique to each individual. Physicians were not trained to specialize in specific diseases, they were trained to specialize in whole patients. It was thought that the function or dysfunction of individual parts of the body could only be understood in the context of an integral whole. The condition of each bodily system reflected the state of all other bodily systems, and the way these systems related to one another was unique for each person. Similar external causes, therefore, might affect two people in very different ways.<sup>163</sup>

In the 1920s and 1930s, holistic approaches to disease were widely revived.<sup>164</sup> Historians have suggested that in part this revival was part of a broader conservative reaction to modernity. In this reading, people were uncomfortable with what they saw as the breakdown of national community into atomized individuals, and sought to revive images of the nation as a unified whole. The body has strong metaphorical associations with the nation, and so these political and

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<sup>161</sup> Paul McHugh and Phillip R. Slavney, *The Perspectives of Psychiatry*, 2nd ed. (Baltimore: Johns Hopkins University Press, 1998), 46-48.

<sup>162</sup> Lindeman, *Medicine and Society in Early Modern Europe*, 71-72; Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, 30-46.

<sup>163</sup> Mary Lindemann, *Medicine and Society in Early Modern Europe* (Cambridge: Cambridge University Press, 1999); Charles E. Rosenberg, "The Therapeutic Revolution: Medicine, Meaning, and Social Change in Nineteenth-Century America," in *The Therapeutic Revolution: Essays in the Social History of American Medicine*, ed. Morris Vogel and Charles E. Rosenberg (Philadelphia: University of Pennsylvania Press, 1979).

<sup>164</sup> Christopher Lawrence and George Weisz, "Medical Holism: The Context," in *Greater than the Parts: Holism in Biomedicine, 1920-1950*, ed. Christopher Lawrence and George Weisz (New York: Oxford University Press, 1998), 1-2.

social anxieties were reflected in how people talked about the “natural order” of the body.<sup>165</sup> As Christopher Lawrence writes, “holistic concepts were employed to argue that the ideal community was an organic whole.... They were ... ways of making sense of a world splintered by the Great War, before which some sort of harmony had seemed to reign.”<sup>166</sup>

In more concrete terms, the revival of holistic thinking in medicine in the interwar period was a reaction to the rapid introduction of laboratory technologies to clinical practice. The trend, particularly after World War One, was toward standardization and large-scale clinical assessment. Blood tests, x-rays, urine analysis, and other tests were developed by biomedical researchers, not physicians, and they were rapidly changing how physicians categorized, diagnosed, and treated disease. Significantly, these tests could not be interpreted by just anyone. To understand the results, one needed special training, and physicians simply did not have the time to do the work themselves.<sup>167</sup> “Medical students could be taught to appreciate and even rely on their findings. But no ordinary medical graduate would be expected to be expert in the taking and interpretation of bacteriological cultures, ophthalmologic findings, X-rays, and the esoteric curves of the sphygmograph.”<sup>168</sup> As a result, physicians were coming to rely on laboratory experts to interpret what they saw at the bedside.

There was a strong backlash against this trend from physicians who believed that their patients’ symptoms could only be properly understood only if they were considered in context with other aspects of the patients’ state. The numbers and readings produced by new technologies were important, but on their own they did not tell the physician enough to

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<sup>165</sup> Lawrence and Weisz, “Medical Holism,” 4-5.

<sup>166</sup> Lawrence, “Continuity in Crisis,” 268.

<sup>167</sup> Lawrence, “Continuity in Crisis,” 174.

<sup>168</sup> Ibid.

understand the patient. In the interwar years, this type of holistic thinking was given support from biomedical science itself, especially by new discoveries in physiology and endocrinology about the way that bodily systems communicated with one another through hormones and the nervous system. In his 1932 book *The Wisdom of the Body*, for instance, Harvard physiologist Walter Cannon famously popularized the idea that the body was a whole system with each part of the body responding to minute changes in the whole to maintain bodily equilibrium, a process Cannon dubbed “homeostasis.”<sup>169</sup>

Seen from the perspective of medical holism, knowledge of how specific body parts worked was necessary but not sufficient. Psychiatric knowledge could only be judged to be scientifically valid only if that knowledge was contextualized in relation to the unique qualities of the individual patient.<sup>170</sup> What set psychiatric science apart was its ability to consider these factors in the context of an individual’s whole condition. Taken narrowly, this meant that psychiatric disease could not be assumed to be rooted solely in the brain, since the brain and the rest of the central nervous system was part of the whole body system. Taken more broadly, the holistic approach suggested that psychiatric knowledge was incomplete if it was limited to the body as a unit of analysis. The body, of course, was affected by its environment, and its environment was not just physical, it was also social. Cannon’s concept of homeostasis could be understood as a mechanism by which individuals adjusted to the conditions both inside and outside their bodies, a mechanism that helped explain how social interactions were translated

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<sup>169</sup> Walter B. Cannon, *The Wisdom of the Body* (New York: W.W. Norton, 1932).

<sup>170</sup> Engstrom, *Clinical Psychiatry in Imperial Germany*, 107-108.

into biological effects. In this view, the 1936 ban on bio-social theories was an affront to science.<sup>171</sup>

Pavlov's work was particularly useful to psychiatrists because they could use it to support all four of these basic positions. Psychiatrists who advocated laboratory-based science could plausibly argue that only Pavlov's "strictly objective" laboratory methods could produce scientific knowledge about the mind. Protagonists of the ontological theory of disease could point to Pavlov's interest in uncovering the fundamental physical processes that caused disease. But Pavlov had also been interested in interactions between the body and its environment, which translated easily into the language of medical holism. And his theory also implied that each individual had a unique configuration of "nervous processes," suggesting that basic research would have to involve work with actual patients in the clinic. For academic psychiatrists, Pavlov's ideas were very useful rhetorically.

Pavlov's theory was most powerful, however, when it was presented as a synthesis of all these views. Psychiatrists seem to have felt intuitively that eventually, when we fully understand the physical process that produces thought, we will be able to see psychiatric illness as both a specific disease entity and as something that affects the whole person. Even more grandly, as David Joravsky points out, people assumed that in this future state of perfect knowledge scientists would be able to show how the "objective" electrical and chemical processes in the brain were linked to the conscious thoughts being thought by that brain. Particularly ambitious psychiatrists, then, use Pavlovian theory to present their work as the sought after synthesis, the

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<sup>171</sup> See chapter 4 where I discuss Giliarovskii's attempt to roll back the 1936 ban on bio-social approaches.

true psychiatry of the future. It was precisely this vision of a unified theory of psychiatry that was endorsed as the official consensus theory in 1951.<sup>172</sup>

And yet, the approach to psychiatry that was actually used in psychiatric hospitals in the 1950s was something altogether different. In practice, Pavlovian laboratory techniques did not produce useful results. Pavlovian clinical techniques, however, did produce useful results because they provided hospital administrators with new ways of rationalizing their hospitals and disciplining their patients. The “protective hospital regime” advocated by the Pavlovians helped keep overcrowded hospitals quiet.

What is more, Pavlovian psychiatry required hospital staff to keep more extensive records and follow much stricter regimens with their patients. “Pavlovian psychiatry” thus brought about changes in hospital management that psychiatrists had been pushing for ever since the 1930s when shock therapies first appeared on the scene. Pavlovian principles made it easier to carry out shock therapy, and easier to assess its results. Indeed, the technologies that were associated with the “Pavlovian” revolution were particularly useful for producing large amounts of new about psychiatric patients. This did not translate into new insights into the etiology or pathology of mental illness. Instead, it laid the groundwork for a resurgence of classical hospital psychiatry, psychiatry devoted to observing symptoms, tabulating data, and trying to build up long-term profiles of disease. Instead of producing a new unified psychiatry, I argue, the Pavlovian moment ultimately provided the tools that enabled clinical psychiatrists to develop clinical methodologies and forms of knowledge that proved to have long-lasting use in the context of Soviet psychiatric hospitals and psychiatric research.

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<sup>172</sup> Joravsky, *Russian Psychology*, 383.

The harsh criticisms of Soviet psychiatry in 1936 and 1937 left the leaders of the profession in a confusing and dangerous position. It was clearly their task to reorient Soviet psychiatry toward the needs of the industrializing nation, to create a “truly soviet” psychiatry. And yet all prior attempts to create a distinctively soviet psychiatry had ended in failure and disgrace. And of course psychiatrists, particularly those in positions of responsibility, felt the pressure of Stalin’s Great Terror which was reaching a crescendo at precisely the time when their field was in the most disarray. In 1937, then, Soviet psychiatrists found themselves wondering what was in store for their profession.

The lack of any positive program for Soviet psychiatry was palpable in an essay written by Moscow professor Mikhail Gurevich on the twentieth anniversary of the October revolution in 1937. The anniversary of the revolution was a traditional time of taking stock and boasting about the progress of one’s field under Soviet power. In Gurevich’s piece, however, the story of psychiatry under Soviet power was a story of deviations and mistakes. In the 1920s and 1930s psychiatrists had embraced reflexology, pedology, defectology, and eugenics. All of them had been found to be over simplified, anti-materialist, and pseudoscientific, and all had been discarded.<sup>173</sup> Rozenshtein’s approach to borderline cases of mental illness was singled out as the most recent mistake. His evaluations, Gurevich wrote, “did not use sufficiently objective methods, followed the line of feeling, psychologization, intuition, and led to a partial return to the phenomenological approach to psychiatry which it was thought had long ago been sent to the archive.” Rozenshtein had led Soviet psychiatrists to fixate on minute individual variation, leading “mild neurotics, hysterics, etc to be counted among the insane.” The All-Union Congress in 1936 had found this method to be unscientific and unworthy of soviet medical practice. But

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<sup>173</sup> M. O. Gurevich, "20 let sovetskoi psikhiiatrii," *Nevropatologiya i psikhiiatriia* 6, no. 10 (1937): 15-20

this was the most Gurevich could say for Soviet psychiatry: “We can simply note with satisfaction that these mistakes have been acknowledged, that the appropriate conclusions are being taken from them both for theory and for practice.” Just what those “appropriate conclusions” might mean for Soviet psychiatry was not yet clear.<sup>174</sup>

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<sup>174</sup> Ibid., 21-22.



## CHAPTER 1

### SOVIET PSYCHIATRIC HOSPITALS AND MODERN MEDICINE, 1939-1949

Every psychiatric hospital should have a clinical-diagnostic laboratory, an autopsy lab, and an x-ray office: otherwise it will simply be a madhouse [*sumasshedshi dom*] of the old type. ...

-- Pavel Posvianskii, Director of the RSFSR Central Institute of  
Psychiatry, speaking at a 1950 meeting of the Collegium of Minzdrav  
RSFSR<sup>1</sup>

In 1936, insulin shock therapy came to Soviet psychiatric medicine. Psychiatrists in the USSR had experimented with fever therapy and other methods of “active biological treatment” before, but the introduction of insulin shock therapy marked the beginning of an important new stage in the history of Soviet psychiatry.<sup>2</sup> Like other forms of convulsive therapy such as Metrozol shock and electroshock, insulin shock therapy was hailed as a potential panacea, a

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<sup>1</sup> P. B. Posvianskii, in G. N. Beletskii (Chairman), “Protokol No. 58 zasedaniia kollegii MZ RSFSR,” 16 November 1950, GARF, f. a-482, op. 49, d. 1519, ll. 16, 18.

<sup>2</sup> Malaria fever therapy was in use in the USSR by 1925 and experimentation with prolonged sleep therapy using Cloetta’s mixture had begun in 1934. “Meditsinskii otchet psikiatricheskoi bol’nitsi im. Kashchenko za 1925,” TsAGM, f. r-389, op. 1, d. 5, l. 30.M. Ia. Sereiskii and Fel’dman, “Problema dlitel’nogo narkoza v psikiatrii,” reported in “V Moskovskom obshchestve nevropatologov i psikiatrov,” *Nevropatologiia, psikiatriia, psikhogigiiena* 5, no. 5 (1936): 882-895. Sereiskii had reportedly been experimenting with prolonged sleep using Kleasi’s methodology since 1929; in 1934 he began to use Cloetta’s mixture and sodium amital. S. I. Konstorum, “Inostrannaia literatura po shizofrenii za 1934 g.,” *Nevropatologiia, psikiatriia, psikhogigiiena* 5, no. 5 (1936): 865-873. Ivanov-Smolenskii claimed that V. P. Protopopov had been the first Soviet psychiatrist to use prolonged sleep therapy (also in 1934). A. G. Ivanov-Smolenskii, *Ocherki patofiziologii vysshei nervnoi deiatel’nosti (Po dannym I. P. Pavlova i ego shkoly)* (Moscow: Medgiz, 1949), 238.

medical treatment that could actually cure the mad. As one psychiatrist declared at a 1938 conference in Moscow, “Active therapy of psychoses is a new path, one that raises the level of psychiatry, brings it closer to other medical disciplines.”<sup>3</sup>

Both psychiatrists and medical administrators were excited by the possibility that these new methods of treatment could bring about a fundamental change in how psychiatric hospitals operated. Without any proven form of treatment, most people with psychoses either improved on their own or lingered in psychiatric hospitals for years. As a result, the psychiatric “hospitals” bore little resemblance to the sort of institution that most people thought of when they heard the word “hospital.” Modern hospitals were thought of as places of treatment, places where the tools of contemporary science were brought to bear on the problems of the human body. Shock therapies raised hopes that psychiatry would now join the rest of medicine. Patients would be assessed with recognizably scientific tools, and those assessments would help psychiatrists decide which specific medical treatments to give them. As the director of the RSFSR Central Institute of Psychiatry put it, “Every psychiatric hospital should have a clinical-diagnostic laboratory, an autopsy lab, and an x-ray office: otherwise it will simply be a madhouse [*sumasshedshi dom*] of the old type.”<sup>4</sup>

There were two fundamental obstacles to the realization of this vision. The first was the condition of psychiatric hospitals in the USSR, which was truly awful. In order to make “active therapy” a central part of ordinary psychiatric practice, the Commissariat of Public Health would have to find a way to reduce overcrowding, increase the number of staff, provide them with

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<sup>3</sup> "V Moskovskom obshchestve nevropatologov i psikiatrov," *Nevropatologiya i psikhiatriia* 7, no. 3 (1938): 160.

<sup>4</sup> P. B. Posvianskii, in G. N. Beletskii (Chairman), “Protokol No. 58 zasedaniia kollegii MZ RSFSR,” 16 November 1950, GARF, f. a-482, op. 49, d. 1519, ll. 16, 18.

training, give them instruments, and provide the medicines and drugs needed to carry out the new methods of treatment. All of this required money and resources, both of which were in short supply. The second problem was the shock therapies themselves: they were not the panaceas they had been made out to be. Psychiatrists tried to figure out which treatments worked best for specific types of illness, but patterns were hard to discern. Some patients seem to respond well, while other patients did not. No one knew how the treatments worked when they did. Far from ushering in a new era of rationally prescribed medical treatment, the shock therapies marked the beginning of an era that some described as reckless empiricism.

### “The Fight Against Agitation”

Insulin shock therapy was developed in Europe between 1933 and 1935, and reports of this early work had been reported in the USSR.<sup>5</sup> By December 1936 a Moscow psychiatric institute had done over 100 treatments using insulin therapy and the lead researcher was able to boast that their preliminary results indicated that the method was actually more effective than had been initially reported in Europe.<sup>6</sup> In contrast, the first paper on insulin therapy published in the United States was not in print until mid-1937.<sup>7</sup> The immediate reason that insulin therapy was adopted so quickly in the Soviet Union was the immigration in 1936 of Arthur Kronfeld, a well-regarded German psychiatrist who had been forced to flee the Nazis. He came to the USSR by

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<sup>5</sup> S. I. Konstorum, "Inostrannaia literatura po shizofrenii za 1934 g.," *Nevropatologiia, psikhiaetriia, psikhogigiena* 5, no. 5 (1936): 865-873.

<sup>6</sup> M. Ia. Sereiskii, "Sovremennye problemy lecheniia shizofrenii," in *Trudy 2-go vsesoiuznogo s"ezda nevropatologov i psikhiatrov. 25-29 dekabria 1936 g.*, ed. M. B. Krol' and A. O. Edel'shtein (Moscow: 1937), 574-575; A. S. Kronfel'd and E. Ia. Shternberg, "Lechenie shizofrenii insulinovym shokom," in *Trudy 2-go vsesoiuznogo s"ezda nevropatologov i psikhiatrov. 25-29 dekabria 1936 g.*, ed. M. B. Krol' and A. O. Edel'shtein (Moscow: 1937), 603-608.

<sup>7</sup> The man who brought insulin therapy to America was Joseph Wortis. Wortis went on to write a book on Soviet Psychiatry, in part because of his interest in biological methods of treatment. Shorter, *A History of Psychiatry*, 211-212.

way of Zurich, and quickly set about duplicating (and improving upon) the insulin treatments he had seen in there.<sup>8</sup>

Other major research clinics in the USSR quickly took up the study of insulin therapy. In 1937 several papers on insulin therapy were given in meetings of the Moscow Society of Neuropathologists and Psychiatrists and published in edited volumes. By 1938 the main Soviet psychiatric journals began to publish review articles on the burgeoning European literature on the subject. In 1939 there were six major articles by Soviet researchers on insulin and metrazol shock therapies, and in 1940 and 1941 the “active biological treatments,” and insulin therapy in particular, had become the main subject of psychiatric research. In 1941 two whole issues of *Neuropathology and Psychiatry* were devoted almost exclusively to articles on insulin shock and seizure therapy. Between 1939 and 1941 insulin therapy, prolonged narcosis, and Cardiazol therapy (the Soviet version of Metrazol) became the standard treatments for schizophrenia; older methods either fell by the wayside or were relegated to the status of “symptomatic” therapy.

For elite psychiatrists and Narkomzdrav officials, these were exciting years because they saw the possibility that the new therapies would lead to a new modernization of the psychiatric system. But the introduction of these new therapies also served to highlight just how deep the problems were in Soviet psychiatric hospitals. Simply maintaining elementary order was a constant problem, one that psychiatric hospital workers commonly referred to as “the fight against agitation” [*bor'ba s vzbuzhdeniem*]. Keeping order was particularly difficult because psychiatric hospitals were so often overcrowded. “Crowding seriously affects the patients’

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<sup>8</sup> Iu. S. Savenko, "120-Letie Artura Kronfel'da (1886-1941). Tragediia zhizni i tvorchestva artura Kronfel'da - klassika i vse eshche sovremennika," *Nezavisimy psikhiatricheskii zhurnal*, no. 1 (2007).

conditions,” reported one psychiatrist. “One patient excites another, and the potential multiplies for arguments and aggressive outbursts.”<sup>9</sup>

When they were admitted, patients were stripped of their street clothes and belongings, had their heads shaved, were issued new underclothes, and were dressed in hospital gowns.<sup>10</sup> New arrivals were often assigned to “bed regime” [*postel'nyi rezhim*] for the first two to or three days after their arrival, a tactic that was said to “make the patient realize he was in a hospital and not a ‘madhouse.’”<sup>11</sup> Some hospitals gave patients distinctive clothing to wear when they went outside so that hospital staff could tell at a glance if a patient had permission to leave the wards.<sup>12</sup> Inside the hospital psychiatrists and nurses subjected patients to a strict schedule for waking and sleeping, eating, exercising, bathing, walking outside and, of course, receiving medical treatment. Doors between wards were kept locked, and staff kept close watch on where patients went and what they did, regularly counting to make sure patients were in the places that they were supposed to be.<sup>13</sup>

Most psychiatric hospitals in the Soviet Union had been built in the 1880s and 1890s, and they had been built in rural areas outside of towns and cities, intentionally placed apart from

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<sup>9</sup> Dr. Iagodka (Head physician for the 6<sup>th</sup> Women’s Ward, in A. B. Aleksandrovskii, “Stenogramma konferentsii vrachei pri 1oi Moskovskoi gorodskoi psikhiatricheskoi bol'nitsy,” 9 March 1948, TsMAM f. 1126, op. 1, d. 57, ll. 26-27.

<sup>10</sup> St. 66 *Osnovnye polozheniia po organizatsii i rabote psikhiatricheskikh bol'nits* (Moscow: 1947), available at [www.talagi.ru/library/arhiv\\_doc1.htm](http://www.talagi.ru/library/arhiv_doc1.htm) (accessed April 28, 2007); V. V. Mikheev and A. V. Neiman, *Uchebnik nervnykh i psikhicheskikh boleznei dlia srednikh meditsinskikh shkol*, 3rd ed. (Moscow: Medgiz, 1946), 186. Rybalka, “Prikaz po psikhonev. gorodskoi bol'nitse No. 4 im. Gannushkina,” 12 March 1961, TsMAM f. 533, op. 1, d. 55, l. 42.

<sup>11</sup> Mikheev and Neiman, *Uchebnik nervnykh i psikhicheskikh boleznei*, 187.

<sup>12</sup> A. I. Kofman (Gl. Vrach), “Godovaia ob"iasnitel'naia zapiska po godovomu otchetu po 2 Moskovskoi zagorodnoi psikh. bol'nitse za 1949 g.,” TsAGM, f. 551, op. 1, d. 232b, l. 12.

<sup>13</sup> On internal rules for locking doors and counting patients, see N. Krylova (Gl. vrach), “Prikaz 143a po psikhonevrologicheskoi gorodskoi bo'nitse No. 3,” 6 June 1957, TsAGM, f. 1126, op. 1, d. 100, l. 18; V. N. Rybalka (Gl. Vrach), “Prikaz no. 571 po psikhonevrologicheskoi gorodskoi bol'nitse No. 4 im. Gannushkina,” 18 December 1961, TsMAM f. 533, op. 1, d. 55, l. 52.

society at large.<sup>14</sup> The windows of the buildings were usually covered with grates to prevent suicides and the grounds were surrounded by fencing.<sup>15</sup> Once inside, patients were subjected not only to the formal discipline of the hospital regime, but also to the informal discipline of the other patients. Like prisons, psychiatric hospitals had their own subcultures, complete with a repertoire of slang and anecdotes and a prison-style rough justice. This culture was described by a patient who wrote to the government to in the late 1940s after a stay in “the Kashchenko Madhouse” [*Sumasshedshii dom im. Kashchenko*]:

They dress you ... in a torn, dirty gown and lock you up, say, in the 5th ward, which is a corridor 50-60 meters long. The windows [*fortochki*] don't open. The corridor is totally filled with cigarette smoke and has 5 rooms, each with 12 beds. There is no place in a room to put chairs or stools. They eat in the corridor. ...

On the ward neither the toilet nor the sink works. ... At night clothes are dried in the corridor on the tables where patients eat. But the main thing is that sick officers and soldiers lie next to syphilitics whose noses are falling in. Dishes are washed with cold water, and they say that “at this stage syphilis is not infectious.” I just spent time in that hospital, though I didn't need those methods of treatment. They gave me 10 shots of glucose with magnesium and kept me in that place, a prison, not a hospital, for 20 days. You can't protest, else they send you to the violent ward [*boinoe otdelenie*]. No cultural work goes on. At night, when the physicians leave, things get really bad. You take a tranquilizer, but you can't sleep: they smoke, curse, tell dirty stories [*pokhabnye anekdoty*], and judge with their own court. Last year the patients judged one patient themselves, and hanged him. That affair was glossed over. The night attendants sleep sweetly, and the attending physicians don't check in.”<sup>16</sup>

This sort of environment could be frightening even for the hospital staff, though as a postwar textbook for psychiatric nurses noted, “those who have decided to dedicate themselves

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<sup>14</sup> A. Tret'iakov (Narodnyi komissar Zdrav. RSFSR), "O sostoianii psikhiatricheskoi pomoshchi v RSFSR i o neobkhodimykh meropriiatiakh ee uluchsheniia," 22 October 1940, GARF, f. a-482, op. 47, d. 3, l. 2.

<sup>15</sup> See, for instance, the description of window bars at Moscow's Gannushkin hospital. TsAGM, f. 533, op. 1, d. 55, l. 54.

<sup>16</sup> A. D. Suvorov to Supreme Soviet Deputy V. M. Molotov, 4 February 1950, GARF, f. r-8009, op. 1, d. 825, ll. 89-80a [file uses idiosyncratic pagination].

to psychiatry quickly grow accustomed to this.”<sup>17</sup> One might assume that hospital workers used straightjackets or other restraints to immobilize particularly disturbed patients, but in fact this was rare because Soviet psychiatric hospitals were forbidden by law to use any restraints. Tools like straightjackets were portrayed as symbols of the tsarist regime’s repressive, inhumane policies toward its people in general, and as symbols of old-regime psychiatrists’ role in the custodial, non-medical approach to psychiatric care. The Bolshevik revolution had overthrown that repressive regime, and Soviet psychiatrists had broken with the past: they were now medical liberators of the oppressed mind, not wardens or jailors.<sup>18</sup> When Estonian psychiatrists were found to be using straightjackets, Minzdrav sent them a firm rebuke: “So far as straightjackets are concerned, they are frankly reminiscent of the old madhouses. Straightjackets have long ago been abandoned in our hospitals.”<sup>19</sup>

Some Soviet psychiatric hospitals did use isolation rooms for patients who were particularly violent, and these were tolerated, though frowned on. But while physically restraining patients was seen as inhumane, chemically restraining them with tranquilizing drugs was encouraged as a necessary and important part of the “fight against agitation.”<sup>20</sup> Patients who

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<sup>17</sup> Mikheev and A. V. Neiman, *Uchebnik nervnykh i psikhicheskikh boleznei*, 191-192.

<sup>18</sup> Soviet psychiatrists generally traced their adherence to a “no restraint” policy to Moscow psychiatrist Sergei Korsakov. T. I. Iudin, *Ocherki istorii otechestvennoi psikiatrii* (Moscow: Medgiz, 1951), 150. On Korsakov’s introduction of no restraint, see Julie Vail Brown, “The Professionalization of Russian Psychiatry: 1857-1911” (PhD, University of Pennsylvania, 1981), 196-210. Nineteenth century Russian psychiatrists were deeply involved with German psychiatry, which is probably where Korsakov and other Russians were exposed to the ideology of “no restraint.” According to historian Eric Engstrom, “no-restraint” became an article of faith in German psychiatry in the 19<sup>th</sup> century, a basic part of the story that students were taught about how their profession had moved from ignorance and violence into the bright future of enlightened science. Eric J. Engstrom, *Clinical Psychiatry in Imperial Germany: A History of Psychiatric Practice* (Ithaca: Cornell University Press, 2003), 59-61.

<sup>19</sup> V. A. Grombakh (St. nauchnyi sotrudnik Instituta psikiatrii MZ SSSR) to the head physician of Tallin Psychiatric Hospital, after July 1948, GARF, f. r-8009, op. 33, d. 4, l. 46.

<sup>20</sup> Recommended tranquilizers included opiates like morphine and pantopon, tranquilizers like chloral hydrate and scopolamine, and anti-parkinsonism drugs like apomorphine hydrochloride. Mikheev and Neiman, *Uchebnik*

refused drugs were forced to take them through injections or enemas.<sup>21</sup> When tranquilizers failed, nurses were told to subdue patients by using hot baths that lasted for an hour or more, or by wrapping them in a wet sheet. Both of these methods were said to “have beneficial influence on agitated patients in all psychoses.”<sup>22</sup>

Hospital staff defined “agitation” very loosely. It could mean patients arguing over a game of checkers, or it could mean disturbed patients suffering from hallucinations or an uncontrollable outburst of motor activity. Agitation could also mean bizarre, violent, or self-destructive behavior. In 1946, one hospital reported, they had seen six attempted suicides, dozens of pieces of property destroyed (benches, tables, beds), and 60 cases of patients eating glass.<sup>23</sup> Injuries and violence were daily occurrences. In 1953 psychiatric hospitals had an average of 418 attacks by patients on other patients.<sup>24</sup> Injuries to staff were also not uncommon, and the Soviet government paid psychiatric hospital workers a hazard bonus of 15% on top of the standard salary, and 30% higher for those who worked on wards for disturbed [*bespokoinye*] patients.<sup>25</sup>

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*nervnykh i psikhicheskikh boleznei*, 192; M. O. Gurevich and M. Ia. Sereiskii, *Uchebnik psikiatrii*, 5th ed. (Moscow: Medgiz, 1946), 114.

<sup>21</sup> Mikheev and A. V. Neiman, *Uchebnik nervnykh i psikhicheskikh boleznei*, 192.

<sup>22</sup> *Ibid.*, 193.

<sup>23</sup> "Vozbuzhdenie i antisotsial'noe proiavlenie bol'nykh" in "Otchet kafedry i kliniki psikiatrii Kirgizskogo meditsinskogo instituta v gorode Frunze za 1946," GARF, f. r-8009, op. 5, d. 265, l. 10.

<sup>24</sup> In 1953, according to Giliarovskii, 79 hospitals in the RSFSR reported 17,500 attacks on staff and 33,000 attacks on other patients. V. A. Giliarovskii (Chairman of the All-Union Society of Neuropathologists and Psychiatrists), et. al. to M. Kovrigina (Ministr Zdrav. SSSR), mid-1956, GARF, f. r-9592, op. 1, d. 209, l. 7.

<sup>25</sup> According to a petition written by several leading psychiatrists, psychiatric hospital workers also earned early retirement – every year of work in the psychiatric hospital counted as 1.5 years toward retirement. The psychiatrists were trying to get these rights extended to psychiatric workers in non-hospital institutions. V. A. Giliarovskii (Chairman of the All-Union Society of Neuropathologists and Psychiatrists), et. al. to M. Kovrigina (Ministr Zdrav. SSSR), mid-1956, GARF, f. r-9592, op. 1, d. 209, ll. 7-9. On hazard pay for psychiatrists, see also F. A. Artem'ev, ed., *Spravochnik nauchnogo rabotnika* (Moscow: AMN SSSR, 1948), 113.



Fighting agitation went far beyond tranquilizing patients, however: it provided one of the psychiatric hospital's key organizing principles. Patients in psychiatric hospitals were sorted into different wards, not based on their diagnosis, but on their behavior. Thus most patients in psychiatric hospitals would be placed either in wards for "calm" patients or wards for "agitated" patients. (New patients were first sent to a treatment-oriented ward that mixed both "calm" and "agitated" new arrivals.) These wards were further subdivided by sex. In large hospitals, there were thus multiple wards for "agitated women," "calm men," and so forth.<sup>26</sup> A patient's behavioral status became quickly evident to hospital workers: if he lived on the ward for agitated men, then he was clearly an agitated patient. If his behavior changed, the patient might be transferred from the "agitated" ward to the "calm" ward.

Being assigned to a specific ward could have important implications for how a patient experienced the hospital. Calm patients might be allowed to walk about the hospital grounds with other patients, while agitated patients would be assigned close supervision. Calm wards would be dimly lit at night, while wards for agitated patients were sometimes brightly lit all night long to enable staff to see what was happening. All patients were carefully watched and frequently counted, but agitated patients were subject to extreme scrutiny, with staff watching them even when they went to the toilet. Participation in labor therapy programs, reading

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<sup>26</sup> The standard system also included a "somatic ward" where patients suffering from somatic illnesses could be treated and where infectious patients could be isolated, as well as a ward for "weak" and "recovering" patients. Some hospitals also had special wards for epileptics, children, war invalids, or neurosurgical patients. Gurevich and Sereiskii, *Uchebnik psikhiiatrii*, 125; G. G. Karanovich (Nachal'nik otdela psikhiatricheskoi pomoshchi MZ RSFSR), "Metodicheskoe pis'mo: Kachestvennye pokazateli raboty psikhiatricheskikh boln'its," 15 March 1948, GARF, f. a-482, op. 47, d. 8454, ll. 34ob-35.

newspapers, listening to the radio, and watching movies were also regulated differently by ward.<sup>27</sup>

Being sent to a psychiatric hospital had serious legal ramifications, including the loss of citizenship rights like the right to vote.<sup>28</sup> Once admitted to the hospital, patients could be held against their will if the psychiatrists judged them to be dangerous to themselves or others. Psychiatrists could also decide to check patients out to a guardian, usually a family member, which meant that the patient lost his legal ability to enter into contracts and the guardian acquired the right to dispose of his property. (The designated guardians did not have the right to refuse the guardianship, and became responsible for housing and caring for the patient.) When the patient was checked out of the hospital, his psychiatrist sent his file to the local health authorities (usually the regional neuropsychiatric dispensary), and placed him on a registry of mental patients who required follow-up treatment and observation.<sup>29</sup> A stay in a psychiatric hospital, then, was not just a harrowing experience of life “behind the prison bars of the psychiatric

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<sup>27</sup> V. N. Rybalka (Gl. Vrach), “Prikaz no. 295a po psikhonevrologicheskoi gorodskoi bol'nitse No. 4 im. Gannushkina,” 2 July 1962, TsMAM f. 533, op. 1, d. 55, ll. 65-66.

<sup>28</sup> Article 135 of the 1936 Soviet Constitution stripped “the mad” [*umalishennye*] of voting rights. This wording caused psychiatrists some trouble, since the term “*umalishennye*” was not one that was used in medical practice, and it was unclear whether or not it should apply to all mental patients, or just to certain categories. In 1945 the term still had not been strictly defined, and psychiatrists in different places were applying it as they saw fit. M. Kalinin and A. Andreev, “Postanovlenie TsIK no 330, O poriadke nevneseniia v spiski izbiratelei lits, priznannykh umalishennymi,” 23 October 1937, GARF, f. a-482, op. 32, d. 20, l. 4; “Instruktsiia Oblastnoi vrachebnoi komisii po osvidetel'stvovaniuu lits dlia resheniia voprosa o vnesenii ili nevnesenii, a takzhe ob iskluchenii iz spiskov izbiratelei priznannykh umalishennykh ...,” undated [pre-war], GARF, f. a-482, op. 47, d. 648, ll. 26-29; T. Ia. Khvilivitskii (Gl. psikhiatr g. Leningrada) in A. N. Motnenko (Chairman, Nachal'nik Uprav. Gorbol'nits i Poliklinik MZ SSSR), “Stenogramma soveshchaniia psikhiatrov pri upravlenii gorbol'nits NKZ SSSR,” 30 November 1945, GARF, f. r-8009, op. 5, d. 249, ll. 22-25; Gurevich and Sereiskii, *Uchebnik psikhiatrii*, 130-131.

<sup>29</sup> “Instruktsiia o napravlenii, prime i vypiske bol'nykh iz psikhiatricheskikh bol'nits: utverzhdena NKZ SSSR 5 noiabria 1939 g.,” in A. L. Barsuk and P. M. Zinov'ev, *Kratkoe rukovodstvo po psikhiatrii dlia uchastkovykh vrachei* (1949), 245-248; E. A. Pappé, “Zakonodatel'stvo ob opeke psikhicheskikh bol'nykh,” in A. L. Barsuk and P. M. Zinov'ev, *Kratkoe rukovodstvo po psikhiatrii dlia uchastkovykh vrachei* (1949), 240-244.

hospital,” but an event with serious legal consequences that could follow a person for years or even decades.

### **Bringing “Modern Medicine” to Soviet Psychiatric Hospitals**

Psychiatrists themselves were demoralized by the conditions that they saw in psychiatric hospitals. From early on in their training, Soviet psychiatrists were tutored to believe that they were helping to advance their profession, leaving behind the ghastly tsarist “madhouses” with their straightjackets and their bars, and replacing them with something new, modern, and scientific. Establishing laboratories and medical routines in psychiatric hospitals became a way for them to demonstrate to themselves and others that they were helping to realize this dream. Yes, the reality was still grim, but it was a matter of personal and professional pride to show that they were working to change it. “In general,” explained one of the standard textbooks of the 1940s, “we are trying to make the internal organization of the psychiatric hospital more like the organization of a somatic hospital. Bars, patients under lock in isolators, shackling, and other such attributes of the semi-prison regime [*polutiuremnogo rezhima*] in the old madhouses have been driven out.”<sup>30</sup>

In attempting to modernize the psychiatric system, Soviet public health officials were working against decades of damage and neglect. Many psychiatric hospitals had been destroyed during World War One and the Russian Civil War, and others had been damaged or left untended. From 1914 to 1922 the number of psychiatric hospitals in the territory of the RSFSR dropped from 96 to 77, a 20% decline,<sup>31</sup> while the number of psychiatric beds fell from

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<sup>30</sup> Gurevich and Sereiskii, *Uchebnik psikhiatrii*, 128.

<sup>31</sup> L. Prozorov, "Nastoiashchee polozhenie dela psikhiatricheskoi pomoshchi v SSSR," *Zhurnal nevroptologii i psikhatrii imeni S.S. Korsakova* 18, no. 1 (1925): 93-112; L. L. Rokhlin, "Problemy organizatsii bol'nichnoi

approximately 28,000 to 11,000, a whopping 60% decline.<sup>32</sup> By the 1930s, the number of psychiatric hospitals in the RSFSR reached its pre-war level of 96 and the number of psychiatric hospital beds in the RSFSR hovered around 33,000 – only slightly higher than the number of psychiatric hospital beds before the revolution.<sup>33</sup> (See Figure 1.1.) Although the Soviet health authorities often talked about reforming the psychiatric hospitals, little of the promised aid filtered down to psychiatric hospitals. “The internal regime, appearance, and methods of work of the psychiatric hospitals has undergone very little change,” wrote one prominent psychiatrist in 1936. “.... the heavy legacy of the tsarist regime has still not been liquidated.”<sup>34</sup>

By the mid-1930s, though, psychiatrists had begun to agree that the main cause of these conditions was the high number of “chronic patients.” People with forms of mental illness that might actually respond to treatment were not the people who occupied most of the beds in psychiatric hospitals. Rather, the people taking up the majority of the beds were those who were too ill to live outside the hospital and who did not respond to treatment. Speaking at a national congress in 1936, one psychiatrist estimated that the USSR as a whole had approximately 47,000 psychiatric beds, but “the vast majority” were occupied by chronic patients. “We have almost no beds at all for new patients,” he lamented. “Even some of the socially dangerous patients,

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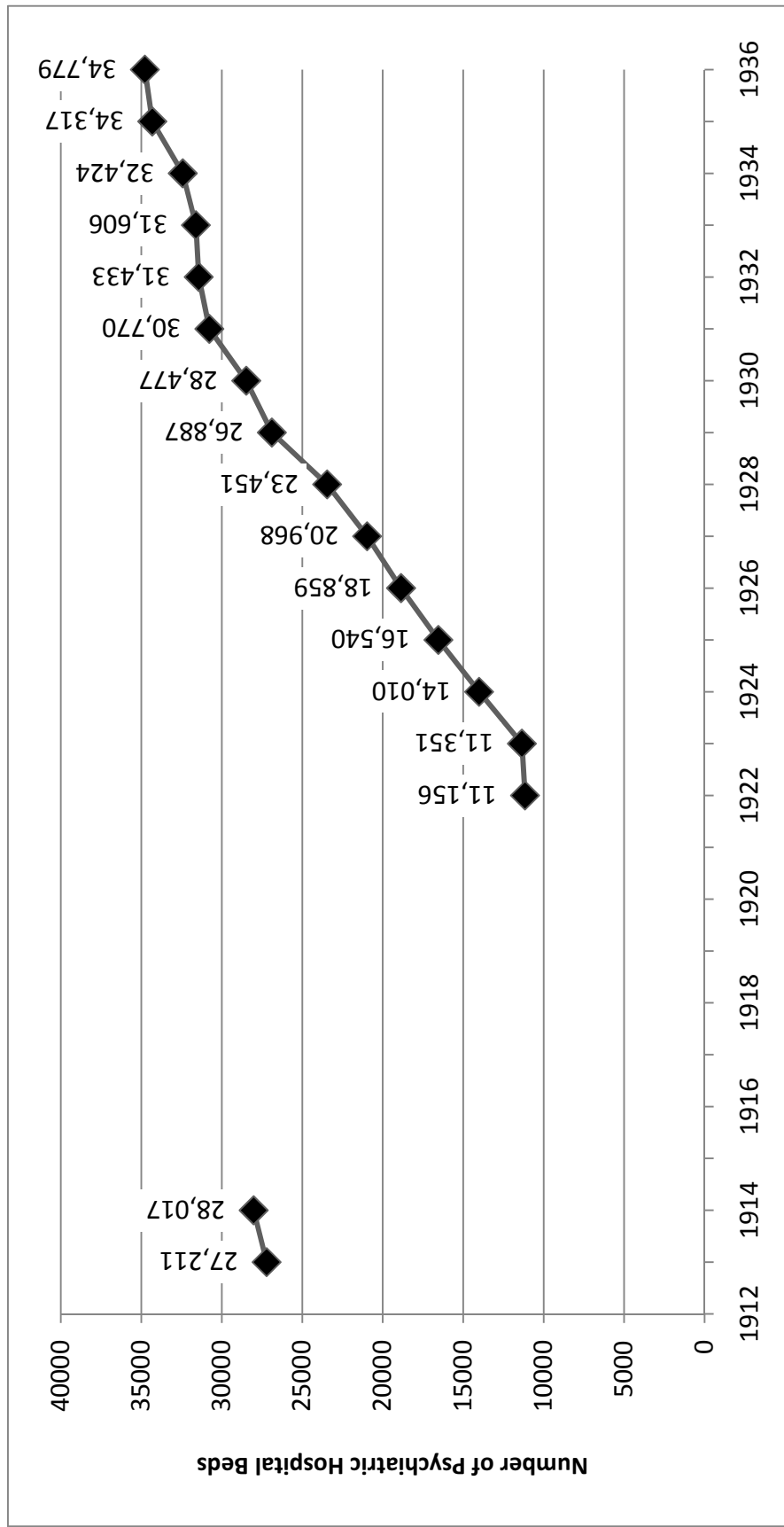
psikhiatricheskoi pomoshchi," in *Problemy organizatsii psikhiatricheskoi pomoshchi*, ed. L. L. Rokhlin, Trudy Ukrainskoi Psikhonevrologicheskoi Akademii (Khar'kov: Gosmedizdat USSR, 1936), 11-38.

<sup>32</sup> According to Iudin, the number of patients in psychiatric hospitals in the RSFSR and Ukraine and dropped from 42,229 in 1912 to 12,982 in 1922. Iudin, *Ocherki istorii otechestvennoi psikhiatrii*, 369.

<sup>33</sup> E. Babaian, “Spravka o sostoianii psikhonevrologicheskoi pomoshchii naseleniiu SSSR,” 20 May 1961, GARF, f. r-8009, op. 1, d. 1411, l. 102.

<sup>34</sup> L.L. Rokhlin, "Problemy organizatsii bol'nichnoi psikhiatricheskoi pomoshchi," in *Problemy organizatsii psikhiatricheskoi pomoshchi*, ed. L. L. Rokhlin, Trudy Ukrainskoi Psikhonevrologicheskoi Akademii, vol. 6 (Khar'kov: Gosmedizdat USSR, 1936), 13.

Figure 1.1. Number of Beds in RSFSR Psychiatric Hospitals, 1912-1923



Sources: Adapted from L. Prozorov, "Nast. polozhenie dela psikh. pomoshchi v SSSR," *ZhNiP* 18, no. 1 (1925): 93-112; idem., "Polozhenie dela psikhiatricheskoj pomoshchi v RSFSR v 1924 godu," *ZhNiP* 19, no. 1 (1926): 97-102; idem., "Nastoiashchee polozhenie dela psikhiatricheskoj pomoshchi v RSFSR (Obzor za 1926 g.)," *ZhNiP* 21, no. 1 (1928): 89-103; idem., "Nastoiashchee polozhenie dela psikhiatricheskoj pomoshchi v RSFSR (Obzor za 1927 g.)," *ZhNiP* 22, no. 2 (1929): 235-240; idem., "Obzor polozheniia dela psikhiatricheskoj pomoshchi v RSFSR (Koechnaia pomoshch')," and L.L. Rokhlin, "Problemy organizatsii bol'nichnoi psikhiatricheskoj pomoshchi," in *Problemy organizatsii psikhiatricheskoj pomoshchi*, ed. L. L. Rokhlin, (Khar'kov: Gosmedizdat USSR, 1936), 11-38.

dangerous to themselves and to those around them remain in the population. . . ."<sup>35</sup> Instead of devoting their time to discovering and treating early cases of mental illness, psychiatrists found themselves struggling with the never-ending-crises of hospital management while helping the chronically insane to live out their days.

The new “active treatments” like insulin shock therapy were seen as potential solutions to the problem of “chronics” and overcrowding. The crux of the problem, however, was that to successfully use the active therapies, psychiatric hospitals first had somehow get a hold of scarce drugs, find space where the treatment could be done in quiet and isolation, train staff members, and devote precious staff hours to looking after just one or two patients. Before they could incorporate active therapy into their everyday practices, in short, psychiatric hospitals had to transform themselves into less crowded, better staffed, better supplied institutions. As a result, Soviet psychiatric hospitals were slow to adopt active therapies.

In 1939 Cardiozol shock and insulin therapy were used in only a few psychiatric hospitals, and virtually all of these were in the major centers of psychiatric research in Moscow, Leningrad, Kharkov, and Kiev. Psychiatric hospitals in those cities all reported treating between 200 and 500 people per year with insulin therapy. Some provincial hospitals also reported experimenting with these methods, but most reported treating only between 5 and 50 patients with insulin. (There were several outliers like Gor’kii psychiatric hospital, which reported 285 patients treated with insulin in 1938, and the Psychiatric hospital in the city of Stalino, which reported treating 806 people with insulin).<sup>36</sup>

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<sup>35</sup> "Stenogramma s'ezda psikhiatrov i nevroptologov," December 1936, GARF, f. r-8009, op. 1, d. 47, l. 68.

<sup>36</sup> These numbers are sometimes hard to read; in the case of these last two hospitals, it is unclear if the number given refers to the number of patients treated, or the number of injections given. Provincial hospitals do seem to have had access to *sul'fozin*, a drug used to induce fever in patients, and some reported giving as many as 1,500

Pressed by the public health bureaucracy to use the newest methods of treatment, psychiatric hospital directors pointed out that their budget allocations still did not provide funds for long courses of expensive medical treatment. Medicine was expensive, salaries were expensive, and medical equipment was expensive. In order to modernize their hospitals they would need more money, more staff, and, ideally, new buildings.<sup>37</sup> Insulin shock therapy required special equipment, rooms, and care: treatment could last for 10-12 hours, and was best done in a quiet, sterile room. Patients needed to be watched closely in case of complications, and this required hospital personnel who could spend long hours overseeing just a few patients. “The ideal space for seizure therapy,” according to Narkomzdrav’s official instruction, “is a spacious, well lit, well ventilated room that easily accommodates 10-12 patients, connected by broad doors to a small treatment room [*protsedurnaia*] of 12-14 square meters.”<sup>38</sup>

Such ideal conditions contrasted starkly with the conditions in which psychiatrists actually worked. Psychiatric hospitals had gone for years, and in some cases for decades, with very little funding for even basic building maintenance. Some psychiatric hospitals lacked electricity and many lacked adequate heat. Kerosene lamps and outhouses were common.<sup>39</sup> As the government’s 1940 report put it, “increasing the quality of work is very closely connected

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*sul’fozin* injections in a year. Correspondence between hospital directors and Narkomzdrav SSSR in response to a query about active treatment, March 1939, GARF, f. r-8009, op. 5, d. 164, ll. 209-269.

<sup>37</sup> At a 1940 conference, hospital directors frequently discussed lack of funding commensurate with the needs of active treatment. See in particular comments by Berger, Sereiskii, Gontarevskii, Chugveeva, and Kravtsov. “Stenogramma zasedaniia dekadnika glavvrachei psikhiatricheskikh boln’its NKZ SSSR,” 19 March 1940, GARF, f. r-8009, op. 5, d. 209, ll. 38ob, 41, 65ob, 70ob, 96ob-97.

<sup>38</sup> M. O. Gurevich (Glav. Psikhiatr MZ SSSR), “Instruktsiia po sudorozhnoi terapii Terapevticheskoi sektsii psikhiatricheskoi komissii UMS NKZ SSSR i Terapevticheskoi komissii pravleniia vsesiouznogo ob-va nevropatologov i psikhiatrov pri blizhaishem uchastii N. S. Vasil’voi i R. A. Rotshteina, pod redaktsiei prof. M. Ia. Sereiskogo (proekt),” January 1940, GARF, f. r-8009, op. 5, d. 164, l. 1.

<sup>39</sup> A. Tret’iakov (Narodnyi komissar Zdrav. RSFSR), “O sostoianii psikhiatricheskoi pomoshchi v RSFSR i o neobkhodimykh meropriiatiiakh ee uluchsheniia,” 22 October 1940, GARF, f. a-482, op. 47, d. 3, l. 7.

with equipping psychiatric hospitals.” If new methods of treatment were to become the norm, these conditions would have to be changed.<sup>40</sup> Most psychiatric hospitals, a 1940 government investigation found, were simply too overcrowded to use the newest methods of biological treatment. The hospitals did not have extra rooms to devote to insulin shock therapy, nor did they have the extra nurses needed to watch over patients while they slept or convulsed.

Still, in their yearly reports to Narkomzdrav psychiatric hospital directors made clear that they understood that “active treatment” *should* be at the center of their work. For example, since 1938 the psychiatric hospital in Poltava had been struggling to do some active therapy. In 1940 their efforts remained quite small scale, but the hospital’s director was able to present these modest successes as progress toward the future of a properly modern medical psychiatry. “At the Poltava Psychiatric Hospital,” he wrote, “mistrust [for biological treatments] has long been overcome, and ‘therapeutic nihilism,’ the passive attitude to the patient that has lasted for centuries, has been replaced with energetic, invigorating therapeutic activity, with therapeutic enthusiasm.”<sup>41</sup>

By the end of 1940 psychiatric hospital directors had reason to think that they might get more government support. The leaders of Narkomzdrav USSR met in November 1940 and agreed that the time had come to devote more resources to modernizing the psychiatric system. They would add 5,000 new beds to the USSR’s psychiatric hospitals, increase the number of

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<sup>40</sup> "O sostoianii psikhiatricheskoi pomoshchi v RSFSR i o neobkhodimyykh meropriiatiakh ee uluchsheniia," 22 October 1940, GARF, f. a-482, op. 47, d. 3, l. 6.

<sup>41</sup> The Poltava hospital had done 70 insulin injections and 56 camphor seizures in 1938, and 167 and 94 respectively in 1939. In 1940 they increased the number treatments to 217 insulin shocks, and 106 camphor seizures. Other forms of somatic treatment in use at the hospital included insulin in “small doses,” malaria therapy, blood transfusions, “auto-hemoterhapy,” “protein therapy,” “oxygen treatment,” “organo-therapy,” and a large number of narcotic tranquilizers. Krapirkin (Head Physician of Poltava Psychiatric Hospital), “Godovoi otchet Poltavskoi psikhiatricheskoi bol’ntisy za 1940 god,” undated [1940], GARF, f. 8009, op. 5, d. 190, ll. 9, 12ob-13.



outpatient psychiatric offices in polyclinics, and establish new neuro-psychiatric dispensaries in 28 cities. They also approved a general shift to wide scale use of active therapy. Narkomzdrav's own Directorate of the Chemical-Pharmaceutical Industry was ordered to allocate each psychiatric hospital more of the drugs they needed to actually do active therapy. Each hospital was to get 200 kilograms of sodium amital (for sleep therapy) and 200 kilograms of Cardiazol (for seizure therapy). Regional health departments were also told to help psychiatric hospitals to "introduce and broaden methods of treatment that have been approved by the Psychiatric Commission of Narkomzdrav USSR's Scientific Medical Council."<sup>42</sup> These were small steps compared to the scale of the problems, but psychiatrists were optimistic that public health officials were beginning to understand the new needs of modern psychiatric medicine.

At around the same time, Narkomzdrav USSR developed a new set of basic regulations [*polozhenii*] for psychiatric hospitals that were updated and standardized to reflect the new realities of psychiatric practice in the age of "active therapy." These regulations mandated that all psychiatric hospitals were to use laboratory methods in their work and provide their patients with "all modern methods of treatment." Larger hospitals were to have a whole complex of small laboratories, including laboratories for biochemistry, serology, bacteriology, electrophysiology, psychology, radiology, and anatomy. Smaller hospitals were not required to have their own specialized laboratories, but they were required to establish agreements with nearby hospitals so that they would have access to all of these techniques. Even small psychiatric hospitals were required to have their own "clinical laboratory."<sup>43</sup>

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<sup>42</sup> G. A. Miterev (Chairman), "Protokol No. 37 zasedaniia kkollegii NKZ SSSR," 25 November 1940, GARF, f. r-8009, op. 1, d. 35, ll. 33-36.

<sup>43</sup> *Osnovnye polozheniia po organizatsii i rabote psikhiatricheskikh boln'its* (Moscow: 1947), points 28-29, 57; available at [www.talagi.ru/library/arhiv\\_doc1.htm](http://www.talagi.ru/library/arhiv_doc1.htm) (accessed April 28, 2007).

By 1941, then, Narkomzdrav had resolved to devote resources to transforming psychiatric hospitals into institutions that more closely resembled “normal” medical hospitals. “Active therapy” was to be central to these modernized psychiatric hospitals. The practice of active therapy was to be guided by the use of technologies like urine analysis and x-rays, and these practices were to be standardized for the entire USSR by a set of rules that were drawn up by Narkomzdrav. This was the vision that continued to guide Soviet public health officials well into the 1950s, but the 1941 plan itself had to be shelved. Before a final draft of the plan could be signed, Germany invaded the Soviet Union.<sup>44</sup>

### **Soviet Psychiatric Hospitals during World War Two**

The war was a major setback for those who had hoped to introduce active therapy to Soviet psychiatric hospitals. During the war active therapy all but came to a halt and survival became the main priority for psychiatric hospitals.<sup>45</sup> Hospital directors focused on ensuring that their hospital farms produced enough food to feed patients through the winter, on stockpiling enough fuel to keep them from freezing, and on preventing outbreaks of infectious disease. In the

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<sup>44</sup> Narkomzdrav had drafted the psychiatric hospital regulations in early 1941, and the psychiatric commission discussed final changes to them on June 12 and June 19. The author of the *polozhenie*, Andrei Snezhnevskii, acknowledged that most of the articles in the document were simply copied from the statute for urban hospitals [*ustav gorodskoi bol'nitsy*]. M. O. Gurevich (Chairman), “Protokol zasedaniia psikhiatricheskoi komissii UMS NKZ SSSR,” 12 June 1941, GARF, f. r-8009, op. 5, d. 212a, ll. 8-18, esp. l. 13; M. O. Gurevich (Chairman), “Stenogramma zasedaniia psikhiatricheskoi komissii UMS NKZ SSSR,” 19 June 1941, GARF, f. r-8009, op. 5, d. 212a, ll. 1-7.

<sup>45</sup> The director of Penza Psychiatric Hospital, for instance, reported to Moscow in 1944 that his hospital was doing “primarily expertise work,” and that “active therapy has been reduced because of lack of medications ... insulin therapy is being done in single cases.” Every patient, however, was reported to be working in the hospital fields. *Godovoi otchet Penzenskoi psikhiatricheskoi bol'nitsy za 1944 g.*, GARF, f. r-8009, op. 5, d. 243, ll. 61ob, 63. In Moscow, active therapy dropped off rapidly during the first two years of the war, but by 1943 Moscow psychiatric hospitals were giving active treatment to a significant portion of their patients, with most treating 10-20%. In absolute numbers 1,507 patients were given active treatment in 1943, and the Moscow health department planned to give it to 2,799 in 1944. I. S. Iolovich (Gorodskoi psikhiatr g. Moskvy), in “Protokol soveshchaniia v otdele o sostoianii psikhonevrologicheskoi pomoshchi,” 26 May 1942, GARF, f. a-482, op. 47, d. 648, l. 2; and “Lechebno-proizvodstvennyi i metodicheskii plan nevro-psikhiatricheskikh uchrezhdenii Moskvy,” sometime after 1 November 1943, TsAGM, f. 1126, op. 1, d. 38, l. 49.

winter of 1941-1942 many psychiatric hospital directors found themselves entirely cut off from contact with government health officials, left to manage their patients as best they could.<sup>46</sup>

Without enough food, soap, or fuel, they fought a losing battle against dysentery, malnutrition, and tuberculosis. Everywhere psychiatric patients died at an alarmingly high rate.<sup>47</sup>

The situation was particularly desperate in areas of the country that found themselves on the front lines of the war. In these areas, psychiatric hospitals directors also had to cope with bombardment, blackouts, and the very real possibility of German occupation.<sup>48</sup> They tried to send as many patients as possible away from the hospitals, some to live with relatives, others to live on collective farms.<sup>49</sup> In Moscow and Leningrad psychiatric hospitals evacuated thousands of patients further to the east where the evacuated patients were added to already crowded wards at psychiatric hospitals in places like Riazan', Kostroma, and Kazan.<sup>50</sup> In 1941-1942 as the German army advanced, 44 of the Soviet Union's 144 psychiatric hospitals were destroyed, about 30 percent of the total. The figure of 30 percent, however, does not capture the full magnitude of the

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<sup>46</sup> S. V. Kurashov (Zam. NKZ RSFSR), "Protokol soveshchaniia o sostoianii psikhiaticheskikh bol'nits i podgotovka ikh k osenne-zimnemu periodu," 16 May 1942, GARF, f. a-482, op. 47, d. 648, l. 1. The hospitals that did not abandon "active therapy" were those that hosted central research institutes in evacuation, like Tomsk, Ufa, and Kuibyshev. P. B. Posvianskii and T. I. Gol'dovskaia, "Khronika: Vserossiiskaia konferentsiia po voprosam psikhii," *Nevropatologiia i psikhii* 13, no. 5 (1944): 63-74.

<sup>47</sup> On the high rate of death in psychiatric hospitals during WWII, see D. D. Fedotov (Chairman), "Stenogramma zasedaniia uchenogo soveta instituta psikhii MZ SSSR," 21 March 1956, GARF, f. r-9592, op. 1, d. 21, l. 7. For a particularly gripping case, see the report of the inspection of Tomsk psychiatric hospital in 1942, where inspectors found patients suffering from extreme malnutrition, outbreaks of dysentery and tuberculosis, and very high mortality. "Akt obsledovaniia i analiza prichin smertnosti psikhicheskikh bol'nykh v Tomskoi psikh. bol'nitse," undated [1942], GARF, f. a-482, op. 47, d. 656, l. 21.

<sup>48</sup> "Kratkie dannye o sostoianii i deiatel'nosti psikhiatricheskoi seti leningrada v period otechestvennoi voyny," undated [1943], GARF, f. a-482, op. 47, d. 1396, l. 3.

<sup>49</sup> A. A. Sokolova (Gl. Vrach Riazanskoi psikhiatricheskoi bol'nitsy) and G. G. Karanovich (Gl. Psikhiatr NKZ RSFSR), in "Protokol soveshchaniia v otdele o sostoianii psikhonevrologicheskoi pomoshchi," 16 May 1942, GARF, f. a-482, op. 47, d. 648, ll. 4, 9-10.

<sup>50</sup> The newly freed-up beds in Moscow and Leningrad were then used as hospital beds for soldiers. I. S. Iolovich (Gorodskoi psikhiatr g. Moskvy), in "Protokol soveshchaniia v otdele o sostoianii psikhonevrologicheskoi pomoshchi," 26 May 1942, GARF, f. a-482, op. 47, d. 648, l. 1.

destruction because the hospitals in these areas of the USSR were also some of the largest psychiatric hospitals in the country. So while only 30 percent of psychiatric hospitals were destroyed, nearly 50 percent of all psychiatric *beds* were destroyed, falling from 67,571 in 1941 to 32,759 in 1942. The number of psychiatric beds in the USSR did not reach pre-war levels again until 1951. (See Figures 1.2-1.3.)

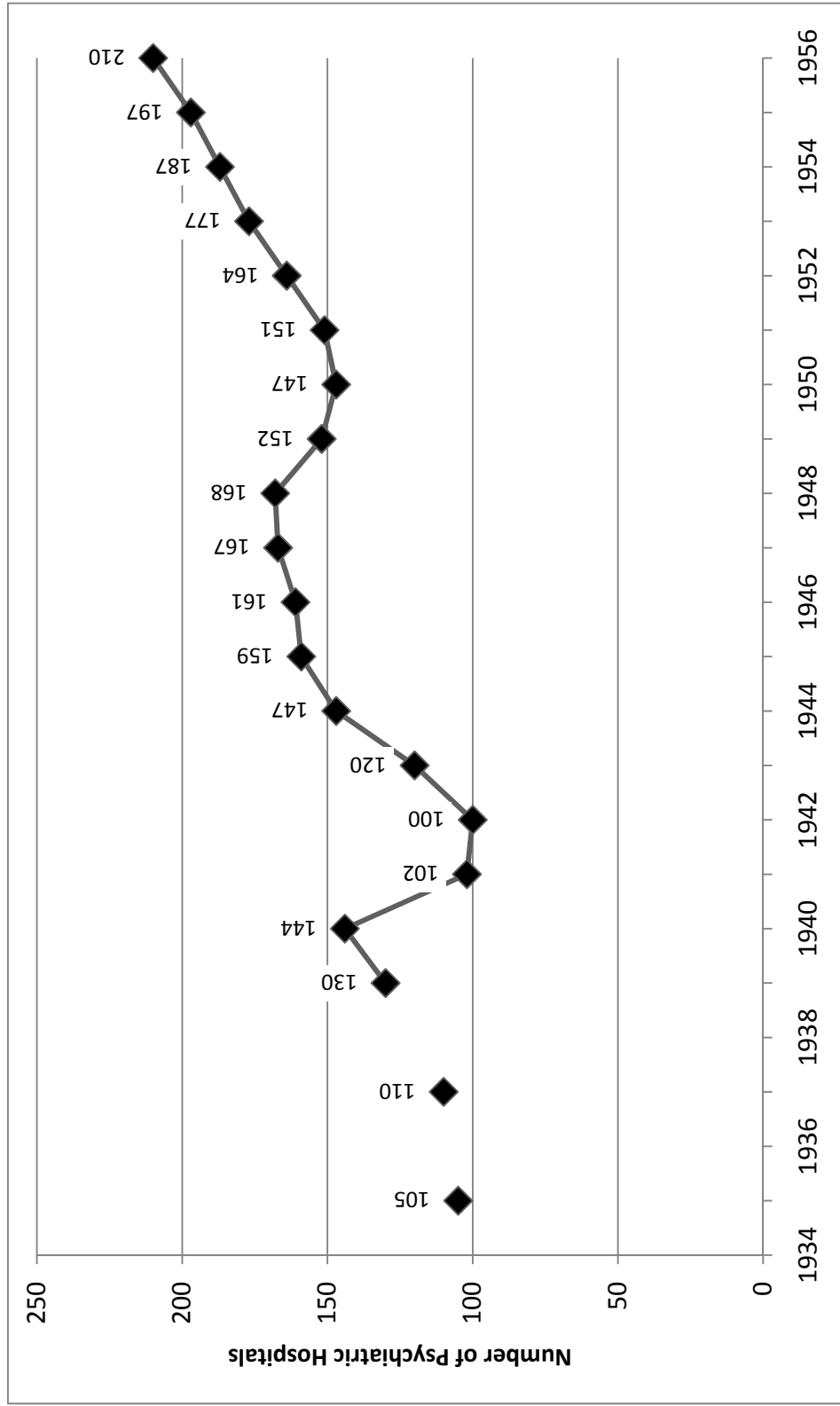
Psychiatric hospitals further from the front struggled to set up new wards to handle injured soldiers suffering from psychiatric problems and to accommodate patients who had been evacuated from Moscow and Leningrad. In August 1941, for example, 500 patients were evacuated from Moscow's first Psychiatric Hospital to the Kostroma Oblast' Psychiatric Hospital, 200 miles north-east of Moscow. The Kostroma hospital had been built in 1908 to accommodate only 400 patients and in 1940 it was already housing 1,123, nearly three times this number.<sup>51</sup> The extra patients sent to Kostroma from Moscow boosted the hospital population to 1,600 patients.<sup>52</sup> Rooms that the hospital had once used for labor therapy or for cultural activities were converted into living space. Beds were crowded in so tightly that people could not walk between them, and some beds were even put into the hospital cafeteria. Living in such close quarters, patients were at high risk for the spread of infectious disease, a danger that was increased by a severe shortage of soap for washing and a lack of firewood for heating bath water. Dysentery began to spread, with 5 cases in October, 54 cases in November, and 90 cases in December. That winter, ten percent of the patients evacuated to Kostroma from Moscow died.

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<sup>51</sup> "Godovoi otchet Kostromskoi psikhiatricheskoi bol'nitsy za 1941 god," GARF, f. a-482, op. 47, d. 132, l. 12ob; "O sostoianii psikhiatricheskoi pomoshchi v RSFSR i o neobkhodimyykh meropriiatiakh ee uluchsheniia," 22 October 1940, GARF, f. a-482, op. 47, d. 3, l. 4.

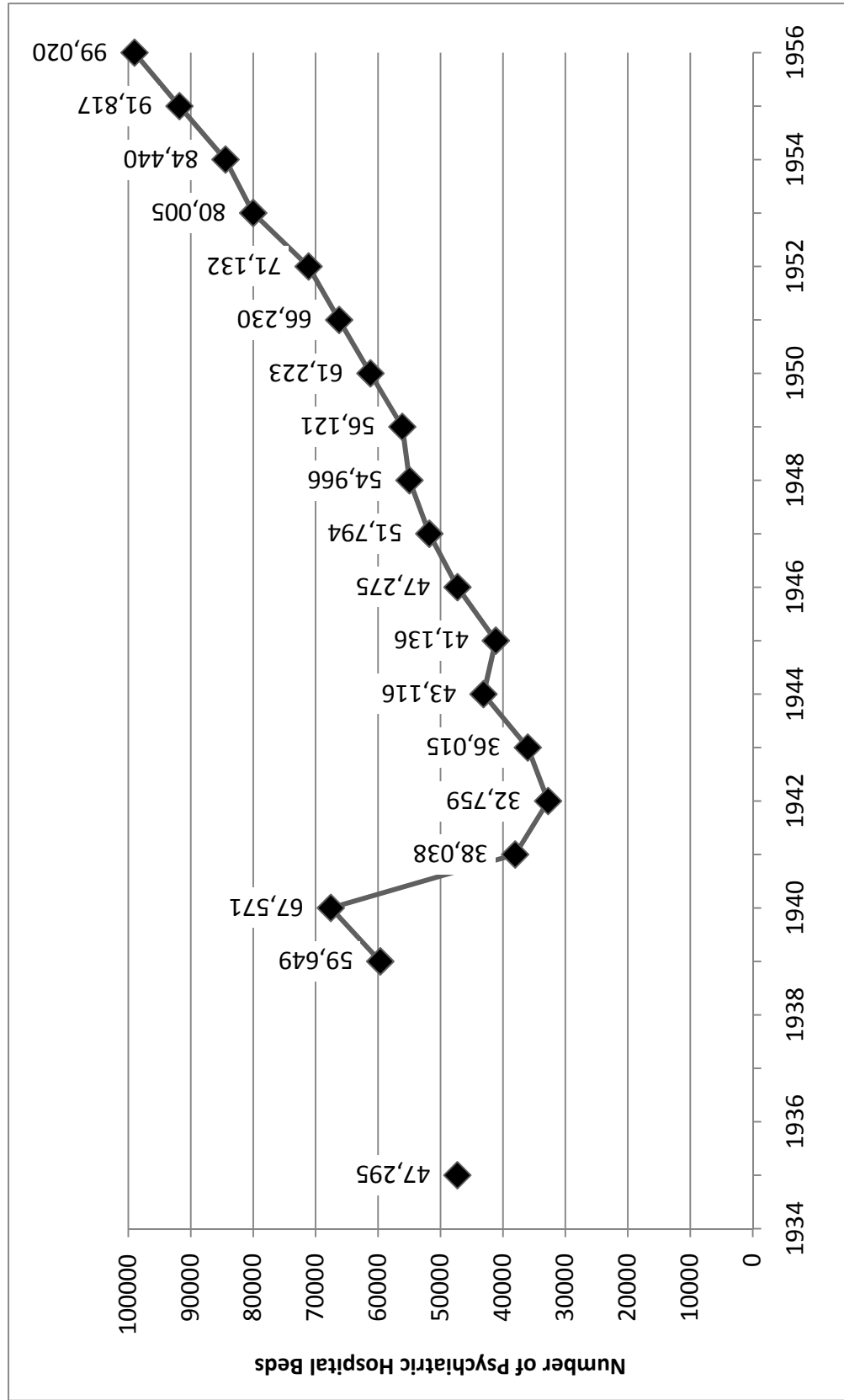
<sup>52</sup> The Kostroma hospital also took in evacuees from Valdai psychiatric hospital, and patients from Leningrad, Kalinin, Pskov, Riazan', Vitebsk, and other oblasts. "Godovoi otchet Kostromskoi psikhiatricheskoi bol'nitsy za 1941 god," GARF, f. a-482, op. 47, d. 132, ll. 13-22; "Spisok psikhiatricheskikh bol'nits po RSFSR (po sostoianiiu na 1/X-1941 g.)," GARF, f. a-482, op. 47, d. 133, ll. 1-4.

Figure 1.2. Number of Psychiatric Hospitals in the USSR, 1935-1956



Sources: Narkomzdrav/Minzdrav USSR reports sent to the Central Statistical Administration (TsSU), 1934-1956. "Otchety o seti, deiatel'nosti i kadraKh meditsinskikh uchrezhdenii Soiuza," RGAE, f. 1562, op. 18, dd. 96, 203, 245, 260, 270, 291, 318, 351, 410, 442, 481, 545, 613, 686, 757 ; op. 27, dd. 48, 139, 259.

Figure 1.3. Number of Psychiatric Hospital Beds in the USSR, 1935-1956



Sources: Narkomzdrav/Minzdrav USSR reports sent to the Central Statistical Administration (TsSU), 1934-1956. "Otchety o seti, deiatel'nosti i kadrah meditsinskikh uchrezhdenii Sotiuza," RGAE, f. 1562, op. 18, dd. 96, 203, 245, 260, 270, 291, 318, 351, 410, 442, 481, 545, 613, 686, 757 ; op. 27, dd. 48, 139, 259.

The war also had a serious effect on psychiatric hospital infrastructure. In areas affected by the front, psychiatric hospital buildings were damaged or destroyed by bombardment, while in areas that were not occupied many buildings fell into disrepair. In 1944 Narkomzdrav ordered local health officials to invest funds in reconstruction and repair, but in practice these orders had little effect. Narkomzdrav did budget money to help regional health departments rebuild, but in many cases rebuilding proved to be exceedingly difficult. Hospital directors who wanted to rebuild could not hire construction firms to do the work or could not find construction materials to build with.<sup>53</sup> Narkomzdrav issued nearly identical orders again in 1946, 1948, and 1950,<sup>54</sup> but reports from around the USSR in 1948 and 1949 confirmed that much of the money budgeted for reconstruction was not being used.<sup>55</sup> Psychiatric hospitals that did successfully rebuild seem to have done so by creating their own resources. For example, the frustrated director of a psychiatric hospital in Ukraine eventually abandoned hope of finding a construction firm to do the work and decided to do it himself. He bought heavy machinery, hired laborers, and slowly rebuilt the hospital.<sup>56</sup> Similarly, at other psychiatric hospitals orderlies [*sanitarki*] were sometimes hired to work on condition that they would help do construction.<sup>57</sup>

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<sup>53</sup> G. G. Karanovich (Gl. psikhiatr MZ RSFSR), "Spravka," undated [1948], GARF, f. a-482, op. 47, d. 8454, l. 38; "Reshenie Kollegii MZ SSSR o psikhiatrii (proekt)," 11 Feb 1949, GARF, f. r-8009, op. 1, d. 757, l. 14.

<sup>54</sup> Prikaz MZ SSSR No. 226, "V tseliakh uluchsheniia raboty v psikhiatricheskikh bol'nitsakh...," 13 April 1946, GARF, f. r-8009, op. 1, d. 722, ll. 109-113; Prikaz MZ SSSR no. 446, "O meropriiitaiakh po uluchsheniiu nevro psikhiatricheskoi pomoshchi naseleniiu," 20 July 1948, GARF, f. r-8009, op. 1, d. 725, ll. 16-22; Prikaz MZ SSSR No. 33, "Postanovka lechebnogo dela i iukhoda za bol'nymi v psikhiatricheskikh bol'nitsakh...," 12 January 1950, GARF, f. r-8009, op. 33, d. 264, ll. 1-2.

<sup>55</sup> G. G. Karanovich (Nach. Otdela psikh. Pomoshchi MZ RSFSR), "Spravka," undated [1948], GARF, f. a-482, op. 47, d. 8454, l. 38.

<sup>56</sup> By 1951, he and his staff had rebuilt enough space for 187 beds, but were providing care to 287 patients. Zelenchuk (Gl. vrach Igrenskoi psikh. bol'nitsy) to E. I. Smirnov (MZ SSSR), "O vosstanovlenii Igrenskoi psikhonev. bol'nitsy," 6 June 1951, GARF, f. r-8009, op. 33, d. 399, ll. 159-164.

<sup>57</sup> Novikov, in G. N. Beletskii (Chariman; Minister MZ RSFSR), "Protokol no. 58 zasedaniia kollegii MZ RSFSR," 16 November 1950, GARF, f. a-482, op. 49, d. 1519, l. 33.

Of all the problems that beset post-war psychiatric hospitals in the USSR, overcrowding was by far the most ubiquitous and the most widely discussed. Directors of psychiatric hospitals commonly blamed overcrowding on the German army, which had physically destroyed or damaged so many buildings.<sup>58</sup> In 1945 the number of functioning psychiatric hospital beds in the USSR remained at 60% of the prewar level, and the number of beds only exceeded the 1940s level in 1952 (See Figure 1.4).<sup>59</sup>

In addition to blaming the Germans, directors of psychiatric hospitals also blamed overcrowding on “chronic patients,” people who spent many years in psychiatric hospitals without improvement. Most people who passed through the psychiatric system in a given year did not remain in the hospital: they recovered quickly, or were checked out to their families to be checked up on through outpatient dispensaries. A minority, however, were too ill to leave the hospital, and these people became the object of a great deal of worry on the part of psychiatric administrators, because a hospital’s performance was in part measured against how many times each bed “turned over” in the course of a year. According to a 1949 report, 47% of patients in psychiatric hospitals stayed for less than a year, while another 29% were hospitalized one to three years, and 24% stayed for more than three years.<sup>60</sup> Thus the number of beds available for new patients became smaller with every year. Even if only a handful of additional patients were

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<sup>58</sup> See, for instance, the Ministry of Health’s explanation of overcrowding, particularly in Kazan psychiatric hospital, to the Central Committee. Shabanov (Deputy Minister of Health USSR) to G. Malenkov (Sek. TsK VKP(b)), 8 March 1951, sekretno, GARF, f. r-8009, op. 32s, d. 948, ll. 56-57.

<sup>59</sup> While the number of psychiatric hospital beds remained significantly lower than in 1940, the number of psychiatric hospitals quickly exceeded pre-war levels. By 1948 there were 168 psychiatric hospitals in the USSR, 53 more than in 1940. Most of the quickly restored hospitals, however, were relatively small, with only 50-100 beds. Narkomzdrav USSR produced a report in 1937 showing that there were 106 psychiatric hospitals in the country, but that the 26 largest (those with 750 beds or more) housed over half of all the beds. “Godovoi otchet o rabote uchrezhdenii zdravookhraneniia za 1937 g. po Soiuzu SSR,” undated [1938], GARF, f. 8009, op. 1, d. 259, l. 4.

<sup>60</sup> E. I. Smirnov (Chairman, USSR Minister of Health), “Stenogramma zasedaniia Kollegii MZ SSSR,” 11 February 1949, GARF, f. r-8009, op. 1, d. 757, l. 105.



added, the result over time would be a hospital full of “chronics.” In the parlance of the public health bureaucracy, the beds that they occupied were considered to be “immobilized” or “silted up.”<sup>61</sup>

Table 1.1 illustrates how this process happened in the 1940s. From 1945 to 1953 the average number of patient visits per bed fell from 2.74 to 2.27. At the same time, the number of days that each bed was occupied (“bed-days”) increased from an average of 271 in 1945 to an average of 393 days per bed in 1953. These figures suggest that bed turnover fell to a point where hospitals no longer had unoccupied beds to offer new patients, and instead bunked patients two to a bed. Hospital reports, government inspections, and Minzrav correspondence corroborate this story. By 1952, according to one report, the average psychiatric hospital in the RSFSR was at 112.8% of capacity, and the largest psychiatric hospitals were at 128.7%. In some hospitals, crowding went as high as 160%.<sup>62</sup>

The problems posed by overcrowding were exacerbated by a massive shortage of psychiatric hospital staff. Psychiatrists in the provinces often had huge case loads, with each psychiatrist overseeing 200-300 patients, and in some cases even more.<sup>63</sup> Minzdrav RSFSR

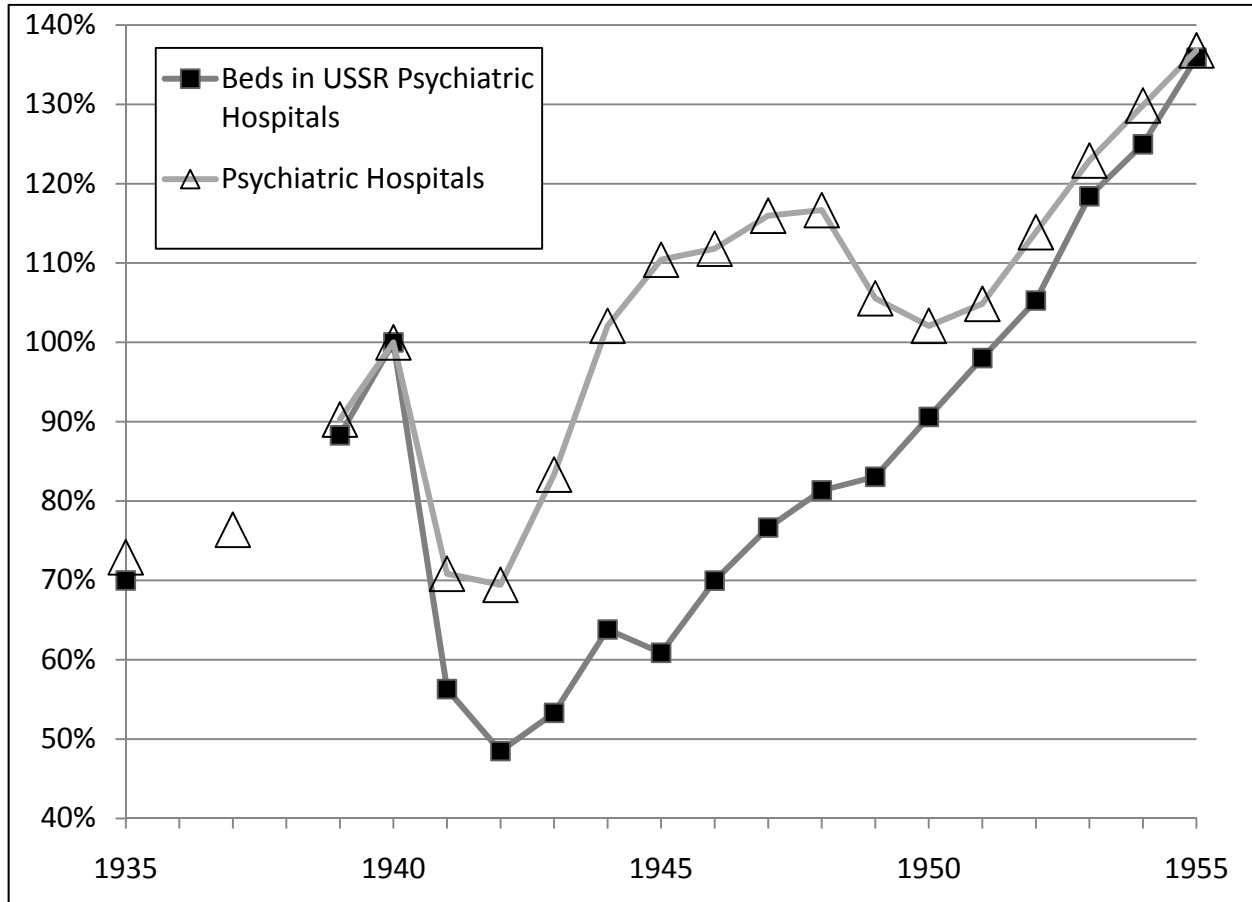
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<sup>61</sup> G. G. Karanovich (Nachal'nik otdela psikhiatricheskoi pomoshchi MZ RSFSR), “Metodicheskoe pis'mo: Kachestvennye pokazateli raboty psikhiatricheskikh boln'its,” 15 March 1948, GARF, f. a-482, op. 47, d. 8454, ll. 34ob-35. Historian Jack Pressman describes an identical logic at work in American state psychiatric hospitals during the same period. He compares hospital beds to “turnstiles” which move at different rates, or which stop altogether if a patient simply stands at the gate. “No matter how swiftly most of the turnstiles spin, some small portion of patients will prove stubbornly resistant to treatment. The occupancy of a bed by one of these semi-permanent residents leads to tragic consequences, however, in that it eliminates one of the turnstiles for use by many other potential patients. Over time, even a low retention rate will retire enough beds that an institution’s ability to process the large number of patients pressing at the entrance will be significantly impaired.” Jack D. Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge: Cambridge University Press, 1998), 154.

<sup>62</sup> The psychiatric hospitals in Barnaul and Voroshilovo-Ussurisk were both reported to be at 160% of capacity. M. I. Lapidés (i.o. zav. orgmetodotdelom, gos. instituta psikh. MZ RSFSR), “Nekkotorye itogi deiatel'nosti psikhonevrologicheskikh stacionarov i dispanserov RSFSR po godovym statisticheskim i meditsinskim otchetam za 1952 god,” undated [archived 8 April 1953], GARF, f. a-482, op. 49, d. 5772, l. 1.

<sup>63</sup> GARF, f. r-8009, op. 1, d. 1035, l. 45; GARF, f. a-482, op. 49, d. 6628, l. 117.

**Figure 1.4. Psychiatric Hospitals and Psychiatric Hospital Beds in the USSR, 1935-1955, as Percentage of 1940 Level**



*Sources:* Adapted from Narkomzdrav/Minzdrav USSR reports sent to the Central Statistical Administration (TsSU), 1934-1956. "Otchety o seti, deiatel'nosti i kadrakh meditsinskikh uchrezhdenii Soiuzna," "Otchet MZ SSSR o seti, deiatel'nosti i kadrakh med. Uchrezhdenii po SSSR," RGAE f. 1562, op. 18, dd. 96 (1937), 203 (1940), 245 (1941), 260 (1942), 270 (1943), 291 (1944), 318 (1945), 351 (1946), 410 (1947), 442 (1948), 481 (1949), 545 (1950), 613 (1951), 686 (1952), 757 (1953); op. 27, dd. 48 (1954), 139 (1955), 259 (1956).

*Note:* The decline in hospital numbers in 1949-1952 is almost certainly an artifact of bureaucratic reporting. Minzdrav's 1949 report includes a note explaining that some oblasts and Union Republics were excluded from the total because of problems in their reports connected to ongoing unification of hospitals and polyclinics. "Otchet Ministerstva zdravookhraneniia Soiuzna SSR o seti, deiatel'nosti i kadrakh meditsinskikh uchrezhdenii SSSR za 1949g," RGAE, f. 1562, op. 18, d. 481, l. 2

**Table 1.1. USSR Psychiatric Hospital Beds, Bed Days, and Patient Visits, 1937-1954**

Year	Beds in Psychiatric Hospitals	Beds as % 1940	Total Bed Days	Average Days per Bed	Total Patient Visits	Average Visits Per Bed
1937	49,183	72.8%	16,408,000	333.6	105,424	2.14
1938	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
1939	59,649	88%	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
1940	67,571	100%	<i>n/a</i>	<i>n/a</i>	133,400	1.97
1941	38,038	56%	<i>n/a</i>	<i>n/a</i>	73,100	1.92
1942	32,759	48%	<i>n/a</i>	<i>n/a</i>	93,133	2.84
1943	36,015	53%	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
1944	43,116	64%	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
1945	41,136	61%	11,161,600	271.3	112,800	2.74
1946	47,275	70%	13,548,500	286.6	115,856	2.45
1947	51,794	77%	16,661,300	321.7	126,129	2.44
1948	54,966	81%	18,169,000	330.5	139,382	2.54
1949	56,121	83%	19,355,900	344.9	141,465	2.52
1950	61,223	91%	22,585,400	368.9	155,632	2.54
1951	66,230	98%	25,807,400	389.7	162,122	2.45
1952	71,132	105%	28,112,500	395.2	169,024	2.38
1953	80,005	118%	31,481,300	393.5	181,596	2.27
1954	84,440	125%	~35,000,000	414.5	236,432	2.8

*Sources:* Adapted from Narkomzdrav/Minzdrav USSR reports sent to the Central Statistical Administration (TsSU), 1934-1956. "Otchety o seti, deiatel'nosti i kadrakh meditsinskikh uchrezhdenii Soiuza," RGAE f. 1562, op. 18, dd. 96 (1937), 203 (1940), 245 (1941), 260 (1942), 270 (1943), 291 (1944), 318 (1945), 351 (1946), 410 (1947), 442 (1948), 481 (1949), 545 (1950), 613 (1951), 686 (1952), 757 (1953); op. 27, dd. 48 (1954), 139 (1955), 259 (1956).; "Stenogramma zasedniiia uchenogo soveta institute psikiatriia MZ SSSR," GARF, f. r-9592, op. 1, d. 21, l. 2.

reported in 1948 that fewer than half of the positions in psychiatric hospitals were filled.<sup>64</sup> They made up the difference by forcing staff to work double shifts, something that most were willing to do because they needed the money. Many were widows, and the salaries for nurses and

<sup>64</sup> G. G. Karanovich (Nach. otdela psikiatricheskoi pomoshchi MZ RSFSR), "Spravka," undated [1948], GARF, f. a-482, op. 47, d. 8454, l. 40.

orderlies [*sanitarki*] were not considered large enough to survive on.<sup>65</sup> With fewer people to keep watch over patients, hospital staff had a harder time managing the wards. While a ward nurse was distracted by one patient, others were left unsupervised. These moments of inattention left traces in hospital archives only when something went badly wrong, usually when patients committed suicide or escaped while workers were distracted.<sup>66</sup>

### **“A Brilliant Example of The Self-Sacrificing Work of Psychiatric Hospital Staff during the Great Patriotic War”: Dmitrii Fedotov and the Litvinov Psychiatric Hospital Scandal**

During the war, Narkomzdrav officials praised psychiatrists who were able to manage on their own despite difficult conditions,<sup>67</sup> and public praise was particularly lavished on a psychiatric hospital in Kalinin oblast’ called the Litvinov Psychiatric Hospital. This institution was held up as an example of how patriotism and enthusiasm could overcome all obstacles. The story of the director of this hospital, Dmitrii Fedotov, is instructive because he went on to play a central role in setting Narkomzdrav policy for psychiatry in the late 1940s. Understanding where he came from helps us understand his outlook and that of other psychiatrists who, like him, had come to Moscow from a background as provincial psychiatric hospital director. Studying

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<sup>65</sup> A. L. Andreev (Gl. Vrach bol’nitsy im. Kashchenko), in G. N. Beletskii (Chairman, Ministr Zdravookhraneniia RSFSR), “Protokol no. 58 zasedanii kollegii MZ RSFSR,” 16 November 1950, GARF, f. a-482, op. 49, d. 1519, l. 29. Nurses with no medical education were paid 225 rubles/month. *Sanitarki* and other junior staff were paid 200 rubles/month. For those with over 10 years service these rates increased to 355 and 260 rubles respectively. Nurses with a medical school degree earned 265 ruble/month to start, and could go up to 375 rubles/month. Psychiatrists started at 900 rubles/month and went up to 1200. F. A. Artem’ev, ed., *Spravochnik nauchnogo rabotnika: Sbornik zakonov, ukazov, postanovlenii i rasporyazhenii pravitel’sтва i vedomstvennykh materialov po voprosam truda nauchnykh rabotnikov meditsinskikh uchrezhdenii* (Moscow: AMN SSSR, 1948), 107-110.

<sup>66</sup> See, for instance, the case of a patient on the Gannushkin Hospital’s 6<sup>th</sup> Disturbed Ward who hung herself while her nurse was out of the room attending to another disturbed patient. “Prikaz no. 310-a po psikhonevrologicheskoi gorodskoi bol’nitse No. 4 im. Gannushkina,” 14 July 1961, TsAGM, f. 533, op. 1, d. 55, l. 45.

<sup>67</sup> Unsigned, “Material po proverke otdela psikhiatricheskoi pomoshchi MZ RSFSR,” undated [1948?], GARF, f. a-482, op. 47, d. 8454, ll. 4-4ob.

Fedotov's story also tells us something about the ethos of the Narkomzdrav officials who promoted him. This is particularly striking, because Fedotov's success was built on blatant violations of the law.

A psychiatrist who served under Fedotov in the 1950s later remembered him as a strong, decisive leader. "He was a businesslike boss, 'a man of action' [*chelovekom deistviia*]. Staff members... thought that he looked like the image of Peter the First as described by Aleksei Tolstoi and in the Soviet film. Among ourselves we called him, "Peter the First."<sup>68</sup> When the war began in 1941, however, Fedotov was rejected for military service, apparently turned down because of his father, a village priest, had been exiled by the Soviet government in the early 1920s.<sup>69</sup> Fedotov had graduated from Smolensk Medical Institute in 1931, spent two years in the army, and had then worked for three years as a district psychiatrist in Moscow oblast'. From 1937 to 1940 he had worked in Krasnodar as an assistant in the psychiatry department of Kuban Medical Institute, and then as deputy director of the Krasnodar regional psychiatric hospital.<sup>70</sup> When the war began he was studying psychiatry in Moscow as a graduate student under renowned psychiatrist Grunia Sukhareva.<sup>71</sup> When he was rejected for military service he was instead sent to Kazan, where he worked for several months as a psychiatrist at Kazan Psychiatric

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<sup>68</sup> V. B. Gurvich, "Perelistyvaia istoricheskie stranitsy otechestvennoi psikhiiatrii," in *Vydaiushchiesia psikhiiatry Rossii (istoriia i sovremennost')*: *Materialy XVI Kerkbikovskikh chtenii*, ed. Tat'iana Borisovna Dmitrieva and Iurii Anatol'evich Aleksandrovskii (Moscow: GNTs SSP im V. P. Serbskogo, 2007), 39-43.

<sup>69</sup> This information comes from a brief account by one of Fedotov's former students, Viktor Ostroglazov, now the director of the psychiatry department at Moscow's Sklifosovskii Center for Emergency Medicine. Ostroglazov gives no date for the father's exile, but does say that Fedotov had to "overcome the suspicion of the regime" to go to medical school at age 18. Fedotov turned 18 in 1925. Viktor Ostroglazov, *O tekh, komu my dolzhny. Ch'iu shkolu my prodolzhaem* (2006), available from <http://www.psyhelp.ru/texts/fedotov.htm> (accessed 27 April 2007).

<sup>70</sup> According to Ostroglazov, Fedotov ended up there because of a connection with one Iu. S. Nikolaevskii, "who later became a famous scientist." Ostroglazov, *O tekh, komu my dolzhny*.

<sup>71</sup> "Dmitrii Dmitrievich Fedotov (K 60-letiiu so dnia rozhdeniia)," in *ZhNiP* 68 no. 7 (1968): 1101.

Hospital. Then, in January 1942, Fedotov was given the task of rebuilding the Litvinov Psychiatric Hospital.

The Litvinov Hospital was located in a small village, Burashevo, in Kalinin oblast'. The hospital was – and remains – famous among Russian psychiatrists as the hospital where Mikhail Litvinov founded one of Russia's first schools for psychiatric administrators.<sup>72</sup> The hospital had originally been built to house 600 beds, but by 1939 it held 1,200 beds and 1,389 patients.<sup>73</sup> When the German army approached in October 1941 the hospital staff checked out as many patients as they could from the hospital, and only 530 patients remained when the Germans arrived on October 17. For the next month the staff continued to run the hospital as best they could, feeding the patients from stores of potatoes and groats. Then the Germans demanded that the buildings be freed up for their own use, took the food stored in the hospital, and forbade staff to help the psychiatric patients. Staff who were inclined to break this order were told that they would meet the same fate as the patients if they got in the way. The hospital had a piece of farm land about 30 kilometers away, and the Germans began to transfer the patients to that piece of land. In all 80 patients were driven to the farm, where the Germans shot them. On November 20 they began to kill the patients who remained in the hospital, giving 350 lethal doses of narcotic. By December 5, all 530 patients in the Litvinov hospital had been murdered.<sup>74</sup>

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<sup>72</sup> Vladimir Iakovenko, one of the founders of modern Russian psychiatry, worked there under Litvinov as a resident for five years in the 1880s. T. M. Karavanova, "Pamiati M. P. Litvinova (K 75-letiiu psikhiatricheskoi bol'nitsy imeni M. P. Litvinova)," *Zhurnal nevropatologii i psikhatrii im. S.S. Korsakova* 60, no. 8 (1960): 1045-1048; V. G. Sotskov, "Ot kolonii dlia dushevnobol'nykh k oblastnoi psikhiatricheskoi bol'nitse (K 100-letiiu Psikhiatricheskoi bol'nitsy im. M. P. Litvinova)," *Zhurnal nevropatologii i psikhatrii im. S.S. Korsakova* 84, no. 5 (1984): 771-773; "150-letie Vladimira Ivanovicha Iakovenko, 1857-1923," *NPZh*, no. 4 (2007).

<sup>73</sup> G. G. Karanovich (Nachal'nik Otdela Psikhopomoshchi NKZ RSFSR), "Spravka o koechnom fonde psikh. bol'nits RSFSR (po sostoianiiu na 1.1.41)," 22 October 1940, GARF, f. a-482, op. 47, d. 3, ll. 40-42.

<sup>74</sup> I. S. Iolovich (Gorodskoi psikhiatr g. Moskvy, Upolnomochennyi NKZ RSFSR) to A. F. Tret'iakov (RSFSR Commissar of Public Health), "Dokladnaia zapiska o zverstvakh nemetskikh okkupantov v Psikhiatricheskoi

The Soviet Army retook the territory around the Litvinov Hospital early in January 1942, and the German soldiers set fire to the hospital, destroying several of the hospital's main buildings. Three of the remaining buildings were taken over by the Soviet Army to be used for wounded soldiers. When Dmitrii Fedotov arrived to take over as the hospital's director, he found only two buildings left that could be used for psychiatric patients, with enough space to squeeze in 300 beds.<sup>75</sup> Fedotov did whatever he could to get the hospital running again. He took things from the government warehouse without permission and without paying. He bought meat for the hospital at market prices. He freely gave clothing to hospital doctors and staff. As he later told the collegium of Narkomzdrav RSFSR:

Many patients were entering the hospital because the front was nearby. This made it necessary to get the hospital running in very short order, materials had to be found through various methods, and the purchase of these materials wasn't always done correctly; there were cases when false accounts were filled out [*kogda pisalis' fiktivnye scheta*].<sup>76</sup>

Fedotov was able to quickly increase the number of beds from 300 to nearly 900, to restore water, heat, and electricity to the hospital, and to develop the hospital farm. His ability to get things done brought him to the attention of the *oblast'* government, and he became the head of the Kalinin *Oblast'* Health Department.<sup>77</sup> In 1945 he joined the Party.<sup>78</sup> Fedotov's most audacious

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bol'ntse imeni Litvinova v sele Burashevo Kalininskoi oblasti" (undated, probably January 1942), GARF, f. a-482, op. 47, d. 657, ll. 4-8. This archival folder includes several other short *akty* describing the same events, all of which support Iolovich's account. The exception is an *akt* published in a newspaper that puts the number killed at "about 1,000," approximately double the number that Iolovich reported to Narkomzdrav. "Akt o zlodeiskom umershchelenii nemtsami bol'nykh, nakhodivshikhsia na izlechenii v Bol'ntse imeni Litvinova," *Proletarskaia Pravda*, 3 January 1942); clipping held in GARF, f. a-482, op. 47, d. 657, l. 41.

<sup>75</sup> Tveritin (I.o. gl. vracha Kalininskoi psikh bol'nitsy) to A. F. Tret'iakov (NKZ RSFSR), 12 January 1952, GARF, f. a-482, op. 47, d. 657, ll. 19-21; "Protokol no. 16 zasedanii Kollegii MZ RSFSR," 12 September 1946, GARF, f. a-482, op. 47, d. 4278, l. 161.

<sup>76</sup> D. D. Fedotov, "Protokol no. 16 zasedanii Kollegii MZ RSFSR," 12 September 1946, GARF, f. a-482, op. 47, d. 4278, 161.

<sup>77</sup> "Protokol no. 16 zasedanii Kollegii MZ RSFSR," 12 September 1946, GARF, f. a-482, op. 47, d. 4278, 161.

scheme was reestablishing electrical power to the hospital. As newspaper accounts emphasized, Fedotov and his staff had run high-voltage lines to the hospital from a local power station. Local kolkhoz chairmen had asked him to connect their farms to the lines at the same time, and Fedotov had done so. He had apparently spent so much money on the electrical lines, however, that he didn't feel he could give electricity away for free. Instead he set up contracts with the kolkhozes and they paid the *oblast'* Health Department for access. Fedotov had in effect turned the *oblast'* health department into a power company.<sup>79</sup>

This scheme came to the attention of Minzdrav RSFSR in 1946, and Fedotov was brought to Moscow to answer for it. He insisted in his defense that he had done what he needed to do: the front was close by, the hospital was getting new patients every day, and he needed to get it running very quickly. For their part, the collegium members were by turns condescending (he was inexperienced) and harsh (“out of control,” “outside the law”). The Minister berated Fedotov for trying to justify his actions, and was particularly upset about the electricity scheme (“How could you allow yourself such things! [*Kak vy mozhete pozvoliat' sebe takie veshchi!*].” The minister concluded, however, that Fedotov was not a criminal. The electricity scheme was blamed on the corrupting influence of an unscrupulous electrical engineer, and Fedotov was let off with a “stern demerit with a warning” [*strogii vygovor s poreduprezhdeniem*].<sup>80</sup> Fedotov went back to Kalinin where he kept his job teaching in the local pedagogical institute. In 1947 he was brought back to Moscow as the new head of Minzdrav USSR's Main Department of Prevention

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<sup>78</sup> “Dmitrii Dmitrievich Fedotov,” in *ZhNiP* 82 no. 2 (1982): 150-151.

<sup>79</sup> The *kolkhozy* had paid Fedotov 25,000 rubles before inspectors from Moscow uncovered the scheme and nullified the contracts. “Protokol no. 16 zasedanii Kollegii MZ RSFSR,” 12 September 1946, GARF, f. a-482, op. 47, d. 4278, ll. 161-165.

<sup>80</sup> “Protokol no. 16 zasedanii Kollegii MZ RSFSR,” 12 September 1946, GARF, f. a-482, op. 47, d. 4278, ll. 161-165.



and Treatment Services [*GU lechprof. pomoshch*']. From 1947-1951, he was the official in charge of all hospitals in the Soviet Union, psychiatric and otherwise.<sup>81</sup>

Even by the standards of the Soviet Union, the war and early postwar years were times of extreme shortage. Fedotov proved to be an ideal “man of action,” a practical administrator who knew how to find resources without depending on Moscow to send them to him, a man who could use local connections to find what he needed “under the floor” or “on the left” – through personal connections, *blat*’, or the black market. Fedotov was hired despite his administrative warning, his *strogyi vygovor s preduprezhdeniem*, and despite his background as the son of a class enemy. The new Minister, Efim Smirnov, was surrounding himself with young, talented administrators, and Fedotov had proven himself to be capable. Fedotov’s impressive performance was probably brought to Smirnov’s attention by Sergei Kurashov, Fedotov’s former boss at the Kazan psychiatric hospital. Kurashov had been hired by Minzdrav during the war, and the two men now became close allies in Moscow. Fedotov’s promotion and his subsequent key role in the development of psychiatric policy during the Late Stalin period reflect the values and priorities of the post-war Soviet government.

### “Active Therapy” after the War

By 1944 psychiatric hospitals in the Soviet Union had virtually ceased giving patients “active biological treatment,” and so Narkomzdrav USSR issued a *prikaz* ordering psychiatric hospital directors to resume using the active treatment methods.<sup>82</sup> The Narkomzdrav official who chaired a 1945 meeting of psychiatric hospital directors told his audience that this *prikaz*

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<sup>81</sup> “Dmitrii Dmitrievich Fedotov,” in *ZhNiP* 82 no. 2 (1982): 150-151.

<sup>82</sup> S. A. Kolesnikov (Zam. NKZ SSSR), “Prikaz No. 220: Ob organizatsii psikhiatricheskoi pomoshchi,” 13 April 1944, GARF, f. r-8009, op. 1, d. 477, l. 268.

“establishes all the necessary conditions to significantly expand methods of active therapy in psychiatric hospitals,” and he urged them to revive methods that existed before the war.<sup>83</sup>

Leading psychiatrists were enthusiastic about this idea,<sup>84</sup> but in practice it was very difficult for them to implement. The war had left psychiatric hospitals overcrowded, rundown, and chronically short of essentials like food, clothing, and clean water.

In 1946, Narkomzdrav – now renamed Minzdrav (the Ministry of Public Health) – issued another *prikaz* with wording that was almost identical to the *prikaz* that had been issued in 1944. Again, they ordered psychiatric hospital directors to expand their use of active therapy and laboratory methods.<sup>85</sup> And again hospitals moved much more slowly than Minzdrav officials liked.<sup>86</sup> In 1948 Minzdrav began a new push to get psychiatric hospitals to reengage with active treatment. Some hospitals, according to a Minzdrav RSFSR report, had not yet “moved away from medical passivity, the vestiges of war time,” but the time had now come for them to do so. Conditions in psychiatric hospitals had improved enough that “there is now a satisfactory base for active therapy to be done systematically.”<sup>87</sup>

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<sup>83</sup> A. N. Motnenko (Chairman, Nachal'nik Uprav. Gorbol'nits i Poliklinik MZ SSSR), “Stenogramma soveshchaniia psikhiatrov pri upravlenii gorbol'nits NKZ SSSR,” 30 November 1945, GARF, f. r-8009, op. 5, d. 249, l. 5.

<sup>84</sup> See for instance, Pavel Posvianskii's remarks to the 1944 All-Russian conference, where he told the audience that psychiatric hospitals should now be restructured using an interdisciplinary approach and stressing the importance of medical research and active treatment. P. B. Posvianskii and T. I. Gol'dovskaia, “Khronika: Vserossiiskaia konferentsiia po voprosam psikhiatrii,” *Nevropatologii i psikhiatriia* 13, no. 5 (1944): 65.

<sup>85</sup> G. A. Miterev (Ministr Zdravookhraneniia SSSR), “Prikaz no. 226,” 13 April 1946, GARF, f. r-8009, op. 1, d. 722, l. 111.

<sup>86</sup> Prikaz MZ SSSR no. 446, “O meropriiitiiakh po uluchsheniuiu nevro psikhiatricheskoi pomoshchi naseleniiu,” 20 July 1948, GARF, f. r-8009, op. 1, d. 725, ll. 16-22; Prikaz MZ SSSR, “O sostoianii psikhonevrologicheskoi pomoshchi i merakh k ee uluchsheniuiu,” 11 February 1949, GARF, f. r-8009, op. 33, d. 399, l. 172.

<sup>87</sup> G. G. Karanovich (Chairman), “Protokol proizvodstvennogo soveshchaniia sotrudnikov Otdela psikhiatricheskoi pomoshchi MZ RSFSR,” April 2, 1948, GARF, f. a-482, op. 47, d. 8455, l. 28.

This message was sent out to psychiatric hospital directors and disseminated at staff meetings. At a 1948 meeting of the psychiatrists of Moscow Psychiatric Hospital No. 1, a senior psychiatrist told the staff that it was time to look to the future and to focus on the medical side of their work, but that they had been right to set their house in order first:

If we examine all the work of the hospital for the postwar period, we will see that the first years were dedicated to economic tasks [*khoziastvennym zadacham*], to restoring the hospital economy. That was correct: how can one do a good job treating patients, if they are cold and uncomfortable, if water is dripping from the ceiling, if there are not enough underclothes, shoes, coats, equipment, medicine?<sup>88</sup>

At the same meeting, another senior psychiatrist lamented that before the war they had been using a wider range of active treatment methods, but had not returned to them after the war ended. Both speeches conveyed a sense that promising prewar research and precious clinical experience had been lost during the war, as well as a hope that finally reconstruction would end and they could pick up where they left off.<sup>89</sup>

By 1948 and 1949 most psychiatric hospitals were doing some active therapy, but they were by no means giving active therapy to a majority of their patients. A study found that only 54 of 87 psychiatric hospitals in the RSFSR were using active therapy, and that on average they gave these treatments to only 14.6% of their patients.<sup>90</sup> (See Table 1.2.) The director of one central research institute, Vasilii Giliarovskii, found that most psychiatric hospitals were giving active treatment to just 5-15% of their patients. The only bright spots were hospitals that had

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<sup>88</sup> I. V. Strelchuk (Gl. Psikhiatr g. Moskvy) in E. N. Kameneva (Chairman), “Stenogramma otchetnoi konferentsii s uchastiem vrachei vsego otdela,” 1 February 1948, TsAGM, f. 1126, op. 1, d. 56, ll. 20-22.

<sup>89</sup> E. N. Kameneva in E. N. Kameneva (Chairman), “Stenogramma otchetnoi konferentsii s uchastiem vrachei vsego otdela,” 1 February 1948, TsAGM, f. 1126, op. 1, d. 56, ll. 46-47.

<sup>90</sup> From the wording of the report it is unclear whether 14.6% refers to the total number of patients in the RSFSR (i.e., including hospitals that did no active treatment), or whether 14.6% refers only to the 54 hospitals that did give active treatment. If the latter, then the average across all 87 RSFSR psychiatric hospitals was considerably lower than 14%. A. Portnov (Nach. Otdela psikhonev pomoshchi MZ SSSR), Otchet o rabote psikhonev. otdela MZ SSSR za 1950 goda,” after 1 January 1951, GARF, f. r-8009, op. 33, d. 263, l. 9.

some connection to a university department or research institute. Giliarovskii proposed establishing a formal mentorship between university clinics and psychiatric hospitals, with each clinic taking on 2-3 hospitals. In this way the knowledge and skills of the university clinic could be transferred quickly to every psychiatric hospital in the Soviet Union.<sup>91</sup>

**Table 1.2. Active Therapy Done in RSFSR Psychiatric Hospitals, 1949**

Method of Active Therapy	Percentage of All Patients	Percentage of All Patients Given Active Treatment
Insulin shock therapy	7.8%	53.6%
Electroconvulsive therapy (ECT)	4.8%	33.0%
Sleep therapy	1.0%	6.9%
Combination insulin + (ECT, sleep, etc).	.5%	3.6%
Pharmaceutical convulsive therapies*	.4%	2.9%
TOTAL	14.60%	100.0%

\* “Pharmaceutical convulsive therapies”: Primarily Cardiazol (Metrazol) and camphor.

*Source:* Adapted from A. A. Portnov (Nach. Otdela psikhonevrologicheskoi pomoshchi MZ SSSR, “Otchet o rabote psikhonevrologicheskogo otdela MZ SSSR za 1950 g.,” after 9 December 1950, GARF, f. r-8009, op. 33, d. 263, l. 9.

*Note:* According to Portnov, only 14.6% of patients in RSFSR psychiatric hospitals received active treatment in 1949. I have calculated the % of total patients receiving each type of treatment by simply multiplying 14.6 by the percentage of each treatment. Unfortunately, I do not have absolute figures for the number of patients who passed through RSFSR psychiatric hospitals in 1949.

Hospital directors were not exaggerating when they said that their hospitals were in trouble; if anything, their reports to Minzdrav seem have been overly optimistic. Support for psychiatric hospitals in the post war was indeed miserable, and without key drugs and laboratory equipment they simply could not fully implement active treatment. Many psychiatrists looked to Minzdrav to help get them out of their situation by sending them aid or by forcing local authorities to give them support. Psychiatric hospitals’ lack of clout within the Soviet

<sup>91</sup> V. A. Giliarovskii (Dir. Inst. Psikhiiatrii MZ SSSR) in L. A. Koreisha (Acting Chairman), “Stenogramma zasedaniia biuro prezidiuma UMS MZ SSSR,” 30 November 1949, GARF, f. r-8009, op. 2, d. 1368, l. 16.

governmental system was repeatedly demonstrated by psychiatrists' inability to force other organizations to vacate psychiatric hospital property, despite standing orders from Minzdrav and Sovmin. Regional health departments were notorious for putting psychiatric hospitals at the bottom of their list of priorities, so this strategy was probably not unreasonable.<sup>92</sup>

Lack of money and political connections, however, could not account for all of the difficulties in obtaining drugs like insulin. During the late 1940s, the Soviet pharmaceutical industry suffered from severe underproduction, shoddy manufacturing processes, problems with suppliers, and problems with raw materials. Even if hospitals had the money and the connections, they sometimes simply could not buy certain things. These deficit goods included such mainstays of psychiatric care as insulin, glucose, and barbiturates, but also key tools in hospital management like soap.<sup>93</sup> Psychiatrists were affected particularly by shortages of insulin and tranquilizers, since insulin shock therapy was the most widely used method of treatment, and tranquilizers were considered key tools in the "fight with agitation."<sup>94</sup> The senior psychiatrist on

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<sup>92</sup> The largest psychiatric hospitals were directly subordinated to Minzdrav RSFSR, while smaller hospitals were subordinated to *oblast'* health departments. In 1947, Minzdrav RSFSR intervened to deliver aid directly to psychiatric hospitals under local jurisdiction because they were not getting crucial supplies. The supplies delivered came from Minzdrav's budget for psychiatric services, "thus reducing central funds intended for psychiatric hospitals under republic jurisdiction." G. G. Karanovich (Nach. Otdela psikhiatricheskoi pomoshchi MZ RSFSR), "Otchet o rabote otdela psikhiatricheskoi pomoshchi MZ RSFSR za 1947 g.," undated [1948], GARF, f. a-482, op. 47, d. 8454, l. 1.

<sup>93</sup> Mary Schaeffer Conroy, "The Soviet Pharmaceutical Industry and Dispensing, 1945-1953," *Europe-Asia Studies* 56, no. 7 (November 2004): 965-969; At a 1948 conference one leading psychiatrist blamed the leadership of the pharmaceutical directorate: "a significant portion of the guilt for these unspent funds ... falls on the head of GAPU, on comrade Petrichenko, who gives little effort to ensuring that our psychiatric hospitals are supplied with necessary medications (glucose, insulin, and others) and medical equipment." G. G. Karanovich, "Spravka," undated [1948], GARF, f. a-482, op. 47, d. 8454, l. 39.

<sup>94</sup> See, for instance, the complaints of head physicians at the 1948 conference on active treatment. G. G. Karanovich (Predsedatel'; nachal'nik otdela psikhopomoshchi MZ RSFSR), "Protokol soveshchaniia po voprosam organizatsii lechebnoi raboty v psikhiatricheskikh bol'nitsakh," 13 April 1948, GARF, f. a-482, op. 47, d. 8454, ll. 20-20ob. As a 1949 meeting of the Minzdrav SSSR collegium was about to close, someone shouted from the floor that the problem of insulin needed to be resolved: "We have no insulin whatsoever." The speaker was told by the Minister that "As far as insulin goes we're poorly off in general. ... we're getting to the point where we'll have to

one ward for disturbed men at Moscow Psychiatric Hospital No. 1 reported in 1948 that the lack of drugs had “greatly complicated the work of the ward,” and she pointed to this lack of drugs to help explain the high level of violence on her ward.<sup>95</sup> Other physicians complained that they could not fully implement active therapy without laboratory equipment or laboratory chemicals. Head physicians were known to sometimes go to great lengths to obtain these things for their hospitals, travelling to pharmaceutical warehouses to obtain deficit medicines and using personal connections to get needed supplies.<sup>96</sup>

Not everyone was receptive to the idea that overcrowding was to blame for the low levels of active therapy. Psychiatric hospital directors discussed these issues with leading psychiatrists in Moscow at a 1948 conference, and one of the Moscow psychiatrists who responded to them was Andrei Snezhnevskii, then a 44 year-old docent from the Central Institute of Advanced Medical Study. In his remarks, Snezhnevskii rejected the idea that hospitals had to be in good condition in order for active treatment to be done. In fact, he said, “The quality of therapeutic work needs to be raised regardless of the general condition of the hospital, regardless of the state of its economy.” In order for proper active therapy to be done hospitals should prioritize certain key jobs: an autopsy laboratory, a scientific consultant, and a general medicine ward were all

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stop production of penicillin.” “Stenogramma zasedanii kollegii MZ SSSR,” 11 February 1949, GARF, f. r-8009, op. 1, d. 757, l. 118.

<sup>95</sup> In 1947, she reported, there had been 117 cases of patients attacking one another, and 70 cases of patients attacking staff. Dr. Berezina (Second Male Disturbed Ward), in A. B. Aleksandrovskii, “Stenogramma konferentsii vrachei pri loi Moskovskoi gorodskoi psikhiatricheskoi bol'nitsy,” 9 March 1948, TsMAM f. 1126, op. 1, d. 57, ll. 24-24ob.

<sup>96</sup> The best example that I have found of this sort of activity comes from before the war, but the work of historians like Elena Osokina suggest that *blat*’ and black market connections probably played a large role in the operations of postwar psychiatric hospitals as well. A. Dorsht (Gl. Vrach psikhiatricheskoi bol'nitsy v. g. Voroshilovske, Ordzhonikidzevskogo kraia) in G. A. Miterev (Predsedatel', Narkom. Zdrav. SSSR), “Stenogramma zasedaniia kollegii NKZ SSSR no. 37,” 25 November 1940, GARF, f. r-8009, op. 1, d. 35, l. 45ob.

necessary. If basic scientific and organizational principles were followed, Snezhnevskii believed, even chronic patients would respond to treatment up to 25% of the time.<sup>97</sup>

It is worth dwelling briefly on Snezhnevskii and his opinion because of his later importance to Soviet psychiatry, especially during the “Pavlov Years” that began in 1950. That year, Snezhnevskii was singled out by leaders in the Central Committee of the Communist Party to become the leader of the fight against rootless cosmopolitanism in psychiatry, and in 1951 he replaced his mentor, Mark Sereiskii, as head of the psychiatry department at the Central Institute of Advanced Medical Study. He also became the editor of the USSR’s only psychiatric journal, *Nevropatologiya i psikhiatriia*. He remained in this post until his death in 1987, by which time he had become internationally infamous for his major role in sending political dissidents to psychiatric hospitals. In 1948, though, Snezhnevskii was not yet known widely. He was finishing his doctoral dissertation and lecturing at the Institute of Advanced Medical Study, but had published few papers of his own, and is virtually absent from the archival record from these years.

Snezhnevskii had begun his career in psychiatry when active therapy was just beginning. Born in Kostroma in 1904, Snezhnevskii graduated from Kazan University in 1925, and remained in Kazan after graduation to work under Tikhon Iudin, who was then the head of the psychiatry department.<sup>98</sup> Snezhnevskii gained some recognition during the period when the first

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<sup>97</sup> A. V. Snezhnevskii (Dotsent, Ts. Institut usovershchenstvovaniia vrachei) in G. G. Karanovich (Chairman, Nachal’nik otдела psikhopomoshchi MZ RSFSR), “Protokol soveshchaniia po voprosam organizatsii lechebnoi raboty v psikhiatricheskikh bol’nitsakh,” 13 April 1948, GARF, f. a-482, op. 47, d. 8454, ll. 24-26.

<sup>98</sup> Iudin was a graduate of Moscow University, where he had studied with Vladimir Serbsky. At the time that Snezhnevskii studied with him Iudin was still one of the USSR’s leading proponents of eugenics. Remarkably, Iudin survived the 1930s despite his connection to the eugenics movement, and he died of old age in 1949. Snezhnevskii later billed himself as a student of Iudin’s, even though he did his graduate work under Mark Sereiskii. The biographical sketch of Snezhnevskii published in the *Great Medical Encyclopedia* (BME), does not mention

methods of active therapy were being introduced to the USSR for his success in transforming the psychiatric hospital in Kostroma from a failing and overcrowded rural psychiatric hospital into a well functioning institution where almost all the most modern methods of treatment were in use.<sup>99</sup> In 1933 Snezhnevskii's hospital was visited several times by Lev Rozenshtein, the director of Moscow's Institute of Neuro-Psychiatric Prophylactics Psychiatry, and Rozenshtein was apparently impressed enough with Snezhnevskii's work to invite him to work at his institute in Moscow.<sup>100</sup> There Snezhnevskii became acquainted with the German refugee psychiatrists Eric Sternberg and Arthur Kronfeld, who had brought knowledge of insulin therapy with them to the Soviet Union when they fled the Nazis. Snezhnevskii went on to co-author one of the early instructions on the use of insulin therapy, and later did his graduate work under Mark Sereiskii, the USSR's foremost expert in biological therapies. In 1941, Snezhnevskii had drafted Narkomzdrav USSR's new regulations for psychiatric hospitals, the regulations that went into effect in 1946. Snezhnevskii, in short, was one of the leading members of the generation of Soviet psychiatrists who came of age in the era of active therapy, for whom the medical model of biological psychiatry was self-evident.

In 1949, the senior leaders of Minzdrav USSR finally sat down to discuss the situation in psychiatry, the first time since 1940 that psychiatry had been discussed at the level of the

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Snezhnevskii's graduate school advisor or his doctoral dissertation adviser, both of whom were Jewish. BME 3<sup>rd</sup> ed, s.v. "Snezhnevskii"; "Tikhon Ivanovich Iudin," *Nevropatologĭia i psikhatriia* 19 (82).

<sup>99</sup> Snezhnevskii was head physician at the Kostroma hospital from 1925-1938. "Andrei Vladimirovich Snezhnevskii: K 100-letiiu so dnia rozhdeniia," *Zhurnal nevropatologii i psikhatrii im. S.S. Korsakova*, no. 5 (2004): 4. A. V. Snezhnevskii, "Oblastnaia psikhiatricheskaia bol'nitsa v g. Kostrome," *Sovetskaia nevropatologĭia, psikhatriia i psikhogigiena* 2, no. 10 (1933): 149-154; David Joravsky, *Russian Psychology: A Critical History* (Oxford: Basil Blackwell, 1989), 421-422.

<sup>100</sup> Iu. S. Savenko, "120-letie L'va Markovicha Rozenshteina (1884-1934)," *Nezavisimyi psikhiatricheskii zhurnal*, no. 3 (2004).



Ministry's collegium.<sup>101</sup> This scrutiny from the Ministry made some new resources available to psychiatrists, but it also raised the profile of the problems that plagued psychiatric hospitals, and put these problems on the agenda of the Ministry.

The agenda of this meeting was set by Dmitrii Fedotov, the psychiatrist at the center of the Litvinov Hospital scandal, and Sergei Kurashov, the psychiatrist turned Minzdrav official who brought Fedotov to the attention of the Minister. The two men had similar biographies. In 1949 they were both in their early 40s, and both had started as working psychiatrists in the 1930s, then became the directors of struggling provincial psychiatric hospitals, and then were promoted into the administrative apparatus in Moscow. Fedotov was in charge of the Main Directorate of Treatment and Prevention Services, the division of the Ministry that oversaw most medical treatment facilities, including psychiatric hospitals.<sup>102</sup> Kurashov was in charge of the Main Directorate for Sanatorium Affairs. By 1949 he was also serving as secretary of the All-Union Society of Neuropathologists and Psychiatrists.<sup>103</sup> Fedotov had spent a year studying in Moscow before the war, but neither Fedotov nor Kurashov had ever worked as research scientists. Fedotov and Kurashov brought the perspective of the psychiatric hospital director and working physician to the collegium. Their practical, clinically oriented view of psychiatric medicine sometimes contrasted quite sharply with the views held by the senior professors of psychiatry who dominated the committees and boards that had traditionally set policy standards,

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<sup>101</sup> The last time that Minzdrav's collegium had met to discuss psychiatry was in 1940. The collegium had issued decrees calling for improvement in psychiatry in 1944, 1946, and 1948, but all of them were produced without the collegium actually sitting down to discuss the problem. In 1945 the head of the Directorate of Urban Hospitals did request that the collegium discuss problems in psychiatry, but nothing came of it. Motnenko (Nach. upr. gorbol'nits NKZ SSSR) to V. S. Nikitskii (Sek. kollegii NKZ SSSR) (undated), GARF, f. r-8009, op. 1, d. 521, l. 64.

<sup>102</sup> "Dmitrii Dmitrievich Fedotov (K 60-letiiu so dnia rozhdeniia)," in *ZhNiP* 68 no. 7 (1968): 1101.

<sup>103</sup> Kurashov served as USSR Minister of Health from 1959 to 1965. N. A. Vinogradov, *S. V. Kurashov* (Moscow: Meditinsa, 1967); *Bol'shaia meditsinskaia entisklopediia* 2<sup>nd</sup> ed., s.v. "Kurashov, Sergei Vladimirovich."

and the tension between the younger generation and their elders proved to be an important dynamic in the professional politics of the late 1940s.

Fedotov drafted the main report for Minzdrav's discussion of psychiatry, and he painted a picture of Soviet psychiatry that was extraordinarily bleak.<sup>104</sup> He described overcrowding as "catastrophic." Letters of complaint and physician reports suggested that hospital conditions were deteriorating. Numerous cases of hospital workers violently beating patients had been confirmed.<sup>105</sup> Active treatment had not developed as they had hoped; outside the center, few hospitals had the laboratories, equipment, or staff needed to fully implement the new methods.<sup>106</sup> The Minister was appalled. "I don't want to use stronger language," he said at the conclusion of the meeting, "but in comparison with other divisions of healthcare, this one is in the worst condition."<sup>107</sup> He approved a plan to build a large number of new psychiatric hospitals, and he supported a request to the USSR Council of Ministers for funding to make this possible. The construction proposal was drafted in 1949 by a commission of leading psychiatrists,<sup>108</sup> and in

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<sup>104</sup> This report was mandated by a July '48 decree that was drafted by the All-Union Society of Neuropathologists and Psychiatrists at their Third Congress (1948) and approved by the Ministry. The one item in it that seems to have had any effect was the very last clause, which said that psychiatry should be discussed in the collegium. "Prikaz MZ SSSR #446: O meropriiiaitiakh po uluchsheniuu nevro-psikhiatricheskoi pomoshchi naseleniiu," 20 July 1948, GARF, f. r-8009, op. 1, d. 725, ll. 16-22.

<sup>105</sup> Moscow's Psychiatric Hospital for Chronic Patients was singled out as a particularly egregious example, housing 2,700 people in a hospital built for 1,200. GARF, f. r-8009, op. 1, d. 757, l. 98.

<sup>106</sup> D. D. Fedotov, "Otchet," 11 February 1949, GARF, f. r-8009, op. 1, d. 757, ll. 99-100.

<sup>107</sup> E. Smirnov (Chairman), "Stenogramma zasedanii Kollegii MZ SSSR," 11 February 1949, GARF, f. r-8009, op. 1, d. 757, l. 119.

<sup>108</sup> The commission formed to write the request to Sovmin included: Kurashov, Shmar'ian (Head Psychiatrist), Gurevich (1<sup>st</sup> Moscow Medical Institute, Serbsky Institute), Karanovich (Head Psychiatrist MZ RSFSR), Fedotov, Giliarovskii (Institute of Psychiatry MZ SSSR), Zelenskii (Kharkov), Osipova (Institute of Psychiatry MZ SSSR). E. Smirnov (Chairman), "Stenogramma zasedanii Kollegii MZ SSSR," 11 February 1949, GARF, f. r-8009, op. 1, d. 757, l. 119.

their plan they called for 33,650 new beds for psychiatric patients in the USSR, a dramatic 50% increase over the current 64,500 beds.<sup>109</sup>

In addition to focusing attention on overcrowding, Fedotov's report also highlighted problems with the way that psychiatric medicine was being practiced. The most glaring example came from reports on the diagnosis of schizophrenia. Psychiatric hospitals were reporting wildly different patterns of diagnosis in their year-end reports. Some hospitals diagnosed schizophrenia in 45% of their patients or even more; others diagnosed schizophrenia in only 15% of patients. A similar range was found for the diagnosis of epilepsy, personality disorder, and "unclear cases."<sup>110</sup> Fedotov blamed psychiatric research institutes. It was their task, he told the collegium, to help establish clear rules for diagnosis. Their failure to do so "leads practical physicians to mistake a schizophrenia-like syndrome for schizophrenia, which leads to serious consequences."<sup>111</sup> For Fedotov, this was emblematic of a larger set of problems in psychiatric research institutes, where researchers focused too much on big theoretical questions of consciousness and lost sight of their basic task, which was to connect their theories of the mind to the practical work of diagnosing and treating patients. He wryly observed to the collegium that "there are enough good scientists in our organization that it wouldn't hurt them to go out for six months to the Iakovenko hospital. They could talk with psychiatrists there and do some diagnosis

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<sup>109</sup> The plan called for the construction of 12,700 hospital beds, 17,950 beds in colonies, and 3,000 beds for children. Most of these beds were to be built in the RSFSR and Ukraine. E. Smirnov, "Reshenie zasedanii Kollegii MZ SSSR," 11 February 1949, GARF, f. r-8009, op. 1, d. 757, l. 22.

<sup>110</sup> "Ia. Kalashnik (Nach. otdela p/nev pomoshchi MZ SSSR), "Otchet o rabote psikhonevrologicheskogo otdela MZ SSSR za 1949 g.," undated, GARF, f. r-8009, op. 33, d. 109, l. 62.

<sup>111</sup> E. Smirnov (Chairman), "Stenogramma zasedanii Kollegii MZ SSSR," 11 February 1949, GARF, f. r-8009, op. 1, d. 757, l. 100.

and treatment of patients.” A little time in the provinces, he hoped, would help reorient them to reality and get them back to working on useful projects.<sup>112</sup>

Minzdrav’s Psychiatry Commission followed up on the problems of diagnosis at a December 1949 meeting. Eleven psychiatrists were present, including the Ministry’s head psychiatrist, Aleksandr Shmar’ian, and the director of the Serbsky Institute, Tsetselia Feinberg. Why were diagnoses so inconsistent? The participants agreed that there was a problem but they did not agree on what was causing it. No one seems to have entertained the thought that these figures were accurate accounts of real variation in mental illness from one place to another. They presumed, probably rightly, that major mental illness tends to occur at more or less the same rate everywhere. So when they saw this wild variation in the numbers being reported, they assumed that human error was to blame. Like Fedotov, some suggested that the problem lay with the research institutes, and that researchers should focus on practical problems of treatment.<sup>113</sup>

Most, however, suggested that provincial psychiatrists were poorly trained and the solution was education. If research institutes bore any blame in the matter, it was because they had not done enough to educate practicing psychiatrists. The problem could be solved by organizing more conferences, consultation visits, and access to specialized literature. Shmar’ian asserted that the culprit was bad lab tests: 60% of schizophrenia diagnoses were wrong, he claimed, because psychiatrists did not know how to use their equipment properly, or lacked the

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<sup>112</sup> E. Smirnov (Chairman), “Stenogramma zasedanii Kollegii MZ SSSR,” 11 February 1949, GARF, f. r-8009, op. 1, d. 757, l. 101.

<sup>113</sup> “Protokol no. 1 zasedaniia Psikhiatricheskoi komissii pri Otdel’ psikho-nev pomoshchi MZ SSSR” (Dec. 1, 1949), GARF, f. r-8009, op. 33, d. 158, ll. 20-22. In 1952, Minzdrav RSFSR’s psychiatry department reported even greater variation, with institutions in Moscow oblast’ diagnosing schizophrenia in over 60% of cases, while institutions in Leningrad diagnosed schizophrenia in 14-18% of cases. “Otchet MZ RSFSR o deiatel’nosti psikhonevrologicheskikh stacionarov i dispanserov RSFSR za 1952,” GARF, f. a-482, op. 49, d. 5772, l. 4.

right chemicals or supplies.<sup>114</sup> Finally, there was a view that the problem was more complicated. Psychiatrists were diagnosing patients according to different criteria because of different “schools” of psychiatry that conceptualized mental illness in different ways. If this were the case, then the solution would be to impose a unified set of criteria on everyone, and then to have all head physicians and their deputies undergo attestation to make sure they were up to speed on the rulers.<sup>115</sup>

The experts at this meeting succeeded in articulating the discipline’s key problems. Diagnosis was unreliable, hospitals overcrowded, treatment ineffectual. Psychiatric researchers focused too much on the high-prestige work of developing their own conceptual frameworks, neglecting practical matters like defining criteria for diagnosis. Different “schools” of psychiatry used different conceptual frameworks to understand disease, and thus their diagnoses were sometimes widely divergent. And rank-and-file psychiatrists were often poorly trained, poorly equipped, and faced with catastrophic overcrowding. For psychiatry as a discipline, the situation was precarious. As Andrew Abbott observes in his study of professional work, a profession that has no effective treatment will in the long run generate knowledge that is “just generalities without legitimacy.”<sup>116</sup> As Party and state agencies became more aware of psychiatry’s very real problems, the psychiatrists’ situation became increasingly tenuous. If another professional group were to come along and offer treatments that *did* seem to be effective, that group would have

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<sup>114</sup> “Protokol no. 1 zasedaniia Psikhiatricheskoi komissii pri Otdel psikho-nev pomoshchi MZ SSSR” 1 December 1949, GARF, f. r-8009, op. 33, d. 158, ll. 20-22

<sup>115</sup> Karnovich mentioned three “schools”: “Leningrad, Moscow, and Ukrainian.” “Protokol no. 1 zasedaniia Psikhiatricheskoi komissii pri Otdel psikho-nev pomoshchi MZ SSSR,” 1 December 1949, GARF, f. r-8009, op. 33, d. 158, ll. 20-21; “Ia. Kalashnik (Nach. otdela p/nev pomoshchi MZ SSSR), “Otchet o rabote psikhonevrologicheskogo otdela MZ SSSR za 1949 g.,” undated, GARF, f. r-8009, op. 33, d. 109, l. 61.

<sup>116</sup> Andrew Abbott, *The System of Professions: An Essay on the Expert Division of Labor* (Chicago: University of Chicago Press, 1988), 102.

very real possibility of “capturing” jurisdiction over areas of work that had belonged to psychiatrists.

## **Conclusion**

In 1940 Soviet psychiatrists were optimistic that they would soon be able to actively affect their patients’ illnesses using new biological methods of treatment. These treatments would help free up space in overcrowded hospitals and they would also enhance the impression that Soviet psychiatric hospitals were becoming more modern. Patients, families, and other physicians would begin to look at psychiatrists as healers and as men of science. Psychiatrists particularly welcomed biological treatments because they changed the “character” of the hospital. The hospital space was reorganized to allow for treatment to be done, the day was organized around routines of treatment, and the work routines of nursing staff and orderlies could be further regimented around the routines of checking temperatures, analyzing blood pressure, sterilizing needles, and charting the progress of patients. Psychiatric hospitals would physically be transformed into institutions that embodied the scientific principles of modern medicine.

Even before the war this dream had begun to come up against the realities of the drastically underfunded Soviet psychiatric system. But the war forced psychiatrists to abandon their active treatments for four years. Many of them spent these years at the front, where they experimented with biological methods of treatment on soldiers. Others remained behind to try to keep psychiatric hospitals and their patients alive. After the war these hospitals remained in catastrophic physical condition, and the lack of support from Minzdrav made Minzdrav’s own decrees impossible to fully implement. By 1949 active treatment was being done in many

hospitals, but fewer than one-quarter of patients were receiving these “most modern methods,” far fewer than psychiatrists had hoped for. Electroshock was quickly becoming the most widely used method of treatment because it only required electricity, but there had been few real breakthroughs. Whereas the 1930s had seen a flurry of newly invented methods, the 1940s saw mild modifications and improvements of the existing methods of treatment.

The lack of new breakthroughs and the continued problems in psychiatric hospitals were alarming to leading psychiatrists and public health administrators, and in 1949 they started to look for scapegoats. The mutual recriminations that followed took on serious political weight as they were caught up in the “science wars” of the Late Stalin Era.<sup>117</sup> In January and February the first salvos of the campaign against “rootless cosmopolitanism” were appearing in the press, and Minzdrav officials were increasingly under pressure to identify examples of “cosmopolitanism” in the various medical disciplines and specialties. By the end of 1949 psychiatrists were deeply embroiled in controversies over who was to blame for the problems in psychiatry and what cosmopolitanism might mean in their field. Overcrowding, active treatment, and the proper organization of psychiatric hospitals all played central roles in the debates that followed, and in the “Pavlov” solution.

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<sup>117</sup> This apt phrase comes from Ethan M. Pollock, *Stalin and the Soviet Science Wars* (Princeton, N.J.: Princeton University Press, 2006).

## CHAPTER 2

### “BEHIND THE FAÇADE OF HYSTERICAL SYMPTOMS”: WARTIME PSYCHIATRY AND SOVIET MODELS OF THE MIND, 1941-1945

... a primary role is played by the moral-psychological factor, the consciousness of duty, the moral uplift, the desire to win, the belief in success, in the leader, the consciousness that he [the soldier] is defending a just cause in the name of his motherland, of his people. All of this makes people capable of acting without rest, without experiencing fatigue ... carrying out miracles of bravery, achieving heroism.

- V.K. Khoroshko, *Uchenie o nevrozakh* (Moscow: Medgiz, 1943), 22.

#### Introduction

During the Second World War, many Soviet psychiatrists left their psychiatric hospitals and treated patients suffering from a much broader range of mental problems. Unlike their work in peacetime when they mainly treated people suffering from debilitating psychoses like schizophrenia, during the war psychiatrists saw soldiers who were suffering from everything from major brain wounds to psychological breakdown. The central problem of their publications during the war was separating “organic” injuries from “functional,” physical wounds from psychological reactions.

Most psychiatrists came to evacuation hospitals with the belief that newly developed laboratory technology and physiological theory would help them demystify the psychological ills of war that had dominated the work of psychiatrists during the First World War. Using x-rays, biochemistry, and other laboratory techniques, they would debunk the notion that traumatic



neurosis and shell shock were psychological disorders. Soldiers suffering from seemingly inexplicable mental problems could now be shown to have small but significant physiological changes in their nervous systems. As these psychiatrists discovered, however, the reality of wartime psychiatric disorders was much more complex than they had expected. Far from discarding psychological explanations and psychotherapy, many frontline psychiatrists embraced them, and used an eclectic mixture of active therapy, hypnosis, and suggestion to cure their patients of hysterical symptoms.

To prove that hysterical symptoms were not caused by psychological reactions, some psychiatrists developed elaborate models to explain how changes in body chemistry or neurological processes could affect the mind. In so doing they laid the basis for exciting developments in the fledgling field of neuropsychology. They also laid the foundations for bitter postwar arguments about the nature of the mind and its relationship to the body. I examine these postwar developments in some depth in Chapters Four and Five. In this chapter, I first discuss the role that psychiatrists played in the Soviet Army in World War Two and the changing ways that soldiers with mental disorders were sorted and treated. In the second half of the chapter I focus on the debate about the nature of a peculiar wartime ailment, *glukhonemota*, or “deaf-mute syndrome.” This debate sheds light on the multiple ways that Soviet psychiatrists conceptualized the mind and the variety of approaches that they were exploring to explain mental disorder.

### **Psychiatric Services in the Soviet Army, 1941-1945**

When the German army invaded the Soviet Union in 1941, medical planners foresaw only a very minor role in the military medical system for psychiatrists. According to Red Army regulations, the psychiatrist’s role was simply to treat soldiers who developed “true” mental illness (psychoses). In the course of the war, however, the Red Army delegated a much broader

range of problems to psychiatrists, and 1945 psychiatrists had become key figures in a new system of “hospitals for the lightly injured” where they played an important role in diagnosing and treating patients categorized as “contused.” Some Soviet psychiatrists saw this wartime expansion of their professional domain as a vindication of the significance of their expertise for Soviet society, and even before the war ended they had begun to argue for an expanded role for psychiatric expertise in post-war Soviet society.

### **Planning for War**

Psychiatric policy for the Red Army was formulated at the psychiatry department of the Military Medical Academy in Leningrad. Among the senior staff at the institute were many who had served as psychiatrists or medics in World War One or the Russian Civil War, and the institute’s director, Victor Osipov, had himself been in charge of the department since 1915. Osipov and his staff were thus living symbols of the continuity in military psychiatry between the Tsarist Army in World War One and the Red Army in World War Two.<sup>1</sup> In 1934, Osipov and his staff published a long report analyzing the effectiveness of psychiatric treatment in World War I in the Russian, French, British, American, and German armies.<sup>2</sup> Their central finding was

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<sup>1</sup> How Osipov remained director of this department through revolution, civil war, and the Great Purges is an open question, though theories and rumors abound in the memoirs of Russian psychiatrists. He certainly did not keep a low profile: he was one of the physicians who treated Lenin during his final illness, he was a visible member of medical professional societies in Leningrad (including chairman of the Leningrad Psychotechnics Society). At the 1936 All-Union Congress of Neuropathologists and Psychiatrists, it was Osipov who delivered the most stinging rebuke for Lev Rozenshtein and his broad diagnosis of schizophrenia. L. G. Veber, "Tvorcheskaia deiatel'nost' Viktora Petrovicha Osipova: K 40-letnemu iubeleiu," *Nevropatologiya, psikhiaetriia, psikhogigiena* 4, no. 9-10 (1935): 1-6; I. K. Ziuzin, "Nauchnaia, pedagogicheskaia, vrachebnaia i obshchestvennaia deiatel'nost' professora Viktora Petrovicha Osipova," *NiP* 10, no. 3 (1941): 3-7; N. I. Bondarev, "Viktor Petrovich Osipov," *NiP*, no. 4 (1948): 76-78. On Osipov’s involvement in Lenin’s last illness and the Leningrad psychotechnics society, see A. A. Portnov, "Vospominaniia o razvitiu otechestvennoi psikhiaetrii," in *Voprosy sotsial'noi i klinicheskoi psikhiaetrii i narkologii*, ed. B. D. Tsygankova (Moscow: 2000), 271-272; Mikhail Ivanovich Buianov, *Lenin, Stalin i psikhiaetriia* (Moscow: Rossiiskoe obshchestvo medikov-literatorov, 1993), 63-66.

<sup>2</sup> In his article on the organization of psychiatric services in WWI, military psychiatrist Nikolai Bondarev concluded that the system used by the American Army had been the most effective and should serve as a model for psychiatric services in the Red Army in any future war. He particularly liked the American army’s unified chain of evacuation hospitals, in which a soldier who did not recover after a few days would be evacuated to a medical center

that soldiers who had been diagnosed in the First World War with “shell shock” or “traumatic neurosis” fared best when they were treated quickly and brusquely rather than being evacuated to the rear for a long course of treatment. Minor psychiatric disorders should be treated as close to the front as possible. As one of the Academy’s psychiatrists concluded, “it would be a serious mistake and dangerous for the army if these patients were to be evacuated from the front.”<sup>3</sup>

These recommendations were translated directly into Red Army policy. In 1941 the directive on psychiatric care that was in place accepted the estimate of 1.5-2% psychiatric casualties of per 1,000 soldiers (15-20 soldiers per 1,000); an army division of 12,000 soldiers was expected to have approximately 18 psychoses and 100-150 neuroses. Based on those figures, the Red Army planners called for each army field hospital to have a small psychiatric ward with just five beds where soldiers could be given up to a month for treatment and rest. If they had not recovered, they would then be evacuated to psychiatric hospitals in the rear.<sup>4</sup>

The 1941 directive instructed physicians not to be too quick to assume that mental disorders were of no consequence. Two of the most common causes of psychoses were expected to be “bruises and concussions of the brain” and “brain injury,” and soldiers with brain injuries were to be given extensive treatment. Along with brain injuries, however, the authors of the 1941 directive anticipated “psychoses and psychoneuroses due to exhaustion [*istoshchenie*],” reactive

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behind the front line, given a neuro-psychiatric exam, and then either treated or evacuated further to a psychiatric ward in a base hospital. N. I. Bondarev, "Organizatsiia nevropsikhiatricheskoi i psikhonevrologicheskoi pomoshchi v Krasnoi armii v vremia voiny," in *Psikhozy i psikhonevrozy voiny*, ed. V. P. Osipov (Leningrad: OGIZ, 1934), 137. On the organization of military psychiatry in the American Army during WWI see Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge, Mass.: Harvard University Press, 2001), 123-132.

<sup>3</sup> N. I. Bondarev, "Organizatsiia nevropsikhiatricheskoi i psikhonevrologicheskoi pomoshchi v Krasnoi armii v vremia voiny," in *Psikhozy i psikhonevrozy voiny*, ed. V. P. Osipov (Leningrad: OGIZ, 1934), 134-138. For a summary of the Military Medical Academy’s work in the 1930s, see Paul Wanke, *Russian/Soviet Military Psychiatry, 1904-1945* (London: Frank Cass, 2005), 42-56.

<sup>4</sup> Glavnoe voenno-sanitarnoe upravlenie Krasnoi armii (GVSU KA), *Ukazaniia po organizatsii psikhiatricheskoi pomoshchi i psikhiatricheskoi ekspertizy vo vremia voiny*, 2nd ed. (Moscow: Medgiz, 1941), 3-6.

psychoses and reactive psychoneuroses,” and “hysterical psychoses and psychoneuroses.”<sup>5</sup> When they encountered these types of problems, physicians were to “take a firm line.” Hysterical soldiers were not to be evacuated to the rear under any circumstances, nor were they to be sent to sanitariums, relieved of duty, or discharged from the army. They were to be treated and returned to the front.<sup>6</sup>

After the war, Nikolai Timofeev, the man in charge of the Red Army’s psychiatric program, admitted that he had seriously underestimated how much psychiatrists would be needed.<sup>7</sup> According to Timofeev, the problem was that the Military Medical Academy planners had not anticipated that psychiatrists would be the ones caring for soldiers classified as *kontuzhennye*, “the contused.” Based on the Military Medical Academy’s analysis of World War One, the Red Army had expected 15-20 soldiers per 1,000 to develop psychiatric problems. This would have been about right, according to Timofeev, if psychiatrists had only been required to deal with the insane. But most soldiers who developed mental disorders were thought to have head injuries, not psychiatric diseases like schizophrenia. These soldiers were classified as *kontuzhennye*, a label that was less stigmatizing than “insane,” but which was also extremely vague. Among the *kontuzhennye* were some who were clearly suffering from concussion, others

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<sup>5</sup> The other categories included mental disorders caused by intoxication and infection (encephalitis, syphilis, etc), epilepsy, schizophrenia and manic depression, mental retardation and personality disorders. *Ukazaniia po organizatsii psikhiatricheskoi pomoshchi*, 8-10

<sup>6</sup> *Ibid.*, 6-7.

<sup>7</sup> When the war began in 1941, the 43 year-old Timofeev was in Khabarovsk where he was serving as head of the Khabarovsk Medical Institute and head military psychiatrist for the Far East. Timofeev had spent most of his entire career working under Victor Osipov at the Military Medical Academy, and in 1941 he was transferred back to Leningrad to serve as head psychiatrist for the Leningrad front. In 1942 Timofeev was promoted to the position of head military psychiatrist for the USSR Commissariat of Defense. (His predecessor had been killed by enemy shelling.) Timofeev held the position of head psychiatrist for the Soviet military until 1968. "Nikolai Nikolaevich Timofeev (K 70-letiiu so dnia rozhdeniia)," *Zhurnal nevropatologii i psikhatrii im. S.S. Korsakova* 68, no. 9 (1968): 1420-1421; "Nikolai Nikolaevich Timofeev," *ZhNiP* 79, no. 5 (1979): 663. The previous Head Psychiatrist of the Red Army, S. P. Ronchevskii (another Military Medical Academy man) was killed in 1941. P. F. Gladkikh and A. E. Loktev, *Sluzhba zdorov'ia v velikoi otechestvennoi voine, 1941-1945* (St. Petersburg: 2005), 635.

who were perhaps suffering from a mild concussion or perhaps something more serious, and still others who were clearly suffering but who had no obvious injuries.<sup>8</sup>

Soviet military planners had, of course, anticipated that soldiers would suffer from head injuries. What they had not anticipated was the magnitude of the problem: by early 1942, officials were estimating that 5-10 percent of all wartime injuries would affect the central or peripheral nervous system.<sup>9</sup> There were far too few neurosurgeons to meet demand, so evacuation hospitals enlisted as many trained neuropathologists as they could to “pick up the knife,” leaving few trained specialists to deal with soldiers who did not require brain surgery.<sup>10</sup> Soldiers diagnosed as “contused” who had no obviously broken parts ended up being passed from hospital to hospital until they were far in the rear. In 1941-1942, only 20% of the *kontuzhennye* evacuated to the rear were able to return to their units, leaving the vast majority out of action.<sup>11</sup>

The Red Army’s failure to cope with the large number of *kontuzhennye* in 1941 was one part of the larger story of the general chaos that beset the Army’s medical service following the invasion of the USSR by the German army. In June and July of 1941, caches of army medical supplies were destroyed in large numbers by German bombardment, and others were simply lost along with Soviet territory. Evacuation hospitals that were set up were assembled hastily, lacked

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<sup>8</sup> N. N. Timofeev, "Predvaritel'nye itogi iz opyta organizatsii nevropsikhiatricheskoi pomoshchi v velikuiu otechestvenuiu voinu," in *Trudy tsentral'nogo instituta psikhiatrii MZ RSFSR*, ed. P. B. Posvianskii and A. S. Shmar'ian (Moscow: 1947), 63-64.

<sup>9</sup> D. S. Futer, "Prakticheskie zadachi nevrologii voennogo vremeni," *Nevropatologiya i psikhiatriya* 11, no. 3 (1942): 5. Futer’s report was originally given at a conference for evacuation hospital neuropathologists, neurosurgeons and psychiatrists held in Molotov, 14 February 1942.

<sup>10</sup> I. Z. Vel'vovskii and I. I. Kartsovnik, "O ratsional'nom postroenii psikhonevrologicheskoi pomoshchi v usloviakh raboty tylovykh gosptalei," in *Sbornik nauchnykh rabot evakogospitalei*, ed. A. N. Pravdin (Moscow: Medgiz, 1942), 28.

<sup>11</sup> Timofeev, "Predvaritel'nye itogi iz opyta organizatsii nevropsikhiatricheskoi pomoshchi v velikuiu otechestvenuiu voinu," 63-64.

equipment, and were seriously understaffed. There was a drastic lack of beds near the front for all specialties, not just neurology or psychiatry. To make matters worse, some of the evacuation hospitals that were functioning had to be torn down and pulled back to prevent them from being captured. Contused soldiers were often evacuated to the deep rear because that was the only place for them to go.<sup>12</sup>

As the war progressed, however, front-line medicine improved significantly. Until 1942, medical administrators had little choice but to evacuate *kontuzhennye* to the rear. Psychiatrists were particularly concerned by this, not only because they thought it kept lightly injured soldiers away from combat needlessly, but because they thought evacuation to the rear itself made mental problems worse and led to a much longer convalescence.<sup>13</sup> Their task, after all, was “retention of cadres,” as Nikolai Timofeev bluntly stated in a January 1943.<sup>14</sup> Following the doctrine established by the Military Medical Academy, psychiatrists again concluded that in wartime the key to successful treatment for mental disorders was quick treatment as close to the front as possible. In 1941 this was very difficult, because there was only one psychiatric ward per army. This changed at the end of 1941, when large military hospitals began to organize their own psychiatric departments. These departments became the “front-line center for neuro-psychiatric services and expertise.” In the first half of 1942 the army added psychiatric wards to its second line of sorting hospitals, with each department headed by army psychiatrists. Soldiers could be treated in these wards for up to 20 days before being evacuated further to psychiatric hospitals in

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<sup>12</sup> E. I. Smirnov, “Rech’...” in *Trudy 2ogo Plenuma ('43)*, p. 24. P. F. Gladkikh and A. E. Loktev, *Sluzhba zdorov'ia v velikoi otechestvennoi voine, 1941-1945*, vol. 2005 (St. Petersburg: 2005), 114-116.

<sup>13</sup> I. A. Berger, "O profilaktike nevro-psikhicheskoi invalidnosti," in *Trudy 2-go plenuma Gosspital'nogo soveta Narkomzdrava SSSR, 20-25 dekabria 1942 g.*, ed. S. I. Milovidov (Moscow: Medgiz, 1943), 403-404.

<sup>14</sup> N. N. Timofeev, quoted in Speshnevskii and Kevork'ian, "Materialy frontovoi konferentsii nevropatolgoov psikhiatrov, neurokhirurgov N-skogo fronta, sostoiavsheisia 2-3.1.1943," *NiP* 12, no. 5 (1943): 54.

the rear.<sup>15</sup> With neurologists focused primarily on open head wounds and wounds to the peripheral nervous system that required surgery, psychiatrists were left to focus on soldiers who, in the words of Red Army head psychiatrist Nikolai Timofeev, were suffering from “closed trauma of the brain and the psychogenic and asthenic factors of long battle.”<sup>16</sup>

At the same time that the Red Army’s psychiatric services were being bolstered, a new type of hospital was being created for “the lightly injured” [*lego-ranenyie*], a category that included many patients in need of neurological and psychiatric care. These “hospitals for the lightly injured” (*Gospitali dlia legko ranenykh*, or GLRs) were first introduced on the Western Front in January 1942, and initially they were intended to simply provide a place where lightly wounded soldiers could be cared for near the front. They made it possible for the lightly injured to be kept in the front zone without overburdening field hospitals that needed to focus on seriously injured soldiers in need of surgery or other intensive care.<sup>17</sup> Soon after they were introduced a military psychiatrist suggested dedicating one of them to the exclusive treatment of *kontuzhennye*. This would provide a place where the main specialties involved in treating the contused – ears-nose-throat doctors, psychiatrists, and neurologists – could be brought together under one roof. When everything worked as planned, *kontuzhennye* arrived at the GLR within two to three days of being injured and were thus given treatment in the acute phase of their

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<sup>15</sup> Ia. M. Ezerskii, quoted in Speshnevskii and Kevork'ian, "Materialy frontovoi konferentsii nevropatolgoov psikhiatrov, neirokhirurgov N-skogo fronta, sostoiavsheisia 2-3.1.1943," *NiP* 12, no. 5 (1943): 52.

<sup>16</sup> N. N. Timofeev, quoted in Speshnevskii and Kevork'ian, "Materialy frontovoi konferentsii nevropatolgoov psikhiatrov, neirokhirurgov N-skogo fronta, sostoiavsheisia 2-3.1.1943," *NiP* 12, no. 5 (1943): 53.

<sup>17</sup> Glavnoe voenno-sanitarnoe upravlenie Krasnoi armii (GVSU KA), “Ukazanie GVSU KA po organizatsii lecheniia legkoranenykh i legkobil'nykh,” 31 January 1942, in *Zdravookhranenie v gody Velikoi otechestvennoi voiny, 1941-1945: Sbornik dokumentov i materialov*, ed. M. I. Barsukov and D. D. Kuvshinskii (Moscow: Meditsina, 1977), 96-99.

illness.<sup>18</sup> A December 1942 report claimed that the assembled team of speech therapists, audiologists, neurologists and psychiatrists were able to return up to 90% of patients who completed the treatment to service.<sup>19</sup> By April 1942 the army had increased the number of GLRs from one per army to three per army (190 total), and by July 1944 there were 295 functioning GLRs.<sup>20</sup>

**Table 2.1: Number of *kontuzhennye* in the Soviet Army per 1,000 soldiers, 1941-1944**

Year of the War	<i>kontuzhennye</i> per 1,000 soldiers
1 (1941-1942)	15.7
2 (1942-1943)	25.8
3 (1943-1944)	39.2

*Source:* N. N. Timofeev, "Predvaritel'nye itogi iz opyta organizatsii nevropsikhiatricheskoi pomoshchi v velikuiu otechestvenuiu voinu," in *Trudy tsentral'nogo instituta psikhiatrii MZ RSFSR*, ed. P. B. Posvianskii and A. S. Shmar'ian (Moscow: 1947), 69.

This type of hospital devoted exclusively to the treatment of *kontuzhennye* did not become a reality for most parts of the army until 1943,<sup>21</sup> but once in place they seem to have made a real difference. In 1941 nearly 100% of soldiers diagnosed as 'contused' had been evacuated from the army zone to the rear. In 1942 this figure was still 70%. By 1944, however, the number of *kontuzhennye* evacuated further from the front than army-level hospitals had fallen to 20%, despite the fact that the number of soldiers diagnosed as *kontuzhennye* continued to rise.

<sup>18</sup> Timofeev, "Predvaritel'nye itogi iz opyta organizatsii nevropsikhiatricheskoi pomoshchi v velikuiu otechestvenuiu voinu," 78-79.

<sup>19</sup> L. A. Neiman, "Voprosy organizatsii lechebnoi pomoshchi kontuzhennym," in *Trudy 2-go plenuma Gosspital'nogo soveta Narkomzdrava SSSR, 20-25 dekabria 1942 g.*, ed. S. I. Milovidov (Moscow: Medgiz, 1943), 390-391. Ia. S. Temkin was the psychiatrist who proposed setting up GLRs for *kontuzhenie*. For a similar proposal for multi-disciplinary regional centers that would combine neurosurgery, neurology, psychiatry, and psychotherapy, see Vel'vovskii, "O ratsional'nom postroenii..." in *Sbornik Sibvo* ('42), 30-31.

<sup>20</sup> E. I. Smirnov, *Voina i voennaia meditsina, 1939-1945* (Moscow: Meditsina, 1979), 198.

<sup>21</sup> O. S. Lobastov and L. I. Spivak, "Organizatsiia psikhonevrologicheskoi pomoshchi vo vremia Velikoi otechestvennoi voiny," in *Sovetskaia psikhiatriia v gody velikoi otechestvennoi voiny: Sbornik nauchnykh trudov*, ed. M. M. Kabanov and V. V. Kovalev (Leningrad: 1985), 12



In some places the effect was even more pronounced. At the same time, however, the percentage of *kontuzhennye* evacuated to hospitals beyond the front zone declined steeply, from 36% in 1942-1943 to only 7.5% in 1943-1944 (See Table 2.2). The combination of more specialized hospitals for *kontuzhennye* and more psychiatric departments made it possible to treat the majority of these soldiers near the front and return them quickly to their units.

**Table 2.2. The Evacuation of Psychiatric Casualties beyond the Borders of the Front Zone (First Baltic Front), 1941-1944**

Year of the War	<i>Kontuzhennye</i> per 1,000 men	Evacuation beyond the Borders of the Front Zone		
		<i>Kontuzhennye</i>	Neuroses	Psychoses
1 (1941-1942)	15.7 per 1,000	37.4%	41.2%	36.5%
2 (1942-1943)	25.8 per 1,000	36%	29.9%	27.0%
3 (1943-1944)	39.2 per 1,000	7.5%	7.1%	11.0%

*Source:* Pleso, cited in Tolstoukhova, 28, 31.<sup>22</sup>

Along with new hospitals for the lightly injured, the Soviet Army also created a new system of official diagnoses. Issued as part of an October 24, 1942, decree, this new system split the category of traumatic injuries of the central nervous system into those which were “organic” and those which were “functional,” that is to say, between clear-cut cases of physical damage to the body and cases where there was no obvious physical injury. Soldiers with serious injuries to the central nervous system were to be evacuated, but those with “functional” disorders were to be evaluated individually to determine if they could continue to do some sort of military work, even if they were not fit for combat duty. Mild cases were kept near the front (within the army or front

<sup>22</sup> German Ivanovich Pleso was a staff member at the Sverdlovsk University psychiatry department 1936 - 1941 and 1946-1948. “Istoriia kafedry psikhii Ural’skoi Gosudarstvennoi Meditsinskoi Akademii,” available at <http://www.sokpb.ru/kafedra-history/> (accessed 13 June 2008).

regions), where they could be treated in the newly established GLRs.<sup>23</sup> In this new system, psychiatrists played the important role of separating soldiers with “organic” injuries from those with “functional” injuries, identifying soldiers who had suffered anatomical wounds, especially brain damage (“organic” injuries), from those who were suffering from disorders that did not have any clear basis in physical damage to the body (“functional” injuries).<sup>24</sup> In practice, this meant that psychiatrists spent much of their time trying to sort and treat *kontuzhennye*.

The Soviet military medical services used the term *kontuzhennye* (“the contused”) as one of their basic categories of sanitary casualty, but the term was continually criticized by both psychiatrists and neurologists as a catchall term that obscured what was actually wrong. When a soldier was injured, he would be quickly categorized as “shot,” “burnt,” “frostbitten,” or “infected.” Those who did not fit into any of these categories were placed into the catchall category, “contused.”<sup>25</sup> In its most basic dictionary definition, the Russian word *kontuziia* (“contusion”) simply means “bruise,” and can refer to a bruise anywhere on the body. It often is

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<sup>23</sup> Prikaz NKO SSSR No. 336 (24 October 1942), "Ob"iavlenie: a) Insruktsii po meditsinskomu osvidetel'stvovaniuu voinskikh kontingentov, b) raspisanie boleznei, v) nastavleniia po opredeleniiu godnosti k voennoi sluzhbe, g) tablitsa dopolnitel'nykh trebovaniu k sostoianiiu zdorov'ia pri raspredelenii po rodam voisk." V. A. Zolotarev, ed., *Priказы narodnogo komissara oborony SSSR: 1937 - 21 iyunia 1941*, Russkii arkhiv: Velikaia Otechestvennaia, vol. 2 (Moscow: Terra, 1994), 347; Timofeev, N. N., "O psikhiatricheskoi pomoshchi i ekspertize v deistvuiushchei armii" in Speshnevskii and Kevork'ian, "Materialy frontovoi konferentsii nevropatolgoov psikhiatrov, neirokhirurgov N-skogo fronta, sostoiavsheisia 2-3.1.1943," *NiP* 12, no. 5 (1943): 54.

<sup>24</sup> During the war, virtually every important psychiatrist – and many of the unimportant ones as well – gave speeches or papers about the need to separate “organic” and “functional” (or psychogenic) disorders. See, for instance, the speeches given at the important psychiatric conference in Tomsk in May 1942 by Posvianskii, Shmar'ian, and Perel'man. When drafting the Red Army's updated rules for military medical expertise, psychiatrists stressed the need to separate soldiers with brain injuries from those with psychological trauma. In particular, they stressed the use of memory tests for this purpose; soldiers who were not making new memories were assumed to have brain damage. “Raspisanie boleznei po psikhonevrologicheskomu razdelu (proekt),” undated [1942], GARF, f. a-482, op. 47, d. 648, l. 22ob. These criteria were included in article 9 of the final version of the regulations, Prikaz 336 (24 October 1942). See N. A. Molodtsov, et al, *Kratkoe rukovodstvo po voenno-vrachebnoi ekspertize* (Moscow: Glavnoe voenno-sanitarnoe upravlenie krasnoi armii, 1944), 67-68.

<sup>25</sup> The Red Army's major categories of sanitary casualty were *ranenye*, *obozhzhennyi*, *obmorozhennye*, *kontuzhennye*, and *bol'nye* [wounded, burned, frostbitten, contused, and sick]. See N. N. Timofeev, "Kontuzhennyi," in *Entsiklopedicheskii slovar' voennoi meditsiny*, ed. E. I. Smirnov (Moscow: Medgiz, 1946), 3: 17-20.

used as shorthand to mean a bruise to the brain, a “concussion” (*kontuziia mozga*). During the war, the term *kontuziia* was also frequently used in the term “air contusion” (“*vozdushnaia kontuziia*”), the effect that the shock wave of an exploding bomb had on the body.<sup>26</sup> For physicians, however, this terminology was often extremely frustrating.<sup>27</sup> As one exasperated neurologist said in 1941, “The existing aggregate concept of '*kontuzhennye*' does not satisfy either theoretical needs or practical measures.” Instead of simply marking “contused” on a soldier’s medical card, he argued, it would be more helpful if medics were to write whether or not the patient had lost consciousness and for how long. Such “objective documentation” would make decisions about evacuation and treatment much easier and more effective.<sup>28</sup> Psychiatrists concurred. As one noted in January 1942, the standard form used by medics did not even include lines for recording mental symptoms. Adding a place for medics to write down psychiatric symptoms on the form they used at first aid stations would be a first step toward better diagnosis.<sup>29</sup>

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<sup>26</sup> “Kontuziia,” in *Entsiklopedicheskii slovar' voennoi meditsiny*, vol. 3, ed. E. I. Smirnov (Moscow: Medgiz, 1946): 20-24.

<sup>27</sup> There was apparently some criticism of the term “*kontuziia*” even before the war. In a pre-war monograph, according to Abashev-Konstantinovskii, Khar'kov professor V. P. Nedokhlebov wrote that “...the term '*kontuziia*' is ‘absolutely useless,’ and that the very theory of commotion, contusion, compression ‘is the most confused field of surgery,’ ‘juggling terminology.’” A. L. Abashev-Konstantinovskii, *Vozdushnaia kontuziia mozga* (Riga: 1945), 11. On criticism of the concept early in the war, see for instance, the discussion held in December 1942 in Tashkent, where E. V. Maslov in particular argued that the term “*kontuzhenie*” was no more than a synonym for “traumatic neurosis” and should be abandoned in favor of more diagnostically useful terms. “Nauchnaia konferentsiia psikhiatrov srednei azii po voprosam voennoi psikhii 18-20.XII.1942,” *NiP* 12, no. 5 (1943): 67-71.

<sup>28</sup> L. B. Perel'man, “O lechenii posle kontuzionnoi glukhonemoty,” *NiP* 11, no. 4 (1942): 74-75. In his pamphlet on post-contusional deaf-mute syndrome, Perel'man wrote passionately about his dislike for the term “*kontuzhenie*.” He saw the term as a synonym for “traumatic neurosis,” and complained that it didn’t tell the physician anything about the pathology or etiology of the individual’s disorder. Its use in military practice, he concluded, “soils statistics [zasoriaia soboi statistiku].” L. B. Perel'man, *Reaktivnaia postkontuzionnaia glukhonemota: Ee raspoznavanie i lechenie* (Moscow: Medgiz, 1943), 5.

<sup>29</sup> I. A. Berger, quoted in I. I. Lukomskii, “Rabota Moskovskogo obshchestva nevropatologov i psikhiatrov v period Velikoi otechestvennoi voiny,” *NiP* 11, no. 5 (1942): 65.

A large number of soldiers classified as *kontuzhennye* were, of course, suffering from concussions. For Soviet soldiers in the Second World War, after all, the head was the fourth most commonly injured body part, after arms, legs, and chest. By 1945 front line medics had treated approximately 7.7 million head injuries.<sup>30</sup> Not surprisingly, then, most of the soldiers who were marked “*kontuzhennye*” at the front did have some sort of head injury, anything from a mild concussion to serious brain damage.<sup>31</sup> And, again not surprisingly, nearly half of all the papers that psychiatrists and neurologists gave at conferences and published in journals focused on the diagnosis and treatment of concussions and brain injuries.<sup>32</sup> Even so, a sizable group of *kontuzhennye* fell into a gray area. These were soldiers who reported having been near an explosion and who suffered from physical problems reminiscent of head injury but who had no obvious physical injuries. They frequently had one paralyzed limb or were both deaf and mute.<sup>33</sup>

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<sup>30</sup> According to analysis of 14.3 million histories of illness (out of approximately 15.2 million injuries treated during the war), head wounds accounted for 5.4% of all injuries. Wounds to the legs accounted for 35.6%, wounds to the arms 35.2%, and wounds to the chest 9%. G. F. Krivosheev, *et al.*, eds., *Grif sekretnosti sniat: Poteri Vooruzhennykh Sil SSSR v voynakh, boevykh deistviyakh i voennykh konfliktakh: Statisticheskoe issledovanie* (Moscow: Voenizdat, 1993), 137.

<sup>31</sup> Some specialists reported that the majority of *kontuzhenie* were suffering from psychological problems. Khoroshko, for instance, suggested that “probably the majority” of *kontuzhenie* were suffering only from psychogenic reactions. Khoroshko, *NiP* 1942 no 5 pp. 5-17. Others, like Abashev-Konstantinovskii, claimed that they *kontuzhenie* were almost entirely suffering from physical damage due to explosions and other trauma. Some of this difference can be attributed to the different stages of evacuation where psychiatrists worked. Abashev-Konstantinovskii worked in the front zones of the Bryansk and First Baltic Fronts, and claimed that 69% of *kontuzhenie* there had concussions, 25% had some signs of brain damage, and only 6% were suffering from psychogenic reactions. Abashev-Konstantinovskii, *Vozdushnaia kontuziia mozga*, 13-14.

<sup>32</sup> The estimate of “nearly half” comes from a rough analysis that did on tables of contents in *NiP* for the years 1941-1945. To arrive at this figure I entered basic title-author-date information for 663 articles into a database and coded each article with keywords based on subject. An analysis of keywords found that 102 of the 663 articles were devoted to injuries of the brain, the central nervous system, or the peripheral nervous system, or 43%.

<sup>33</sup> Timofeev, the Red Army’s head psychiatrist during the war, estimated that 10-15% of *kontuzhennye* were primarily suffering from “neurotic reactions” combined with mild head injuries, while another 14-22% were suffering from head injuries with “mild neurotic layers.” By 1944, there were roughly 40 *kontuzhennye* per 1,000 soldiers in the active army. Timofeev, “Predvaritel’nye itogi iz opyta organizatsii nevropsikhiatricheskoi pomoshchi v velikuiu otechestvenuiu voynu,” 69.

These were the soldiers who became the subject of contentious debate about the connection between the body and the mind.

In May 1942, the Moscow Society of Neuropathologists and Psychiatrists established a committee to research the problem of “contusion,” particularly “air contusion,” and to write an instruction to help physicians diagnose and treat soldiers.<sup>34</sup> The commission concluded that “air contusion” was far too vague a term and that the soldiers given this diagnosis were in fact suffering from various problems and in need of different types of treatment. “Very many” of the “so-called *kontuzhennye*” were suffering from problems that were psychological in origin (“psychogenic reactions”), the commission found. They recommended that these soldiers be separated as quickly as possible from soldiers who had physical head injuries. Soldiers with psychological reactions were to be treated close to the front, while those with serious concussions or brain injuries were to be evacuated to hospitals farther to the rear. The commission recommended giving soldiers with psychogenic reactions no more than 14 days to recover, “of which approximately half of the time may be spend in bed in the hospital, and the other half on rest in the unit or in the recovery battalion.”<sup>35</sup>

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<sup>34</sup> The commission’s original members were Aleksandr Luriia, Iakov Ratner, and A. N. Gai. When the commission presented its findings, however, Luriia had been replaced by Vasilii Khoroshko. I. I. Lukomskii, “Rabota Moskovskogo obshchestva nevropatologov i psikhiatrov v period Velikoi otechestvennoi voiny,” *NiP* 11, no. 5 (1942): 75; “Zasedanie komissii obshchestva nevropatologov i psikhiatrov, vydelennoi v zasedanii 20.V.1942 dlia obsuzhdeniia voprosa o pomoshchi kontuzhennym,” *NiP* 11, no. 5 (1942): 82-83.

<sup>35</sup> Soldiers with serious concussions [*sotriasiennii mozga*] were to have no fewer than 21 days of bed rest, and were to be evacuated beyond the front zone to evacuation hospitals, where they would spend at least one month. Evacuation to the deep rear, however, was to be done only incrementally. Soldiers with serious concussions were to be handled according to Prikaz #184 st. 8 (central nervous system injury), while those with psychological reactions were to be handled under Prikaz #184 st. 7 (functional disorders). “Zasedanie komissii obshchestva nevropatologov i psikhiatrov, vydelennoi v zasedanii 20.V.1942 dlia obsuzhdeniia voprosa o pomoshchi kontuzhennym,” *NiP* 11, no. 5 (1942): 82-83.

## Deaf-Mute Syndrome and the Question of Hysteria

When reading the Soviet medical literature from these years, one is reminded that the battlefield in World War Two was extraordinarily loud. Physicians reported finding hearing damage in many of their patients, damage caused by exploding shells, artillery barrages, mines, and the other loud sounds that assaulted the ears. In 1942, one physician reported that 90% of *kontuzhennye* in his care had some sort of damage to their hearing.<sup>36</sup> Most of these hearing problems were minor, but a significant number of *kontuzhennye* arrived at sorting hospitals unable to hear, and some could neither hear nor speak.<sup>37</sup> As a wartime handbook for military-medical experts explained, total loss of hearing in both ears was rare, even in cases of brain damage.<sup>38</sup> What then was the cause of this so-called “deaf-mute syndrome”?

From early on in the war, deaf-mute syndrome was reported in conference papers and journal articles. Psychiatrists and neurologists agreed in broad terms about its symptoms. These were patients who had entirely lost hearing in both ears, and who communicated only through writing or gestures. They tended to be apathetic and immobile, and made no little effort to communicate with their physicians.<sup>39</sup> Some were deeply depressed, “in some cases even with

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<sup>36</sup> G. S. Tsimmerman, in “Preniia,” *Trudy 2-go plenuma Gospiatal'nogo soveta Narkomzdrava SSSR, 20-25 dekabria 1942 g.*, S. I. Milovidov, ed. (Moscow: Medgiz, 1943), 428. Other estimates were not as high as Tsimmerman's, but were still very significant. Ovcharenko, for instance, reported finding hearing problems in 57% of *kontuzhenie* who arrived at his hospital in the deep rear. P. P. Ovcharenko, "K klinike, diagnostike i lecheniiu kontuzii i sotriasiinii golovnogo mozga," in *Voennaia meditsina glubokogo tyla v otechestvennuu voinu*, ed. K. N. Pavlovskii (Tashkent: Gos. Izd-vo UzSSR, 1943), 424.

<sup>37</sup> One physician who had served in hospitals in the front zone reported that 35% of *kontuzhenie* had *glukhonemota*, a figure that did not include soldiers who were deaf but not mute, or who stuttered. By 1943, the author had seen over 400 cases of *glukhonemota*. Ia. I. Mints, "Entsefalograficheskie dannye i postkontuzionnaia glukhonemota," *NiP* 13, no. 3 (1944): 63-68. Writing after the war, another army medic reported that 40% of *kontuzhenie* in his care had *glukhonemota*, and that it was the most common functional disorder of the nervous system. G. G. Shumkin, "O sindrome glukhonemoty pri vozduzhnykh kontuzii," *NiP* 14, no. 5 (1945): 50-51.

<sup>38</sup> Molodtsov, *et al*, *Kratkoe rukovodstvo po voenno-vrachebnoi ekspertize*, 90-91.

<sup>39</sup> A. M. Sviadoshch, "Opyt raboty psikhiatra v armeiskom raione," in *Problemy sovremennoi psikhiiatrii*, ed. L. L. Rokhlin and T. P. Simson (Moscow: AMN SSSR, 1948), 450.

suicide attempts,” while others were easily offended and “capricious.”<sup>40</sup> Deaf mute syndrome was notoriously difficult to treat, since the soldiers suffering from it could neither hear the physician’s instructions nor respond to verbally to questions.<sup>41</sup> And it provoked controversy because it raised the possibility that soldiers were suffering from hysteria.

Hysteria was also a controversial diagnosis because professional psychiatrists and neurologists could not agree on what it meant and because soldiers took it to be a weasel word used to cover up cowardice and lack of will. Hysteria, of course, is a diagnosis with a long and controversial history. Like their European colleagues, Russian psychiatrists had been deeply influenced by the work of luminaries like Charcot and Freud, while the Russian physiologist Ivan Pavlov had developed his own experimental model of hysteria in dogs. By the 1930s, however, Soviet psychiatrists were deeply divided over the meaning and even the use of the term.<sup>42</sup> Textbooks from the mid-1930s agreed that hysteria should be used to refer to “particular forms of reaction to psychic experience [*psikhicheskoe perezhivanie*],” but rejected any more

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<sup>40</sup> A. G. Ivanov-Smolenskii, "Opyt lecheniia surdomutizma kontuzionno-kommotsionnogo proiskhozhdeniia," in *Voенno-meditsinskii sbornik*, vol. 2, ed. L. A. Orbeli (Moscow: Izd-vo Akademii nauk SSSR, 1946), 206.

<sup>41</sup> *Gulkhonemota* was observed in soldiers from the war with Finland, and discussed by psychiatrists at a June 1941 meeting of the Ukrainian psychoneurological Institute (UPNI). A. I. Geimanovich, "O spetsificheskome i nespetsificheskome v vozdušnoi kontuzii," *NiP* 12, no. 5 (1943): 4. The earliest report on *glukhonemota* in World War Two that I have been able to find was a paper given at a conference for hospital directors in Cheliabinsk oblast' on 20 December 1941. L. B. Perel'man, "O lechenii posle kontuzionnoi glukhonemoty," *NiP* 11, no. 4 (1942): 74-75. At a February 1942 conference in Molotov, psychiatrists gave similar accounts. D. S. Futer, "Nauchnaia konferentsiia nevropatologov, neirokhirurgov i psikhiatrov evakogospitalei g. Molotova v Molotovskoi oblasti 14-15.II.1942 g.," *NiP* 11, no. 3 (1942): 98-104.

<sup>42</sup> The lack of agreement about the nature of hysteria and the nature of neuroses in general was most fully illustrated at a conference held in Kharkov in June 1934 where a dozen papers were given on the subject. In the discussion period, military psychiatrist Victor Osipov summed up the proceedings as indicating that since “the issue stands at quite an indeterminate degree of development, we will still have to work much more. ... My suggestion at the current time is not so much to classify, as to work on practical nomenclature.” *Trudy pervogo ukrainskogo s"ezda nevropatologov i psikhiatrov*, ed. L. L. Rokhlin and O. I. Vol'fovskii (Khar'kov: Ukrainskaia psikhonevrologicheskaia akademiia, 1935), 556-557.

rigorous definition.<sup>43</sup> The Red Army's 1941 decree on psychiatric illness mandated that "hysterics" were to be returned quickly to the front without treatment.<sup>44</sup> On the field, soldiers took a dim view to the whole idea of hysteria. The author of the USSR's official account of neuroses in the war called hysteria a "stigmatizing diagnosis... almost synonymous with simulation."<sup>45</sup>

Psychiatrists' front-line experiences with "deaf-mute syndrome," however, raised the possibility that hysteria was in fact widespread in the Red Army. By their own accounts, most soldiers who suffered from deaf-mute syndrome had been near an explosion that produced loud noise and sharp changes in air pressure; common sense suggested that these extremes damaged the ears. Such damage to the ears from sudden and intense changes in air pressure was referred to as "baro-trauma," and was indeed a common cause of hearing damage.<sup>46</sup> Already in 1941, however, psychiatrists and neurologists were beginning to recognize that not all soldiers suffering from *glukhonemota* were suffering from physical damage to the ears. In the majority of cases soldiers showed few of the neurological signs of deafness or muteness. As a wartime handbook for military-medical experts explained, total loss of hearing in both ears was rare, even in cases of brain damage. Physicians in sorting hospitals were told to be alert for soldiers who had total loss of hearing, but who were not dizzy and who lacked other basic neurological

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<sup>43</sup> V. A. Giliarovskii, *Psikhiatriia: Rukovodstvo dlia vrachei i studentov* (Moscow and Leningrad: Gos. izd. biologicheskoi i meditsinskoi literatury, 1935), 627.

<sup>44</sup> *Ukazaniia po organizatsii psikhiatricheskoi pomoshchi i psikhiatricheskoi ekspertize vo vremia voiny*, 6-7.

<sup>45</sup> S. N. Davidenkov and V. A. Gorovoi-Shaltan, eds., *Nervnye bolezni: Osobennosti ikh vozniknoveniia, techeniia, preduprezhdeniia i lecheniia vo vremia voiny*, ed. E. I. Smirnov, *Opyt sovetskoi meditsiny v velikoi otechestvennoi voine, 1941-1945 gg.*, vol. 26 (Moscow: Medgiz, 1949), 19.

<sup>46</sup> Glavnoe voenno-sanitarnoe upravlenie Krasnoi armii (GVSU KA), *Ukazaniia po sortirovke, evakuatsii, lecheniiu i ekspertize lorrnenykh, baro- i istero-travmatikov i lorbol'nykh* (Moscow: Medgiz, 1942).



symptoms of deafness.<sup>47</sup> Such patients, psychologist Alexander Luriiia argued in 1942, were suffering from “disorders of consciousness.”<sup>48</sup>

“Consciousness,” however, was another controversial topic, and while psychiatrists and neurologists were in broad agreement about the symptoms of deaf-mute syndrome, they were unable to agree about what caused it or how it should be treated. Some psychiatrists reported successfully treating patients using psychotherapy or hypnotism, while others relied on bed rest, electrical shocks, injections of vodka, or simulated suffocation.<sup>49</sup> In some cases deaf mute syndrome persisted for months or even years, while in others soldiers regained their ability to hear very quickly, even instantaneously. What was causing these strange symptoms? Were they caused by psychological factors, or physical injury to the nervous system? Should deaf-mute syndrome be categorized using existing diagnostic labels like “traumatic neurosis” or “hysteria”? Could deaf-mute syndrome perhaps help scientists gain new insights into the underlying processes that produced neuroses?

### **Hysteria and Soviet Patriotism**

At 11 am on April 18, 1945, a 31 year-old soviet soldier named F— regained consciousness. He thought he had been unconscious for about ten seconds, and could remember that before losing consciousness there had been a flash of light and the sound of a

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<sup>47</sup> Molodtsov, *et al*, *Kratkoe rukovodstvo po voenno-vrachebnoi ekspertize*, 90-91.

<sup>48</sup> A.R. Luriiia, speaking on 20 May 1942. Quoted in I. I. Lukomskii, "Rabota Moskovskogo obshchestva nevropatologov i psikhiatrov v period Velikoi otechestvennoi voiny," *NiP* 11, no. 5 (1942): 78.

<sup>49</sup> The most comprehensive meta-analysis of wartime psychiatric literature was done for the 35-volume medical history of the war. This analysis mentions the following most commonly used methods of treatment for *glukhonemota*: rational psychotherapy, electro-therapy (faradizations of cheeks, ears, throat; d'arsonvalization), speech therapy, ether narcosis, “strengthening therapy” (usually exercise and vitamins), suggestion, injections of Epsom salts (sernokislaia magneziiia), calisthenics, labor therapy, injections of alcohol, massage, hypnosis, calcium chloride injections, bed rest, tranquilizers, moral education. S. N. Davidenkov, "Isteriia," in *Nervnye bolezni: Osobennosti ikh vozniknoveniia, techeniia, preduprezhdeniia i lecheniia vo vremia voiny*, ed. S. N. Davidenkov and V. A. Gorovoi-Shaltan, *Opyt sovetskoi meditsiny v velikoi otechestvennoi voine, 1941-1945 gg.* vol. 26 (Moscow: Medgiz, 1949), 72-80.

shell. He felt as if his “head was in a fog,” and quickly discovered that he could neither hear nor speak. Within an hour he arrived at a first-aid station, then was taken to a battalion medical unit. From there he was driven by car to a field hospital about 15 km from the front. He arrived at 2 pm, three hours after his injury, and was examined by Abram Sviadoshch, a young psychiatrist, who diagnosed F— with “post-contusional deaf-muteness.”

When F— arrived, according to Sviadoshch, he sat very still, gazing straight ahead and rarely blinking. When Sviadoshch examined him, F— let him know through gestures that he could not hear or speak and wrote “Contused” on a piece of paper. When Sviadoshch asked him aloud, “Can you hear?” F— shook his head. Sviadoshch was incredulous:

... To the words: “Do you hear me?” shakes his head. Writes: “I can’t hear anything.” And then responds to oral request to show his tongue by sticking it out. To the exclamation, “Come on, you can hear very well!” negatively shakes his head, confirms that he is absolutely deaf and dumb, and then again shows his tongue when asked to do so by doctor during physical exam. To a written statement that he had shown his tongue in response to an oral request and that, therefore, he has not lost his hearing, shrugs his shoulders doubtfully and writes that he is absolutely deaf. After this ceases to react to oral requests.<sup>50</sup>

Sviadoshch concluded that F— had suffered a mild concussion and a significant “acoustic and barometric trauma,” and that these conditions had resulted in “a curious state of elective inability to hear his surroundings [*svoeobraznoe sostoianie izbiratel'nogo neslyshan'ia okruzhaiushchego*].”<sup>51</sup> That same day Sviadoshch gave F— an injection of calcium chloride solution. F— felt feverish and briefly lost consciousness. “After a minute he woke and found that his hearing had been fully restored to the left ear and was slightly diminished in the right. In the first few minutes speech returned with a strong stutter, which by the end of the day had

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<sup>50</sup> Sviadoshch, “Opyt raboty psikhiatra v armeiskom raione,” 450-451.

<sup>51</sup> Sviadoshch took a detailed life history, and found that F— had no family history of psychiatric illness, had developed normally as a child, had possessed a “sociable, irascible character,” and had never experienced any hearing or speech problems. A former postal worker who had completed six years of school, F— had been fighting at the front for over three years. He had been injured three times, but this was his first contusion. Ibid., 450-451.

become less pronounced....” On April 27, F— was checked out to his unit “with an insignificant difficulty with speech.” The treatment had taken just over one week.<sup>52</sup>

Why did F— lose his ability to speak and hear, while those around him did not? After all, the battlefield was a tremendously loud place, and concussions were hardly rare events. Why did most people resist deaf-muteness while others fell ill? What could this tell psychiatrists about the structure of the personality and the connections between mind and body? Deaf-mute syndrome was particularly controversial because some psychiatrists thought that it was caused by psychological trauma and that soldiers were suffering from a form of hysteria. Other psychiatrists saw this as a slur on the patriotism of the soldiers who fell ill. They sought to explain how the soldiers might develop a “functional disorder” that looked like hysteria but which in fact was a form of bodily dysfunction that was beyond the soldier’s control. In so doing they developed explanatory frameworks for mental disorder that excluded the conscious mind and that minimized the importance of subjective experience.

The equation of patriotism with mental stamina was well established in psychiatric thought during the war,<sup>53</sup> and military psychiatrists even enshrined this doctrine in the field

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<sup>52</sup> Ibid., 450. For a brief description of Sviadoshch’s method, see S. N. Davidenkov, "Isteriia," in *Nervnye bolezni: Osobennosti ikh vozniknoveniia, techeniia, preduprezhdeniia i lecheniia vo vremia voiny*, ed. S. N. Davidenkov and V. A. Gorovoi-Shaltan, *Opyt sovetskoi meditsiny v velikoi otechestvennoi voine, 1941-1945 gg.* (Moscow: Medgiz, 1949), 76. It seems that the method is still used, at least sporadically, in Russian psychiatry. The “kal’ tsievyi udar po Sviadoshchu” is included on the curriculum as part of Lecture 14 of N. N. Petrov’s course, “Psikhiatriia v konsul’tativnoi praktike,” [http://www.psychology.ru/education/programs/02\\_02\\_03.stm](http://www.psychology.ru/education/programs/02_02_03.stm) (accessed 9 March 2006).

<sup>53</sup> At Narkomzdrav’s December 1942 conference on military medicine, for instance, one of the leading experts in preventative psychiatry explained that, “The powers of compensation of the central nervous system and of a personality with a healthy social background and patriotic mind set [*zdorovkh sotsial’nykh i patrioticheskikh ustanovok*] are great enough to overcome even the most intense neuro-psychic syndromes...” Berger, “O profilaktike nevro-psikhicheskoi invalidnosti,” 403. Chaplina uses similar language to describe the “mobilization of inner resources” in her paper on female hysteria in the war. M. P. Chaplina, “Osobennosti nevrotycheskikh reaktsii u zhenshchin, sviazannye s voennym vremenem,” in *Voprosy sotsial’noi i klinicheskoi psikhonevrologii*, vol. 8, vol. 8, ed. E. K. Krasnushkin (Moscow: 1946), 62.

manuals they wrote for army medics.<sup>54</sup> Victor Osipov described the personality [*lichnost'*] as the site of conscious control and claimed that the *lichnost'* was strengthened by political consciousness and ideology. As Osipov put it, "... the higher the political-moral level of the Red Army soldier, the higher and stronger his political, class consciousness, then the easier he suppresses [*podavliaet*] the natural biological endocrine-autonomic reaction, the neuro-vascular changes that produce the emotional state, not allowing the biological side to acquire a mastering influence over his personality [*gospodstvuiushchee vliianie nad svoei lichnost'iu*], thus making his personality less open to being overcome by a psychotic reaction."<sup>55</sup>

The idea that patriotism could overcome physical obstacles had powerful political resonance, enough so that physicians who wrote about the effects of exhaustion sometimes felt the need to include a caveat about patriotism. In the preface to his 1943 textbook on neuroses, for instance, neurology professor Vasilii Khoroshko preemptively defended himself from criticism: "This author would be extremely upset if someone reading his description of the fatigue neurosis or exhaustion took his advice about prevention and treatment of these disorders ... as discouragement in these days of general patriotic uplift." Khoroshko assured his readers that he did not mean to imply that soldiers would develop neuroses because of over-exhaustion. In fact they would be protected by the "love for the motherland" and "thoughts of the desired victory."<sup>56</sup>

Because psychiatrists believed that the "moral psychological factor" could overcome mental disorder, they saw psychological breakdown as a sign that a soldier was not truly

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<sup>54</sup> As one guide told medics, "... the consciousness [*soznanie*] of people defending their motherland, convinced in the justness of their cause, makes the organism stronger, more durable [*vynoslivee*], more capable to defend itself." *Molodtsov, et al, Kratkoe rukovodstvo po voenno-vrachebnoi ekspertize*, 86.

<sup>55</sup> V. P. Osipov, "Osnovy raspoznavaniia psikhovozov i psikhoticheskikh sostoiianii v praktike voennogo vracha," in *Voprosy psikhiatricheskoi praktiki voennogo vremeni*, ed. V. P. Osipov (Leningrad: 1941), 3-37. This chapter was reprinted in 1943 as a stand-alone pamphlet with a *tirazh* of 2,000. (Tashkent: Gosizdat UzSSR, 1943).

<sup>56</sup> Khoroshko, *Uchenie o nevrozakh*, 4.

dedicated to the cause of victory. At a 1942 conference, for instance, Tikhon Geier, the psychiatrist in charge of giving psychiatric evaluations to soldiers at one of Moscow's main psychiatric hospitals, said that he believed soldiers who came down with "purely hysterical" illnesses were people who were "weak, amoral, psychopaths, or socially degenerate [*zapushchennykh*]." <sup>57</sup> He believed that soldiers who maliciously faked their symptoms should be sent to the front. Those whose symptoms were "benignly exaggerated" should be given education to help them overcome their problem, but should not be exempted from military service. <sup>58</sup> This view was shared as by Izrail Berger, the head psychiatrist for Moscow *oblast'*, who divided neuropsychiatric patients into those who had serious problems but wanted to help themselves, and those who *thought* they had serious problems but did not want to help themselves. The latter group, he said, "are very demonstrative, very difficult; they secure income and various benefits [*dobivaiutsia renty i razlichnykh l'got*], and have a clearly negative attitude toward work." <sup>59</sup>

Soviet Army regulations explicitly sought to avoid giving soldiers any hope that they might get out of the army by developing a neurotic reaction. In 1942, the Commissariat of Defense issued a new set of rules for determining medical fitness for service. <sup>60</sup> Hysteria fell

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<sup>57</sup> T. A. Geier, quoted in I. I. Lukomskii, "Rabota Moskovskogo obshchestva nevropatologov i psikhiatrov v period Velikoi otechestvennoi voiny," *NiP* 11, no. 5 (1942): 67. Geier was in charge of the "expertise department" at Moscow's P. B. Gannushkin Psychiatric Hospital.

<sup>58</sup> *Ibid.*, 70

<sup>59</sup> Berger, "O profilaktike nevro-psikhicheskoi invalidnosti," 405.

<sup>60</sup> Until 1942, the military operated under *Prikaz* NKO SSSR No. 184 (1 July 1940), "Vvedenie 'Instruktsii po meditsinskomu osvidetel'stvovaniuu voinskikh kontingentov,' 'Nastavleniia po opredeleniiu godnosti, vremennoi ili postoiannoi negodnosti k voennoi sluzhbe' i drugikh meditsinskikh rukovodiashchikh dokumentov." It was replaced by *prikaz* NKO SSSR No. 336 (24 October 1942), "Ob"iavlenie: a) Insruktsii po meditsinskomu osvidetel'stvovaniuu voinskikh kontingentov, b) raspisanie boleznei, v) nastavleniia po opredeleniiu godnosti k voennoi sluzhbe, g) tablitsa dopolnitel'nykh trebovaniu k sostoianiuu zdorov'ia pri raspredelenii po rodam voisk." V. A. Zolotarev, ed., *Prikazy narodnogo komissara oborony SSSR: 1937 - 21 iyunia 1941*, Russkii arkhiv: Velikaia Otechestvennaia, vol. 2 (Moscow: Terra, 1994), 347.

under “temporary but expressed reactive disorder of a psychogenic character” (article 9c), and soldiers suffering from it were designated as fit for service, or, in particularly bad cases, fit for non-combat duty.<sup>61</sup> When the order was being drafted, psychiatrists advised the army that, when it came to soldiers with “hysterical reactions,” physicians should take a “tactful but firm line to avoid setting them up for illness” [*chtoby ne dat’ ustanovki na bolezni*]. At most the soldier should be given a short period of treatment in a recovery battalion and then returned to his unit.<sup>62</sup>

Soldiers with deaf-mute syndrome were not eligible to get out of the army even if they never regained their hearing and speech. Medics were instructed to inform soldiers of this early on so that they would not cling to their symptoms in hopes of a discharge. Deaf-mutes who did not recover within two months were found “fit for non-combat duty” and assigned to jobs at the front or in the rear.<sup>63</sup>

### “Behind the Façade of Hysterical Symptoms”

During the First World War, many Russian psychiatrists had come to the conclusion that “traumatic neurosis” was caused by psychological trauma. Polemics over the “traumatic neurosis” concept had continued into the 1920s, and during the Second World War these polemics were revived in the debate over deaf-mute syndrome and functional disorders of wartime. Several leading psychiatrists made clear that they wanted to avoid what they saw as the excessive “psychologism” of early twentieth century psychiatry, and they particularly wanted to debunk the idea that “traumatic neurosis” was primarily a psychological reaction to battlefield

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<sup>61</sup> “Raspisanie boleznei po psikhonevrologicheskomu razdelu (proekt),” 9 September 1942, GARF, f. a-482, op. 47, d. 648, ll. 18-21; *Molodtsov, et al, Kratkoe rukovodstvo po voenno-vrachebnoi ekspertize*, 67-68.

<sup>62</sup> “Protokol soveshchaniia v otdele o sostoianii psikhonevrologicheskoi pomoshchi,” 9 September 1942, GARF, f. a-482, op. 47, d. 648, ll. 22ob-23. P. M. Zinov’ev and N. N. Timofeev gave a presentation on the draft of prikaz 336 at this meeting.

<sup>63</sup> *Molodtsov, et al, Kratkoe rukovodstvo po voenno-vrachebnoi ekspertize*, 90-92. See also GVSU KA, *Ukazanie po sortirovke...lorranenykh* (M: ’42), p. 8.

conditions.<sup>64</sup> Twenty-five years after the last war, they claimed, scientific and conceptual advances allowed Soviet psychiatrists to see “behind the façade of hysterical symptoms” and to debunk the conceptual framework of the previous generation.<sup>65</sup> In contrast to the meager toolkit used by physicians in the First World War, these psychiatrists boasted that they now had “the newest methods of examination,” and that this enabled them to greatly increase their knowledge of the underlying physiology of battlefield disorders. As one prominent psychiatrist put it in December 1942, “At the present time we can already speak more concretely not only of the nature [of the injury], but also of the location of the injury, of the primary injury of one or another part of the central nervous system in traumatic encephalopathy.”<sup>66</sup> The symptoms that had once been thought of as psychological were in fact caused by physical injuries. They were

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<sup>64</sup> Comparisons to World War One were very frequent and very explicit. In some cases psychiatrists who made this comparison had themselves been physicians in World War One. Others had gone to medical school in the 1920s and spent their formative years working closely with recovering soldiers. At major conferences held in 1942, for instance, leading psychiatrists gave entire talks devoted to the organization of psychiatric care in World War One and its lessons for the current war. P. Posvianskii, “O zadachakh i strukture nevro-psikhiatricheskogo gosptalia i nevro-psikhiatricheskikh otelenii v sisteme evakogospitalei,” in A. S. Shmar’ian and P. B. Posvianskii, eds., *Biulleten' nauchnoi konferentsii Tsentral'nogo Instituta Psikhatrii po voprosam nevropatologii i psikhatrii voennogo vremeni: 30 maia - 1 iunia 1942* (Tomsk: 1942), 9. Red Army head psychiatrist Nikolai Timofeev’s 25 December 1942 speech about parallels with World War One is described in I. I. Lukomskii, “Sessia Moskovskogo obschestva nevropatolgov i psikhiatrov,” *NiP* 12, no. 2 (1943): 79.

<sup>65</sup> Tolstoukhova used this phrase to help explain why number of soldiers diagnosed with brain injuries increased so dramatically in their hospital in the third and fourth years of the war. They had, she said, become “better able to recognize the organic-traumatic essence ... behind the façade of hysterical syndromes.” L. N. Tolstoukhova, “Osnovnye voprosy voennoi psikhatrii v raione glubokogo tyla (Glavy iz monografii),” in *Voprosy psikhatrii voennogo vremeni*, ed. P. F. Malkin (Sverdlovsk: 1947), 71.

For Mikhail Gurevich, the project of breaking up the category of “traumatic neurosis” went back to the late 1930s. In his memoir, psychologist Konstantin Platonov relates how Gurevich assigned him a topic for his doctoral dissertation. Gurevich was then working as a consultant to the Ministry of Aviation, where Platonov worked as a psychologist. He told Platonov, “The theory of the old traumatic neurosis, which in my youth I gave no little effort, and which is so pertinent to aviation, requires deep reexamination. Break it into two. You, Nikolai Vasil’evich, take head trauma in pilots, and you, Konstantin Konstantinovich – their psychogenic condition. Traumatic neurosis should be reborn in these two areas.” K. K. Platonov, *Moi lichnye vstrechi na velikoi doroge zhizni: Vospominaniia starogo psikhologa* (Moscow: Institut psikhologii RAN, 2005), 229.

<sup>66</sup> Sereiskii in “Preniia” from *Trudy Zogo plenuma gospit soveta* (M 43), 435. On the same lines, see Shmar’ian’s 1943 article: “The whole complex of the science of the human nervous system, all the newest achievements of soviet neurophysiology and pathophysiology have been directed toward giving a deeper biological explanation [*traktovku*] of the fundamental pathological processes in brain trauma.” A. S. Shmar’ian, “Obshchie i chastnye zakonomernosti psikhopatologii travmy golovnogo mozga,” *NiP* 12, no. 6 (1943): 3.

“organic” problems, disorders caused by broken parts or mechanical dysfunction inside bodies.<sup>67</sup> Deaf-mute syndrome was best understood as a non-conscious disruption of neurological processes, not as a neurosis, and certainly not as a form of hysteria.

This view was advocated by three prominent Moscow psychiatrists, Mikhail Gurevich, Aleksandr Shmar’ian, and Mark Sereiskii. Gurevich and Sereiskii were the directors of prestigious academic psychiatry departments at the First Moscow Medical Institute and the Central Institute for Advanced Medical Studies, respectively, and Aleksandr Shmar’ian was the research director of the Central Institute of Psychiatry and the head psychiatrist for Narkomzdrav USSR’s evacuation hospital department. Their opinions carried great weight in the field, and each of them directed a small group of researchers who promulgated similar views.

At the last meeting of the Moscow Society of Neuropathologists and Psychiatrists before the evacuation of Moscow in October 1941, Mikhail Gurevich presented a paper about x-rays he had taken of contused soldiers.<sup>68</sup> The soldiers suffered from headaches, clouded mental states, and general fatigue, but the neuropathologists who had examined them found no signs of physical injury, and thus suspected them of exaggerating their symptoms [*aggravatsiia*]. When Gurevich examined them, he found them apathetic and unable to make decisions for themselves.<sup>69</sup> He also found symptoms of hysteria. Gurevich reported, however, that by x-raying the soldiers he had detected microscopic shards of metal embedded in their bodies, including in the tissue of the brain and nervous system. A bomb had apparently exploded with enough force

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<sup>67</sup> My terminology draws on Paul McHugh and Phillip R. Slavney, *The Perspectives of Psychiatry*, 2nd ed. (Baltimore: Johns Hopkins University Press, 1998), esp. 234.

<sup>68</sup> The meeting was held on 8 October 1941. I. I. Lukomskii, "Rabota Moskovskogo obshchestva nevropatologov i psikhiatrov v period Velikoi otechestvennoi voiny," *NiP* 11, no. 5 (1942): 61-62.

<sup>69</sup> He diagnosed them with apathetic-abulic syndrome [*apaticheski-abulicheski sindrom*]. Abulia is “the loss or impairment of the ability to make decisions or act independently.” Merriam-Webster Medical Dictionary on MedlinePlus, available at <http://www.nlm.nih.gov/medlineplus/medlineplusdictionary.html>.



to send tiny shards through the bone of the soldiers' skulls. "There is no doubt," Gurevich concluded, "that the appearance of this form in the current war depends on the particularities of modern weaponry."<sup>70</sup> Modern technology not only enabled him to detect microscopic changes, it also contributed to new forms of illness.

Other psychiatrists and neurologists frequently cited Gurevich's discovery of "microshards" in *kontuzhennye* as proof that modern technology was enabling them to debunk the idea that traumatic neurosis was caused by psychological factors. With the help of sophisticated tests, they would now discover the true (organic) causes of what had once been mysterious wartime illnesses.<sup>71</sup> In addition to x-rays, psychiatrists and neurologists used electroencephalography, chemical analysis, and other laboratory methods to identify previously undetected changes in the structure or function of the body. Along with Gurevich's microscopic shards of metal, they highlighted changes in pressure in the skull and the spine, chemical changes in the blood or spinal fluid, changes in muscle tone, and changes in the reaction of the autonomic nervous system.<sup>72</sup> At a December 1942 meeting in Moscow, Aleksandr Shmar'ian reported that his team of researchers had examined 40 soldiers who had been diagnosed with psychogenic disorders after suffering "air concussions." Using encephalography, they found that 38 of these soldiers had "disturbances of fluid circulation with primary localization in the frontal lobes of the brain in the form of external or internal hydrocephaly." Shmar'ian concluded that it would be a mistake to think that these soldiers were suffering from psychogenic illness or

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<sup>70</sup> M. O. Gurevich, "O travmaticheskom porazhenii mozga mel'chaishimi oskolkami," *NiP* 11, no. 5 (1942): 3-5.

<sup>71</sup> See, for instance, Osipov's discussion of Gurevich's work in V. P. Osipov, "Zadachi Akademii Meditsinskikh Nauk v oblasti psikiatrii," in *Uchreditel'naia Sessia Akademii Meditsinskikh Nauk SSSR, 20-22 dekabria 1944 g.* (Moscow: Medgiz, 1945), 121.

<sup>72</sup> See for instance, N. S. Shteinvil', "O vozdushnoi kontuzii," *NiP* 14, no. 5 (1945): 57-58.

hysteria. In fact, they had underlying physiological problems in their bodies that were producing “functional” disorders. If properly diagnosed, these soldiers could expect to fully recover and return to the front.<sup>73</sup>

According to these psychiatrists, deaf-mute syndrome was caused by precisely this type of subtle physiological injury. In a few cases, they were willing to admit, deaf-mute syndrome might be caused by psychological processes, but in most cases soldiers who lost their ability to hear and speak because their bodies were injured by the tremendous power of modern weaponry. Deaf-mute syndrome should be considered a traumatic injury in the physical sense of the term.

Just where these physical injuries might be and why they caused deaf-mute syndrome was a matter of some discussion. Mark Sereiskii, speaking at the December 1942 meeting of Narkomzdrav SSSR’s *Gospital’nyi sovet* [Military Hospital Council], suggested that the injuries were primarily in the subcortical areas of the nervous system. He reported that he had used encephalography to study 100 patients with deaf-mute syndrome, and that he had found “significant general external hyper-productive hydrocephaly,” which was causing the “occlusion blockade” of some ventricles in the brain.<sup>74</sup> In October 1943, Aleksandr Shmar’ian advanced a different theory, claiming that exploding shells damaged the way the brain worked rather than the actual anatomical structures in the brain. Deaf-mute syndrome, he claimed, was mainly caused by “functional displacements [*sdvigi*] in the brain rather than anatomical-destructive changes.” These “functional displacements” produced a clouded mental state [*oglushchenost’*], apathy, and general “inhibition” [*zatormozhennost’*]. The soldiers also suffered

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<sup>73</sup> A. S. Shmar’ian, quoted in S. I. Milovidov, ed., *Trudy 2-go plenuma Gospital'nogo soveta Narkomzdrava SSSR, 20-25 dekabria 1942 g.* (Moscow: Medgiz, 1943), 439-440.

<sup>74</sup> M. Ia. Sereiskii, quoted in S. I. Milovidov, ed., *Trudy 2-go plenuma Gospital'nogo soveta Narkomzdrava SSSR, 20-25 dekabria 1942 g.* (Moscow: Medgiz, 1943), 435-436.

sensory deficits – not just deaf-muteness, but also blindness or loss of feeling in limbs. All of this increased the patients' tendency to sit alone, unmoving, even unresponsive, and “to further fence the patient off from reality....”<sup>75</sup>

As Shmar'ian's description makes clear, the patients he saw were suffering from serious psychological disorders. In some cases, as in Gurevich's microscopic shards of metal, these psychological disorders were attributed to structural damage to the brain or nervous system. But even with modern x-ray machines, psychiatrists could not find physical damage to the brains of most of their patients, though they could still find tell-tale changes in blood chemistry or spinal fluid pressure that suggested that the complex function of body had been upset. For researchers like Gurevich, Shmar'ian, and Sereiiskii, the key point was that soldiers suffering from deaf-mute syndrome were experiencing a problem that happened *to* them and *in* them. Their symptoms were not the outcome of ideas in their heads, and so there was no point in discussing their personal problems or experiences. Nor were these patients choosing to engage in bad behaviors that could be unlearned, so there was no point in lecturing them or giving “rational psychotherapy.” These patients were being affected by physiological processes going on inside their bodies, processes that affected consciousness, but which arose independently of the psyche. The psychiatrists' goal was to understand these processes, and to use physiological methods to restore the soldier to himself.

### **“The Will to Recovery:” Rational Psychotherapy and Deaf-Mute Syndrome**

Not all psychiatrists were convinced that deaf-mute syndrome was caused by subtle anatomical injuries. Laboratory findings certainly suggested that some physiological changes had

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<sup>75</sup> A. S. Shmar'ian, "Obshchie i chastnye zakonomernosti psikhopatologii travmy golovnoogo mozga," *NiP* 12, no. 6 (1943): 3-4.

taken place in the body, but what those laboratory findings meant was a matter of interpretation. Psychiatrists widely accepted the idea that psychological processes were ultimately physical processes, and that if a soldier experienced psychological changes he must be experiencing some sort of changes at the neurophysiological level. For materialist scientists, this was simply axiomatic. What was less clear was the role played by conscious thought. Many psychiatrists during the war became convinced that deaf-mute syndrome was caused by psychological trauma because they were able to cure quickly and dramatically using psychotherapy. The key, they argued, was to “mobilize the will.”

In 1943 a physician named F. I. Ioffe wrote an article describing his experiences working with *kontuzhennye* at N— evacuation hospital. Deaf-mute syndrome was a very real problem, according to Ioffe, because physicians saw deaf-mute patients “at all stages of evacuation.” In his experience, soldiers who lost their hearing or ability to speak had indeed suffered physical injuries in some cases. But their injuries were not the root cause of their deaf-muteness. Ioffe thought that the deaf-mute syndrome that physicians were trying to treat was a psychological disorder, and it was caused by psychological trauma.

Ioffe was convinced of this because of his success using “suggestion therapy.” Very soon after a soldier arrived – preferably on the first day – Ioffe held his first session with the patient. This type of psychotherapy worked best if done in a proper setting, and the key to the method, Ioffe explained in his article, was the doctor himself. To cure deaf-mute syndrome, the doctor needed to impose his will on the patient. When the patient was admitted to the hospital, Ioffe forbade him to have any written contact with other patients on the ward, and forbade him to smoke.: “For the purpose of psychological influence, a table is set up with various instruments (scalpels, spatulas, pincers, tuning fork [*kamerton*], etc) and medicines (bromide, valerian) . . .

The patient sits next to this table, the physician – opposite.” It was in this setting that the physician would have set about working on Lieutenant K—, a 22 year old lieutenant who had served in the army since 1940.

On 19 February 1942 K— was brought to a sorting evacuation hospital (SEG) with a diagnosis of deaf-mute syndrome after contusion. According to the available documentation, he lost consciousness on 12 January 1942 when a bomb exploded. The medical form from the forward area was marked “kontuziia.” In the history of illness, physicians from previous stages of evacuation had written: “Converses through writing. Examination by neuropathologist – no organic symptoms found. Diagnosis: brain trauma with symptoms of mutism.” When he arrived at the ward on 19 February he did not have speech or hearing.

Internal organs without detectible deviation, reaction of pupils and craniocerebral nerves – normal. Motor, reflex, and sensory spheres are without substantial changes.

20 February, morning, on an empty stomach underwent a session of suggestion therapy...<sup>76</sup>

Surrounded by his instruments, Ioffe set to work. Using both words and gestures, he asked K— to cough. When he did, Ioffe pointed out that this proved K— still had the ability to produce sound. Then Ioffe started in on a series of physical manipulations, using a metal instrument to massage the area around K—’s eyes, then massaging his neck and throat, and finally his tongue. This massage began with a light touch to the surface of the skin, then increased in pressure until it was “far from pleasant.” The manipulation of the tongue was supposed to induce a gag reflex. During intervals between these procedures K— was instructed to look at Ioffe and to repeat after him the vowel sounds “a”, “o”, “u”, “e”. Once he had become proficient at this, K— was told to move on to simple words like “mama” and “papa,” and then his own name. This first session was “decisive,” according to Ioffe, and the physician should

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<sup>76</sup> F. I. Ioffe, "Glukhonemota voennogo vremeni i ee lechenie," *NiP* 12, no. 5 (1943): 39-41.

“patiently achieve these results in the first day regardless of the amount of time or the amount of energy.” This could take as little as 35 minutes or as long as 4.5 hours.

Ioffe did not record how long it took to reach a breakthrough in the case of Lieutenant K—, but in the first session K— did manage managed to produce “all the vowel sounds and his name,” though he did so with a stutter. Ioffe prescribed faradization (a light electrical current) for his throat, and blue light therapy [*solliuks*] for his ears. Though K— could now produce sound, his symptoms improved only gradually, and it was five months before he was able to return to the front. Ioffe charted his progress:

23 February examined by laryngologist. Ears-nose-throat organs without visible change.

25 February hears well; speaks with extreme stutter. Faradization of throat replaced by diathermy.<sup>77</sup> Withdrawn [*zamknut*], not very social. Blushes during conversation. Dispirited by his condition. Says that in the past he was a teacher in a primary school, and that he never stuttered.

7 March stutter persists. Feels oppressed by hospital conditions, asking to be checked out. Has become more sociable with patients. When in calm state stutters less.

15 March went before commission and was found unfit under group III, limited fitness under fourth group according to the second article of decree No. 18478 with reexamination in three months.

At the end of June 1942 came to the ward to say goodbye – left for the front. Felt generally good, speech pure, without stutter.<sup>79</sup>

According to Ioffe, K—’s treatment worked because Ioffe himself was able to interact with his patient in a way that “mobilize[d] his will to recovery.” The deaf-mute syndrome was

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<sup>77</sup> Diathermy [*diatermiia*]: “the generation of heat in tissue by electric currents for medical or surgical purposes.” Merriam-Webster Medical Dictionary on MedlinePlus, available at <http://www.nlm.nih.gov/medlineplus/mplusdictionary.html>.

<sup>78</sup> The prikaz in question was prikaz NKO No. 184 (1 July 1940), “Vvedenie ‘Instruksii po meditsinskomu osvidetel'stvovaniuu voinskikh kontingentov,’ ‘Nastavleniia po opredeleniiu godnosti, vremennoi ili postoiannoii negodnosti k voennoi sluzhbe,’ i drugikh meditsinskikh rukovodiashchikh dokumentov.” V. A. Zolotarev, ed., *Prikazy narodnogo komissara oborony SSSR: 1937 - 21 iyunia 1941*, Russkii arkhiv: Velikaia Otechestvennaia, vol. 2 (Moscow: Terra, 1994), 347.

<sup>79</sup> Ioffe, “Glukhonemota voennogo vremeni i ee lechenie,” 41.

caused by K—'s false belief that he could not speak; this psychological fixation could be overcome by person-to-person interaction that acted "on the consciousness [*soznanie*] of the patient" and brought about psychological healing. Using this method, Ioffe claimed, the physicians at N— evacuation hospital had been able to return 70% of their deaf-mute patients to active duty, and the rest had been either sent to non-combat posts (about 15%) or evacuated to hospitals in the rear (another 15%).<sup>80</sup>

While physicians like Ioffe based their work on fuzzy ideas about consciousness and often insufficiently worked out notions of "a will to recovery," a more systematic and experimentally grounded approach was developed by a group of researchers led by psychologist Aleksandr Luriiia. The center for this research was Evacuation Hospital No. 3120, a hospital established in 1942 in the southern Urals at an old sanatorium in a village called Kisegach, on the banks of two small lakes near the city of Chelyabinsk.<sup>81</sup> Alexander Luriiia had worked closely with psychologist Lev Vygotsky in the 1920s and 1930s. After the 1936 ban on pedology and psychotechnics and the associated ban on Vygotsky's theories, Luriiia had returned to medical school and gone into brain-injury research.<sup>82</sup> As the director of the Kisegach hospital he gathered many former colleagues that he had worked with in Moscow and Kharkov, including Lev Perel'man and Bliuma Zeigarnik, professors of neurology and psychology respectively. Based on their study of soldiers with deaf-mute syndrome in 1941 and 1942, Perel'man and Zeigarnik

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<sup>80</sup> Ioffe, "Glukhonemota voennogo vremeni i ee lechenie," 40.

<sup>81</sup> During the war Grashchenkov was responsible for neurosurgical care of soldiers who had brain injuries or injuries of the peripheral nervous system. Grashchenkov himself oversaw a neurosurgical hospital in Moscow. Soldiers with more serious injuries who needed long-term care were evacuated further away from the front, to the Evacuation Hospital 3120 in the village of Kisigach, near Chelyabinsk. The filial-hospital, organized and directed by Alexander Luriiia, had 400 beds, and operated for three years before being transferred back to Moscow. A. M. Vein and N. A. Vlasov, *Nikolai Ivanovich Grashchenkov, 1901-1965* (Moscow: Nauka, 1985), 24-25; A. R. Luria, *Etapy proidennogo puti: Nauchnaia avtobiografiia* (Moscow: Izd. MGU, 1982), 129-131; Elena Luriiia, *Moi otets A.R. Luriiia* (Moscow: Gnozis, 1994), 100-105.

<sup>82</sup> Luriiia, *Moi otets*, 89.

developed a theory that deaf-mute syndrome was caused by the soldier's strongly held but false belief that he was deaf and mute.<sup>83</sup> Like Ioffe, they prescribed rational psychotherapy as a cure. They reported having treated 300 patients with *glukhonemota* in the first two years of the war. They failed to restore speech in only 5% of their patients, Perel'man reported; 11% had partially regained speech, and 84% had fully regained both speech and hearing.<sup>84</sup>

The theory that Zeigarnik and Perel'man published posited a two-stage model of deaf-mute syndrome. In the first stage, soldiers suffered a physical injury: a bomb or a shell exploded, and their ears were overwhelmed by the sudden change in air pressure and the extreme sound. For a brief moment, they were truly deaf. In the second stage, the soldier reacted psychologically to this physical event, "fixing" the symptom of deafness. Physiologically, they now had the ability to hear, but they continued to believe that they could not. Any exaggeration of their symptoms was unconscious [*bessoznatel'naia*]; the soldier truly believed that he was deaf and mute, and this (mistaken) belief was the cause of his pathological symptoms.<sup>85</sup>

These false beliefs were often unintentionally encouraged by army physicians, Perel'man believed. Front-line medics referred deaf-mutes for assessment by neurologists or otolaryngologists and the soldiers often spent weeks or months waiting to see the specialist, all the while becoming more and more convinced that their condition was serious. In other hospitals,

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<sup>83</sup> In 1942 and 1943 Zeigarnik conducted psychological tests on 117 patients with deaf-mute syndrome, giving them tests of memory, mental reaction speed, and ability to draw pictures. Based on these tests, she identified three sub-groups: soldiers who had suffered a concussion (19.6%), soldiers with no sign of concussion but with difficulty controlling their emotions (24%), and soldiers who had no signs of concussion and no difficulty controlling their emotions, but had "weak character" (56.4%). She concluded that in all three groups the inability to speak or hear was psychological. Whether the soldiers had suffered a concussion or not, their "leading illness was reactive, the entire course and outcome of the illness was determined by its psychogenic character." B. V. Zeigarnik, "Psikhologicheskii analiz postkontuzionnykh narushenii slukha i rechi," in *Reaktivnaia postkontuzionnaia glukhonemota: Ee raspoznavanie i lechenie*, ed. L. B. Perel'man (Moscow: Medgiz, 1943), 43-51.

<sup>84</sup> L. B. Perel'man, *Reaktivnaia postkontuzionnaia glukhonemota: Ee raspoznavanie i lechenie* (Moscow: Medgiz, 1943), 38.

<sup>85</sup> Perel'man, *Reaktivnaia postkontuzionnaia glukhonemota*, 16-17.



medics gave soldiers “every conceivable injection,” and these failed treatments further increased the patients’ beliefs that they were physically injured and that their injuries were very resistant to treatment.<sup>86</sup> By treating the mental disorders as physical injuries and giving soldiers physical treatments, doctors strengthened their own belief that the patient was incurable and strengthened the patient’s beliefs as well.

Once the Kisigach team had become convinced that their patients were suffering from psychological problems, they started an aggressive program of “rational suggestive therapy” in order to “destroy the pathological beliefs [*ustanovki*] in illness, and strengthen the patient’s conscious belief that his ears are not injured and that they require no special treatment.”<sup>87</sup> To do this, they used both psychological and physical interventions to strengthen the patient’s will power. Psychological treatment involved both overt and hidden forms of suggestion. “In an accessible manner” they categorically told their patients that there was nothing wrong with them physically and that their hearing and speech “would definitely reappear in the days soon after the treatment.” They paired this “direct” suggestion with indirect methods, physical props intended to make the soldiers think that the doctors giving them some sort of magic bullet medical treatment. Perel’man gave his patients injections of Epsom salts that gave them a warm feeling in the face and tongue. He also recommended applying weak electrical current (faradization) to their ears, throat, and mouth. None of this was expected to have any important physiological effects on the body, but they were expected to increase the patient’s belief that something “medical” was being done to him and that he would be cured.<sup>88</sup>

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<sup>86</sup> Ibid., 34-35.

<sup>87</sup> Ibid.

<sup>88</sup> Ibid., 35-36.

It was important that the physician truly believed that the problem was psychological in nature because if he did not, then he would not project complete confidence, and would not be able to convince his patient. “The success of therapy,” Perel’man wrote, “is based on the complete assurance of the researcher in the character of the injury and, in particular, [belief] in the fact that the patient does not have true loss of speech in primary perception, though the further processing of the primary perception may be delayed, inhibited.”<sup>89</sup>

Perel’man also gave his patients a course of speech therapy. He started by writing questions on paper and asking the patient to read them and respond in writing. The first questions on the list were legible, but as the list progressed the questions were intentionally written more and more illegibly, until they were entirely indecipherable. While the patient was reading the questions, the doctor would simultaneously ask the questions out loud. According to Perel’man, “Experience showed that if the patient retained hearing, then in the great majority of cases, the patient, without noticing that he was doing it, would begin to answer the oral questions rather than the written questions.” The patient would continue to answer the questions even though they were not decipherable on the page. If the patient’s injuries were not psychological, then this test would expose this “true disorder of hearing,” because the patient “ceased to answer the written question as soon as the written question became illegible.”<sup>90</sup> As soon as the patient made some sort of sound, Perel’man recommended focusing all attention on this success. This initial success could then be built upon in subsequent sessions. The physician should do everything possible to prevent the patient from “fixating” on what was wrong; the role of the doctor was to focus his attention on the ability that he did have, and to “use these first successes to cheer him up.”

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<sup>89</sup> Ibid., 27.

<sup>90</sup> Ibid.

Perel'man combined these psychological exercises with “general strengthening treatment” (vitamins) and training [*vospitanie*], including cultural and political discussions, labor therapy, and physical activity like taking walks, skiing, and doing calisthenics. These activities were thought to have both psychological and physical effects. They would help “raise the tone of the autonomic nervous system” and recover from their “neuro-psychic insufficiency and emotional lability,” which would in turn make it easier to “maximally transfer the patient to active activity [*aktivnuiu deiatel'nost'*].”<sup>91</sup> The key, Perel'man argued, was to “mobilize the activity of the patient himself,” getting the patient to believe that he could regain his speech, and making him want to strive to improve his speaking ability even when not working directly with the physician.<sup>92</sup>

By using rational psychotherapy, Perel'man, Ioffe, and others sought to turn deaf-mute soldiers back into active, patriotic Soviet citizens, to convince them to reengage with the world and to return to the fight against the Germans. Rational psychotherapy and suggestion rested on a belief that the conscious will could have a powerful effect on the body. Other methods of psychotherapy were used as well, especially hypnosis, and even psychoanalysis,<sup>93</sup> but “rational psychotherapy” was the most common approach. The term “rational psychotherapy” had been

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<sup>91</sup> Perel'man, *Reaktivnaia postkontuzionnaia glukhonemota*, 34-35; see also L. B. Perel'man, "O lechenii posle kontuzionnoi glukhonemoty," *NiP* 11, no. 4 (1942): 74-75; L. B. Perel'man, "Raspoznavanie, lechenie i evakuatsiia bol'nykh s postkontuzionnym reaktivnym rasstroistvom rechi i slukha," *NiP* 12, no. 5 (1943): 38

<sup>92</sup> Perel'man, *Reaktivnaia postkontuzionnaia glukhonemota*, 36.

<sup>93</sup> On the use of hypnosis on *kontuzhenye*, see, for instance, I. M. Vish, quoted in P. B. Posvianskii and T. I. Gol'dovskaia, "Khronika: Vserossiiskaia konferentsiia po voprosam psikhiiatrii," *NiP* 13, no. 5 (1944): 69.

A physician named Z. S. Shvarts was reported to have used psychoanalysis to treat *glukhonemota*, and to have published about this in a collection of papers published by the Leningrad clinical military hospital in 1942. The physician who reported this dismissed psychoanalysis as too cumbersome and long-lasting to be useful in wartime. F. I. Ioffe, "Glukhonemota voennogo vremeni i ee lechenie," *NiP* 12, no. 5 (1943): 40. The term “psychoanalysis” implies the use of Freud’s methods, though not necessarily an acceptance of his theoretical model based on human sexuality. For another wartime discussion of psychoanalysis and its interest and usefulness as a method, see Khoroshko, *Uchenie o nevrozakh*, 73.

proposed in the early twentieth century by Swiss neurologist Paul Dubois, and had been popular in Russia since Dubois's work was first published in Russian translation in 1912.<sup>94</sup> According to historian Edward Shorter, "Dubois offered a highly rationalistic philosophy of 'persuasion,' using the doctor-patient relationship to persuade the patient to change his or her ways in a kind of Socratic dialogue in which medical advice constantly tugged patients toward betterment."<sup>95</sup> This sort of "rational psychotherapy" to treat war neuroses was common in European armies during the First World War, and could still be found in use by some psychiatrists of the older generation in the West during World War Two.<sup>96</sup> And while in Europe the older psychotherapeutic traditions of Janet and Dubois seem to have been subsumed by Freudian approaches to the mind, in Russia in the 1940s it was these older approaches, particularly Dubois's, which remained in use, and which could still be discussed and advocated without fear of being accused of "idealism."<sup>97</sup> Patients suffering from deaf-mute syndrome were suffering from a disorder of the will: they could recover by changing their minds, choosing to adopt a different set of behaviors. Through their choice, they could affect their bodies, "mobilize their internal resources," and ultimately resume their duties as defenders of the Soviet Union.

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<sup>94</sup> Other important books on neurosis and psychotherapy were published around the same time, including Janet (1903, 1911) and Dejerine (1912). Freud's *Interpretation of Dreams* was first published in Russian translation in 1904. Translations of most of Freud's works were published by the Soviet state publishing house in 1922. V.K. Khoroshko, *Uchenie o nevrozakh* (Moscow: Medgiz, 1943), 151-153. See also Miller, *Freud and the Bolsheviks*, 25-26. One of the frustrating aspects of Miller's book on Freud is that he never really discusses non-Freudian psychotherapy or how it was used in the Soviet Union. Theories such as Dubois's which minimize or deny the role of the unconscious are simply not discussed.

<sup>95</sup> Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley, 1997), 138-142.

<sup>96</sup> Shephard, *A War of Nerves*, 217-218

<sup>97</sup> Other major figures in pre-Freudian psychotherapy include Dejerine, Janet, and Charcot. Freud built his theories in large part using elements found in the work of his predecessors, and their ideas clearly had an impact in Russia which was at least equal to the impact of Freud himself. Miller's book would have been much stronger (if less streamlined) if it had included even a small discussion of how these other theories of psychological medicine were received and developed in Russia. On this point see Hans Pols, "The Pursuit of Psychoanalysis under Conditions of Communism: Review of Martin A. Miller, *Freud and the Bolsheviks: Psychoanalysis in Imperial Russia and the Soviet Union*. New Haven: Yale University Press, 1998," *Left History* 7, no. 2 (2001): 108-114.

## Medical Holism and Functional Disorders of the Mind

Ioffe, Perel'man, and other proponents of the “psychogenic” theory of *glukhonemota* protested that they were not trying to impugn soldiers’ patriotism, but to some psychiatrists any psychogenic theory was unacceptable. Two psychiatrists from the psychiatry department at Sverdlovsk University made this case particularly strongly. They objected to the use of the term “hysteria” to describe deaf-mute syndrome because it implied “more or less unacknowledged tendencies of the personality.”<sup>98</sup> At a 1943 conference, one prominent psychiatrist had given a paper in which he claimed that 30-34% of patients in neuro-psychiatric hospitals were suffering from hysterical reactions. The Sverdlovsk psychiatrists responded indignantly, “Could it be that over one third of healthy young men, unconditionally dedicated to their Motherland and the great majority of them passionately awaiting the hour when they can return to the ranks of the army of liberators – could it be that they have some sort of constitutional relationship to the hysterical reaction? ... Of course not. Such a notion would be totally absurd.”<sup>99</sup>

Many psychiatrists shared this view, and they sought explanations that could explain how non-conscious processes might lead to functional psychological disorder. They grounded their explanations in holistic theories of the mind-body that had been developed by physiologists in the 1920s and 1930s, and they used these theories to offer models of the mind that relied on metaphors of hierarchy and control. Deaf-mute syndrome could be both a functional disorder *and* a disorder of the body without involving the psyche.

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<sup>98</sup> L. N. Tolstoukhova, "Osnovnye voprosy voennoi psikhologii v raione glubokogo tyla (Glavy iz monografii)," in *Voprosy psikhologii voennogo vremeni*, ed. P. F. Malkin (Sverdlovsk: 1947), 112-113.

<sup>99</sup> *Ibid.*, 69. (The section on psychogenic illness was written by Tolstoukhova in collaboration with her husband, department director P. Malkin.)

## “Reactivity” and Acquired Predisposition

During the 1920s and 1930s, many physiologists in Europe, America, and the Soviet Union became interested in the role of chemical mediators in the body, and this line of research led to renewed interest in the body’s ability to adapt itself to constantly changing conditions.<sup>100</sup> Probably the most widely recognized researcher in this field was American physiologist Walter Cannon, who publicized a modern version of Bernard’s theory, coining the term “homeostasis” to describe how the body uses neurological and chemical responses to prevent the its “internal environment” from being upset by changes in its environment.<sup>101</sup> Cannon’s work was published in Russian translation in the 1920s and 1930s,<sup>102</sup> and he visited the Soviet Union in August 1935 when the International Congress of Physiology was held in Leningrad.<sup>103</sup> During the Second World War, his work was known and cited by Soviet psychiatrists and neurologists.<sup>104</sup>

In the 1930s, Military Medical Academy psychiatrist Viktor Osipov became interested in Cannon’s findings, and he did a series of his own studies on the role of adrenaline in animals and

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<sup>100</sup> Christopher Lawrence and George Weisz, "Medical Holism: The Context," in *Greater than the Parts: Holism in Biomedicine, 1920-1950*, ed. Christopher Lawrence and George Weisz (New York: Oxford University Press, 1998), 1-22; Elliot S. Valenstein, *The War of the Soups and the Sparks: The Discovery of Neurotransmitters and the Dispute Over How Nerves Communicate* (New York: Columbia University Press, 2005).

<sup>101</sup> Cannon’s concept of homeostasis was indebted to the concept of “*milieu interieur*” hypothesized by French physiologist Claude Bernard in 1878. Elin L. Wolfe, A. Clifford Barger, and Saul Benison, *Walter B. Cannon, Science and Society* (Cambridge, MA: Boston Medical Library, 2000), 144-165.

<sup>102</sup> In 1927, Cannon’s book, *Bodily Changes in Pain, Hunger, Fear, and Rage: An Account Of Recent Researches into the Function of Emotional Excitement* (New York: D. Appleton and Company, 1915), was published in Russian translation with a print run of 3,000 copies. V. B. Kennon, *Fiziologiya emotsii: Telesnye izmeneniia pri boli, golode, strakhe, i iarosti*, ed. B. M. Zavadovskii, trans. V. A. Dorfman and A. G. Kratinov (Leningrad: Priboi, 1927). A second American edition was also released in 1927, but it is unclear to me which edition the Russian translation was based on. Other works by Cannon were published in Russia in 1935, 1943, and 1951. Russian National Library (Leningrad) online catalog, <http://www.nlr.ru> (accessed 7 May 2008).

<sup>103</sup> Elin L. Wolfe, A. Clifford Barger, and Saul Benison, *Walter B. Cannon, Science and Society* (Cambridge, MA: Boston Medical Library, 2000), 333-334.

<sup>104</sup> From 1943 until his death in 1945, Cannon served as President of the American-Soviet Medical Society, an organization founded by medical historian Henry Siegerist primarily to exchange medical literature with the Soviet Union and publicize Soviet medical research in the United States. Wolfe, Barger, and Benison, *Walter B. Cannon*, 498-500; Walter B. Cannon, "Foreword," *American Review of Soviet Medicine* 1, no. 1 (October 1943): 6.

in mental patients. He concluded that adrenaline played a large role in determining how people reacted to their surroundings, but that its effects could be disrupted by other unknown substances that the body produced in some circumstances. Osipov believed that this could help explain mental disorders like manic depression, and that it could also help support a concept he referred to as “acquired predisposition.”<sup>105</sup>

The basic question, according to Osipov, was why some people broke down under stress while others did not. The most likely explanation, he argued, was that people were predisposed. In some cases this predisposition might be inborn or acquired early in life, but in most cases it was acquired while serving in the army: just living under constant fear of death at the front could be enough to change the “tonus” of the nervous system. Front-line life often meant “physical over-exertion, exhaustion, insufficient sleep or lack of sleep, past infections, head trauma, etc,” all factors that might cause soldiers to acquire a predisposition to “psychic injury.”<sup>106</sup> In Osipov’s view, the war itself was the pathogenic factor that helped explain psychological disorders. Osipov translated this view into official instructions for army medics, who were told that “for a reactive condition to develop, there must be asthenization [weakening] of the nervous system or other somatogenic causes weakening it.”<sup>107</sup> A soldier’s psychological reaction was only incidentally related to the explosion of a shell or the experience of fear. These effective causes could only have provoked a response because the emotional and physical strain of soldiering had

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<sup>105</sup> V. P. Osipov, "Materialy k voprosu o geneze affektivnykh sostoianii," *NiP* 10, no. 3 (1941): 7-10.

<sup>106</sup> S. P. Ronchevskii, "O vzaimootnoshenii affektogennykh i ekzogennykh faktorov v strukture nekotorykh psikhovozov voennogo vremeni," *NiP* 13, no. 3 (1944): 10.

Similar views were expressed in E. V. Maslov, "Nevrozy voennogo vrmeeni i ikh lechenie," quoted in "Nauchnaia konferentsiia psikhiatrov srednei azii po voprosam voennoi psikhii 18-20.XII.1942," *NiP* 12, no. 5 (1943): 68; G. E. Sukhareva, quoted in P. B. Posvianskii and T. I. Gol'dovskaia, "Khronika: Vserossiiskaia konferentsiia po voprosam psikhii," *NiP* 13, no. 5 (1944): 66; and T. P. Simson, "Reaktivnye sostoiane u detei, byvshikh v usloviakh okkupatsii," *NiP* 13, no. 3 (1944): 40-45.

<sup>107</sup> Molodtsov, et al, *Kratkoe rukovodstvo po voenno-vrachebnoi ekspertize*, 68.

already caused underlying changes in the body. These material factors were thus the “true” cause of the disorder, and the specific qualities of an individual’s psychological experience or character were largely irrelevant.

Another advocate of this position was Andrei Snezhnevskii, the psychiatrist who in 1951 became the de-facto leader of Soviet psychiatry. In 1943 Snezhnevskii was the director of a front-line hospital and he wrote several articles describing his experience with psychiatric disorders. Soldiers who became delusional while serving at the front, Snezhnevskii wrote, were best understood to be suffering from acquired predisposition. In stressful situations soldiers sometimes broke down or ran away, overwhelmed by fear and dominated by “impulsive reactions of a primitive type.” Snezhnevskii argued that the “comprehensible connections” between their delusions and their situations were tenuous at best, but that all of these soldiers had some fairly recent event in their history that might have weakened their bodies: sickness, contusion, loss of sleep, lack of food, or serious exhaustion. Thus the soldiers had “acquired” a predisposition for psychological disturbance, and this predisposition could be undone by a little rest, food, and warm baths. They must have been suffering primarily from physical exhaustion, and only secondarily from psychological disturbance.<sup>108</sup>

Similar observations were made in Leningrad, where psychiatrists were surprised to see that psychogenic illnesses dropped off steeply in 1943, even though the German attack was actually worse than it had been before. The reason, one of the Leningrad psychiatrists suggested,

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<sup>108</sup> A. Snezhnevskii, "Ob ostrykh bredovykh epizodakh" in Speshnevskii and Kevork'ian, "Materialy frontovoi konferentsii nevropatolgoov psikhiatrov, neurokhirurgov N-skogo fronta, sostoiavsheisia 2-3.1.1943," *NiP* 12, no. 5 (1943): 52.



was that people were getting more food, and were thus more resistant to psychological trauma.<sup>109</sup> During the war (and postwar), there was probably no one who was living a perfectly well-rested, well-fed, unstressful life. As a result, any psychological reactions had to be qualified: were they “pure psychogenic reactions,” or were they psychogenic reactions that had some other cause? Some hospitals added a special line to their registration cards where psychiatrists could indicate the predisposing factor which “caused” the psychological reaction.<sup>110</sup>

### **Deaf-Mute Syndrome and Pavlov’s Theory of Higher Nervous Activity**

While Walter Cannon developed a holistic theory of the mind-body that focused on chemical mediators and the autonomic nervous system as the keys to the body’s ability to adjust to its environment, Ivan Pavlov focused primarily on the cortex of the brain. In the 1920s and 1930s Pavlov developed his own holistic theory of the mind-body that built on the theory of “nervism.” Advocated by prominent nineteenth century Russian thinkers like physiologist Ivan Sechenov and physician Sergei Botkin, “nervism” held that the nervous system played a “leading role” in the body, controlling everything from metabolic processes to immune response to complex thought. Pavlov was a strong proponent of “nervism,” which he opposed to “chemism,” believing that the nervous system ultimately unified and controlled all the processes in the body, including chemical processes. The organism’s responses could not be reduced to chemical

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<sup>109</sup> I. F. Khvilivitskaia, "Pervichnaia psikhicheskaia zaboлеваemost' v Leningrade v period voyny, blokady i poslevoennoe vremia," in *Organizatsionno-metodicheskie voprosy sovremennoi neiropsikhiatrii*, ed. E. S. Averbukh and V. N. Miasishchev (Leningrad: 1948), 33.

<sup>110</sup> The key word here was “soil” or “terrain” (*pochva*). The metaphor was one in which external events “fell” on “already prepared soil,” that consequently produced illness. Like parched land, soil that was not prepared could not bear the fruits of illness. In 1948, psychiatrists at the First Moscow City Psychiatry Hospital reported that they had seen only 9 people with “true reactive conditions”; all the rest had been qualified on the basis of “its terrain [ukazanie na pochvu ego].” B. Aleksandrovskii (Chairman), “Stenogramma Konferentsii vrachei 1-i gorodskoi psikh. bol'nitsy,” 9 March 1948, TSMAM, 1126-1-57, ll. 34-34ob.

reactions or molecular structures, they had to be understood in terms of “a biology of the system.”<sup>111</sup>

Pavlov’s own version of nervism was built on his theory of conditioned reflexes. Like many neurophysiologists in the late nineteenth century,<sup>112</sup> Pavlov conceived of the central nervous system as a hierarchical system consisting of anatomical structures that had developed at different points in human evolution: the oldest, most evolutionarily ancient parts were the “lowest” in the hierarchy, and they were responsible for inborn, instinctual behaviors (unconditioned reflexes). The newest, most evolutionarily recent parts were in the cortex of the brain, and had no inborn function: their role was to provide guidance to the rest of the system, and to control and guide the action of the lower, automatic parts of the hierarchy. This was done through the establishment of conditioned reflexes in response to conditions in the environment.

Conditioned reflexes were established through the interaction of two fundamental processes that took place in the nervous system: excitation and inhibition. By studying how conditioned reflexes changed in response to controlled laboratory experiments, Pavlov identified certain regularities that he attributed to the fundamental laws of “higher nervous activity,” the rules that governed how excitation and inhibition worked in the brain. Personality could be accounted for by the tendency of one or another process to predominate in an individual’s nervous system: thus people who were inward looking, controlled, and unspontaneous were dominated by inhibition, while those who were emotional, impulsive, uninhibited were inclined to excitation. Neuroses could be conceptualized as a pathological imbalance between the processes of excitation and inhibition.

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<sup>111</sup> David Joravsky, *Russian Psychology: A Critical History* (Oxford: Basil Blackwell, 1989), 144.

<sup>112</sup> In psychiatry and neurology, the most influential source of this idea seems to have been J. Hughlings Jackson, who in turn had been directly influenced by Herbert Spencer’s mid-century writings on psychology.

During the war the most articulate spokesman for this approach was Anatolii Ivanov-Smolenskii, a psychiatrist who had worked with Pavlov and who had run a psychiatry clinic attached to Pavlov's research institute. Ivanov-Smolenskii worked as an evacuation hospital doctor during the war, and he believed that the post-contusion syndromes that he saw were caused by "over stimulation" of soldiers' brain cells. According to Pavlov, nerve cells could be damaged by stimulation that was too strong. To prevent injury, these cells entered a physiological state that Pavlov referred to as "protective inhibition." As Ivanov-Smolenskii explained in an article he wrote about deaf-mute syndrome, "the substance of the nerve cells is protected from harmful, destructive influence through functional immobilization. Preventing excessive loss of nerve substance [*nervnoe veshchestvo*], this inhibition encourages processes of assimilation, the restorative metabolism of the nerve cells."<sup>113</sup> The explosion of a bomb or an artillery shell, he speculated, was capable of causing "temporary inhibition of higher coordination and regulation centers" in the brain.<sup>114</sup> In one quick blow, the rest of the nervous system was deprived of instructions from the center. As Ivanov-Smolenskii explained, the nervous system was composed of "... a whole hierarchy of nervous centers, each subordinated one to the other. This system of centers stretches from the spinal cord and medulla oblongata to the hypothalamus, the corpus striatum, and, finally, to the cerebral cortex." When the "regulatory centers" at the top of this hierarchy were shut down by protective inhibition, the "lower centers" gained temporary independence. As a result, the suffering soldier exhibited symptoms of hysteria. Or, as Ivanov-Smolenskii put it, "It is after all precisely this dominance of subcortical

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<sup>113</sup> A. G. Ivanov-Smolenskii, "Opyt lecheniia surdomutizma kontuzionno-kommotsionnogo proiskhozhdeniia," in *Voенno-meditsinskii sbornik*, ed. L. A. Orbeli (Moscow: Izd-vo Akademii nauk SSSR, 1946), 207.

<sup>114</sup> *Ibid.*, 196.

over cortical, first signal system of the brain over second (speech system) ... that is the most characteristic feature of hysterical syndromes.”<sup>115</sup>

The specific symptoms of deaf-mute syndrome, according to Ivanov-Smolenskii, were caused by the inhibition of the parts of the cortex responsible for hearing and speech. The process began with the loud noise of the explosion, which briefly overwhelmed the cells of the brain’s “hearing analyzer.” The “hearing analyzer” was directly linked to the “speech analyzer,” and, following Pavlov’s laws of higher nervous activity, “any inhibition ... has a tendency to irradiate to adjacent or connected areas...” Thus the physical structures involved in hearing and speech remained intact, but the brain cells involved in coordinating these activities were temporarily shut down to protect them. This area of inhibited brain cells sometimes became “pathologically inert,” and could linger for a long time after the initial illness.<sup>116</sup>

Ivanov-Smolenskii’s Pavlovian explanation of deaf-mute syndrome was one of the most explicitly developed, but many other psychiatrists used some variation of his theory, usually suggested in off-hand remarks about the inhibition of the cortex or liberation of the “lower areas” of the nervous system. Some of these were collaborators of Ivanov-Smolenskii, while others had simply been raised in a scientific culture which taught this way of talking about nerve processes. This approach appealed to many because it seemed to offer a physiological explanation for strange symptoms in patients who lacked any obvious physical injuries. By using this framework, physicians were able to point to something that happened to the patient, and to

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<sup>115</sup> Ibid., 196-197.

<sup>116</sup> Ivanov-Smolenskii suggested that the “hearing and speech analyzers” were distinct from anatomical structures – they were temporary reflex structures that could involve multiple parts of the brain. In this article, however, he asserted that they were closely connected to Wernicke’s area and Broca’s area, the two parts of the brain identified as primarily involved in hearing and speech by nineteenth century German researchers. Ivanov-Smolenskii further suggested that Broca’s area was associated, perhaps even identical to, Pavlov’s “second signal system.” Ibid., 207-208.

processes in the patient. They thus avoided the suggestion that what the patients were thinking about mattered, and might actually produce illness even without an explosion. Inhibition was not the result of anything that patients thought or did: it was a non-conscious, physiological response to external stimulation.

### **Deaf-Mute syndrome and the Autonomic Nervous System**

Pavlov insisted that all conditioned reflexes were routed through the cortex of the brain, a version of nervism that German historian Torsten Rüting has referred to “the dictatorship of the cortex.”<sup>117</sup> In the 1930s, however, some of Pavlov’s students began to explore ideas very similar to Walter Cannon’s, and began to explore the important role that the autonomic nervous system played in regulating non-conscious processes in the body. This approach was notably developed by Pavlov’s successor at the Institute of Experimental Medicine, physiology professor Leon Orbeli. Like Cannon, Orbeli believed that the autonomic nervous system helped the body maintain its equilibrium with the environment. In instances of extreme danger, the nervous system would release large amounts of the chemical adrenaline into the body, enabling the individual to respond to a threat. (Cannon referred to this as the “fight or flight” response.)<sup>118</sup> Orbeli’s research on the autonomic nervous system had great appeal for psychiatrists because they saw it as a way to give non-psychological explanations for symptoms that had once been thought of as hysterical.<sup>119</sup> The autonomic nervous system, one psychiatrist quipped, could be thought of as “the transmission belt” between the environment, the body, and the psyche, “a

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<sup>117</sup> Quoted in Kirill O. Rossianov, review of *Pavlov und der neue Mensch: Diskurse über Disziplinierung in Sowjetrussland*, by Torsten Rüting, and *Pavlov's Physiology Factory: Experiment, Interpretation, Laboratory Enterprise*, by Daniel Todes, *Kritika* 6, no. 3 (2005): 647-655.

<sup>118</sup> Wolf, et al., *Walter B. Cannon*, 166-189, esp. 170.

<sup>119</sup> N. S. Chetverikov, "K voprosu o klinicheskikh vegetativnykh sindromakh. Soobshchenie IV: Vegetativnaia nervnaia sistema i psikhiairiia," *NiP* 13, no. 3 (1944): 45-50.

bridge across the chasm between functional and organic, reaction and process, neurosis and psychosis.”<sup>120</sup>

The most prominent and outspoken proponent of this approach was Moscow psychiatrist Vasilii Giliarovskii. Using concepts drawn from Cannon, Orbeli, and several other physiologists, Giliarovskii conceptualized deaf-mute syndrome as a problem that developed “from below,” caused by a traumatic event that affected the “lower” elements of the nervous system, which in turn impacted the higher areas and ultimately the conscious mind. Giliarovskii hypothesized that when a bomb exploded, the soldier’s body struggled to adapt to the dangerous and quickly changing environment. In some cases, excessive stimulation could overwhelm the body’s natural adaptive response. As a result, the soldier would be flooded with chemicals like adrenaline, and the normal relationship between the parts of the nervous system would be disrupted. These non-conscious processes in the lower levels of the nervous system caused the symptoms of hysteria.<sup>121</sup>

Giliarovskii stressed that soldiers with deaf-mute syndrome were not suffering from disorders of behavior or will. Even if a psychiatrist convinced them that they could speak, it would be no use. What they needed was some outside intervention that could help undo the

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<sup>120</sup> Gurvich’s biography is not altogether clear to me, but he had worked under Lev Rozenshtein at the Institute of Neuropsychiatric Prophylaxis in the 1930s, and continued to work there in the late 1930s and into the 1940s after it was reorganized as the Central Institute of Psychiatry. Gurvich made these comments at a 1942 conference in Omsk. Note that his comments were reported by Giliarovskii, who may have highlighted Gurvich’s words to bolster support for his own theory of traumatic hysteria. V. A. Giliarovskii, "Konferentsiia nevropatologov i psikiatrov evakogospitalei po travmam nervnoi sistemy v Omske 18.VII.1942 g.," *NiP* 12, no. 1 (1943): 79.

<sup>121</sup> Giliarovskii referred to this transition to a different state of homeostasis as a “vegetative shift.” V. A. Giliarovskii, "O roli vegetativnykh narushenii v geneze istericheskikh rasstroistv posle kontuzii," *Khirurgiia*, no. 3-4 (1942): 34-41; V. A. Giliarovskii, "O sushchnosti istericheskikh rasstroistv v svete novykh dannykh v uchenii o vegetativnoi nervnoi sisteme," *NiP* 11, no. 6 (1942): 22-27; V. A. Giliarovskii, "O roli somato-vegetativnykh narushenii v geneze psikhogenii voennogo vremeni," in *Trudy 2-go plenuma Gospital'nogo soвета Narkomzdrava SSSR, 20-25 dekabria 1942 g.*, ed. S. I. Milovidov (Moscow: Medgiz, 1943), 378; V. A. Giliarovskii, "O lechenii bol'nykh s istericheskimi reaktsiiami v sisteme evakogospitalei," *Gospital'noe delo*, no. 9 (1944): 20-22.

underlying physiological disorder of the nervous system.<sup>122</sup> Giliarovskii's preferred method was "ether narcosis," a dose of ether gas given to the deaf-mute soldier through a mask. In 1942 he and his assistants used this method to cure a deaf-mute soldier named F-:

Red Army soldier F., 32 years old, contused October 12, 1941. Lost consciousness for two hours. When he came to himself he could not hear or speak. Has been in various hospitals over the course of six months. When he arrived contact was made using writing and gesture. He is taking his condition hard, wants to be healed. After a two-week preparation the patient was given ether. With the first whiff of ether he gave sharp active resistance and screamed: "Save me! I'm suffocating!" Five minutes later (20g ether) the mask was removed. The patient was in a state of euphoria, spoke easily and freely, heard well, was happy, joyous, cried, smiled. He remained for two more weeks, after which he was checked out to his unit.<sup>123</sup>

Giliarovskii thought that F's recovery was caused by the effects of the ether on his autonomic nervous system. The drug helped return the nerves to their normal resting state, thus restoring enervation to the higher centers of the brain.

Other psychiatrists also found ether narcosis useful for curing deaf-mute syndrome, but they were less certain about how or why it worked.<sup>124</sup> Some argued that it actually affected the higher centers of the brain, ridding the patient of excessive inhibition that had prevented him from speaking, while others speculated that the ether worked by exposing the soldier's true ability to speak, and still others speculated that the extreme fear caused by the sensation of

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<sup>122</sup> V. A. Giliarovskii, "O sushchnosti istericheskikh rasstroistv v svete novykh dannykh v uchenii o vegetativnoi nervnoi sisteme," *NiP* 11, no. 6 (1942): 22-27; V. A. Giliarovskii, "O lechenii istericheskikh rasstroistv rechi i slukha u kontuzhennykh," in *Trudy 2-go plenuma Gosspital'nogo soveta Narkomzdrava SSSR, 20-25 dekabria 1942 g.*, ed. S. I. Milovidov (Moscow: Medgiz, 1943), 380-381.

<sup>123</sup> T. A. Nevzorova and O. G. Iurova, "Lechenie istericheskikh rasstroistv u kontuzhennykh po metodu vegetativnykh sdvigo," *NiP* 11, no. 6 (1942): 67-71.

<sup>124</sup> The ether narcosis method had been pioneered during World War One by German psychiatrists, and Soviet psychiatrists explicitly attributed their own use of the method to their experiences in World War One or their knowledge of the literature from that time. Ukrainian psychiatrist Evgenii Popov credited German psychiatrists Max Rothmann with inventing the ether narcosis treatment for hysteria, and attributed his own use of ether to the World War One literature. E. A. Popov, "Terapiia nekotorykh istericheskikh rasstroistv voennogo vremeni v sviazi s opytom primeniia eterizatsii," in *Voennaia meditsina glubokogo tyla v otechestvennuu voinu*, ed. K. N. Pavlovskii (Tashkent: Gos. Izd-vo UzSSR, 1943), 414-416. Paul Frederick Lerner, *Hysterical Men: War, Psychiatry, and the Politics of Trauma in Germany, 1890-1930* (Ithaca, N.Y.: Cornell University Press, 2003), 116.

suffocation provoked a new surge of adrenaline in the body, essentially scaring the patient back into a state of health.<sup>125</sup> Giliarovskii rejected these explanations. Soldiers were not faking their symptoms, he asserted, and fear was not a necessary part of the treatment. He had achieved a similar effect by injecting soldiers with alcohol, which did not produce the feeling of suffocation, but did help rid the patient of his symptoms of deaf-muteness. Thus, Giliarovskii concluded, the therapeutic effect was not a consequence of fear; it was the result of the direct action of the narcotic on the autonomic nervous system.<sup>126</sup>

Giliarovskii's views were very widely disseminated, and had a significant impact on the way that other physicians understood deaf-mute syndrome and hysteria. Many evacuation hospital physicians learned the principles of psychiatry from Giliarovskii in a special four month course that he taught in Omsk during the war.<sup>127</sup> His views on hysteria were also the only ones published in Narkomzdrav's journal for evacuation hospital doctors, and his views were picked up and repeated by prominent neurologist Nikolai Chetverikov, a leading specialist on the autonomic nervous system.<sup>128</sup> Chetverikov praised Giliarovskii's approach because it offered

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<sup>125</sup> E. A. Popov, "Terapiia nekotorykh istericheskikh rasstroistv voennogo vremeni v sviazi s opytom primeniia eterizatsii," in *Voennaia meditsina glubokogo tyla v otechestvennoi voine*, ed. K. N. Pavlovskii (Tashkent: Gos. Izd-vo UzSSR, 1943), 414-416; S. I. Gol'denberg, "O zakrytykh travmakh mozga s kartinoi tak nazyvaemogo travmaticheskogo nevroza," *NiP* 12, no. 5 (1943): 30-35.

<sup>126</sup> V. A. Giliarovskii, "O sushchnosti istericheskikh rasstroistv v svete novykh dannykh v uchenii o vegetativnoi nervnoi sisteme," *NiP* 11, no. 6 (1942): 24. Some psychiatrists, notably V. P. Osipov, criticized ether narcosis. In the official medical history of the war the authors agreed with Osipov that, "The massive psychological fear, of course, decreases the value of these methods, despite their effectiveness." S. N. Davidenkov, "Isteriia," in *Nervnye bolezni: Osobennosti ikh vozniknoveniia, techeniia, preduprezhdeniia i lecheniia vo vremia voiny*, ed. S. N. Davidenkov and V. A. Gorovoi-Shaltan, *Opyt sovetskoi meditsiny v velikoi otechestvennoi voine, 1941-1945 gg.* (Moscow: Medgiz, 1949), 77.

<sup>127</sup> "Psikhonevrologicheskaiia rabota v Omske v dni voiny," *NiP* 11, no. 5 (1942): 85

<sup>128</sup> Between 1941-1946, Chetverikov published ten articles in *Nevropatologiia i psikhiatriia*, the making him tied for second most articles with Mikhail Gurevich. Giliarovskii was tied for 5<sup>th</sup> place with six articles. Nikolai Grashchemkov, the editor of the journal and Chetverikov's boss, was a distant first, with 21 articles published in *NiP* during 1941-1946.



hope that psychiatrists could extricate themselves from the “vicious cycle of psychiatric ideas and terms that are close to idealistic mechanisms.”<sup>129</sup>

### **Postwar Verdicts on “Deaf-Mute Syndrome” and War Trauma**

After the war several leading psychiatrists published reviews of the wartime research on “so-called traumatic neuroses.” These postwar assessments are particularly interesting because of the degree to which their authors differed from one another in both their conclusions and their emphasis. Viktor Osipov, the long-time director of the psychiatry department at the Military Medical Academy, declared that the war had vindicated those who believed that most of the “functional” disorders of wartime were in fact caused by bodily injuries. In virtually all cases, he said, Soviet researchers had found evidence of some sort of organic injury to the body, either using x-rays that detected microscopic shards of metal in the brain, or using microscopes to detect damage to brain cells, “microstructural injuries of blood vessels,” and the “deformation” of other brain structures.<sup>130</sup> Osipov cited Perel’man’s work on deaf-mute syndrome, but interpreted Perel’man’s findings to support his own conclusion that the main cause of deaf-mute syndrome was “organic.”<sup>131</sup> Osipov did not deny that psychological factors could play a role in wartime, or that in some cases psychological trauma might be the cause of hysteria in a soldier, but he insisted that “pure” cases of psychological trauma were vanishingly rare.<sup>132</sup> He applauded

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<sup>129</sup> N.S. Chetverikov, quoted in M. O. Gurevich and G. E. Sukhareva, "Dostizheniia sovetskoi psikhiiatrii za gody otechestvennoi voiny," in *Trudy tsentral'nogo instituta psikhiiatrii MZ RSFSR*, ed. P. B. Posvianskii and A. S. Shmar'ian (Moscow: 1947), 56. For Chetverikov’s praise of Giliarovskii, see also N. S. Chetverikov, "K voprosu o klinicheskikh vegetativnykh sindromakh. Soobshchenie IV: Vegetativnaia nervnaia sistema i psikhiiatriia," *NiP* 13, no. 3 (1944): 45-50.

<sup>130</sup> V. P. Osipov, "Travmaticheskii psikhonevroz i psikhonevrotravmatizm," in *Voенno-meditsinskii sbornik vol. 3*, ed. L. A. Orbeli (Moscow: AN SSSR, 1946), 50-51.

<sup>131</sup> *Ibid.*, 50. Timofeev also criticized Perel’man for his approach to *glukhonemota*, arguing that Perel’man was too ready to discount organic factors and to overestimate the psychogenic. Timofeev, “Predvaritel’nye itogi iz opyta organizatsii nevropsikhiiatricheskoi pomoshchi v velikuiu otechestvenuiu voinu,” 66-67

<sup>132</sup> Osipov, "Travmaticheskii psikhonevroz," 46

the willingness of Soviet researchers to abandon the World War One era attempts to find purely psychological explanations because this opened them up to looking at the physiological complexity that had not been previously seen because people had not been looking. Osipov saw these Soviet findings as the final blow in an argument about the nature of war trauma that went back to the turn of the century. Finally, he declared, German psychiatrist Herman Oppenheim had been vindicated in his belief that “traumatic neurosis” was caused by tiny lesions in the brain. “I think that if Oppenheim ... had known of these signs,” Osipov concluded, “... he would not have given up his position in 1916.”<sup>133</sup>

Another senior psychiatrist, Mikhail Gurevich, concurred that WWII had closed the book on the “traumatic neurosis” controversy. “The unbelievable confusion created after the First World War thanks to the vague term ‘traumatic neurosis’ may now be considered to have been liquidated. The argument about whether ‘traumatic neurosis’ is organic or functional-psychogenic is now a non-subject and of interest to no one.”<sup>134</sup>

Others, however, drew very different conclusions. Vasilii Giliarovskii published an entire monograph, *Starye i novye problemy psikiatrii* [Old and New Problems of Psychiatry], in which he developed his argument that deaf-mute syndrome and other “hysterical” disorders should be understood as *emotional* traumas, not psychological traumas. Instead of calling them “psychogenic,” he proposed, they should be referred using his own neologism, “timogenic,” based on the Greek root meaning ‘emotion.’ Looking forward to the postwar, Giliarovskii warned that wartime experiences might still come back to haunt the psyches of Soviet soldiers. “Psychotraumatic experiences may not manifest themselves at all externally,” he wrote, “but

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<sup>133</sup> Ibid., 48.

<sup>134</sup> M. O. Gurevich and G. E. Sukhareva, "Dostizheniia sovetskoi psikiatrii za gody otechestvennoi voiny," in *Trudy tsentral'nogo instituta psikiatrii MZ RSFSR*, ed. P. B. Posvianskii and A. S. Shmar'ian (Moscow: 1947), 45.

they may long retain their pathogenic action which may let themselves be known in the future in some sort of reaction.”<sup>135</sup>

Perhaps surprisingly, the most comprehensive Soviet review of the wartime psychiatric research was also the most categorical in its support for psychological explanations. This review was part of a massive study of wartime medicine published by Minzdrav USSR in 35 volumes, *The Experience of Soviet Medicine in the Great Patriotic War, 1941-1945* [*Opyt sovetskoi meditsiny v velikoi otechestvennoi vone, 1941-1945 gg.*].<sup>136</sup> The volume on “nervous illnesses” was edited by neurologist Sergei Davidenkov and psychiatrist Vladimir Gorovoi-Shaltan, both influential Leningrad professors. Davidenkov and Gorovoi-Shaltan.<sup>137</sup> The research was based primarily on histories of illness held at the Military-Medical Museum in Leningrad, and reportedly involved the analysis of millions of cards – though the published work sadly followed the norms of Stalin-era publication and gave no absolute figures; all information was reported in relative numbers, as percentages of an unnamed total.<sup>138</sup> In their articles on “hysteria” and “reactive conditions,” the two specialists argued that wartime evidence clearly showed that “these conditions are psychogenic, purely hysterical, combined with organic changes in the brain.” They were not convinced by attempts to show that symptoms like glukhonemota were

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<sup>135</sup> V. A. Giliarovskii, *Starye i novye problemy psikiatrii* (Moscow: Medgiz, 1946), 5-6.

<sup>136</sup> "V Sovete Ministrov Soiuzo SSR: O nauchnoi razrabotke i obobshchenii opyta sovetskoi meditsiny za vremia Velikoi Otechestvennoi Voiny, 1941-1945," *Sovetskoe zdravookhranenie*, no. 4-5 (1946): 3-4. The project was widely advertised for subscription in the medical press and was published with a print-run of 500,000. "Mnogotomnyi trud 'Opyt sovetskoi meditsiny v velikoi otechestvennoi voine 1941-1945 gg,'" *NiP* 18, no. 6 (1949): 3-7.

<sup>137</sup> Gorovoi-Shaltan was the director of the psychiatry department at Leningrad's Military-Medical Academy. Davidenkov was a respected neurologist was the director of the department of nervous illnesses at the Leningrad Institute for Advanced Medical Studies. "Vladimir Antonovich Gorovoi-Shaltan," *NiP* 20, no. 4 (1951): 78; "Davidenkov, Sergei Nikolaevich," in *Bol'shaia meditsinskaia entsiklopediia*, 2<sup>nd</sup> ed. (Moscow, 1958 ), 6: 633-634.

<sup>138</sup> On analyzing histories of illness at the Military-Medical Museum, see the fragmentary memoir of Boris Petrovskii, the editor of volume 19 (vascular injuries). Boris Vasil'evich Petrovskii (1908-2004), available at <http://www.biograph.ru/bank/petrovskiyi.htm> (accessed 5 January 2006).

“anatomically caused brain dysfunction” because psychotherapy was so effective in treating patients.<sup>139</sup> If psychotherapy could cure the patient, Davidenkov concluded, then the cause of the disorder must have been psychological. He had no time for Giliarovskii’s ether treatment or Sviadoshch’s injections of calcium, because “The massive psychological fear, of course, decreases the value of these methods, despite their effectiveness.”<sup>140</sup> In fact, he himself had come to the conclusion that “in hysterical surdomutism a positive result can be achieved using any psychotherapeutic method.” When psychotherapy alone had been used psychiatrists had gotten almost 100% recovery, leading Davidenkov to conclude that “the grandiose methods of treatment are superfluous and give a lower percentage of recovery.”<sup>141</sup>

Though Davidenkov argued for a psychological cure, he also offered a physiological explanation for deaf-mute syndrome based on Pavlovian theory. Auto-suggestion, he believed, essentially “turned off ... the whole speech zone” in the brain. The brain would recover on its own if given enough time, but to speed things up the psychiatrist could intervene with psychotherapy.<sup>142</sup> The point that had been lost on some psychiatrists, Davidenkov said, was that Pavlov’s physiological explanation did not replace or contradict a psychologically-comprehensible explanation. Pavlov was simply giving physicians a set of terms that could be used to describe the underlying processes of thought. This should not be taken to mean that the

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<sup>139</sup> S. N. Davidenkov, "Isteriia," in *Nervnye bolezni: Osobennosti ikh vozniknoveniia, techeniia, preduprezhdeniia i lecheniia vo vremia voiny*, ed. S. N. Davidenkov and V. A. Gorovoi-Shaltan, *Opyt sovetskoi meditsiny v velikoi otechestvennoi voine, 1941-1945 gg.* (Moscow: Medgiz, 1949), 59, 78-79, 89.

<sup>140</sup> Davidenkov, "Isteriia," 77

<sup>141</sup> *Ibid.*, 78

<sup>142</sup> *Ibid.*, 62.

content of thought had no effect on the brain or the body. The mind was no less real or powerful for having been described by Pavlov.<sup>143</sup>

## **Conclusion**

Soviet psychiatrists did not have a unified concept of neurosis or war trauma before the war began, and during the war this lack of coherence was reflected in the various and eclectic approaches to psychiatric disorder. Most of the methods that were used, including etherization, faradization, and rational psychotherapy, had originally been used in World War One. They were now tried again, and in some cases given new explanations. The institutional context that psychiatrists worked in was significant. By the third and fourth years of the war, psychiatrists near the front worked primarily in hospitals for the lightly wounded (*GLRs*), where they examined, treated, and sorted soldiers who were suffering from a wide range of injuries, some of them neurological – especially concussions, and some of the psychological. They worked alongside other specialists like neurologists, surgeons, and otolaryngologists, and together they made use of what diagnostic technology was available to them. Working on a diverse patient population alongside other specialists encouraged psychiatrists to look for small signs of concussion, malnutrition, or other bodily injury, and to interpret their findings in light of somatic models of the mind. They were also encouraged to experiment to figure out what might work.

The psychiatrists who worked in the front zones tended to be younger and to have had less experience with prior wars, while the psychiatrists who worked at evacuation hospitals far behind enemy lines were often older and more experienced, and also worked with a narrower group of patients, soldiers who had suffered some sort of injury at the front, who had been suffering from their symptoms for a long time already, and who had passed through many sorting

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<sup>143</sup> Ibid., 57.

hospitals before landing in a psychiatrist's office in the Urals, Kazan, or Samarkand. The psychiatrists in evacuation hospitals were less likely to work alongside other specialists, and they tended to have well established views on the nature of war trauma and hysteria and how they should be treated.

As I will discuss in Chapters Three and Four, some of these psychiatrists turned their wartime models of the mind into fully blown research agendas after the war. Vasili Giliarovskii developed his theory of deaf-mute syndrome into a broad theory of the "somatopsyche." Aleksandr Shmar'ian used his studies of brain injuries to support his theory of "three factors" in brain pathology. The research done at the Kisegach evacuation hospital by Lev Perel'man and others was developed into the beginnings of cognitive neuroscience by their leader, Aleksandr Luriiia. As I will discuss in Chapter Four, these psychiatrists and psychologists helped form a loose community of researchers in the postwar, a group of scientists who were all trying to combine new physiological and biochemical approaches to old disciplines like psychology and psychopathology to create new insights into the workings of the brain. Most of them offered their own theories, and hoped that their personal approach would become the new conceptual framework for Soviet psychiatry; as a result, they frequently disagreed with one another. Nevertheless, for a brief period in 1946-1947 they were able to put on a show of unity when the legitimacy of their enterprise was challenged by Anatolii Ivanov-Smolenskii and his hegemonic claims for Pavlov's theory of higher nervous activity.

## CHAPTER 3

### THE PSYCHIATRIC CONSEQUENCES OF THE WAR: WAR INVALIDS AND THE ROLE OF PSYCHIATRISTS IN POSTWAR SOVIET SOCIETY, 1944-1949

The Soviet people have worked very hard and suffered a great deal ... If we can overcome the long-held opinion that psychiatry is just a custodial discipline [*prizrencheskaia distsiplina*], and accept that psychiatry is a discipline of great prophylactic and therapeutic importance, and if psychiatry can become part of somatic medicine and vice versa, both in theory and in practice, then I think that the interests of affairs will not suffer: conditions will be created for the improvement of medical services, for the strengthening of the neuropsychic sphere, and for raising the productivity of labor and productive possibilities so necessary for accomplishing the tasks of the five year plan.

-- Vasilii Giliarovskii, Director of the USSR Academy of Medical Sciences Institute of Psychiatry, speaking before the USSR Ministry of Health Scientific Medical Council in March 1947<sup>1</sup>

#### Introduction

Many Soviet soldiers suffered brain injuries and psychological trauma during World War Two, and by 1944 psychiatrists were worried. They remembered the First World War and the 1920s, and they worried that the harrowing experiences of World War Two might produce another generation of “traumatics,” psychologically damaged soldiers who haunted the offices of psychiatric dispensaries to secure the meager insurance benefits that a psychiatric diagnosis might bring them. Most psychiatrists wanted to avoid encouraging the belief that psychological

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<sup>1</sup> V. A. Giliarovskii, cited in L. V. Gromashevskii (Chairman), “Stenogramma zasedaniia prezidiuma UMS MZ SSSR,” 6 March 1947, GARF, f. r-8009, op. 2, d. 1037, ll. 21-22.

trauma could earn benefits, but they worried that psychological trauma might yet prove damaging to postwar soviet society. What if the psychological experience of war had undermined the health of the Soviet population? Would they be able to cope with the demands of reconstruction?

Psychiatrists believed that they had an important role to play in rehabilitating soldiers, helping them to overcome their concussions, brain wounds, and “psychological reactions,” and helping to return them as functioning members of postwar society. Psychiatrists also saw the postwar period as an opportunity to change the way that other physicians looked at psychiatry. Psychiatric expertise, they argued, could and should help to rebuild Soviet society. World War Two had shown that mental health was profoundly affected by diet, infections, working conditions, and morale, not just shrapnel to the head and horrific experience. Even after the war, therefore, psychiatrists could play an important role in helping industrial managers to improve production, university administrators to improve student learning, and housing planners to create apartment designs that encouraged healthy, rested, productive citizens. Psychiatrists could also help their fellow physicians recognize and treat bodily illnesses that were associated with mental suffering, and could help them understand the effects that physical injuries had on the mind. Psychiatrists, in short, should be given a role to play outside the walls of the asylum.

While psychiatrists aspired to transform their discipline, Soviet citizens suffering from psychiatric disorders faced the disheartening reality of the postwar Soviet psychiatric system. Soldiers returning from the war sought services from psychiatric institutions that were only barely functioning. In some places buildings had been destroyed or taken over by government agencies. In those institutions that survived, treatment was complicated by lack of personnel, lack of medicines, lack of food, and by pervasive and often catastrophic overcrowding. Under



these circumstances, war invalids competed for resources with people suffering from schizophrenia, manic depression, epilepsy, syphilis, and neuroses. The result was frustration, complaints, and, ultimately, recognition on the part of public health administrators that psychiatry's core tasks were becoming impossible to carry out.

In this chapter I begin by discussing psychiatric services for war invalids, particularly neuropsychiatric dispensaries and Military Hospitals for Neuropsychiatric Disorders. I then examine psychiatrists' early postwar debates about how psychiatry should develop after the war. I show how some psychiatrists tried to reframe the discipline's jurisdiction in terms of mental health instead of insanity. "Mental hygiene," these psychiatrists hoped, could help all Soviet citizens overcome the experiences of the war. Finally I discuss Minzdrav USSR's institutional reorganization in 1949 and the fairly narrow set of tasks that were assigned to neuropsychiatric dispensaries and mental hygiene.

### **Psychiatric Invalids and Postwar Anxiety**

During the war, psychiatrists worried that soldiers with head injuries and psychological trauma would become long-term problems for Soviet society, and, even before the war ended, these fears were substantiated by reports that psychological disorders were on the rise among new patients at neuropsychiatric dispensaries. In 1943, neuropsychiatric dispensaries in Moscow reported, 55% of new patients had some type of traumatic brain disorder and 30% were suffering from "so-called neuroses and hysterical and neurotic reactions connected with psychological trauma at the front" [*t.n. nevrozy, istericheskie, nevroticheskie reaktsii, sviazannye s psikhogeniei na fronte*].<sup>2</sup> Psychiatrists were also worried that, later in life, people who had suffered head

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<sup>2</sup> In 1944 the Moscow city psychiatric organization used a system of categorization that they suggested should be adopted by all psychiatric dispensaries. According to this system, their patients fell into the following categories: Traumatic cerebrasthenia, 30%; Traumatic encephalopathy, 15%; Traumatic epilepsy, 10%; Psychopathic

injuries would develop psychological problems or easily break down under stress. Even after their physical wounds healed, Moscow psychiatry professor Mikhail Gurevich explained, soldiers who had suffered head trauma would be left with “long-lasting residual defects and, particularly important, a weakened [*astenizirovannuiu*] nervous system, which under unfavorable conditions provides the terrain [*pochva*] for various diseases (hysteria, neuroses, etc) to develop.”<sup>3</sup> In other cases brain injuries left the victim with a changed personality, a phenomenon that psychiatrists referred to as “posttraumatic psychopathization of personality” [*posttravmaticheskaia psikhopatizatsiia lichnosti*].” As one postwar psychiatric nursing textbook explained, a person affected in this way would be diagnosed with “psychopathy,” a broad term for people with “character disorders,” people with “peculiarities of mental formation [*psikhicheskii sklad*] ... which are difficult for themselves and those around them and which they experience as something unhealthy [*kak nechto boleznennoe*].”<sup>4</sup> Soldiers who developed these personality problems did not need treatment, as a hospital director noted in his 1949 report, “but,” he wrote, “at the same time they do not hold up [*uderzhivaiutsia*] under the general conditions of work, they change their place of residence, drifting [*perekochyvaia*] from town to town, so long as there is the possibility of using medical certificates and getting material help.”<sup>5</sup>

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Development of Personality as a result of brain trauma, 0; So-called neuroses, hysterical reactions, connected with psychogenic events at the front, 30%; Schizophrenia and other endogenic diseases, 15%. “Lechebno-proizvodstvennyi i metodicheskii plan psikhiatricheskoi seti g. Moskvy na 1944 g.,” undated [after 1 November 1943], TsAGM, f. 1126, op. 1, d. 38, l. 13ob.

<sup>3</sup> M. O. Gurevich, “K probleme khronikov i invalidnosti v psikhiiatrii,” in *Trudy psikhiatricheskoi kliniki im. S. S. Korsakova*, vol. 8, ed. M. O. Gurevich and A. O. Edel'shtein (Moscow: Izdanie 1-go MOLMI, 1945), 206-207.

<sup>4</sup> V. V. Mikheev and A. V. Neiman, *Uchebnik nervnykh i psikhicheskikh boleznei dlia srednikh meditsinskikh shkol*, 3rd ed. (Moscow: Medgiz, 1946), 151-153.

<sup>5</sup> “Godovoi otchet Kievskogo respublik. psikho-nevrologicheskogo gosptalia za 1949,” undated [1949], GARF, f. r-8009, op. 33, d. 167, l. 16.

Without professional help, in other words, these soviet citizens were liable to turn into socially disruptive vagrants.

Psychiatrists' apprehensions grew in 1944 as war invalids became visible fixtures in the streets and markets of Soviet cities, frequently blamed for robberies, hooliganism, and violent crime, and speculation.<sup>6</sup> "The markets of big cities are literally overflowing with war invalids," one man wrote in a 1944 letter to the government. He worried that welfare agencies were doing little to help these invalids, that few firms would hire them, and thus without help or employment they would be corrupted by speculation and trade. "With his own eyes" he had seen "an invalid of the Patriotic War, wearing his medal, and standing and selling cigarettes [*papirosy*] by the piece."<sup>7</sup>

Psychiatrists looked to the lessons learned in the aftermath of World War One and the Russian Civil War to interpret what they saw in the 1940s.<sup>8</sup> Most of the psychiatrists working in the USSR in the 1940s still remembered the 1920s. Senior psychiatrists had worked as physicians or psychiatrists during the First World War, and they had participated in the debates of the day over the nature of "traumatic neurosis." Younger psychiatrists who had begun their careers in the 1920s or 1930s had not experienced the war directly but had still spent time

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<sup>6</sup> Elena Zubkova, *Russia After the War: Hopes, Illusions, and Disappointments, 1945-1957*, trans. Hugh Ragsadle (Aronk, NY: M. E. Sharpe, 1998), 24; Mark Edele, "A 'Generation of Victors?' Soviet Second World War Veterans from Demobilization to Organization, 1941-1956" (PhD, University of Chicago, 2004), 387-390.

<sup>7</sup> Reznik proposed creating a "*Komitet po delam invalidov OV pri SNK SSSR*," and offered to send Mikoian a draft *polozhenie*. I. Firsov (Zam. Zav. Sekretariata NKZ SSSR) to A. N. Sukhov (NKSobes RSFSR) and G. A. Miterev (NKZ SSSR), "Perepiska s SNK SSSR po voprosu okazaniia pomoshchi invalidam OV," 8 August 1944, GARF, f. r-8009, op. 1, d. 502, ll. 165-166.

<sup>8</sup> See, for instance, Red Army head psychiatrist N. Timofeev's speech at the 25 December 1942 conference. I. I. Lukomskii, "Sessia Moskovskogo obschestva nevropatolgov i psikhiatrov," *Nevropatologiya i psikhiatriia* 12, no. 2 (1943): 79. See also Pavel Emdin's speech at the April 1944 conference held in Moscow. *NiP* 1944, no. 5, p. 74; and E. N. Kameneva's comments at a conference of Moscow's first psychiatric hospital in 1947, "Stenogramma konferentsii vrachei pri 1-oi Moskovskoi gorodskoi psikhiatricheskoi bol'nitsy," 1 February 1947, TsAGM, f. 1126, op. 1, d. 49, ll. 14-16.

treating the veterans who populated neuropsychiatric dispensaries and hospitals in the Soviet Union in the interwar period. Izrail Berger, the Head Psychiatrist for Moscow Oblast' during World War Two, was an example of a psychiatrist whose first experiences as a psychiatrist had been spent working with veterans of World War One. Born in 1895, Berger had served as a soldier during World War One and the Civil War, then went to medical school and became a psychiatrist.<sup>9</sup> He later recalled how as a clinician in Moscow in the 1920s and 1930s he had been constantly reminded of the effects that war had on the mind because his clinic was filled with patients suffering from the long-term consequences of head injury and wartime psychological traumas [*voennye psikhogenii*]. Now in charge of organizing psychiatric services in Moscow oblast', Berger concluded that if psychiatrists did not respond quickly, Soviet neuropsychiatric dispensaries would face a similar situation after World War Two.<sup>10</sup>

Berger was not alone in fearing an epidemic of “insurance neuroses” [*rentnye nevrozy*].<sup>11</sup> In 1945, for instance, the Head Psychiatrist for the City of Moscow, Ivan Strel'chuk, told a conference of the nation's leading psychiatrists that, “In Moscow right now there are about 5,500 war invalids.<sup>12</sup> We find that 44% of them are not doing anything [*nichem ne zanimaiutsia*]. They sell things at markets, they get drunk, etc. If we do not give serious attention to finding work for war invalids, we may find ourselves with very unpleasant consequences.” Strel'chuk suggested that the government should pass a law allowing socially dangerous people to be committed to

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<sup>9</sup> “Izrail' Abramovich Berger,” *Zhurnal nevropatologii i psikhatrii im. S.S. Korsakova* 62, no. 12 (1962): 1881-1882.

<sup>10</sup> Ibid.

<sup>11</sup> D. E. Melekhov, “Printsipy i formy organizatsii raboty po vosstanovleniiu trudosposobnosti invalidov otechestvennoi voiny s nevropsikhicheskimi zabolovaniiami,” in *Sovetskoe zdravookhranenie*, no. 3 (1946): 26.

<sup>12</sup> Strel'chuk's claim that there were only 5,500 war invalids in Moscow seems very low, considering that Zubkova estimates the number of war invalids in the country in 1945 to be 2 million. Zubkova, *Russia After the War*, 24.

psychiatric hospitals against their will.<sup>13</sup> Echoing Berger and Strelchuk, the Director of the First Moscow Psychiatric Hospital warned his staff to be on guard for people who wanted to take advantage of the psychiatric system. “Can insurance neuroses [*rentnye nevrozy*] happen here? They can. In our socialist country we should not have loafers [*progul'shikov*] – but there are individual cases. Are there criminals among those who fought four years at the front? Unfortunately, there are. They are not so many, but they do exist.”<sup>14</sup>

Part of psychiatrists' anxiety came from the fact that they did not know how many war invalids were actually suffering from psychiatric problems or where they might be. To solve this problem, the people in charge of organizing psychiatric services around Moscow proposed to set up a centralized registration system that would allow them to monitor and treat soldiers with postwar psychiatric difficulties. The basic idea was proposed by Izrail Berger at a 1942 conference. He wanted psychiatrists to fill out a standard card for every war invalid they treated and to send copies to a central location so they could be analyzed. The data collected could then be used to figure out trends and make decisions about what services might be needed.<sup>15</sup> Berger urged Narkomzdrav to create neuropsychiatric rehabilitation hospitals and neurological wards where soldiers could be given specialized treatment. He also suggested that the Social Insurance Ministry, Narkomsobes RSFSR, could create psychiatric nursing homes for war invalids.<sup>16</sup>

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<sup>13</sup> “Stenogramma soveshchaniia psikhiatrov pri Upravlenii gorbol'nits Narkomzdrava SSSR,” 30 November 1945, GARF, f. r-8009, op. 5, d. 249, l. 57-58.

<sup>14</sup> “Stenogramma konferentsii vrachei pri Ioi Moskovskoi gorodskoi psikhiatricheskoi bol'nitsy,” 1 February 1947, TsAGM, f. 1126, op. 1, d. 49, l. 27.

<sup>15</sup> I. A. Berger, “Ob organizatsii ucheta nevro-psikhicheskoi zaboлеваemosti i invalidnosti v voennoe vremia (tezisy)” (14 December 1942), GARF, f. a-482, op. 47, d. 648, l. 35.

<sup>16</sup> I. A. Berger, “Nevro-psikhiatricheskaia pomoshch' v evakogospitaliakh,” January 1942, cited in I. I. Lukomskii, “Rabota Moskovskogo obshchestva nevropatologov i psikhiatrov v period Velikoi otechestvennoi voiny,” *NiP* 11, no. 5 (1942): 65.

This call for a reliable system of registration was reiterated by Berger and others at conferences throughout the war,<sup>17</sup> and some steps were taken to put their recommendations into action. A formal version of Berger's plan was drafted in spring 1942 and by July the Moscow Social Insurance Department had agreed to create a prototype psychiatric nursing home.<sup>18</sup> In 1944 the Moscow city health department established a city-wide card registry to gather information about neuro-psychiatric war invalids and set up a research office to study those cards and make recommendations. The information they used was provided by Moscow's district psychiatrists, who were based at the city's 15 neuropsychiatric dispensaries.<sup>19</sup> In December 1944 Narkomzdrav RSFSR published an instruction making it mandatory for all psychiatric institutions in the RSFSR to register war invalids suffering from neuropsychiatric disorders. Health officials from the district and oblast' levels were to make quarterly reports to Narkomzdrav's psychiatry department.<sup>20</sup>

### **Neuropsychiatric Dispensaries After the War**

The notoriously bad records that Berger complained about mean that historians will probably never know with certainty how many former soldiers were treated for neuropsychiatric disorders after the war. Psychiatrists estimated that approximately 25% of all war invalids belonged to the "neuropsychiatric group," meaning that they suffered from brain injuries, spinal

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<sup>17</sup> See comments by D. E. Melekhov, V. A. Giliarovskii, and I. A. Berger, in P. B. Posvianskii and T. I. Gol'dovskaia, "Khronika: Vserossiiskaia konferentsiia po voprosam psikhatrii," *NiP* 13, no. 5 (1944): 70

<sup>18</sup> A. L. Barsuk and T. M. Bogomolova, "Kliniko-statisticheskii obzor raboty moskovskoi oblastnoi nevropsikhiatricheskoi bol'nitsy im. Iakovenko za dva goda otechestvennoi voiny," in *Voprosy sotsial'noi i klinicheskoi psikhonevrologii*, vol. 8, ed. E. K. Krasnushkin (Moscow: 1946), 220-229.

<sup>19</sup> I. A. Berger, V. A. Grombakh, and M. A. Dzhagarov, "O rabote Moskovskoi grodoskoi psikhaitricheskoi organizatsii," *NiP* 13, no. 6 (1944): 75.

<sup>20</sup> "Ob organizatsii ucheta invalidov OV s nevro-psikhicheskimi zabolevaniiami," *NiP* 14, no. 4 (1945): 77.

injuries, injuries to the peripheral nervous system, or psychological disorders.<sup>21</sup> Roughly one-third of the soldiers in the neuropsychiatric group were suffering from either psychological problems or brain injuries, or approximately 8-10% of all war invalids in the USSR.<sup>22</sup> By 1945, according to a report prepared for the Central Committee of the Party, there were approximately two million war invalids in the Soviet Union.<sup>23</sup> If approximately ten percent of these had psychiatric disorders, this would put the number of war invalids in need of psychiatric treatment at approximately 200,000. This figure, of course, would not have included the unknown but certain much larger number of soldiers who were suffering from brain injuries, nervous system disorders, or psychological trauma, but who were not officially classified as ‘invalids.’

For soldiers with psychological problems, doctors in neuropsychiatric dispensaries played crucial roles as gatekeepers. In order to gain access to disability benefits, they had to be classified as an ‘invalid,’ and this meant frequent recertification by expert commissions based at dispensaries. The dispensaries also controlled access to psychiatric hospitals, specialized sanitariums, and other services. For invalids, gaining access to these services proved to be very difficult. Some of the problems faced by invalids have become legendary: frequent recertification, labor boards that found them fit to work despite serious disability, a lack of

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<sup>21</sup> Brain wounds and psychological injuries were treated in neuro-psychiatric dispensaries. Injuries to the spine or peripheral nervous system were treated in policlinics. A. S. Vol'f and M. M. Anikin, “Sovremennye voprosy lechebnoi i sotsial'noi pomoshchi invalidam otechestvennoi voyny s travmaticheskimi porazheniiami nervnoi sistemy,” in *Mediko-sanitarnye posledstviia voyny i meropriiatiia po ikh likvidatsii: Trudy vtoroi konferentsii (17-19 dekabria 1946 g.)*, vol. 2., ed. N. A. Semashko, et al. (Moscow: Izd-vo AMN SSSR, 1948), 110.

<sup>22</sup> Vol'f and Anikin claimed that 1/3 of their 25% (8.3%) were suffering from brain injuries or psychological problems. This figure of 8.3% is relatively close to the estimate given by Dmitrii Melekhov, who claimed that approximately 10% of all war invalids were suffering from “neuro-psychiatric illness.” A. S. Vol'f and M. M. Anikin, “Sovremennye voprosy lechebnoi i sotsial'noi pomoshchi invalidam,” 110; Melekhov, “Printsipy i formy organizatsii raboty,” 26.

<sup>23</sup> Zubkova, *Russia After the War*, 24. See also, “Zapiska zaveduiushchego otdelom Upravleniia kadrov TsK VKP(b) B.D. Petrova G. M. Malenkovu ‘O neobkhodimosti perestroika dela lechebnoi pomoshchi invalidam Otechestvennoi voyny’ (25 apreliia 1945 g.),” in E. Iu. Zubkova, et al, eds., *Sovetskaia zhizn', 1945-1953, Dokumenty sovetskoï istorii* (Moscow: ROSSPEN, 2003), 308.

prosthetics. For neuropsychiatric invalids, however, the first problem was a lack of neuropsychiatric dispensaries. The war had dealt a devastating blow to the Soviet Union's system of outpatient psychiatric institutions, including neuropsychiatric dispensaries. By 1942 the number of neuropsychiatric dispensaries in the USSR had fallen by almost 50%, from 61 dispensaries in January 1941 to 34 dispensaries in January 1942. The dispensary system had returned to its pre-war number by 1944 but nearly half of these dispensaries were in Moscow and Leningrad, and even these were not functioning at their pre-war capacity. Many major cities in the RSFSR had no psychiatric dispensary, and there were virtually no dispensaries outside the RSFSR, even in Ukraine where dispensaries had been fairly numerous and well organized before the war.<sup>24</sup> (In Kiev, the psychoneurological hospital for war invalids maintained an outpatient office that filled the place of a dispensary.<sup>25</sup>) For neuropsychiatric invalids, then, the first hurdle was simply finding a psychiatrist who could examine them.

In 1944, 1946 and again in 1948, Narkomzdrav USSR issued orders calling for neuropsychiatric dispensaries to be opened (or reopened) in every oblast' and republic.<sup>26</sup> These orders, had a little effect, however, because they were not fully funded. Regional or district health departments were responsible for paying salaries for neuropsychiatric dispensaries, but Narkomzdrav USSR did not create a budget line-item for additional salaried positions. For regional governments to establish neuropsychiatric dispensaries, they would have had to have

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<sup>24</sup> Unsigned, "Material po proverke otdela psikhiatricheskoi pomoshchi MZ RSFSR," undated [1948], GARF, f. a-482, op. 47, d. 8454, l. 2.

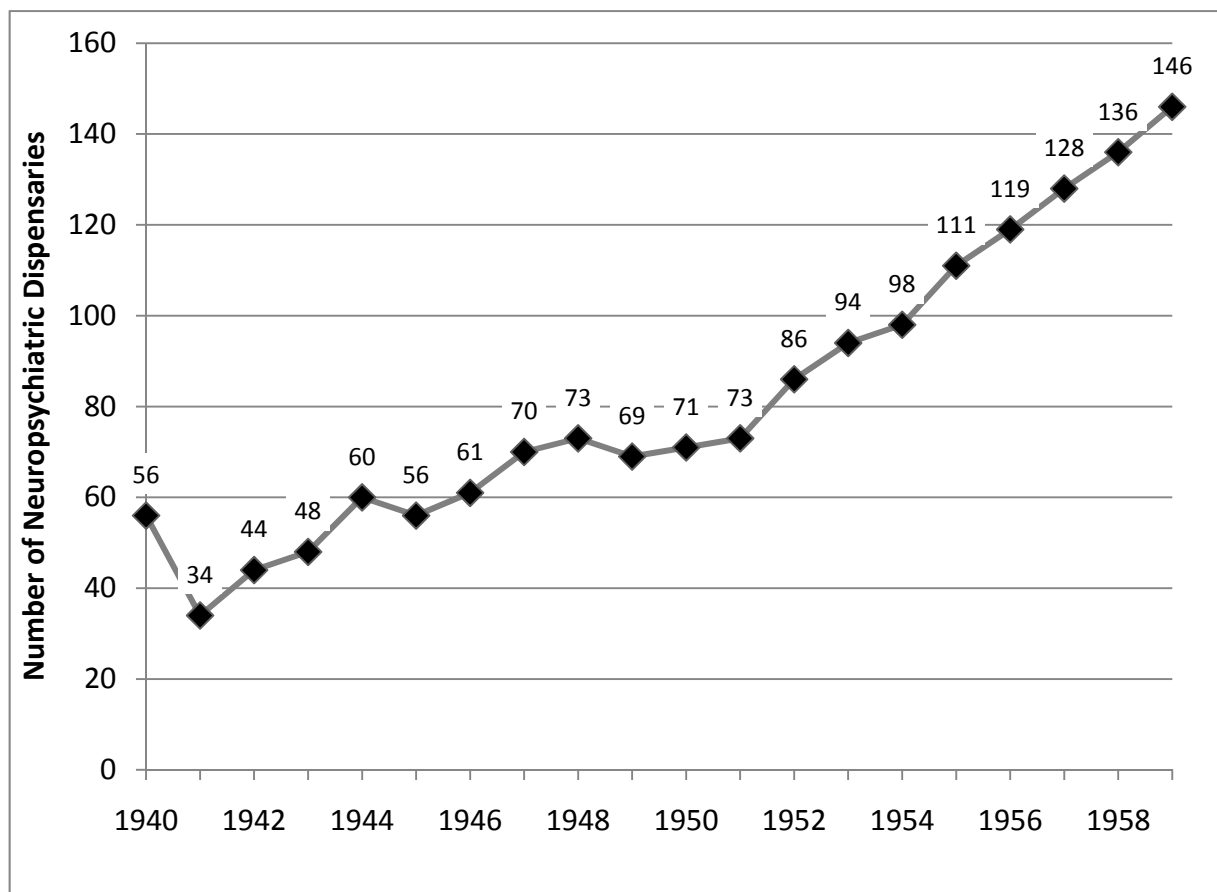
<sup>25</sup> "Godovoi otchet Kievskogo respublik. psikho-nevrologicheskogo gosptalia za 1949," undated [1949], GARF, f. r-8009, op. 33, d. 167, l. 4.

<sup>26</sup> Kolesnikov (Zam. NKZ SSSR), "Prikaz NKZ SSSR no. 220: Ob organizatsii psikhiatricheskoi pomoshchi," 13 April 1944, GARF, f. r-8009, op. 1, d. 477, ll. 267-268; G. A. Miterev (NKZ SSSR), "Prikaz MZ SSSR no. 226," 13 April 1946, GARF, f. r-8009, op. 1, d. 722, ll. 110-112; E. Smirnov (MZ SSSR), "Prikaz MZ SSSR no. 446: O meropriiatiakh po uluchsheniiu psikho-nevrologicheskoi pomoshchii," 19 July 1948, GARF, f. r-8009, op. 1, d. 725, ll. 20-21.



drawn funds away from other departments and projects, something few were willing to do.<sup>27</sup> As a result, in the 1940s the number of neuropsychiatric dispensaries in the USSR increased only marginally, from 56 in 1940 to 69 in 1949 (See Figure 3.1). In Ukraine in 1949, there were still no independent neuropsychiatric dispensaries,<sup>28</sup> and the same was true for most of the *oblasts* in the RSFSR.<sup>29</sup>

**Figure 3.1. Neuropsychiatric Dispensaries in the USSR, 1940-1959**



*Sources:* Data adapted from yearly Ministry of Health USSR reports to the Central Statistical Administration (TsSU). “Otchet MZ SSSR o seti, deiatel’nosti i kadrakh med. Uchrezhdenii po SSSR,” *RGAE*, f. 1562, op. 18, dd. 203 (1940), 245 (1941), 260 (1942), 270 (1943), 291 (1944), 318 (1945), 351

<sup>27</sup> G. G. Karanovich, cited in “Stenogramma zasedanii Kollegii MZ SSSR,” 11 February 1949, GARF, f. r-8009, op. 1, d. 757, l. 107.

<sup>28</sup> “Otchet o vypolneniia plana nauchno-issled rabot Odesskogo nauchno-issled psikhonevrologicheskogo instituta” (1949), GARF, f. r-8009, op. 33, d. 120, l. 15.

<sup>29</sup> “Renshenie zasedanii Kollegii MZ SSSR (proekt),” 11 February 1949, GARF, f. r-8009, op. 1, d. 757, l. 15.

(1946), 410 (1947), 442 (1948), 481 (1949), 545 (1950), 613 (1951), 686 (1952), 757 (1953); op. 27, dd. 48 (1954), 139 (1955), 259 (1956), 399 (1957), 532 (1958), 908 (1959).

The lack of dispensaries meant that soldiers and other people who had “borderline” psychiatric problems were unable to get help. It also meant that patients released from psychiatric hospitals could expect little government support. As one Narkomzdrav USSR inspector commented in 1945, the almost total absence of dispensaries “...particularly concerns the large contingent of borderline forms: patients with psychogenic and somatogenic reactions. This is a contingent of patients that requires particular types of medical-prophylactic measures and that needs broad dispensary service and rational labor-placement. These patients cannot be sent to psychiatric hospitals....”<sup>30</sup> Psychiatric hospital directors complained that without dispensaries their jobs became much more difficult, since patients who were in the early stages of remission had to be held in the hospital instead of being released to the oversight of a dispensary. As a result, psychiatric hospital beds were tied up much longer, and fewer people could be treated.<sup>31</sup>

### **Military Hospitals for Invalids of the Patriotic War**

In addition to neuropsychiatric dispensaries, soldiers could receive treatment in special military hospitals for war invalids [*gospitaly dlia invalidov Otechestvennoi voiny*], a system that included hospitals for soldiers with neurological and psychiatric injuries.<sup>32</sup> The hospitals for

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<sup>30</sup> The speaker was Z. A. Solov’eva, a psychiatrist who had worked at the Serbsky Institute since the 1920s, and who served as an inspector for Narkomzdrav SSSR in the 1940s. According to Solov’eva, there were 60 active dispensaries in the RSFSR in 1945, 15 of them in Moscow and 12 in Leningrad. Z. A. Solov’eva, cited in A. N. Motnenko (Chairman), “Stenogramma soveshchaniia psikhiatrov pri upravlenii gorbol’nits NKZ SSSR,” 30 November 1945, GARF, f. 8009-5-249, ll. 13-16.

<sup>31</sup> G. G. Karanovich, “Spravka,” undated [1948], GARF, f. a-482, op. 47, d. 8454, l. 37.

<sup>32</sup> The category hospital referred to as “*Gospital dlia invalidov Otechestvennoi voiny*” (Hospital for invalids of the Patriotic War) was one of 8 official categories of hospital in the Minzdrav USSR system. The others were: *uchastkovakai boln’litsa* (district hospital), *raionnaia bol’nitsa* (raion/local hospital), *gorodskaiia bol’nitsa* (urban hospital), *oblastnaia (kraevaia, respublikanskaia) bol’nitsa* (oblast’/krai/republic hospital), *psikhonevrologicheskaia bol’nitsa* (psychoneurological hospital), *tuberkuleznaia bol’nitsa* (tuberculosis hospital),

invalids with neuropsychiatric disorders were administered by Narkomzdrav USSR's Department of Medical Aid to Invalids of the Patriotic War [*Otdel meditsinskoi pomoshchi invalidam Otechestvennoi voiny*], and they primarily served soldiers who had suffered head injuries. In 1949, for instance, at the Psychoneurological Hospital for Invalids of the Great Patriotic War in Kiev,<sup>33</sup> 74.4% of soldiers had suffered either open or closed head injuries, while another 8.8% had suffered injuries to the spine or the peripheral nervous system.<sup>34</sup> As the Kiev hospital's report indicated, however, soldiers who had suffered head injuries were experiencing a wide range of neurological and psychiatric problems as well. Some of these problems were quite grave, including epileptic seizures and strokes. Many soldiers also experienced general changes to their character or their intelligence, and some experienced "hysterical fits," including "recurrence of previous episodes of surdomutism, astasia-abasia, and other disorders of a hysterical character." Still others experienced psychological problems like depression and paranoia [*psikhogennaia depressiia, psikhogennyi paranoid*].<sup>35</sup>

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and *infektsionnaia bol'nitsa* (hospital for contagious diseases). "Nomenklatura uchrezhdenii zdavookhraneniia (utverzhdno postanovleniem SM SSSR ot 31 okt. 1949 no. 5036)," 21 November 1949, GARF, f. r-8009, op. 1, d. 817, l. 48.

<sup>33</sup> The main building of the Kiev Psychoneurological Hospital for Invalids of the Great Patriotic War was a brick structure built in 1850, and was reportedly a dimly lit and poorly heated, and it was staffed by nine psychiatrists and six neuropathologists, plus a surgeon, radiologist, eye doctor [*okulist*], and general practitioner. In 1949, the hospital had 300 beds, down from a peak of 900 beds when it had served as an evacuation hospital during the last years of the war. Most of the beds (175) were "psychoneurological," while the rest were neurological (80), and "closed psychiatric" (35). That year in Ukraine there were 600 neuropsychiatric beds for war invalids, so this hospital represented half of Ukraine's psychiatric beds for war invalids. "Godovoi otchet Kievskogo respublik. psikho-nevrologicheskogo gospitalia za 1949," undated [1949], GARF, f. r-8009, op. 33, d. 167, ll. 1-7; "Prikaz MZ SSSR," 18 January 1949, GARF, f. r-8009, op. 1, d. 807, ll. 151-159.

<sup>34</sup> "Godovoi otchet Kievskogo respublik. psikho-nevrologicheskogo gospitalia za 1949," undated [1949], GARF, f. r-8009, op. 33, d. 167, l. 12.

<sup>35</sup> "Surdomutism" is the technical term used in English-language (and sometimes, Russian-language) medical literature to refer to deaf-mute syndrome. "Astasia-abasia" refers to strange, often grotesquely distorted ways of standing or ways of walking. "Godovoi otchet Kievskogo respublik. psikho-nevrologicheskogo gospitalia za 1949," undated [1949], GARF, f. r-8009, op. 33, d. 167, l. 15.

**Table 3.1. Total Number of War Invalid Hospitals (and Beds) and Neuropsychiatric Hospitals (and Beds) in the Narkomzrav/Minzdrav USSR System, 1944-1949**

Year	Total Number of Hospitals <sup>36</sup>	Total Number of Beds	Number of Psychoneurological Hospitals <sup>37</sup>	Number of Psychoneurological Beds
1944	373	90,350	n/a	3,000
1945	309	70,750	n/a n/a	
1946	n/a n/a	n/a		n/a
1947	n/a n/a	n/a		n/a
1948	n/a n/a		5	n/a
1949	165	34,500	4	1,050

*Sources:* Data adapted from “Spravka k otchetu GU gosptalei o vypolnenii post. SNK SSSR ot 29.VIII.1945, ‘Ob ulushchenii med. Obsluzhivaniia invalidov Otechestvennoi voiny” (undated [1946]), *GARF*, f. r-8009, op. 1, d. 555, l. 353; E. Smirnov (MZ SSSR), “Prikaz MZ SSSR no. 446: O meropriiatiakh po uluchsheniiu psikho-nevrologicheskoi pomoshchii” (19 July 1948), *GARF*, f. r-8009, op. 1, d. 725, ll. 20-21; E. Smirnov, “Prikaz MZ SSSR” (18 January 1949), *GARF*, f. r-8009, op. 1, d. 807, ll. 151-159.

By the late-1940s psychiatrists were reporting that the fewer soldiers suffering from head injuries were being treated in hospitals. One reason may have been improvement in their diets: during the famine in 1946-1947 a significant group of patients suffered “repeat shocks”; their mental health improved in 1947 as they became physically stronger.<sup>38</sup> By 1948, according to one report, in Leningrad 72.9% of soldiers with head injuries were no longer being treated in hospitals, they were being treated instead in neuropsychiatric dispensaries, and were attempting

<sup>36</sup> In 1949, war invalids were also given treatment in 12 research institutes (3,100 beds). “Prikaz MZ SSSR,” 18 January 1949, *GARF*, f. r-8009, op. 1, d. 807, l. 159.

<sup>37</sup> According to Minzdrav’s 1948 *prikaz*, they were to “retain [the following] hospitals for invalids of the Patriotic War with neuro-psychiatric disorders: Moscow, Kiev, Khar’kov, Mogilev, and Sverdlovsk. A January 1949 *prikaz*, however, no longer listed the Sverdlovsk hospital as psychoneurological. It should noted, however, that in 1949 there were also three hospitals for war invalids with neurological or spinal injuries (330 beds), and two that were specifically neurosurgical (400 beds). E. Smirnov (MZ SSSR), “Prikaz MZ SSSR no. 446: O meropriiatiakh po uluchsheniiu psikho-nevrologicheskoi pomoshchii,” 19 July 1948, *GARF*, f. r-8009, op. 1, d. 725, ll. 20-21; E. Smirnov, “Prikaz MZ SSSR,” 18 January 1949, *GARF*, f. r-8009, op. 1, d. 807, ll. 151-159.

<sup>38</sup> M. N. Bykhovskaia, “Stenogramma konferentsii vrachei 1-oi Moskovskoi gorodskoi psikhiatricheskoi bol’nitsy,” 9 March 1948, TsAGM, f. 1126, op. 1, d. 57, l. 9.

to return to work.<sup>39</sup> Moscow psychiatrists similarly reported that in 1948 “compensation has begun in the majority of invalids of the Patriotic War.”<sup>40</sup>

In addition to these apparent trends in health, there was an institutional factor that probably affected the number of ex-soldiers getting treatment instead in hospitals. In 1948, the government declared that postwar reconstruction had officially been achieved,<sup>41</sup> and the public health ministry began to reduce the number of hospitals that it maintained for invalids of the war (See Table 3.1). Archival holdings for the Department of Medical Aid to Invalids of the Patriotic War reflect this change in its activities; 62 files (*dela*) have been retained from 1948, 41 for both 1949 and 1950, 15 for 1951, and only 4 for 1952-1954, a result, according to the collection’s preface, of the “significant reduction” in the network of invalid hospitals during these years.<sup>42</sup>

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<sup>39</sup> M. N. Genkina, “Meditsinskaia i sotsial'no-proizvodstvennaia kharakteristika invalidov otechestvennoi voiny s neiropsikhicheskimi narusheniami (v Leningrade),” in *Organizatsionno-metodicheskie voprosy sovremennoi neiropsikhiatrii*, ed. E. S. Averbukh and V. N. Miasishchev (Leningrad: 1948), 51-52.

<sup>40</sup> These psychiatrists noted, however, that on 1948 they were seeing a “new wave” of war invalids coming into their hospital. These were soldiers who had suffered head injuries in the war and then developed serious drinking problems. In 1948 they were coming to the hospital with “late complications in the form of secondary alcoholism with dystonia in the vegetative sphere and vascular syndromes and worsening of their traumatic illness.” I. V. Strel'chuk (Gorodskoi psikhiatr), “Ob'iasnitel'naia zapiska po organizatsii nevro-psikhiatricheskoi meditsinskoi pomoshchi Mosgorzdravotdela za 1948 goda,” undated, TsAGM, f. 551, op. 1, d. 184, l. 29.

<sup>41</sup> Jeffrey W. Jones, “In my opinion this is all fraud!': Concrete, Culture, and Class in the 'Reconstruction' of Rostov-on-the-Don, 1943-1948” (PhD diss, University of North Carolina, 2000), 2, cited in Mark Edele, “A 'Generation of Victors'? Soviet Second World War Veterans from Demobilization to Organization, 1941-1956” (PhD diss., University of Chicago, 2004), 2.

<sup>42</sup> “Predislovie k opisi Glavnogo upravleniia lechebno-profilakticheskoi pomoshchi,” GARF, f-8009, op. 33, ll. 4-5. It should be noted that when this reduction in the number of invalid hospitals was going on in the late 1940s and early 1950s, at least three hospitals that had been devoted to military surgery were converted into special neurology and psychiatry hospitals. In 1948, a surgical hospital for war invalids in Gor'kii was re-profiled as the Gor'kii Neurological Hospital for Invalids of the Patriotic War. In January 1953, a surgical hospital for war invalids in Sverdlovsk was re-profiled as a psychoneurological hospital, and the same happened in Kalinin in 1954. “Godovoi otchet Gor'kovskogo nevrologicheskogo gospiatalia dlia Invalidov Otechestvennoi Voiny,” undated [1948], GARF, f. r-8009, op. 33, d. 95, ll. 1-2, 17ob; “Prikaz MZ RSFSR no. 34,” 14 January 1953, GARF, f. a-482, op. 49, d. 6603, l. 164; “Prikaz MZ RSFSR no. 316,” 15 June 1954, GARF, f. a-482, op. 49, d. 8346, l. 180.

### “My Head Requires a Long Treatment”

Captain Aleksandr Davydovich Suvorov was drafted into the Red Army in the summer of 1941 when he was already 40 years old. He served as a military engineer through the entire war, was wounded several times, and suffered repeated concussions. In 1945 Suvorov qualified for one of the early waves of demobilization and returned to his home in Moscow. There he was given an examination by a Medical-Labor Expertise Commission [*Vrachebno-trudovaia ekspertnaia komissii*, or VTEK], which diagnosed him with “traumatic vasopathy with diminished intellect in a psychopathic personality.” His doctors registered him at his district polyclinic as an invalid of the second group and also registered him at a neuropsychiatric dispensary where he was treated by a psychiatrist. As Suvorov put it, “My arms and legs are whole, but my head requires a long treatment.”<sup>43</sup>

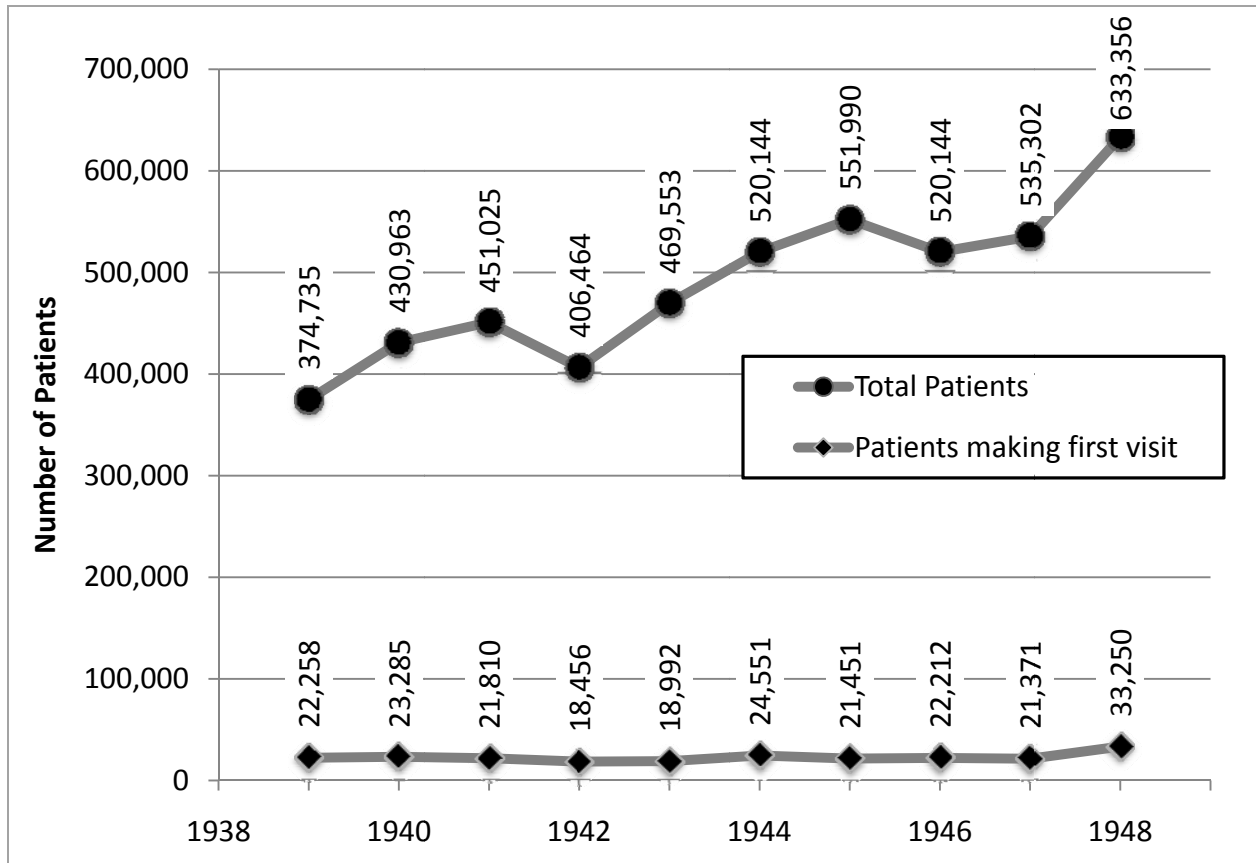
With seventeen neuropsychiatric dispensaries, the city of Moscow had the biggest and most well-equipped system in the USSR; in 1945-1948, the Moscow city dispensary system served an average of 567,700 people per year (See Figure 3.2). The city’s neuropsychiatric dispensaries employed 224 nurses and 143 psychiatrists, and together they were responsible for doing outpatient psychiatric treatment, and also for making visits to patients’ homes. The psychiatrists also served as experts, helping make determinations about draftees’ ability to serve in the military, giving expert testimony in civil and criminal lawsuits, and making determinations about degree of disability for labor certifications.<sup>44</sup> It was in this later capacity that they encountered Aleksandr Suvorov.

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<sup>43</sup> A. D. Suvorov to Supreme Soviet Deputy V. M. Molotov, 4 February 1950, GARF, f. r-8009, op. 1, d. 825, l. 88.

<sup>44</sup> I. V. Strel’chuk (Gorodskoi psikhiatr), “Ob’iasnitel’naia zapiska po organizatsii nevro-psikhiatricheskoi meditsinskoi pomoshchi Mosgorzdravotdela za 1948 goda,” undated, TsAGM, f. 551, op. 1, d. 184, ll. 33,40, 53-56.

**Figure 3.2. Patients Seen At Moscow’s 17 City Neuropsychiatric Dispensaries, 1939-1948**



Source: I. V. Strel'chuk (Gorodskoi psikhiatr), "Ob'iasnitel'naia zapiska po organizatsii nevropsikhiatricheskoi meditsinskoi pomoshchi Mosgorzdravotdela za 1948 goda," undated, TsAGM, f. 551, op. 1, d. 184, l. 31.

Suvorov was registered as a war invalid at the Kuibyshev district neuropsychiatric dispensary in Moscow in 1945. The dispensary, according to Suvorov, shared a building with a Military-Labor Expertise Commission [VTEK], and everyone waiting in line shared a common smoke-filled corridor. People sometimes waited for days to be seen. The patients registered at the dispensary were served by a single psychiatrist, Berta Gekhtman,<sup>45</sup> who also worked at the

<sup>45</sup> Judging from the bare outline of her biography, Berta Gekhtman appears to have been a very normal psychiatrist. Born in Moscow in 1897, Gekhtman was 48 years old in 1945, just three years older than Suvorov. She had graduated in 1921 from Moscow University (1 MGU) with a degree in medicine and had worked as a psychiatrist ever since. She was Jewish, did not belong to the Party, and was married. In 1940 she had been hired to work at the Kashchenko psychiatric hospital and she worked there throughout the war, for which she was awarded the medal, "For the Defense of Moscow." "Personal'nyi spisok spetsialistov-vrachei po sostoianiiu na 1 oktiabria 1949 goda po psikhiatricheskoi bol'nitse im. Kashchenko," RGANI, f. 6, op. 6, d. 1556, ll. 20-23ob.

Kashchenko psychiatric hospital and only received patients at the dispensary twice a week. These receptions lasted 3 hours and during that time, according to Suvorov, Gekhtman saw 30-40 people who had scheduled visits and, if time allowed, 20-30 patients who did not have appointments. Suvorov estimated that she gave 2 or 3 minutes to each of her patients.<sup>46</sup>

Every six months Suvorov had to be re-certified as an “invalid,” and the procedure for doing this was far from easy and they became more difficult when the procedure for re-certification was changed in the late 1940s. In the early post-war years Suvorov had been able to get re-certification simply by going to his local polyclinic, which then sent paperwork to the Medical-Labor Expertise Commission (*Vrachebno-trudovaia ekspertnaia komissiiia*, or VTEK). In the late 1940s, however, Suvorov had to go to both the polyclinic and the neuropsychiatric dispensary and he himself had to gather certification paperwork [*spravki*] from a long list of specialists and then bring it to the Medical-Labor Expertise Commission.

At the Medical-Labor Expertise Commission a psychiatric expert examined the paperwork and made a decision about the case. According to Suvorov, the psychiatrist who certified him, Professor Rodionov, had a reputation among invalids for being unjust, bureaucratic, and incompetent; among themselves they called him “bungler [*portach*].” Rather than judging their degree of disability on the merits, Suvorov alleged, Rodionov sought first and foremost to push ex-soldiers back into the workforce.

If you are in the second group, he gives you third; if you are third – then general [group; i.e., without invalidity]. In this way invalids “miraculously” recover according to Rodionov’s reports. Unfortunately, patients (seriously ill) leave such a dispensary and spit on invalid status. ... Invalids are enraged by this sort of treatment. ... Abuse of invalids [*izdevatel’stva nad invalidami*] has grown beyond any bounds of patience.”<sup>47</sup>

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<sup>46</sup> A. D. Suvorov to Supreme Soviet Deputy V. M. Molotov, 4 February 1950, GARF, f. r-8009, op. 1, d. 825, l. 89.

<sup>47</sup> *Ibid.*, 80a-80b [file uses idiosyncratic pagination].



But the worst of it, Suvorov wrote, was that he was only given certification as an invalid for six months, or even for three months at a time, even though the physicians certifying his status as an invalid knew that treatment would take much longer. In a petition, Suvorov asked he Soviet leader Viacheslav Molotov to simplify the process and to allow the certifications to be given for longer periods of time. The minimum, he suggested, should be one year, and the maximum should be up to 40 years, or even life. “Re-certifications are bothersome,” he concluded. “There is no one to complain to. You don’t know if you should work or get treatment. To work is hard, not to work isn’t an option, and not to get treatment isn’t an option either. We find ourselves in a quandary.”<sup>48</sup>

Many former soldiers decided not to seek help in neuropsychiatric dispensaries. In some cases, they seem to have decided to “spit on invalidity,” as Suvorov put it, because the process was too difficult and too bureaucratic. They had to make the choice between treatment and work and they chose the latter. In other cases, it is likely that soldiers avoided the neuropsychiatric dispensaries because of the stigma attached to a psychiatric diagnosis. One specialist admitted that he used the term “reactive neurosis” instead of “psychogenic neurosis” because he wanted to “avoid traumatizing the patient with the word ‘psych’ in findings that they might be given.”<sup>49</sup> Even psychiatric administrators admitted that the invalid certification system was working poorly and that psychiatrists sometimes failed to complete the necessary paper work in time to renew the patient’s invalid status.<sup>50</sup>

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<sup>48</sup> Ibid., 80b [file uses idiosyncratic pagination].

<sup>49</sup> V.K. Khoroshko, *Uchenie o nevrozakh* (Moscow: Medgiz, 1943), 37.

<sup>50</sup> V. Rybalka (Head Physician of the Gannushkin Psychiatric Hospital), “Prikaz no. 82,” 24 February 1953, TsAGM, f. 533, op. 1, d. 9, l. 35.

## **“The Social Side of Causation”: Renegotiating Mental Hygiene and the Role of Psychiatry in Postwar Soviet Society**

Arguments about postwar priorities broke out even before the war had ended. When rebuilding the psychiatric system, should psychiatrists actively go out into communities to find people who needed psychiatric help? Or should they narrow their focus to patients who were sent to them for treatment? Seen from a slightly different angle, the postwar looked like an opportunity for psychiatrists to renegotiate the jurisdiction of their discipline and to reengage with a broader group of the population. Could Soviet psychiatrists become recognized as specialists in the mental health of the whole population, rather than just doctors for the insane? Should they be?

Narkomzdrav RSFSR convened the first major conference of psychiatrists since before the war in April 1944<sup>51</sup> and this conference served as an important venue for psychiatrists to articulate ideas about how their discipline should be rebuilt after the war. The argument for restoring the status quo was made by Georgii Karanovich, the long-serving head of Narkomzdrav RSFSR’s psychiatry department and member of Narkomzdrav RSFSR’s collegium.<sup>52</sup> Karanovich argued that no fundamental changes to the Soviet psychiatric system were necessary because the existing system was working. He drew this conclusion from his analysis of psychiatric hospital admissions statistics. These statistics, he claimed, showed that the rate of mental illness in the population had not changed during the war. He pointed specifically to the experience of the

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<sup>51</sup> The conference was held in Moscow on April 4-8, 1944. It was reportedly attended by 371 people, representing 44 psychiatric hospitals, 6 military hospitals from 4 different fronts, 4 scientific research institutes, 9 neuropsychiatric dispensaries, and 33 medical school psychiatry departments or clinics. P. B. Posvianskii and T. I. Gol'dovskaia, “Khronika: Vserossiiskaia konferentsiia po voprosam psikhiiarii,” *NiP* 13, no. 5 (1944): 63.

<sup>52</sup> Karanovich served as the head of NKZ RSFSR’s psychiatry department from 1924-1950. He worked closely with Lev Rozenshtein in the 1920s and 1930s, and worked in Rozenshtein’s institute in the Department of Social Psychoneurology. For biographical information, see A. Tret’iakov (Ministr Zdrav. RSFSR) to G. M. Malenkov (TsK VKP/b/), recommendation that Karanovich be given title of “Zasluzhennyi vrach RSFSR,” undated [archived 5 January 1944], GARF, f. a-482, op. 47, d. 1916, ll. 1-2; “G. G. Karanovich,” *ZhNiP* 53, no. 11 (1953): 898.

Kashchenko Psychiatric Hospital, one of Moscow's largest. In 1940 the Kashchenko had admitted 17.6 people per 10,000 from the civilian population of Moscow. In 1943 the hospital saw nearly the same ratio of civilians: 17 per 10,000. In the same period, the ratio of men and women in this group also remained steady: 8.1 women per 10,000 civilians in 1940, and 8.3 per 10,000 in 1943. Patients also fell into the same diagnostic categories and in roughly the same proportion as they had before the war. Even more encouraging, major categories of disease continued to decline: "syphilis of the brain, progressive paralysis, alcoholic psychoses, drug addiction, psychogenic-reactive states" – all of them were continuing to become less and less prevalent. "The Great Patriotic War has not increased the number of mental illnesses," Karanovich concluded. "There is every reason to claim that the noted decline of neuropsychiatric disease in the years of peaceful construction continues in the years of war."<sup>53</sup>

Karanovich's data was drawn from a single psychiatric hospital and thus did not include information about outpatient clinics or information about the situation outside Moscow. His analysis also focused only on civilians, excluding soldiers who were, of course, suffering disproportionately from traumatic head injuries, spinal injuries, infections, and psychological trauma. Karanovich treated these people as a separate population, a group who had been subjected to a particular type of injury and who would need to be given special treatment for only a short time. He called for war invalids to be given housing rights, social aid, jobs, and medical treatment, and for all invalids to be registered with the Commissariat of Public Health and the Commissariat of Social Insurance. He noted that none of these steps had been taken yet, but that "life has already made its demands known." In his view, though, there was nothing in the

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<sup>53</sup> G. G. Karanovich, "Psikhiatricheskaia pomoshch' v usloviakh Velikoi otechestvenoi voiny i ee zadachi na blizhaishie gody," *NiP* 13, no. 5 (1944): 6.

situation that would warrant a re-orientation of the psychiatric system. Psychiatrists should continue to focus their attention primarily on the insane who came to neuropsychiatric dispensaries and psychiatric hospitals.<sup>54</sup>

It was Moscow oblast' psychiatrist Izrail Berger who stressed the need to organize proper registration of war invalids in the community. The point, he told the 1944 conference, was that health officials simply did not know what types of treatment were needed – basic data collection was needed before any final decisions were made.<sup>55</sup> In private, though, he questioned the value of Karanovich's analysis and cast serious doubt on the very possibility of generating usable information. Berger himself had hoped to analyze materials from hospitals around the USSR, but, he lamented to colleagues, "it turned out that such reports are few and they are done using various nomenclatures [of illness], and thus cannot be analyzed."<sup>56</sup> Before usable statistics could be created, Berger argued, Soviet psychiatrists would need to adopt uniform systems of classification and comparable methodology. Psychiatrists, Berger said, could not expect to accurately gauge the health of the population simply by studying the number of people who were checked into the large psychiatric hospitals in Moscow. In order to properly assess "the social

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<sup>54</sup> Ibid., 7.

<sup>55</sup> According to the published account, similar sentiments were expressed by other leading Moscow psychiatrists, including Dmitrii Melekhov, Tikhon Geier, Vasilii Giliarovskii, and Aleksandr Barsuk. P. B. Posvianskii and T. I. Gol'dovskaia, "Khronika: Vserossiiskaia konferentsiia po voprosam psikhii," *NiP* 13, no. 5 (1944): 70-71.

<sup>56</sup> A. N. Motnenko (chairman), "Stenogramma soveshchaniia psikhiatrov pri Upravlenii gorbol'nits Narkomzdrava SSSR," 30 November 1945, GARF, f. r-8009, op. 5, d. 249, ll. 47-48. Like Karanovich, I. A. Berger was an alumnus of Rozenstein's Institute of Neuropsychiatric Prophylaxis, where he worked from 1925-1930. He also taught social psychiatry at the Central Institute for Advanced Medical Study from 1932-1948, while simultaneously working as head psychiatrist for Moscow oblast' (1930-?) and deputy head psychiatrist for the city of Moscow (1943-1951). "Izrail' Abramovich Berger," *ZhNiP* 62, no. 12 (1962): 1881-1882.

side of causation,” they should carry out miniature censuses to find out the actual state of mental health.<sup>57</sup>

Berger’s warning about the poor quality of psychiatric statistics seems to have been well-founded. Throughout the war and postwar period, psychiatrists and their supervisors complained about the quality of record keeping, or lack thereof. For instance, in Moscow only two of the fifteen psychiatric dispensaries kept their district registration files up to date during the war, and afterward many struggled to search out “lost” patients.<sup>58</sup> In Leningrad, psychiatrists discovered that, unknown to them, large numbers of war invalids were registered with the city social insurance department. As a result, the number of war invalids registered at Leningrad psychoneurological dispensaries more than doubled in the second half of 1945.<sup>59</sup>

To find a solution to this problem, Berger suggested that psychiatrists should look to methods used by hygiene specialists, especially Nikolai Semashko, the former Commissar of Public Health and main proponent of social hygiene in the 1920s. In 1945 Semashko, now in his 70s, was again promoting social hygiene methods, and he and other social hygienists agreed that “nervousness” would be an important problem in the postwar, and that hygienists were “essentially not dealing with it.” He encouraged psychiatrists to take the problem on.<sup>60</sup>

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<sup>57</sup> A. N. Motnenko (chairman), “Stenogramma soveshchaniia psikhiatrov pri Upravlenii gorbol’nits Narkomzdrava SSSR,” 30 November 1945, GARF, f. r-8009, op. 5, d. 249, ll. 47-47ob.

<sup>58</sup> Gorodskoi psikhiatr Moskvyy, “Lechebno-proizvodstvennyi i metodicheskii plan psikhiatricheskoi seti g. Moskvyy na 1944 g.,” undated [soon after 1 November 1943], TsAGM, f. 1126, op. 1, d. 38, l. 11-13.

<sup>59</sup> E. S. Averbukh and V. N. Miasishchev, eds., *Organizatsionno-metodicheskie voprosy sovremennoi neiropsikhiatrii* (Leningrad: 1948), 49-50.

<sup>60</sup> V. A. Giliarovskii to I. G. Rufanov (Acting Chairman of the UMS NKZ SSSR), letter (December 23, 1945), GARF, f. r-8009, op. 2, d. 866, l. 37ob. In 1945 Aleksei Sysyn was director of the *kafedra* of Communal Hygiene at the Central Institute for Advanced Medical Studies in Moscow, and director of the newly formed AMN Institute of General and Communal Hygiene. *BME*, 2<sup>nd</sup> ed, s.v. “Sysin Aleksei Nikolaevich.” Semashko, the former Commissar of Public Health, was the long-standing head of the *kafedra* of Social Hygiene at 1 MMI. In 1945 he was also the director of the newly formed Institute of School Hygiene APN RSFSR and chairman of the All-Union Hygiene Society.

Semashko's approach impressed Berger. "Questions of social psychiatry," Berger said, "were studied by zemstvo psychiatrists as well as Soviet psychiatrists, [and] should not slip from our agenda..."<sup>61</sup> Psychiatrists should find the people in society who needed their help, not wait for people to come to them.

In the 1920s and 1930s, the social hygiene approach had been widely hailed as the future of medicine, including psychiatry. Soviet officials (especially then Commissar of Public Health Semashko) were taken with the idea of preventative medicine, a medical system that would not just heal the sick, but which would prevent illness from happening. Under Semashko's sponsorship, enthusiastic physicians experimented with an idea they called "dispensarization," which meant applying sociological research methods to problems of health. Armed with questionnaires, physicians attempted to survey local populations to establish the quality of health of individuals, but also to evaluate living and working conditions. By intervening in the organization of daily life and work, they argued, they would be able to bring about revolutionary changes in the quality of health.

A variation of this approach called "neuropsychiatric dispensarization" was promoted in the 1920s by an enthusiastic group of psychiatrists. In 1925 the leader of this group, a psychiatrist named Lev Rozenshtein, established the State Neuro-Psychiatric Dispensary, an institution that they hoped would become a model for social psychiatry in the Soviet Union.<sup>62</sup> Rozenshtein thought that psychiatrists should go out into the community and carefully evaluate

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<sup>61</sup> A. N. Motnenko (chairman), "Stenogramma soveshchaniia psikhiatrov pri Upravlenii gorbol'nits Narkomzdrava SSSR," 30 November 1945, GARF, f. r-8009, op. 5, d. 249, ll. 47-47ob.

<sup>62</sup> Tikhon Ivanovich Iudin, *Ocherki istorii otechestvennoi psikhiiatrii* (Moscow: Medgiz, 1951), 405; L. M. Rozenshtein, "O nevro-psikhiatricheskoi dispanserizatsii," in *Sovetskaia meditsina v bor'be za zdorovye nervy: Trudy I vsesoiuznogo soveshchaniia po psikhiiatrii i nevrologii i gosudarstvennogo nevro-psikhiatricheskogo dispansera*, ed. A. I. Miskinov, L. A. Prozorov and L. M. Rozenshtein (Samara: Izd. Ul'ianovskogo kombinata PPP, 1926), 20-37.

the mental, physical, and social health of each individual. Once they had analyzed the data, psychiatrists should then have broad authority to help “participate in changing the very conditions of and daily life [byt’] of the dispensarized population.”<sup>63</sup> His dispensary was renamed in 1928, becoming “The Institute of Neuropsychiatric Prophylaxis,” and soon after it was officially recognized as the “leading” psychiatric research institute in the USSR.<sup>64</sup> In the early 1930s the institute dominated Soviet psychiatry both intellectually and organizationally, as symbolically reflected by the fact that the discipline’s main journal was renamed *Sovetskaia nevroptologiya, psikhiairiia, i psikhogigiena* [Soviet Neuropathology, Psychiatry, and Mental Hygiene].

In the productionist milieu of the First Five Year Plan, however, authorities did not smile upon the mental hygienists’ claims that overwork was causing Party activists to develop nervous exhaustion. Such talk was considered tantamount to “wrecking,” and Rozenshtein and the Institute became the objects of intense criticism. In 1935 Izrail Berger himself had declared that mental hygiene was a failure: the notion that psychiatrists could or should work to improve people’s mental health had been overturned by “life itself,” and now psychiatrists realized that the most important factor in improving mental health was socialist construction and the policies of the Communist Party.<sup>65</sup> In 1936 the Communist Party placed an outright ban on closely related fields of applied psychology, pedology and psychotechnics, and shortly thereafter the Institute of Neuropsychiatric Prophylaxis was renamed “The RSFSR Central Institute of Psychiatry.”

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<sup>63</sup> Rozenshtein, “O nevro-psikhiatricheskoi dispanserizatsii,” 23-24.

<sup>64</sup> *BME*, 3<sup>rd</sup> ed., s.v. “Rozenshtein, Lev Markovich (1884-1934)”; *ZhNiP*, no. 1 (1931): 147; L. Rozenshtein and G. Karanovich to M. F. Vladimirkii (NKZ RSFSR), “O rekonstruktsii nevro-psikhiatricheskogo dela v RSFSR,” undated [1931], GARF, f. a-482, op. 24, d. 3, l. 304.

<sup>65</sup> From a paper given by Izrail’ Berger in 1935, as quoted in D. Shefer, “Mezhkraevaia konferentsiia nevroptologov i psikhiatrov v Rostove N/D,” *Nevropatologiya, psikhiairiia, psikhogigiena* 5, no. 6 (1936): 1060.

Though mental hygiene was not officially banned, it was obvious to all that it had fallen into disfavor: the words “mental hygiene” were removed from the masthead of the psychiatrists’ journal and neuropsychiatric dispensaries were given a new set of regulations that did not include “mental hygiene” among their official tasks.<sup>66</sup>

Since the 1920s, neuropsychiatric dispensaries had been central to Rozenshtein’s vision of mental hygiene and in the oppressive atmosphere of the last 1930s their continued role in the reformed psychiatric system fell into question. Some zealous *oblast’* officials interpreted the signals coming from Moscow as an indication that neuropsychiatric dispensaries were to be closed, and in some places this was actually done. In most places, however, the neuropsychiatric dispensaries that Rozenshtein had championed remained open, and after the Second World War virtually all public health administrators seemed to agree that neuropsychiatric dispensaries were important institutions. Indeed, neuropsychiatric dispensaries were frequently held up as *the* institutions that made the Soviet Union’s approach to psychiatry unique from European and American systems.<sup>67</sup> What was uncertain was the role that these dispensaries should play going forward. Some psychiatrists, like Berger, saw the postwar as an opportunity to expand the role played that neuropsychiatric dispensaries played in Soviet society, revitalizing the social functions originally envisioned by Rozenshtein and his mental hygiene movement. Others saw

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<sup>66</sup> The Kharkov mental hygiene institute was also closed in 1937. Tikhon Ivanovich Iudin, *Ocherki istorii otechestvennoi psikiatrii* (Moscow: Medgiz, 1951), 389. M. Kovrigina, “Polozhenie o psikhonevrologicheskom dispansere respublikanskogo, kraevogo, oblastnogo, gorodskogo i raionnogo podchineniia,” 14 December 1953, GARF, f. r-8009, op. 1, d. 1145, l. 55; “Polozhenie o nevro-psikh. dispansere,” 30 may 1941, GARF, f. r-8009, op. 5, d. 32, l. 56.

<sup>67</sup> See, for instance, “Spravka o sostoianii psikhonevrologicheskoi pomoshchi v SSSR za 1954 god,” GARF, f. r-8009, op. 33, d. 656, l. 12.



the postwar as an opportunity to turn them into outpatient clinics that worked more closely in tandem with psychiatric hospitals.

### **Mental Hygiene and Psychiatric Dispensarization after World War Two**

The rhetoric of Soviet health care always gave pride of place to prevention, and thus the decrees issued by Minzdrav always gave some nod to the need for effective “mental hygiene” [*psikhogigiena*]. Psychiatrists, however, did not agree on how mental hygiene should be implemented. Roughly speaking, they fell into two camps which corresponded to the two main organizational principles on which the Soviet health system had been built. The first approach called for a “universal” approach, in which neuropsychiatric dispensaries would be distributed more or less evenly throughout the country and would “dispensarize” the surrounding population, meaning that dispensary psychiatrists would go out into the community, actively search for signs of mental illness, and give advice to people on how to improve their mental health. This “universal” approach had developed as part of the social hygiene movement of the 1920s, and had been advocated most strongly by Lev Rozenshtein and the Institute of Neuropsychiatric Prophylaxis.

The second approach favored a “productionist” or “industrial” model and was particularly associated with changes in health care administration during the First Five-Year Plan. Its advocates acknowledged the desirability of universal access to neuropsychiatric dispensaries, but they argued against psychiatric dispensarization of the entire population.<sup>68</sup> Mental hygiene services, they argued, should be targeted at a few high risk groups and should be integrated with existing health care offices in the places where high risk people worked or studied. Neuropsychiatric dispensaries would help coordinate this mental hygiene work, but

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<sup>68</sup> See Burton, “Medical Welfare,” 31-38.

would primarily serve as outpatient clinics. The dispensary staff would treat patients who were referred to them by other physicians or by psychiatric hospitals and their social surveillance role would be limited to keeping track of people who were registered [*na uchete*] at their dispensary.

In the postwar years this “productionist” approach to mental hygiene was advocated by Aleksandr Shmar’ian and the psychiatrists at the RSFSR Central Institute of Psychiatry. This institute, of course, was the successor to Rozenshtein’s Institute of Neuropsychiatric Prophylaxis. When the institute had been renamed in 1938, its new Director and Deputy Director were explicitly told to reorient the institute, and the same two men, Pavel Posvianskii and Aleksandr Shmar’ian, were still in charge of the institute after the war. In the late 1940s these psychiatrists published a series of articles in which they championed a vision of mental hygiene that would be targeted at groups they deemed to be high risk: industrial workers, university students, and school children. Instead of doing mass “dispensarization” of local populations, as had been done by the Institute of Neuropsychiatric Prophylaxis in the 1920s, Shmar’ian and his colleagues proposed doing “selective dispensarization” [*vyborochanai dispanserizatsiia*].<sup>69</sup> They continued to attack Rozenshtein who, they claimed, had expanded the concept of dispensarization “not only beyond the boundaries of psychiatry, but even beyond medical competence.”<sup>70</sup> In the postwar, psychiatrists should be careful to apply the dispensarization method selectively:

“psychoprophylaxis can and should occupy a definite but strictly limited place in the

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<sup>69</sup> V. S. Gershenzon, “O rabote nevro-psikhiatricheskikh otdelenii medsanchnosti promyshlennykh predpriatii,” in *Trudy tsentral'nogo instituta psikiatrii*, ed. A. S. Shmar'ian and P. B. Posvianskii (Moscow: 1949), 471.

<sup>70</sup> T. I. Gol'dovskaia, “Zadachi psikhoprofilaktiki i psikhogigieny v poslevoennyi period,” in *Trudy tsentral'nogo instituta psikiatrii*, ed. A. S. Shmar'ian and P. B. Posvianskii (Moscow: 1949), 463. Gol'dovskaia did not explicitly say that Rozenshtein had adopted an anti-soviet approach to mental hygiene, but her discussion of the mental hygiene movement in western countries invited this conclusion. She described Western psychiatrists as having notions of using mental hygiene to accomplish “social-reform (pan-mental hygiene expansion), which strongly reeks of an imperialist scent” [...(*panpsikhogigienicheskaia ekspansiia*), kotorye sil'no popakhivaiut imperialisticheskim dushkom.]

multifaceted complex of sanitary and medical-preventative healthification measures.”<sup>71</sup> The goals of postwar mental hygiene should be “on one hand, increasing productivity of labor by strengthening neuro-psychic health and, on the other hand, strengthening neuro-psychic health in connection with correct choice of labor activity.” Psychiatrists should focus on groups at high risk for psychiatric difficulties: school children, university students, and workers in particularly dangerous industries (certain factories, transportation workers, and the air force). Mental hygiene services for these institutions would not be provided by dispensaries, they would be provided by psychiatrists working in the institutions’ own medical stations and policlinics.<sup>72</sup>

As an approach to mental hygiene, the “industrial principle” had the advantage of being more feasible than the calls for universal mental health services. Even so the universalist approach had significant support among psychiatrists, and early in the postwar it seemed as if it also had the support of the Minzdrav USSR. In 1945 and 1946, officials at Minzdrav USSR expressed concern that war invalids were not getting the attention they needed, and they worried particularly about the long-term consequences of wartime injuries. To improve the situation, Minzdrav USSR issued a *prikaz* that included significant changes to the role of neuropsychiatric dispensaries. In addition to medical aid, the dispensaries were now to give patients “the broadest dispensary services, social aid, and rational job placement.” Furthermore, the neuropsychiatric dispensaries were to take on a larger role in their community, “to study the condition of neuropsychiatric illness in your region and guarantee dispensary methods to serve the mentally

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<sup>71</sup> Gershenzon, “O rabote nevro-psikhiatricheskikh otdelenii...,” 469.

<sup>72</sup> Gol'dovskaia, “Zadachi i metody psikhoprofilakticheskoi raboty,” 4. As an example of the value of this type of work, the institute published the results of a two-year long study of the effects of mental hygiene on tram workers. In 1946-1947, the psychiatrists worked out of a medical sanitary unit [*medsanchast'*] that served 18 transport companies. They identified a group of drivers who had suffered electrical trauma, and put them under intense medical observation (dispensarization). Gershenzon, “O rabote nevro-psikhiatricheskikh otdelenii...,” 469-472.

ill. ... Systematically undertake sanitary-enlightenment work among the population to prevent neuropsychiatric illness.” This was a model of local social-medical surveillance that sounded strikingly similar to *dispensarization* as envisioned by social psychiatry advocates of the 1920s.<sup>73</sup>

### **Mental Hygiene and V. A. Giliarovskii’s Theory of “Nervous Demobilization”**

The most prominent proponent of the “universalist” approach to mental hygiene was Vasili Giliarovskii, the director of the newly created Academy of Medical Sciences Institute of Psychiatry. Giliarovskii thought that psychiatric problems would be widespread in the postwar Soviet population and he advocated giving psychiatrists a major role in finding and preventing them. It was, he argued, a matter of state importance.

In 1944 and 1945 Giliarovskii wrote with increasing urgency about a condition he called “nervous demobilization.” Giliarovskii feared that all was not well with Soviet citizens, even those who had fought steadfastly and heroically during the war without suffering mental or physical breakdown. During the war, Giliarovskii claimed, these people had felt a sense of overriding purpose, and this had given them the will “to mobilize their internal resources” and keep themselves going despite the constant physical and mental strain of the war. Since the war was over and the Soviet Union was safe, these people no longer felt the need to keep going, “to mobilize the activeness of his mental and physical forces [*psikhicheskikh i fizicheskikh sil*].” As a result they experienced Giliarovskii called “a peculiar sort of nervous demobilization.”<sup>74</sup> “Our concept of the nervous demobilization syndrome,” Giliarovskii wrote in 1946, “is of serious cases of nervousness [*tiazhelykh kartin nervnosti*] that do not appear immediately under the

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<sup>73</sup> G. A. Miterev (USSR Minister of Health), “Prikaz MZ SSSR No. 226,” 13 April 1946, GARF, f. r-8009, op. 1, d. 722, ll. 109-113.

<sup>74</sup> V. A. Giliarovskii, “O vzaimootnosheniakh somaticheskogo i psikhicheskogo v meditsine,” *Vrachebnoe delo* 27, no. 8 (August 1947): 627.

influence of moments that traumatize the psyche [*travmatiziruiushchikh psikhiku momentov*], but later, when the situation has changed for the better and does not require the former strain...”<sup>75</sup>

Not only did people fall ill because they “demobilized” their wartime willpower, they also fell ill because the war had changed the way that their bodies’ reacted to stress: they had acquired a predisposition to neurosis and mental illness. As Giliarovskii wrote,

...Living through four years of war under conditions of great strain [*napriazheniia*], psychic traumatization [*psikhicheskoi travmatizatsii*], [and] a diet that was insufficient in both quantitative and qualitative terms, has noticeably weakened the health of the masses, reduced the resistance to harmful external factors. The sensitivity to all sorts of hazards has increased, and, as a result of this changed reactivity, incidents now become disease-causing which in the past would not have had any harmful effect.<sup>76</sup>

The average soviet citizen might look healthy enough, all things considered, but for many of them it was just a matter of time before they broke down: their bodies and their nervous systems had been seriously compromised. The traces of war-time trauma could lay dormant for years, until they were “activated” by some new set of conditions, causing the unsuspecting soviet citizen to fall seriously ill.<sup>77</sup>

Giliarovskii’s portrayal of postwar nervousness suggested a population that might not be capable of mobilizing to rebuild Soviet industry, much less to fight another war. And Giliarovskii was not alone: other leading psychiatrists sounded a similar alarm. Vladimir Miasishchev, the director of the Bekhterev Institute in Leningrad, compared psychoses and nervousness to cancer and the flu. Cancer was dramatic, terrible, and frightening, but the flu actually caused much greater economic damage to the state. The same, Miasishchev suggested,

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<sup>75</sup> V. A. Giliarovskii, “Voprosy teorii i praktiki nevro-psikhiatricheskoi pomoshchi v poslevoennoe vremia,” *Sovetskaia meditsina*, no. 7 (1946): 1.

<sup>76</sup> V. A. Giliarovskii to I. G. Rufanov, chairman of the UMS NKZ SSSR, 23 December 1945, GARF, f. r-8009, op. 2, d. 866, l. 36.

<sup>77</sup> “Otchet o vypolnenii plana nauchno-issled. raboty za 1945 god po institut psikhiatrii,” undated, GARF, f. r-9120, op. 2, d. 94, ll. 14ob-15ob.

could be said of psychoses and neuroses. Psychoses were dramatic and frightening, but neuroses were much more pervasive and economically damaging to the state. “Weakening and depletion of the nervous system, so-called ‘nervousness,’” Miasishchev wrote, “can make itself known in everyday life and at work... , [and] while not putting a person into the category of ‘patient,’ qualitatively and quantitatively decreases the productivity of labor and requires neuro-prophylactic measures...” Socialism was the best possible system for promoting mental health, but this did not mean the government could rest easy and simply expect the “positive influence of healthy conditions” to do the job for them. In order to best serve the government, psychiatrists should be allowed to engage in broad social psychiatric measures to assess neurological and psychological health and to take measures to undo the effects of the war.<sup>78</sup>

To support their revival of mental hygiene, Miasishchev, Giliarovskii, and other psychiatrists drew political justification from a 1944 Communist Party decree, “On the Organization of Scientific-Enlightenment Propaganda.” The text of the decree made clear that the Party wanted scientists to give popular lectures on natural science to combat the growing popularity of the Orthodox Church.<sup>79</sup> The psychiatrists, however, interpreted the decree to mean that they should actively spread “mental hygiene propaganda,” and, to this end, the All-Union Society of Neuropathologists and Psychiatrists published a series of popular brochures with titles like, “Nervousness and the Fight against It,” “How to Prevent Childhood Nervousness,” and

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<sup>78</sup> V. N. Miasishchev, “Ob organizatsii meditsinskoi pomoshchi pri nevrozakh i pograniichnykh formakh,” in *Organizatsionno-metodicheskie voprosy sovremennoi neiropsikhiatrii*, ed. E. S. Averbukh and V. N. Miasishchev (Leningrad: 1948), 143-144.

<sup>79</sup> “Postanovlenie TsK VKP(b) ob organizatsii nauchno-prosvetitel’noi propagandy,” 27 September 1944, in *Kommunisticheskaia partiia Sovetskogo Soiuz v rezoliutsiakh i resheniakh, s’ezdov, konferentsii i plenumov TsK. Vol. 6: 1941-1954*, (Moscow: Politizdat, 1971), 121-123.

“Memory and How to Improve It.”<sup>80</sup> Lecturers in Leningrad gave talks on similar themes, always stressing how labor “improves the health of the nervous system when it is organized correctly and systematically, in combination with socialist goals.”<sup>81</sup> Giliarovskii published an article in the popular daily *Ogonyok* about how workers could best organize their daily lives to promote mental health.<sup>82</sup>

But Giliarovskii’s goals were more ambitious than simply spreading information about healthy living. If the government was truly serious about “creating optimal conditions for life and work,” he argued, then it would have to tackle factors that were “damaging neuro-psychic health,” and this would mean giving an institutional base to psychiatrists so that they could research and promote mental health.<sup>83</sup> Giliarovskii was blunter still in his 1945 year-end report to the Academy of Medical Sciences: “Mental hygiene should be restored to its rights, but in changed form” he wrote.<sup>84</sup> In the lexicon of Soviet psychiatry this was a clear reference to the 1936 Central Committee decree that had banned pedology and psychotechnics and which had helped cast mental hygiene into disrepute. That decree had banned pedology under the slogan of “restoring pedagogy to its rights” [*vosstanovleniia pedagogiki v svoikh pravakh*].<sup>85</sup> Giliarovskii

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<sup>80</sup> V. A. Giliarovskii and A. O. Edel'shtein, eds., *Vsesiuznoe obshchestvo nevropatologov i psikiatrov: Otchet o deiatel'nosti za 1937-1947 g.g.* (Moscow: Medgiz, 1948). Copy consulted found in GARF, f. r-9592, op. 1, d. 30, l. 4ob.

<sup>81</sup> V. N. Miasishchev, “O nekotorykh aktual'nykh zadachakh issledovatel'skikh meditsinskikh institutov v oblasti organizatsionno-metodicheskogo rukovodstva,” in *Organizatsionno-metodicheskie voprosy sovremennoi neiropsikhiatrii*, ed. E. S. Averbukh and V. N. Miasishchev (Leningrad: 1948), 5-11.

<sup>82</sup> V. A. Giliarovskii, “Rezhim zdorov'ia i truda,” *Ogonek*, no. 33 (1946): 38-39.

<sup>83</sup> V. A. Giliarovskii to I. G. Rufanov (Acting Chairman of the UMS NKZ SSSR), 23 December 1945, GARF, f. r-8009, op. 2, d. 866, l. 36. Giliarovskii was not alone in wishing that psychiatrists had a “central base” that would put institutional resources behind mental hygiene. Akim Edel'shtein described the lack of a central base as one of their major problems, and explicitly lamented the loss of the Institute of Neuro-Psychiatric Prophylaxis. A. O. Edel'shtein, “Sovetskaia psikhogigiena na sovremennom etape,” *NiP* 16, no. 2 (1947): 9-13.

<sup>84</sup> “Otchet o vypolnenii plana nauchno-issled. raboty za 1945 god po institut psikiatrii,” GARF, f. r-9120, op. 2, d. 94, l. 15ob.

<sup>85</sup> Nikolai Kurek, *Istoriia likvidatsii pedologii i psikhotekhniki* (St. Petersburg: Aleteiia, 2004), 12.

had been closely associated with social psychiatry in the 1930s, and at conferences and meetings in the late 1930s he had sometimes been a lone voice calling for a reconsideration of mental hygiene.<sup>86</sup> His 1945 call for mental hygiene to be “restored to its rights” suggests that he saw the postwar as a time when the status quo established in the 1930s might be renegotiated, and when the ambitious social psychiatry projects of the 1920s might be reestablished, though, as he was quick to add, only “in changed form.”

In its new form, Giliarovskii assured his superiors, mental hygiene would be more humble, more limited in its goals, and more grounded in dialectical materialism and official ideology. Where mental hygiene had gone wrong in the 1920s, according to Giliarovskii, was in trying to bring psychotherapy to the masses and in assuming that analyzing and treating their psyches would result in healthier, happier workers. The war had taught psychiatrists better:

To a certain degree, we are talking about a return to the former mental hygiene, but this should be a different discipline with a particular content. The mental hygiene of the past was mistaken in that it thought of the psyche apart from the body as a whole. Furthermore, its approach to man as an object in need of psychiatric analysis was also incorrect. The psychiatrist working in the capacity of a mental hygienist does the greatest good if he stands behind the back of the general practitioner or the workers who are directly responsible for the conditions of life and work of the laborer. Unseen by the laborer, a friendly hand will remove obstacles in his path, worry about his living conditions, his working conditions, about his tranquility and good mood.<sup>87</sup>

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<sup>86</sup> Moscow psychiatrists met on May 25, 1937 to discuss the Third 5-Year Plan. Giliarovskii suggested three topics: fighting infections of the nervous system; fighting “traumatism and psychotraumatism; and “problems of psychoprophylactics and mental hygiene.” Note that he also proposed studying “*posttravmaticheskie izmeneniia i rol' vegetativnoi nervnoi sistemy*,” suggesting that his wartime ideas about the VNS and hysteria had been incubating for some time. “V Moskovskom obshchestve nevropatologov i psikhiatrov,” *NiP* 7, no. 3 (1938): 150.

<sup>87</sup> V. A. Giliarovskii, “Voprosy teorii i praktiki nevro-psikhiatricheskoi pomoshchi v poslevoennoe vremia,” *Sovetskaia meditsina*, no. 7 (1946): 4. This article was translated into English and published in *The American Journal of Psychiatry*. Interestingly, the only substantive change made to the translated version was the elimination of this final paragraph in which Giliarovskii discussed his vision of a new type of social psychiatry for the USSR. V. A. Gilyarovski, “Soviet Psychiatry in the Post War Period,” *American Journal of Psychiatry* 104 (Nov. 1947): 293-297.



In Giliarovskii's ideal world, workers would have no idea that they were the object of psychiatric intervention. His vision for the postwar was one of a well-regulated society where experts were always there in the background. Psychiatrists, using their knowledge of the mind, would help rebuild Soviet society as a harmonious, mentally healthy whole.

Giliarovskii's gambled that the time was right to renegotiate the jurisdiction of psychiatry in Soviet society, and his gambled proved to be well-founded. In January 1946, Minzdrav USSR's Scientific Medical Council declared his idea for a mental hygiene commission to be "timely and prudent" [*svoevremennaia i tselesoobraznaia*].<sup>88</sup> They asked Giliarovskii to draw up a plan and assemble a staff, and by summer 1946 the commission was up and running.<sup>89</sup> From 1946-1949, the twelve-member commission sought to "guarantee the inculcation of the principles of mental hygiene into all areas of life, both in the work of the healthy person and in work of a properly medical character."<sup>90</sup> Most of the people who were brought in to work on the commission were researchers from Giliarovskii's institute, and several of them had been involved with mental hygiene in the 1920s and 1930s. Indeed, one of them, psychiatry professor Leon Rokhlin, had

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<sup>88</sup> "Protokol #1 zasedaniia prezidiuma UMS NKZ SSSR," 3 January 1946, GARF, f. r-8009, op. 2, d. 866, ll. 1-3.

<sup>89</sup> "Otchet UMS MZ SSSR o rabote za 1946 god," undated, GARF, f. r-8009, op. 2, d. 1018, l. 54. The final structure and membership of the commission were agreed upon in June 1946. "Protokol no. 14 zasedaniia Prezidiuma UMS MZ SSSR," 27 June 1946, GARF, f. r-8009, op. 2, d. 878, l. 48. Most of the members of the commission were drawn from the senior staff at Giliarovskii's institute or the university department that he directed. Members included A. I. Sysin (hygiene), and psychiatrists I. A. Berger, T. P. Simson, E. A. Osiopova, L. L. Rokhlin, M. A. Lebedinskii, G. Kh. Kekcheev, M. O. Gertsberg, O. R. Rebel'skii, I. V. Strel'chuk, M. M. Model'. V. A. Giliarovskii to I. G. Rufanov (chairman of the UMS NKZ SSSR), 23 December 1945, GARF, f. r-8009, op. 2, d. 866, ll. 37ob-38; "Protokol no. 14 zasedaniia Prezidiuma UMS MZ SSSR," 27 June 1946, GARF, f. r-8009, op. 2, d. 878, l. 48.

<sup>90</sup> V. A. Giliarovskii to I. G. Rufanov (Acting Chairman UMS MZ SSSR), 23 December 1945, GARF, f. r-8009, op. 2, d. 866, l. 37ob.

been particularly singled out for criticism in 1931 because of his studies of mental illness among Party activists.<sup>91</sup> He returned to Moscow in 1945 at Giliarovskii's invitation.<sup>92</sup>

Giliarovskii's mental hygiene commission undertook several substantive projects during the three years that it operated. These projects sought to show that "nervousness" was a genuine problem and that trained professionals should actively work to monitor people's health conditions and intervene to improve mental health. To demonstrate the importance and usefulness of dispensarization, Giliarovskii and several of his staff members undertook a two-year study of a group of 1,800 students at the Institute of Foreign Languages. During the war many of the students had suffered from "lack of food, psychological decompensation, and alimentary dystrophy [*nedoedanie, psikhicheskaiia dekompensatsiia, i...alimentarnaia distrofiia*]. Many of them were tired most of the time. When the students were examined by a psychiatrist and an internal medicine specialist they were found to be suffering from cardiovascular problems, neuropsychic reactions, and a wide range of other complaints, from endocrine disorders and rheumatism to tuberculosis. The most common neuropsychiatric condition, according to the researchers, was "asthenic syndrome" - nervous exhaustion. "In most cases,"

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<sup>91</sup> See, for instance, L. L. Rokhlin, "Psikhogigienicheskaia rabota sredi partaktiv," *Zhurnal nevropatologii i psikhiatrii*, no. 3 (1931): 24-30; and idem, *Trud, byt i zdorov'e partiinogo aktiva*, Trudy Ukrainского psikhonevrologicheskogo instituta, vol. 17 (Dvou: Izd. "Proletar", 1931). For criticism of Rokhlin, see "Resheniia XVII partiinoi konferentsii i zadachi zhurnala (K planu raboty na 1932 god)," *Sovetskaia nevropatologiia, psikhiatriia i psikhogigiena* 1, no. 1-2 (1932): 1-9.

<sup>92</sup> V. V. Kovanov (Zav. Sektorom Administrativnovo atdela TsK VKP(b)) and Larionov (otvet. Kontroler KPK pri TsK VKP(b)) to G. M. Malenkov (Sek. TsK VKP(b)), January 1950, *Rossiiskii gosudarstvennyi arkhiv noveishei istorii* (Russian State Archive of Modern History, hereafter RGANI), f. 6, op. 6, d. 1556, l. 5. Before the war Rokhlin had worked in Ukraine, where from 1934-1939 he was in charge of the Ukrainian Psychoneurological Institute in Kharkov. Rokhlin spent the war in evacuation in Uzbekistan's Fergana valley with Moscow's Fourth Medical Institute. He opened the area's first psychiatric clinic and organized psychiatry courses for students from 4 MMI. F. F. Detengof, "Psikhiatriia v Uzbekistane vo vremia voiny [Khronika]," *NiP*, no. 4 (1945): 72; "Leon Lazarevich Rokhlin," *ZhNiP* 84, no. 12 (1984): 1878.

they concluded, "... these disorders are functional, reversible. The number of these disorders decreased as a result of improved living conditions, rest, and treatment."<sup>93</sup>

In 1946, after a year of medical treatment and frequent check-ups, the students were examined again. This time the physicians found far fewer cardiovascular problems, and also "fewer diseases of the stomach, liver, kidneys, and endocrine system." (The exception was tuberculosis, which remained stubbornly unchanged.) The physicians concluded that states of physical and psychological exhaustion were primarily responsible for much of the illness, particularly the cardiovascular problems, and happily credited the improvements to the benefits of mental hygiene.<sup>94</sup> Giliarovskii touted these findings as part of his effort to convince Minzdrav to support mental hygiene. He claimed that the research done on university students showed that his theory of wartime "nervous exhaustion" was correct, and that it was proof that "preventative and mental hygiene work" was crucial to help reverse the damage. As he told Minzdrav, "These were not psychoses, these were mild deviations [*legkie otkloneniia*], but it is very important that in these light deviations the asthenia syndrome had great significance. And it is very important that our young people continued to work under difficult conditions, giving minor reactions; and it is important that the 1946 figures ... indicate a decline, and decline in all indicators. This

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<sup>93</sup> "Godovoi otchet instituta psikiatrii AMN za 1946 god," undated [1946], GARF, f. r-9120, op. 2, d. 250, l. 21. See also V. A. Giliarovskii and B. G. Arkhangel'skii, "Zadachi psikhogigienicheskoi raboty v poslevoennoe vremia," in *Mediko-sanitarnye posledstviia voiny i meropriiatiia po ikh likvidatsii. Trudy vtoroi konferentsii (17-19 dekabria 1946 g.)*, vol. 2, ed. N. A. Semashko (Moscow: 1948), 58.

<sup>94</sup> An abstract of the results of this project were included in the Institute of Psychiatry's year-end report for 1946. The author, M. V. Solov'eva, concluded that, "The fact that neuro-psychic disorders [*nervno-psikhicheskie narusheniia*] occupy one of the first places among the wartime illnesses of students indicates the need for mental hygiene work among higher education students. This work should be done in conjunction with physicians from other specialties and [physicians from] VUZ medical offices." "Godovoi otchet instituta psikiatrii AMN za 1946 god," undated [1946], GARF, f. r-9120, op. 2, d. 250, ll. 21-22. See also Giliarovskii and Arkhangel'skii, "Zadachi psikhogigienicheskoi raboty," 59.

improvement points to the reversibility of all nervous phenomena, all somatic phenomena, and the importance of preventative and mental hygiene work.”<sup>95</sup>

Giliarovskii and his colleagues laid out an ambitious agenda for the Mental Hygiene Committee, aiming to apply similar to the ones they had used for the university students to many other groups in the population, everyone from soldiers to school children to industrial workers to housewives.<sup>96</sup> In a 1948 article for the hygiene journal *Gigiena i sanitaria*, psychologist Mark Lebedinskii wrote enthusiastically about the Mental Hygiene Committee’s far-reaching aspirations. The Committee, he said, had selected groups in the population that they believed were particularly at risk for “somatopsychiatric” problems in the postwar. Demobilized soldiers were singled out for attention, especially those who had become invalids. Their nervous systems had obviously been placed under great strain during long periods when they had to march, or fight, or wait for orders, and in this weakened state soldiers became much more susceptible to “psychic trauma.” Bad news from home, or even no news, might be enough. Wounds not only injured the body, they often left the soldier facing life as a cripple, and this harsh realization could in itself act as a “psychic trauma.” Those who suffered disfiguring injuries had the additional burden of social stigma. For these people, “Whenever anyone around them gives them attention . . . they take it very hard [*oni vosprinimaiut kraine tiazhelo*].”<sup>97</sup> Amputees were at particular risk, because their nervous systems were often burdened by chronic pain. In 1947 and

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<sup>95</sup> V. A. Giliarovskii, “Zadachi somato-psikhiatrii v oblasti teorii i praktiki (Stenogramma zasedaniia prezidiuma UMS MZ SSSR),” 6 March 1947, GARF, f. r-8009, op. 2, d. 1037, l. 17.

<sup>96</sup> Housewives were not getting help from anyone, even though “to a significant degree, the weight of the war lay on them,” according to Giliarovskii. The housewife’s “somatic health and psychological balance” was crucial to the whole family “for maintaining normal conditions for our fundamental workers,” and thus deserved attention from the mental hygiene commission.” V. A. Giliarovskii to I. G. Rufanov, chairman of the UMS NKZ SSSR, 23 December 1945, GARF, f. r-8009, op. 2, d. 866, ll. 36ob-37.

<sup>97</sup> M. S. Lebedinskii, “Aktual'nye zadachi psikhogigenicheskoi raboty,” *Gigiena i sanitaria*, no. 2 (1948): 44.

1948, psychiatrists on the mental hygiene commission worked with amputees, and found that many suffered from what they called “neuroses of the prostheticized” [*nevrozov protezirovannykh*], which they described as “fear of walking with the help of prosthesis... Very often the fundamental cause of these neuroses was that the patient did not receive complete instruction as a user of the prosthesis.” For some of these wounded soldiers, injury, pain, and indifference from doctors led to “serious neuropsychic syndromes.” The mental hygiene commission’s goal, according to Lebedinskii, was to help them avoid “new psychic traumas and unjustified oversteering of the nervous system.”<sup>98</sup>

Lebedinskii was particularly concerned with how demobilized soldiers would cope in universities and how they could be helped to succeed despite the lingering effects of their war injuries. Many “student-invalids,” he found, were having trouble in the classroom even though, in principle, they “fully retained the capability to learn the subject.” Specifically, Lebedinskii found that some former soldiers had trouble answering questions quickly, but could answer adequately after “a small pause.” He also found that some soldiers “experienced particular emotional stress” during exams. For this type of problem, he suggested, teachers and university administrators could help students succeed by making small accommodations that would allow former soldiers to excel in university. Mental hygiene experts were more than willing to help put such programs into place, and in a few universities “medical selection commissions” [*meditsinskie otborochnye komissii*] were already helping to screen students and help them choose their career path. Lebedinskii recommended that panels of medical experts be used in higher education institutions throughout the USSR. Though he did not say as much, Lebedinskii’s suggestion that psychological experts should help choose professional paths for students was quite

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<sup>98</sup> Lebedinskii, “Aktual'nye zadachi,” 45-46.

bold because since the 1936 ban on pedology and psychotechnics, the education authorities had forbidden schools to bring in outside experts (particularly psychologists). The student and the people who knew the student well should make such decisions, it was claimed, not by outsiders whose methods (tests, questionnaires) amounted to “charlatanism.” Like Giliarovskii, Lebedinskii was implicitly arguing that psychological experts be “restored to their rightful place” in the Soviet educational system.<sup>99</sup>

Lebedinskii was also concerned about small children who had grown up during the war. Many children had lived with very little food and in conditions of great deprivation. Some had suffered serious physical injuries, and many more had suffered serious psychological trauma when family or friends died, or were killed in front of them, an experience “which leaves indelible marks on the child’s psyche.”<sup>100</sup> Like the students at the Institute of Foreign Languages, many were developing a whole range of medical problems, especially “nervousness” and personality disorders.<sup>101</sup> Such problems could be fairly easily avoided, according to Lebedinskii, if teachers and school administrators would only listen to psychiatrists and act accordingly. In 1947 and 1948 they worked on several projects aimed at the psychological health of children in schools, including “Principles of psychological work with nervous children in the mass school,” “The psycho-prophylactic regime in preschools [*iasli*]”, and “Methods of mental hygiene work with working adolescents.”<sup>102</sup> They developed plans for an ideal plan of the school day, as well as

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<sup>99</sup> Lebedinskii, “Aktual'nye zadachi,” 45-46; “Prikaz o likvidatsii v shkolakh profkonsul'tatsii i profotbora (11 sentiabria 1936, no. 738),” republished in Nikolai Kurek, *Istoriia likvidatsii pedologii i psikhotehniki* (St. Petersburg: Aleteiia, 2004), 301-302.

<sup>100</sup> Lebedinskii, “Aktual'nye zadachi,” 44.

<sup>101</sup> V. A. Giliarovskii to I. G. Rufanov, chairman of the UMS NKZ SSSR, 23 December 1945, GARF, f. r-8009, op. 2, d. 866, ll. 36ob-37.

<sup>102</sup> “Plan raboty UMS MZ SSSR na 1947 g.,” approved 13 February 1947, GARF, f. r-8009, op. 2, d. 1098, l. 16.

games to play, how to handle tired children, and what to do with children who fell behind in school [*neuspevaemost' detei*].<sup>103</sup>

To realize the ambitious scope of his mental hygiene project, psychiatrists would need help. In 1946 there were only 1,900 psychiatrists in the Soviet Union, far too few to realize such an ambitious set of goals. To enlist the help of other experts, the mental hygiene commission focused much of its efforts on educational lectures and articles. These aimed to convince other professionals to adopt a mental hygiene approach in their work, and they were particularly aimed at physicians, teachers, and public workers [*obshchestvennye rabotniki*], groups who were in a position to help (or harm) the cause of mental hygiene.<sup>104</sup> But Giliarovskii also argued that the Soviet Union should substantially increase the number of psychiatrists who were trained to help monitor mental health. Giliarovskii was particularly impressed by the United States and its postwar efforts to improve mental health. At a 1946 meeting at Minzdrav, Giliarovskii explained that the Americans had over 3,500 psychiatrists, significantly more than the Soviet Union, which had about 1,900, even though America had a lower population than the Soviet Union.<sup>105</sup> What most impressed Giliarovskii were calls by American psychiatrists for a huge increase in the number of psychiatrists; he had even found one article titled, “We need 10,000 psychiatrists.” Giliarovskii reassured his colleagues: “I don’t want to scare you comrades, [by saying] that we

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<sup>103</sup> Lebedinskii, “Aktual'nye zadachi,” 44.

<sup>104</sup> At Semashko’s 1946 conference, according to the UMS MZ SSSR’s year end report, these propositions were discussed by hygienists, physicians, and health care organizers, and, according to the year end report by the UMS, these leading health care workers agreed with Giliarovskii about the need to educate them about the principles of “psychiatry, mental hygiene, and medical psychology. “Otchet UMS MZ SSSR o rabote za 1946 god,” undated. GARF, f. r-8009, op. 2, d. 1018, l. 55.

<sup>105</sup> In 1946, there were 1,880 psychiatrists in the Soviet Union as a whole, according to figures sent to the TsSU by Minzdrav. “Godovoi otchet deiatel'nosti i kadrakh meditsinskikh uchrezhdenii za 1946 god Ministerstvu zdavookhraneniia SSSR,” *RGAE* f. 1562, op. 18, d. 349, l. 12ob. A 1952 report by the USSR’s head psychiatrist put the figure for 1946 slightly higher, 1,932. A. Portnov, “O sostoianii psikhonevrologicheskoi pomoshchi naseleniiu v SSSR,” 18 March 1952, GARF, f. r-8009, op. 1, d. 1035, l. 132.

should have such a number of psychiatrists too. But what is being said here? . . . The author does not have in mind an increase in the number of psychiatrists who are working in the clinic. He says that their increase is needed for work in the extra-psychiatric network [*vnepsikhiatricheskoi seti*], for hygiene work.” The war had shown that psychiatrists could add a great deal to the work of other physicians, Giliarovskii reminded them. “And I think, that in the general plan, this issue should occupy a prominent place among the problems of general hygiene.”<sup>106</sup>

Giliarovskii’s most realistic proposal to Minzdrav was to add a staff psychiatrist to every large general hospital. This was necessary, he argued, because most Soviet physicians simply did not think about the possibility that the disorders that they saw in their offices might have some connection to the mind. And yet, Giliarovskii argued, this was precisely what they were seeing in the postwar years. Cardiovascular disease, ulcers, hypertension and other common postwar maladies, he claimed, were in fact the expression of wartime psychological trauma. Soviet citizens were not the sorts who reacted to wartime experiences with tears or depression. Instead they “somaticized,” transforming their psychological distress into bodily disorder, or, as Giliarovskii put it, “the particular pathologies of wartime . . . are satisfactorily explained precisely from the point of view of the autonomic nervous system and the change of dominant, as physiologists say, the transfer of disorders of higher function to lower levels.”<sup>107</sup>

Most of these problems would be seen in general hospitals and polyclinics, Giliarovskii said, and so the practical solution was to incorporate psychiatric expertise more broadly into general medicine. He complained that most physicians saw psychiatrists only as the people that

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<sup>106</sup> “Stenogramma rasshirennogo zasedaniia Prezidiuma UMS MZ SSSR,” September 27, 1946, GARF, f. r-8009, op. 2, d. 879, ll. 96-96ob.

<sup>107</sup> V. A. Giliarovskii in L. V. Gromashevskii (Chairman), “Stenogramma zasedaniia prezidiuma UMS MZ SSSR,” 6 March 1947, GARF, f. r-8009, op. 2, d. 1037, l. 14.



they called in when they needed to get rid of crazy person who had turned up at their hospital. It would serve the interests of medical care as a whole, Giliarovskii suggested, if more emphasis on mental health were taught in medical school, including psychotherapy, mental hygiene, and medical psychology. And at minimum every large hospital should have one psychiatrist on staff.<sup>108</sup>

The members of Minzdrav's Scientific Medical Council agreed in principle with Giliarovskii that psychiatry was important for general medicine and that "every physician should be familiar with psychotherapy," and appreciate the importance of the mind in producing somatic symptoms, as well as the impact that somatic illness could have on the mind. They invited Giliarovskii to prepare a set of concrete proposals for the Presidium of their council.<sup>109</sup>

Giliarovskii did his best to frame his arguments for mental hygiene in practical terms, emphasizing common-sense steps like increasing the number of psychiatric wards in general hospitals, increasing the number of neuropsychiatric dispensaries and expanding their role in the community, and deemphasizing the role of psychotherapy. He wanted Minzdrav officials to take psychiatry and mental hygiene seriously as practical experts who could help reconstruct Soviet society. At the same time, Giliarovskii was clearly trying to rehabilitate an approach to psychiatry that harkened back to the 1920s and that was tinged with some of the utopianism that characterized the thinking of the early post-revolution years. This utopianism was particularly clear in some of the mental hygiene ideas expressed by Giliarovskii's allies.

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<sup>108</sup> Ibid., l. 21.

<sup>109</sup> L. V. Gromashevskii (Chairman), "Protokol zasedaniia prezidiuma UMS MZ SSSR," 6 March 1947, GARF, f. r-8009, op. 2, d. 1037, ll. 1-3.

In one particularly striking article, hygienist S. A. Gurevich argued that mental hygiene should be taken into account in the construction and reconstruction of Soviet housing after the war. Psychiatrists should have a role in the design of postwar apartments, he claimed, because properly designed housing could help Soviet citizens overcome the effects of “grief for the killed and the lost [*toska po pogibshim i poteriannym*], deprivation, illness, evacuation,” and help them go on to live happy, mentally balanced lives. Housing should be built that allowed people to relax, which meant that buildings should not be too tall and apartments should be occupied by only one family. The apartments themselves should be sunny, uncluttered, and quiet, places where people could enjoy “entirely different sensations and emotions [*vospriiatii i chuvstvovanii*],” where they could relax their bodies “fully and rationally” and relax their minds by “turning off thought, feeling, and will” [*perekluchenie mysli, chuvstva i voli*]. The buildings should be near nature because nature “is a factor which has deep mental-hygienic influence.” Not only should each apartment have a window that looked out onto “river banks, forest, meadows,” each family should also have its own garden where they could get fresh air and light physical exercise. Working in a garden, Gurevich claimed, “has an exceedingly positive effect on the nervous system and is the best form of nervous rejuvenation [*nervnogo perekliucheniiai*] for the city-dweller. . . . From the perspective of mental hygiene, an apartment without a piece of land to go with it is flawed.”<sup>110</sup> At a time when thousands of Soviet citizens were still living in dugouts and struggling to get enough food to eat, such high-minded fantasy about the ideal living space made mental hygiene seem impractical and even disconnected from reality.

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<sup>110</sup> S. A. Gurevich, “Psikhogigienicheskoe znachenie zhilishcha,” *Gigiena i sanitariia*, no. 2 (1948): 14-15.

## **Mental Hygiene and Clinical Psychology**

During the war, some physicians had found psychotherapy useful for treating patients suffering from “hysterical” symptoms like deaf-mute syndrome. After the war some psychologists and psychiatrists tried to capitalize on these successes to rehabilitate clinical psychology as a medical discipline. Applied psychologists had fallen on very hard times in the mid-1930s, when the Party’s decree on pedagogy and psychotechnics banned psychologists from using aptitude tests, and IQ tests in particular, on schoolchildren, university students, and workers. Psychologists who had been working in education or in industry had to cease their activities, and many left the field altogether. Clinical psychologists working in hospitals and psychoneurological dispensaries were left in a state of limbo. In the 1940s many were still employed, particularly by psychiatric hospitals, but the tools that they were allowed to use were severely curtailed. Some psychologists saw their wartime service as an opportunity to renegotiate the status of their discipline with the Party.

Several leading psychiatrists became advocates for clinical psychology, and they did so as part of their larger push to revive mental hygiene. Giliarovskii in particular argued that clinical psychology should play a larger role in medical practice, and he worked closely with psychologist Mark Lebedinskii, a staff member at Giliarovskii’s institute and a member of the Mental Hygiene Committee. Born in 1894, Lebedinskii had served as a medic during World War One, then trained in psychiatry and neurology in Moscow.<sup>111</sup> In the 1920s he took up clinical psychology and became the head of the department of clinical psychology at the Ukrainian Psychoneurological Institute in Kharkov, where he was worked with psychologist Lev

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<sup>111</sup> “Mark Samuilovich Lebedinskii,” *ZhNiP* 81, no. 5 (1981): 786-787.

Vygotskii.<sup>112</sup> During the Second World War Lebedinskii worked as medical director of an evacuation hospital, and in this work he drew on his 1930s research on speech disorders like aphasia.<sup>113</sup> After the war Lebedinskii became an advocate for speech therapy for both soldiers and civilians. Speech problems, Lebedinskii warned, were very widespread after the war, many due to brain injuries, but others – like stuttering in children – caused by psychological trauma. He added that speech disorders themselves, whether caused by physical or psychological wounds, could lead to long term psychological problems, “chronically traumatizing the psyche of the patient, causing psychic layers which complicate and increase the strength of the primary defects of speech.” He recommended that neuropsychiatric dispensaries set up speech therapy offices [*logopedicheskie kabinety*] that would give treatment aimed at the brain, the body, and the psyche. In particular, he recommend psychotherapy that utilized “suggestion in hypnotic state, along with rational psychotherapy and deep study of the patient in a unified psychotherapeutic system.”<sup>114</sup> Lebedinskii himself became the director of a speech therapy office in Giliarovskii’s Moscow clinic, a facility intended as a model for others to emulate.<sup>115</sup>

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<sup>112</sup> Lebedinskii worked closely with Vygotskii’s other collaborators, especially Aleksandr Luriia and Aleksei Leon’teiev. The three moved to Kharkov from Moscow on the invitation of the Ukrainian Psychoneurological Institute, which at the time was directed by psychiatrist Leon Rokhlin. After World War Two, Rokhlin, like Lebedinskii, came to work for Giliarovskii at the AMN Institute of Psychiatry. Anton Yasnitsky and Michel Ferrari, “From Vygotsky to Vygotskian Psychology: Introduction to the History of the Kharkov School,” *Journal of the History of the Behavioral Sciences* 44, no. 2 (Spring 2008): 124-125; A. A. Leontiev, “The Life and Creative Path of A.N. Leontiev,” *Journal of Russian and East European Psychology* 43, no. 3 (May-June 2005): 32-33; G. L. Vygodskaia and T. M. Lifanova, *Lev Semenovich Vygotskii. Zhizn'. Deiatel'nost'. Shtrikhi k portretu* (Moscow: Smysl, 1996), 128.

<sup>113</sup> According to Yasnitsky and Ferrari, in the 1930s the researchers in Lebedinskii’s clinic in Kharkov focused on “the role of inner speech and its loss in a wide range of cortical brain damage syndromes... as well as the restoration and vicarious substitution of psychological functions after brain injury. Yasnitsky and Ferrari, “From Vygotsky to Vygotskian Psychology,” 125. Some of the results of this work were published in M. S. Lebedinskii, “Psikhologicheskii analiz sluchaia senzornoj afazii,” *Nevropatologiya, psikhiatriia, psikhogigiena* 5, no. 4 (1936): 580-614

<sup>114</sup> M. S. Lebedinskii, “Psikhoterapiia pri narusheniakh rechi,” *NiP* 14, no. 6 (1945): 35-39.

<sup>115</sup> I. A. Berger, V. A. Grombakh, and M. A. Dzhagarov, “O rabote Moskovskoi grodoskoi psikhaitricheskoj organizatsii,” *NiP* 13, no. 6 (1944): 77; I. V. Strel’chuk (Gorodskoi psikhiatr), “Ob’iasnitel’naia zapiska po

Lebedinskii and Giliarovskii both called for psychiatrists to reengage with individual psychology. “Psychotherapy’s acceptance has been far from the wide use that it deserves,” Lebedinskii complained,<sup>116</sup> and he urged medical institutes to expand their courses in psychiatry and to add courses in medical psychology and mental hygiene.<sup>117</sup> This call was also picked up by Vladimir Miasishchev, the director of the Bekhterev Psychoneurological Institute in Leningrad. Miasishchev complained that all physicians needed to understand something about psychology so that they could give their patients adequate treatment. As things stood in the mid-1940s, though, medical students were given “no mandatory course in medical psychology, the theory of psychogenic disorders and psychoneuroses, or nervous and mental hygiene.” As a result, “...a physician’s special training, and the methods and general culture of teaching and education [in medical schools], is guaranteed to lead him on a path of theoretical and practical ignorance or under-appreciation of such fundamental medical questions as the role of the psyche in illness, life, and health.”<sup>118</sup>

In March 1947 Giliarovskii made a presentation to Minzdrav’s Scientific Medical Council in which he argued this point, urging the Ministry to “expand medical education in the sense of greater inclusion of knowledge of psychotherapy, psychogenic disorders, and medical

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organizatsii nevro-psikhiatricheskoi meditsinskoi pomoshchi Mosgorzdravotdela za 1948 goda,” undated, TsAGM, f. 551, op. 1, d. 184, ll. 25-26.

<sup>116</sup> Lebedinskii, “Psikhoterapiia pri narusheniakh rechi,” 39.

<sup>117</sup> Lebedinskii suggested that basic courses in psychology and mental hygiene should also be taught to future teachers in pedagogical institutes. Lebedinskii, “Aktual'nye zadachi,” 46-47.

<sup>118</sup> Miasishchev also echoed Lebedinskii’s call for psychotherapy to be used in dispensaries. Each neuropsychiatric dispensary should have a “highly trained psychotherapist who could work with complex psychogenic cases,” Miasishchev argued. And these psychotherapists should be given time to do their job – they could see no more than ten or twelve patients per day. Miasishchev, “Ob organizatsii meditsinskoi pomoshchi pri nevrozakh ..,” 147, 150.

psychology.”<sup>119</sup> The chairman of the meeting agreed that such courses were important and he pointed out that the Ministry was still in the process of deciding its new six-year medical curriculum, so it would be feasible to expand the hours devoted to psychiatry and psychology in the third year.<sup>120</sup> The Scientific Medical Council ultimately approved a resolution that recommended that the Ministry “introduce the teaching of medical psychology in medical institutes.”<sup>121</sup> The next year, the Academy of Medical Science agreed to the same principle: medical psychology should be added to the curriculum of medical institutes.<sup>122</sup>

In his advocacy of psychology, Giliarovskii also argued that medical personnel should again be allowed to use psychological tests [*testy*], even though they had been banned by the Party in 1936. He argued that psychologists had now abandoned their idealist ways. Furthermore, applied psychology had great “practical importance,” so the government (and the Party) should relent on the 1936 ban and allow “research in psychotechnics” and “some form of testing methods” to determine whether people were fit for any given type of work. “Psychology, having left behind its former mistakes, has long ago started down the correct path, ceased to be a speculative science,” Giliarovskii wrote. As proof, he pointed to the experience of the American military. In World War One, he explained, the Americans had used strict psychological testing to screen their soldiers and as a result few American soldiers had broken down during the war. In World War Two the Americans had not used psychological tests to screen recruits, and their soldiers broke down at a much higher rate. This proved the practical value of tests as tools for

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<sup>119</sup> V. A. Giliarovskii, “Zadachi somato-psikhiatrii v oblasti teorii i praktiki (Stenogramma zasedaniia prezidiuma UMS MZ SSSR),” 6 March 1947, GARF, f. r-8009, op. 2, d. 1037, l. 21.

<sup>120</sup> Ivan Rufanov (chairman), “Stenogramma zasedaniia Prezidiuma UMS MZ SSSR,” 6 March 1947, GARF, f. r-8009, op. 2, d. 1037, l. 47.

<sup>121</sup> “Protokol no. 12 zasedaniia Prezidiuma UMS MZ SSSR,” 29 May 1947, GARF, f. r-8009, op. 2, d. 1043, l. 30.

<sup>122</sup> “Protokol #5 zasedaniia Biuro OKM AMN SSSR,” 17 February 1948, GARF, f. r-9120, op. 2, d. 562, l. 13.

professional selection, and Soviet psychologists should be allowed to resume using these techniques.<sup>123</sup> In 1948 the Academy of Medical Sciences Medical-Biological Department agreed in principle that research on the psychology of labor was important and that it should be resumed.<sup>124</sup>

Vladimir Miasishchev went further. In May 1948, he wrote to Malenkov to propose that the government reestablish an Institute of Psychology within the Academy of Sciences system. The RSFSR's Central Institute of Psychology had recently been transferred to the newly created Academy of Pedagogical Sciences, and Miasishchev complained that the psychologists there were focusing strictly on pedagogy to the exclusion of all other psychological topics. He justified his proposal for a prestigious Academy of Sciences institute on the grounds that psychologists had achieved great practical results during the war. In addition to the institute, he called for psychology to be given its own journal, and for psychology to be taught in university courses.<sup>125</sup> Malenkov's office asked for advice from both the Ministry of Health and the Academy of Sciences, and both organizations agreed that Miasishchev's proposal had merit and that the institute was a good idea.<sup>126</sup>

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<sup>123</sup> V. A. Giliarovskii, "Zadachi psikhologii na novom etape ee razvitiia," in *Somato-psikhicheskie rasstrostva. Sbornik trudov Instituta psikhologii AMN*, ed. V. A. Giliarovskii (Moscow: Izd-vo AMN SSSR, 1946), 9-10.

<sup>124</sup> The approval of psychology of labor by the AMN was reported by A. A. Letavet, a former psychotechnics specialist who had himself gone to the Academy of Medical Sciences in 1948 and proposed that they resume this research. "Stenogramma rasshirenogo zasedaniia US, posviashchennogo obsuzhdeniiu voprosov fiziologii truda i nekotorykh problem sovremenoi psikhologii," 24 April 1956, GARF, f. r-8009, op. 2, d. 2234, l. 28.

<sup>125</sup> V. Miasishchev (Direktor Psikhonev. instituta im. Bekhtereva) and A. Kolodnaia (Kand. ped. nauk, patopsikholog) to G. M. Malenkov (Sek. VKP(b)), 10 May 1948, *Rossiiskii gosudarstvennyi arkhiv sotsial'no-politicheskoi istorii (Russian State Archive of Social and Political History, hereafter RGASPI)*, f. 17, op. 132, d. 169, ll. 68-68ob.

<sup>126</sup> N. Vinogradov (Zam. Ministra Zdrav SSSR) to M. Iakovlev (Zam. Zaved. Sektorom otdela propagandy i agitatsii TsK VKP(b)), *sekretno*, 30 July 1949, RGASPI f. 17, op. 132, d. 169, ll. 69; A. V. Topchiev (Gl. uchenyi sek. Prezidiuma AN SSSR) to M. Iakovlev (Zam. Zaved. Sektorom otdela propagandy i agitatsii TsK VKP(b)), 24 October 1949, RGASPI f. 17, op. 132, d. 169, ll. 70-71.

When Miasishchev's proposal was being considered by government officials in late 1948, however, the political landscape in the Soviet Union and within the medical profession had changed significantly. Until 1946-1947, "Pavlov's theory" had been universally praised but interpreted in widely divergent ways. As I will discuss at length in Chapter 4, however, by 1948-1949 the Party had begun to take sides in what had been a parochial debate among medical professionals. It was in this period that Miasishchev's proposal to reestablish an Institute of Psychology was circulated in the government. So while Ministry of Health officials endorsed the plan, the Party did not. In a memorandum to Malenkov, the Party's Department of Agitation and Propaganda wrote that, "As a rule, psychologists ignore I. P. Pavlov's theory of higher nervous activity, claiming that it has allegedly become outdated and has no real significance in explaining psychological processes." Until Soviet psychologists had proven they were on the correct Pavlovian path, there could be no Institute of Psychology. Among those who were guilty of "serious principled mistakes" they listed Aleksandr Lurii, Vasili Giliarovskii, Sergei Rubinstein, Aleksei Leont'ev, and unnamed "others."<sup>127</sup>

The Party's ruling on this matter shut down what had been a brief glimmer of hope for a broader revival of psychological research in the USSR. The question of allowing psychologists to use psychological tests would not be aired openly again until 1956, when Narkomzdrav organized a conference where former pedologists and psychotechnics people aired their complaints.<sup>128</sup> In the intervening years the situation for applied psychology got much worse

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<sup>127</sup> V. S. Kruzhev (Zam. zaved. Otdelom propagandy i agitatsii TsK VKP(b)) and Iu. A. Zhdanov (Zav. Sektora nauki Otdelom propagandy i agitatsii TsK VKP(b)) to Malenkov (Sek. TsK VKP(b)), 28 October 1949, RGASPI f. 17, op. 132, d. 169, ll. 68-73.

<sup>128</sup> N. I. Grashchenkov (Chair), "Stenogramma rasshirenogo zasedaniia US, posviashchennogo obsuzhdeniiu voprosov fiziologii truda i nekotorykh problem sovremennoi psikhologii," 24 April 1956, GARF, f. r-8009, op. 2, d. 2234, 6-121.



before it got better. As I will discuss in Chapter Six, most of the psychology laboratories in psychiatric hospitals were closed, and new regulations for psychiatric hospitals that were drawn up in the early 1950s eliminated did not include psychology laboratories among the basic laboratories that should be included in every large psychiatric hospital (the 1946 psychiatric hospital regulations had included psychology laboratories). During the early 1950s leading psychiatrists argued that psychology was simply a tool that psychiatrists used, not a discipline in itself. At the 1951 Pavlov Session psychologists like Mark Lebedinskii were criticized for setting themselves apart and acting as if they belonged to a scientific discipline that did not have to follow Pavlov's objective rules of higher nervous activity.<sup>129</sup>

### **Psychoneurological Dispensaries and Changing Priorities**

Until 1949, the psychiatric consequences of the war had dominated psychiatric publications. Conferences, edited volumes, research papers, and monographs all focused on what psychiatrists had seen during and just after the war. In 1949 and 1950, however, the war and its aftermath ceased to be central topics of discussion. In part this change in focus was caused by political and ideological pressures: psychiatrists wanted to show that they were contributing to the transformation of their discipline on the basis of Pavlov's theory of higher nervous activity. Political pressure was not the only factor, however. Another reason for the change in emphasis seems to have been a decline in the number of people coming to psychiatric institutions with war-related psychiatric problems. Though Giliarovskii, Berger, and others had predicted that the war would have long-lasting impact on the nation's mental health, by 1948 and 1949 psychiatrists were beginning to suspect that they might have been wrong.

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<sup>129</sup> A. A. Portnov (Nach. Otdela psikhonev. pomoshchi MZ SSSR) to A. N. Cherkashin (Otdel Nauki TsK VKP/b), 7 August 1952, RGASPI, f. 17, op. 133, d. 261, ll. 45-48.

In 1948, Izrail Berger had himself published a paper showing that the psychiatric consequences of the war seemed to be fading from Moscow neuropsychiatric dispensaries. Since the end of the war, the Moscow *oblast'* psychiatrist had been regularly analyzing trends in the diagnoses of first-time patients. In 1945-1946 he had reported that war-related psychiatric disorders were on the rise, including traumatic psychoses, epilepsy, and “borderline” disorders.<sup>130</sup> Over the next three years, however Berger’s findings changed, and in 1948 Berger published a paper that suggested cases of war-related psychiatric disorders were falling significantly. Psychological disturbances like neuroses and depression had all fallen *below* 1940 levels, and even head trauma related psychiatric problems had fallen substantially.<sup>131</sup> The archives of the Moscow health department provide an almost identical set of statistics; the range of diagnoses included was broader than what Berger published, but the numbers and trends are the same.<sup>132</sup> (See Figure 3.3 and Table 3.2.)

Other psychiatrists also remarked on what they perceived as an unexpectedly low number of traumatic neuroses. Giliarovskii’s theory of “nervous demobilization” was discussed at a staff meeting of Moscow Psychiatric Hospital No. 1 in 1947. The director of the hospital reminded his audience of Giliarovskii theory that soldiers had experienced low rates of psychological breakdown during the war because they had been able to “mobilize” their central nervous systems. Giliarovskii had predicted that after the war soldiers would develop psychological and

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<sup>130</sup> I. A. Berger, “Dinamika nevro-psikhicheskoi zaboлеваemosti i organizatsiia vnebol’nichnoi i bol’nichnoi pomoshchi,” abstract published in “Godovoi otchet instituta psikhiiatrii AMN za 1946 god,” GARF, f. r-9120, op. 2, d. 250, l. 28.

<sup>131</sup> I. A. Berger, “Meropriiatiia po likvidatsii posledstviu voiny v oblasti nervno-psikhicheskoi zaboлеваemosti,” in *Problemy sovremennoi psikhiiatrii*, ed. L. L. Rokhlin and T. P. Simson (Moscow: Izd-vo AMN SSSR, 1948), 454-455.

<sup>132</sup> “Ob’iasnitel’naia zapiska po organizatsii nevro-psikhiiatricheskoi meditsinskoi pomoshchi Mosgorzdravotdela za 1948 goda, tom 1,” TsAGM, f. 551, op. 1, d. 184, l. 35.

physical problems when they “demobilized” their nervous systems. So, the hospital director wanted to know, where were these soldiers with demobilized nervous systems?

Now the war is gone and we still don't see psychogenic illnesses. I am connected with *raion* psychiatrists and they are not seeing these illnesses in the number that one could have expected. I am deeply convinced that for the development of psychogenic illnesses the soma does not play a decisive role either; perhaps the constitution has significance, but the environment itself will be decisive. Otherwise I cannot understand why we do not have more insurance neuroses, why there are no traumatic neuroses.... Obviously our social environment does not allow for the development of insurance neuroses [*rentnykh ustanovok*] and traumatic neuroses or psychogenic illnesses despite the huge number of traumatic injuries. We predominantly see organic phenomena, not psychogenic. I am talking about what I see, and I do not see the psychogenic illnesses that it seemed we should see. Perhaps they have taken different form, and perhaps what we see is simply not psychogenic.<sup>133</sup>

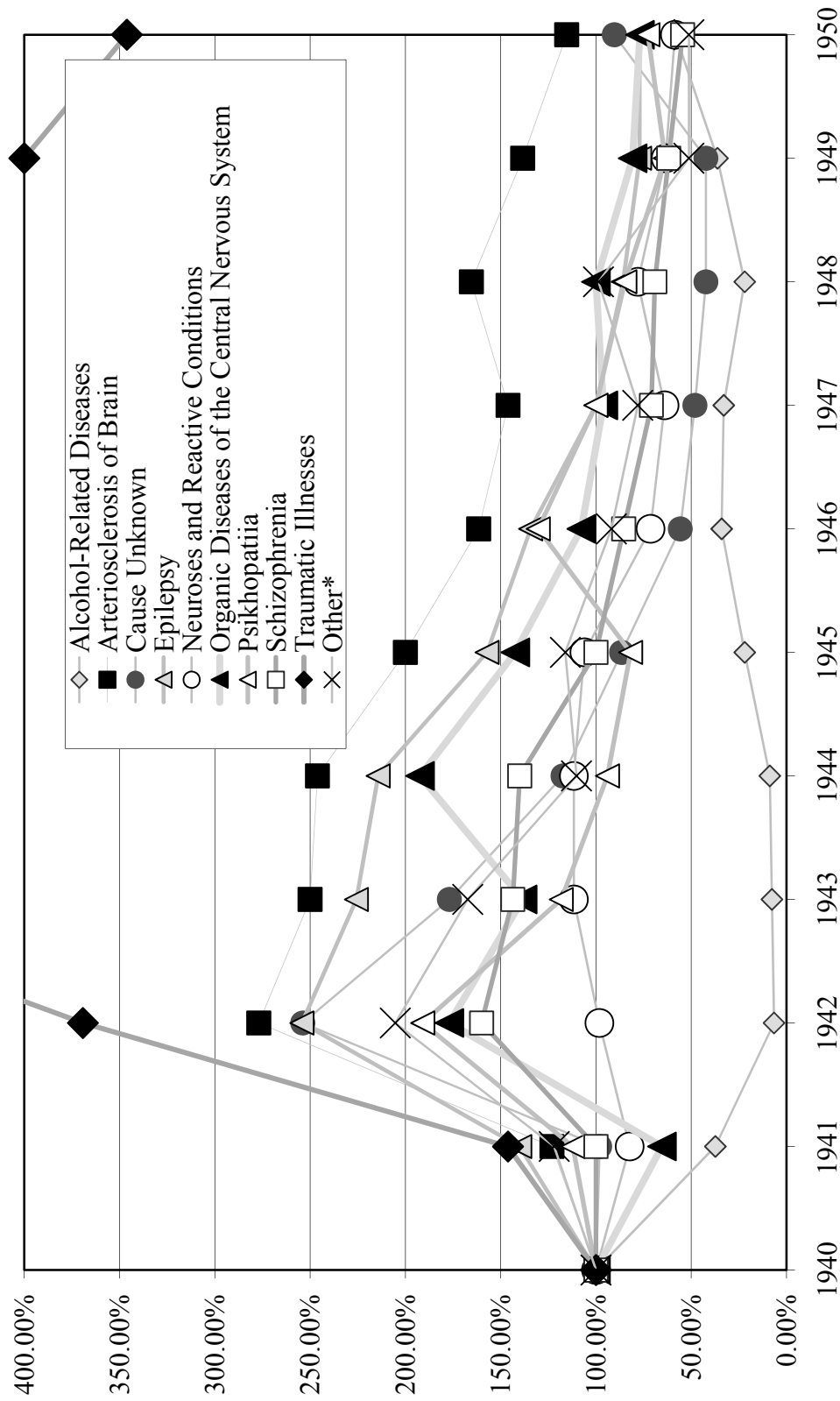
Why had the expected soldiers with psychological trauma not appeared? The psychiatrists at Hospital No. 1 had their guesses. Dr. Elena Kameneva remarked that the patients coming to see her were actually very similar to those that she had seen after the First World War. After that war,” she said, “hysterical reactions were more common two or three years later, and command seizures [*komandnye pripadki*], insufficiency [*neustoichivost'*] of patients was less common.” The difference was not in the symptoms she saw in soldiers but in the diagnoses they were given. In the 1940s, she suggested, psychiatrists were more inclined to diagnose “mild organic injuries” instead of “psychogenic disorders.” The staff on her ward had diagnosed no soldiers with “pure” psychogenic problems because they had always been able to find some “sign of trauma or organic symptoms.”<sup>134</sup> What had changed was the technology and explanatory frameworks used by psychiatrists.

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<sup>133</sup> A. B. Aleksandrovskii (Chairman), “Stenogramma konferentsii vrachei pri 1-y moskovskoi gorodskoi psikhiatricheskoi bol'nitse,” 1 February 1947, TsAGM, f. 1126, op. 1, d. 49, ll. 27-29.

<sup>134</sup> Kameneva in A. B. Aleksandrovskii (Chairman), “Stenogramma konferentsii vrachei pri 1-y moskovskoi gorodskoi psikhiatricheskoi bol'nitse,” 1 February 1947, TsAGM, f. 1126, op. 1, d. 49, ll. 14-16.

**Figure 3.3. Diagnoses of First-Time Patients in Moscow Psychoneurological Dispensaries, 1940-1950, as a percentage of 1940 number per 10,000**



Sources: Adapted from I. V. Strel'chuk (Gorodskoi psikiatr g. Moskvy), "Ob'iasnite'lnaia zapiska po organizatsii nevro-psikh. med. pomoshchi Mosgorzdravotdela za 1948 goda," TsMAM, f. 551, op. 1, d. 184, l. 35; E. Babaian (Zam. Nachal'nika Uprav. Spets pomoshchi MZ SSSR), "Spravka o sostoianii psikhonevrologicheskoi pomoshchii naselenitiu SSSR," 20 May 1961, GARF, f. r-8009, op. 1, d. 1411, l. 15.

**Table 3.2. Diagnoses of First-Time Patients in Moscow Psychoneurological Dispensaries per 10,000 Population, 1940-1950**

Diagnosis	1940		1941		1942		1943	
	Per 10,000	% 1940	Per 10,000	% 1940	Per 10,000	% 1940	Per 10,000	% 1940
Alcohol-Related Diseases	9.1	100.00%	3.4	37.36%	0.6	6.59%	0.7	7.69%
Arteriosclerosis of Brain	2.6	100.00%	3.2	123.08%	7.2	276.92%	6.5	250.00%
Cause Unknown	5.2	100.00%	5.1	98.08%	13.2	253.85%	9.2	176.92%
Epilepsy	3.5	100.00%	4.9	140.00%	8.9	254.29%	7.9	225.71%
Neuroses and Reactive Conditions	16.4	100.00%	13.5	82.32%	16.1	98.17%	18.3	111.59%
Organic Diseases of the Central Nervous System	2.6	100.00%	1.7	65.38%	4.6	176.92%	3.6	138.46%
<i>Psikhopatitii</i>	3.3	100.00%	3.7	112.12%	6.3	190.91%	3.9	118.18%
Schizophrenia	5.5	100.00%	5.5	100.00%	8.8	160.00%	7.9	143.64%
Traumatic Illnesses	1.3	100.00%	1.9	146.15%	4.8	369.23%	7.1	546.15%
Other*	5.29	100.00%	6.45	121.93%	10.86	205.29%	8.85	167.30%

Diagnosis	1944		1945		1946		1947	
	Per 10,000	% 1940	Per 10,000	% 1940	Per 10,000	% 1940	Per 10,000	% 1940
Alcohol-Related Diseases	0.8	8.79%	2	21.98%	3.1	34.07%	3	32.97%
Arteriosclerosis of Brain	6.4	246.15%	5.2	200.00%	4.2	161.54%	3.8	146.15%
Cause Unknown	6.1	117.31%	4.5	86.54%	2.9	55.77%	2.5	48.08%
Epilepsy	7.5	214.29%	5.5	157.14%	4.7	134.29%	3.5	100.00%
Neuroses and Reactive Conditions	18.3	111.59%	17.4	106.10%	11.7	71.34%	10.5	64.02%
Organic Diseases of the Central Nervous System	5	192.31%	3.7	142.31%	2.8	107.69%	2.5	96.15%
<i>Psikhopatitii</i>	3.1	93.94%	2.7	81.82%	4.3	130.30%	3.3	100.00%
Schizophrenia	7.7	140.00%	5.5	100.00%	4.7	85.45%	3.9	70.91%
Traumatic Illnesses	8.6	661.54%	9.1	700.00%	8.5	653.85%	7.4	569.23%
Other*	5.83	110.21%	6.14	116.07%	4.86	91.87%	4.13	78.07%

**Table 3.2. Diagnoses of First-Time Patients in Moscow Psychoneurological Dispensaries, 1940-1950 (Continued)**

Diagnosis	1948		1949		1950	
	Per 10,000	% 1940	Per 10,000	% 1940	Per 10,000	% 1940
Alcohol-Related Diseases	2	21.98%	3.3	36.26%	5.3	58.24%
Arteriosclerosis of Brain	4.3	165.38%	3.6	138.46%	3	115.38%
Cause Unknown	2.2	42.31%	2.2	42.31%	4.7	90.38%
Epilepsy	3	85.71%	2.7	77.14%	2.7	77.14%
Neuroses and Reactive Conditions	12.8	78.05%	10.4	63.41%	9.6	58.54%
Organic Diseases of the Central Nervous System	2.6	100.00%	2.1	80.77%	2	76.92%
<i>Psikhopatitii</i>	2.8	84.85%	2.1	63.64%	2.4	72.73%
Schizophrenia	3.8	69.09%	3.4	61.82%	3	54.55%
Traumatic Illnesses	7.2	553.85%	5.2	400.00%	4.5	346.15%
Other*	5.22	98.68%	2.71	51.23%	2.71	51.23%

Sources: I. V. Strel'chuk (Gorodskoi psikhiatr g. Moskv), "Ob'iasnitel'naia zapiska po organizatsii nevro-psikhiatricheskoj meditsinskoi pomoshchi Mosgorzdravotdela za 1948 goda," TsMAM, f. 551, op. 1, d. 184, l. 35; E. Babaian (Zam. Nachal'nika Uprav. Spets pomoshchi MZ SSSR), "Spravka o sostoianii psikhonevrologicheskoi pomoshchii naseleniiu SSSR," 20 May 1961, GARF, f. r-8009, op. 1, d. 1411, l. 15.

Note: Strel'chuk's 1948 report and Babaian's 1961 report complement one another. The data that they report for 1940, 1944-1948 are exactly the same, but the 1948 report also includes data for 1941-1943, while the 1961 report includes data for 1949-1950

Like Kameneva, Izrail Berger concluded that the situation in Soviet neuropsychiatric dispensaries in 1947-1948 was similar to the situation seen in the early 1920s. The rate of new arrivals had dropped off, leaving behind a hard core of soldiers with long-term disability, a group that Berger described as "... a fairly massive group of borderline patients ... registered with psychiatric institutions, a group that requires constant support and differential medical and preventative measures over a number of years."<sup>135</sup> These soldiers would have a hard time coping with their medical problems whether they had suffered psychological trauma or a brain injury. They kept coming back to neuropsychiatric dispensaries, according to Berger, not because their illnesses were getting worse, but because of "poor apartment conditions, lack of care, loss of primary profession, incorrect labor placement [*trudoustroistvo*], etc." To make matters worse, Berger explained, war injuries often produced a "peculiar defect of the personality": ex-soldiers developed a "pathological attraction to alcohol," and thus alcoholism was a very serious problem among people suffering from neuro-psychiatric problems after the war.<sup>136</sup>

Berger's pessimism seems to have been borne out by future events. In 1950, an internal report to MZ RSFSR concluded that neuroses, traumatic illnesses, arteriosclerosis, alcoholism, and drug addiction were now the foremost psychiatric problems in the RSFSR.<sup>137</sup> The psychiatric consequences of the war, in other words, could be expected to last for quite some time, even if the population escaped with a lower level of disability than some psychiatrists had expected.

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<sup>135</sup> Berger, "Meropriiatiia po likvidatsii posledstviu voyny," 456.

<sup>136</sup> *Ibid.*, 455.

<sup>137</sup> "Doklad Pravitel'stvennoi komissii o sostoianii psikhonevrologicheskoi pomoshchi v RF i merakh po ee uluchsheniui," 31 July 1951, GARF, f. r-8009, op. 33, d. 399, l. 169.

## Conclusion

In November 1949 USSR Minister of Health Efim Smirnov signed an order that reorganized the USSR's system of hospitals and dispensaries. General hospitals and district polyclinics were to be combined to create a new type of institution that Smirnov hoped would improve the quality of care.<sup>138</sup> Though many people did not realize at the time, however, this *prikaz* also effectively ended debate about the role of psychiatric dispensaries in the Soviet medical system. The new system provided for three basic types of psychiatric institution: psychoneurological hospitals, psychoneurological dispensaries, and psychiatric colonies.<sup>139</sup> The term "psychoneurological" itself signaled Minzdrav's intention that these institutions become more than just "madhouses": by combining psychiatry and neurology, they hoped to produce a more materialist and more efficient form of medical practice.<sup>140</sup>

When the planners at Minzdrav drafted this order, they intended for psychoneurological dispensaries to become the "decisive link" in the psychiatric medicine system. Their overriding concern was with the immediate catastrophic condition of psychiatric hospitals, and they saw psychoneurological dispensaries as outpatient clinics that could help relieve the strain that was being put on hospitals. Each *oblast'* would have at least one psychoneurological dispensary which would give outpatient treatment and keep track of psychiatric patients in the population. *Oblast'* dispensaries would also have a 100-bed "stationary ward" where patients with acute

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<sup>138</sup> Chris Burton, "Medical Welfare During Late Stalinism: A Study of Doctors and the Soviet Health System, 1945-1953" (PhD diss., University of Chicago, 2000), 99-101.

<sup>139</sup> E. I. Smirnov, "Prikaz MZ SSSR No. 870: Ob uporiadochenii set ii ustanovlenii edinoi nomenklatury uchrezhdenii zdavookhranenie," 21 November 1949, GARF, f. r-8009, op. 1, d. 817, ll. 36-47.

<sup>140</sup> On the other hand, psychiatric colonies retained some of the stigma that had always gone with mental illness, as signified by the fact that only they and leper colonies were designed as "medical-prophylactic institutions of a special type." A. Portnov in A. V. Dobrodeev (Chairman), "Stenogramma obsuzhdeniia otcheta Tsentral'nogo nauchno-iss. instituta psikhiiatrii MZ SSSR za 1951 g. i plana raboty na 1952 g.," 9 April 1952, GARF, f. r-8009, op. 33, d. 463, ll. 42-43.



cases of mental illness could be briefly hospitalized and treated, thus keeping mild cases of acute mental illness out of psychiatric hospitals. Psychoneurological hospitals would serve several *oblasts* and they would focus exclusively on treatment. When patients improved enough to live with their families they would be checked out to psychoneurological dispensaries. If they did not improve, they would be sent to psychiatric colonies. These colonies would be controlled by part of the health system, not the social insurance system, because even “chronics” were to be given medical treatment.<sup>141</sup>

Dispensaries, then, would not become social research organizations like Lev Rozenshtein had envisioned in the 1920s and Giliarovskii had promoted again in the mid-1940s. Instead dispensaries would treat patients, consult on diagnoses, and do expert evaluations for labor boards or courts. They would be responsible for maintaining the registration files that tracked mental patients in their jurisdiction. Giliarovskii’s plea for mental hygiene to be “restored to its rights” was granted in part: dispensaries once again were mandated to have “mental hygiene offices,” institutions that had been officially closed in the 1930s. But the tasks of these mental hygiene offices were not the tasks that Giliarovskii had envisioned. They were only given the job of teaching classes to local nurses and physicians, giving speeches to local schools and public organizations, and investigating the living conditions of mental patients who were already on dispensary registration lists. They were not tasked with seeking out patients who had been overlooked, nor were they told to study mental health trends in the population at large. The

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<sup>141</sup> S. V. Kurashov, “K voprosu o proektirovanii psikhonevrologicheskikh boln'its,” *ZhNiP* 53, no. 2 (1953): 143-148.

mental hygiene office had become a public relations office for the Soviet system of outpatient psychiatric clinics.<sup>142</sup>

Giliarovskii's post-World War Two attempt to revive mental hygiene demonstrated his commitment to a holistic, bio-social approach to mental illness. He also demonstrated the power of the bio-social paradigm in the context of Soviet society. Marxism, after all, emphasized that consciousness was a product of man's social environment, and that changes in the social environment produced changes in consciousness. This process might be complex, but if it happened to real people it must be a process that was amenable to empirical study. And who better to study the interface between body, mind, and society than mental hygiene experts?

Giliarovskii's modest success in deploying these arguments are also quite remarkable. They demonstrate that in the post-war period many high-level government officials and scientists found it conceivable that psychological expertise might be used to help Soviet soldiers readjust to civilian life, that psychological testing might be rehabilitated and used in schools and industry, and that psychological research might be returned to the good graces of the Party. For a brief window in 1945-1946, it seemed that the cultural repression of the 1930s might lift.

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<sup>142</sup> Sergei Kurashov seems to have been closely involved in crafting the psychiatric services legislation in 1949, and he continued to shepherd the same ideas through Minzdrav after Efim Smirnov left, including the 1953 *polozhenie* on dispensaries. As USSR Minister of Health in the early 1960s he pushed for a significant expansion of psychiatric hospitals and dispensaries, putting into action the plan that he had helped develop in the 1940s. M. Kovrigina, "Polozhenie o psikhonevrologicheskom dispansere respublikanskogo, kraevogo, oblastnogo, gorodskogo i raionnogo podchineniia," 14 December 1953, GARF, f. r-8009, op. 1, d. 1145, ll. 548-556.

## CHAPTER 4

### “TWO INDEPENDENT SCIENCES”: PSYCHIATRISTS, PHYSIOLOGISTS, AND PAVLOV’S THEORY OF HIGHER NERVOUS ACTIVITY, 1940-1948

“...Clinicians should not be in thrall to the laboratory, and in particular, [they should not] expect questions of diagnosis to be resolved solely by testing neurodynamics using physiological methods ... These [tests] give only partial information [*chastnoe*], but the answers must be looked for in the general [*obshchem*], and the general [*obshchoe*], which includes the partial [*chastnoe*], comes only from the competence of the clinician.”

-- Vasilii Giliarovskii, Director of the USSR Academy of Medical Sciences  
Institute of Psychiatry, “The Ways that the Achievements of Physiology Enter  
Psychiatry,” 1948<sup>1</sup>

#### Introduction

Soviet psychiatrists drew heavily on the conceptual vocabulary of physiology to help explain and describe mental illness, and they often went further, probing and conceptualizing the disordered mind using technologies, methodologies, and theoretical models adopted from the work of physiologists. Psychiatrists wanted to be taken seriously as medical researchers who were making valuable contributions to the scientific understanding of the human mind, and they wanted to demonstrate that they were faithfully working within the ideological and philosophical boundaries laid down by the classics of dialectical-materialism. Both goals were served by using the work of physiologists. But physiology became particularly exciting for psychiatrists in the

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<sup>1</sup> V. A. Giliarovskii, "Puti proniknoveniia dostizhenii fiziologii v psikhiiu," *Nevropatologiia i psikhiiu* 17, no. 2 (1948): 12.

1930s and 1940s because of new discoveries about the function of the nervous system, the role of chemical mediators, and discoveries about the structure and function of neurons. These developments were seized on by leading psychiatrists, who used these findings as the basis for their own research agendas. They then turned to the Soviet government to ask for more funding and for special preference for their own institutions and projects, using their cutting edge research and their connections with leading physiologists to justify their special status. Arguments about scientific theory and the role of physiology in psychiatry were thus closely tied to arguments about funding, prestige, and institutional power.

In this chapter I trace interrelated stories of institutional politics and scientific dispute, both of which went back to the 1930s (and in some cases even earlier). The institutional story focuses on the creation and development of the USSR Academy of Medical Sciences, a network of the most prestigious medical research institutes in the USSR that was created in 1944, and which completed, but also upset, the existing hierarchy of medical research institutes. This new scientific hierarchy conferred prestige and influence on some scientists, but it also implied exclusivity, relegating some scientists and even whole disciplines to second-tier status. In 1947 and 1948, psychiatrists found themselves defending their discipline's right to be a member of this exclusive club and thus more broadly the significance of their discipline as a medical science.

The scientific debates that became entwined with this institutional story focused on developments in neurophysiology and biological psychiatry that reopened discussion about the nature of consciousness. Was consciousness solely a function of the cortex of the brain as Ivan Pavlov had believed? Could behavior and complex psychological functions be explained as conditional reflexes laid down in response to past events? Or would new discoveries force a

reevaluation that cast consciousness as an interaction between “center and periphery”? New findings about the structure of neurons, the role of the sympathetic nervous system, and the role of chemical mediators all suggested that the old “cortical dogmatism” was perhaps untenable. What then for the claim that behavior was a response to past events? If the mind was not strictly determined by the reality that surrounded it, would dialectical-materialist theory of perception have to be reevaluated?

These were the questions that engaged elite soviet psychiatrists in the 1930s and 1940s, and they were almost always discussed in relation to Ivan Pavlov’s theory of higher nervous activity and the broader background of classical Russian physiology going back to nineteenth century physiologist Ivan Sechenov. From the time of the Revolution, Bolshevik leaders had demonstratively supported Pavlov and his research on conditional reflexes, and in 1950 the Party would organize a “discussion” where many physiologists (and psychiatrists) would be denounced for deviating from the “doctrine” [*uchenie*] that had been set down by the master. This 1950 “Pavlov Session” was explicitly modeled on the Party’s 1948 intervention in genetics, and scholars have tended to see Pavlov’s theory of higher nervous activity as an analogue of Trofim Lysenko’s neo-Lamarckian theory that acquired genetic traits can be passed on to one’s offspring. As I will show in Chapters 5 and 6, the parallel to Lysenkoism is not altogether mistaken. But Pavlov’s “theory of higher nervous activity” was not simply a pseudoscientific sham like Lysenko’s genetics. It was, rather, a serious physiological theory based on rigorous experimentation, and in the 1930s and 1940s its proponents could still tenably defend Pavlov’s conclusions based on the data and technology available to them.

While scholars have tended to caricature Pavlovian scholars as pseudoscientific opportunists, they have also tended to project the 1950 Pavlov Session backward into the 1930s

and to assume that Pavlov's theory was the only approach that was allowed. In fact, however, Pavlov's theory of the mind was becoming increasingly less central among Soviet physiologists in the late 1930s. Psychiatrists were particularly excited about physiology precisely because they sensed that they were part of a group of scientists who were on the cusp of making real breakthroughs in the scientific understanding of the mind. Psychiatrists believed that they were making serious contributions to this new science, and they saw themselves as the peers of the physiologists, neurologists, histologists, biochemists that they worked with in laboratories, debated at conferences, and served with on editorial boards and government commissions. They hoped that these scientists would come to see them as peers as well.

### **Vasilii Giliarovskii and the USSR Academy of Medical Sciences**

In 1944 the Soviet government reorganized the system of medical research institutions, integrating them into a systematic hierarchy that culminated in a prestigious new body, the USSR Academy of Medical Sciences. Coming at a time when the Soviet army was reporting victory after victory, the creation of the Academy seemed to psychiatrists like a step toward a new postwar era of scientific progress. As one psychiatrist declared in November 1945, "We're now living, comrades, in the epoch of the atom, when a genuine revolution [*nastoiashchaia revoliutsiia*] is taking place ... We will find effective methods of treatment for schizophrenia and other types of disease, we will organize the battle against cancer, like in America. ... We have the Medical Academy and other medical institutions. They can take on themselves the question of developing the fight and active methods of treatment."<sup>2</sup>

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<sup>2</sup> Ivan Strel'chuk, in A. N. Motnenko (Chairman), "Stenogramma soveshchaniia psikhiatrov pri Upravlenii gorbol'nits Narkomzdrava SSSR," 30 November 1945, GARF, f. r-8009, op. 5, d. 249, l. 58.

The Academy of Medical Sciences Institute of Psychiatry was created in 1944 along with the rest of the Academy, and it was directed by psychiatrist Vasili Giliarovskii, the chairman of the psychiatry at the Second Moscow Medical Institute and longtime head of a famously cutting edge experimental clinic. The 69 year old Giliarovskii was already one of the most prominent psychiatrists in the USSR in 1944, but the creation of the Academy Institute made him, at least in theory, the most important and most influential psychiatrist in the Soviet Union. Giliarovskii quickly developed a research program for his new institute that was intended to justify the institute's position as the new leading psychiatric institute in the USSR and to set the scientific agenda for other psychiatric research institutes in the USSR. He argued that if psychiatrists wanted to understand the origins of mental disturbances like hallucinations and delusions, they would have to study the interaction between the cortex of the brain, the central nervous system, and the rest of the body. At a non-conscious level, he believed, the human nervous system must somehow be processing an enormous amount of "signal" information from the far-flung parts of the body and sending back instructions based on the changing situation in the outside world. The conscious mind was not usually aware of these signals, but it was still influenced by them. In fact, he thought, these "elementary sensations" were just as important as the sensations that arrived from the eyes or the ears. Though these stimuli remained "subthreshold," below the level of conscious awareness, they were still had a significant impact on the mind. "The results of this mental work," Giliarovskii wrote, "enter consciousness in the form of preformed conclusions and, under certain conditions, [in the form of] delusional conclusions."<sup>3</sup> The mind, then, had non-conscious processes that could have a serious impact on thoughts and decisions, and significant

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<sup>3</sup> Giliarovskii, "Puti proniknoveniia," 10.

mental activity took place outside the cortex of the brain in the subcortical structures or even in the autonomic (vegetative) nervous system.

Pavlov's theory of higher nervous activity, according to Giliarovskii, provided a framework for understanding the mind as a complex phenomenon. Pavlov had seen the nervous system as the product of a long process of evolution. The simple nervous systems of early animals were preserved in the lower structures of the spinal cord, brain stem, and subcortical structures in the brain. The higher structures in the cortex of the brain were of much more recent evolutionary origin, and they accounted for conscious thought, while the lower areas dealt with automatic function. To fully understand the nature of the mind, and particularly the nature of mental illness, psychiatrists would need to study the interaction between the lower, more ancient levels of the nervous system and the higher, more recent levels in the cortex. This interaction, Giliarovskii claimed, could provide a physiological explanation for the dialectical-materialist theory of the mind, Lenin's "theory of reflection."<sup>4</sup>

Giliarovskii's approach to psychiatry was endorsed by many other psychiatrists. A conference of 108 psychiatrists at Giliarovskii's institute in May of 1947, for instance, concluded that Giliarovskii's methodology was a "correct and fruitful" approach, and that it was particularly useful because it provided a Marxist-Leninist dialectical approach to the mind.<sup>5</sup> Not all leading psychiatrists agreed. Among these were both psychiatrists who were declared Pavlovian fundamentalists and psychiatrists who sought to modify and extend Pavlov's theory.

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<sup>4</sup> Giliarovskii often wrote about Pavlov's evolutionary principles. See, for instance, V. A. Giliarovskii, *Starye i novye problemy psikhiiatrii* (Moscow: Medgiz, 1946). See also the abstract of a speech he gave to a conference at the Institute of Psychiatry in 1947 where he lectured at length on Lenin's theory of reflection and how it was supported by the Pavlovian physiology developed by Bykov and others. Idem., "Otchet o nauchno-issledovatel'skoi rabote institute psikhiiatriia za 1947 god," undated, GARF, f. r-9120, op. 2, d. 420, ll. 114-115.

<sup>5</sup> V. A. Giliarovskii, "Otchet o nauchno-issledovatel'skoi rabote Instituta psikhiiatrii za 1947 god," GARF, f. r-9120, op. 2, d. 420, l. 115.



In 1946 and 1947 their conflict escalated into a politicized and sometimes ad-hominem dispute over the proper role of physiology in psychiatry, and by 1948 these debates had provoked an open discussion of the status of psychiatry as a scientific discipline and the proper limits of Pavlov's theory of higher nervous activity. This conflict was rooted in a history of personal, institutional, and scientific dispute that went back to the early 1930s. To understand why Giliarovskii's approach was considered controversial or mistaken, then, it is necessary to first place it in the context of the interaction between psychiatry, physiology, and dialectical-materialism.

### **Psychiatric Theory, Dialectical Materialism, and Pavlovian Physiology**

Soviet psychiatrists wanted to understand how people's minds came to be disturbed and how they might be healed, and this brought them into contact with other specialists who studied the mind, the brain, and consciousness. Unlike their colleagues in the West, however, Soviet psychiatrists had to contend not only with the research findings of psychologists, physiologists, and neuropathologists, they also had to contend with an official ideology, dialectical materialism, which had a declared position on the true nature of the psyche. This complicated how psychiatrists presented their work, and it meant that psychiatrists had to avoid certain approaches to the mind were considered patently invalid in light of dialectical-materialist theory, particularly any claim that might appear to suggest that the mind was independent of the body. But despite the categorical statements of Soviet philosophers, the foundational texts of dialectical materialism themselves were in fact far from univocal about the nature of the psyche. As a result, Soviet psychiatrists were able to develop a sometimes surprisingly diverse range of approaches to the mind, all of which were able to cite classic texts by Lenin, Engels, or Stalin to support their positions. The philosophical claims found in dialectical-materialism had to be

acknowledged, but they could also be used as a cultural and political resource to support different ends.

The psychiatrists who were in charge of research institutions, hospitals, and government committees in the 1940s came of age in the late nineteenth century and early twentieth century, a time when most members of the Russian intelligentsia believed that natural science could unlock all the basic secrets of the natural world, including the laws governing the human mind. These physicians and scientists were immersed in a culture that accepted as unproblematic the idea that the mind might be governed by natural, explainable processes. The way had been prepared by the previous generation, which had defended materialism and positivism as tools of political and ideological change. Ivan Sechenov's "Reflexes of the Brain" (1863) had been universally read and discussed in intelligentsia circles, and its point of view had become part of the intellectual background of Russian professional life. In the early twentieth century it was "neither radical nor uncommon to assert that what Pavlov termed *psychic secretion* might be explicable as a reflex."<sup>6</sup> In this milieu, most educated Russians, including leading Bolsheviks, assumed that physiologists were discovering facts about the brain and the nervous system that would eventually lead to a complete picture of the laws of the mind. Speculative psychology based on subjective introspection would give way to a physiology of the mind based on the objective experimental study of the "reflexes of the brain."<sup>7</sup>

The basic problem that concerned theorists of dialectical-materialism was perception and its role in consciousness, and particularly the nature of the thoughts inside our heads. When I

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<sup>6</sup> Daniel P. Todes, *Pavlov's Physiology Factory: Experiment, Interpretation, Laboratory Enterprise* (Baltimore: Johns Hopkins University Press, 2002), 229-230. See also Daniel P. Todes, "From Radicalism to Scientific Convention: Biological Psychology in Russia from Sechenov to Pavlov" (PhD, University of Pennsylvania, 1981).

<sup>7</sup> David Joravsky, *Russian Psychology: A Critical History* (Oxford: Basil Blackwell, 1989), 166.

look at a red fire engine, can I assume that the red fire engine that I see is that same red fire engine that everyone else sees? Does the red fire engine exist independently of me and my gaze? This is of course a classic problem of both psychology and philosophy, and continues to be one of the great questions for cognitive neuroscience. For many people the intuitive answer has been yes, the red fire engine is really out there, and we all see it the same way; my red is your red, my truck is your truck. John Locke famously argued that humans begin their lives with minds that are “blank slates” and that all the ideas and concepts that we come to hold are in fact reflections of the really-existing outside world. The counterintuitive but powerful argument against this “realist” position is that the information that we get about the outside world is mediated through physical and psychological filters that we carry around inside our heads. The image in our heads is not the red fire engine itself. What we see starts off as light reflected from the vehicle which travels through space to our eyes, is transformed into signals that travels down nerves and stimulates parts of our brains. The stimulated brain somehow translates this signal into a representation of the fire engine that we can consciously perceive, but that representation is not the same as the light that traveled from the truck, nor is the nerve signal the same as the light. The neural pattern, however it might be produced, is not the same as our subjective perception, the image in our heads. So perhaps the image that we see as “fire engine” is shaped mainly by our brains in the process of coding and decoding complex signals. Emmanuel Kant famously argued this “anti-realist” position, claiming that we were born with certain categories and structures built into our minds and that the raw stuff of perception is always filtered through the lenses of our own conceptual categories. The images in our head, at minimum, are only a mediated experience of whatever is “really” out there. We can experience our own perception of the red fire engine, but we can never know if anyone else experiences the fire engine in the same

way or if our image has much in common with the really existing thing. Taken to an extreme, this position argues that reality is produced through perception, and does not exist outside our encounter with it.<sup>8</sup>

In 1909 Lenin published a book which became one of the foundational texts of dialectical-materialism in the Soviet Union, *Materialism and Empiriocriticism*. In it he made an extreme version of the realist argument. Arguing against other Russian Marxist thinkers, who were inclined to accept the idea that our knowledge of the world might be mediated, Lenin claimed that there is a 1:1 relationship between the material objects we perceive and the perception of those objects in our minds. He called this “the theory of reflection” [*teoriia otrazheniia*] and insisted that “what we see in our heads are ‘copies, pictures, mirror images, reflections’ of external objects.”<sup>9</sup> By the 1930s the theory of reflection had become enshrined in Soviet scientific discourse as the definitive philosophical solution to the problem of how we can know what we know about the world. In the entry for “psyche” in the first edition of the *Bol’shaia Sovetskaia Entsiklopediia* [“The Great Soviet Encyclopedia”], psychologist Aleksei Leon’iev described the “theory of reflection” as “the essence of the Marxist theory of the psyche... the reflection of an existing material reality independent from ourselves.”<sup>10</sup>

One of the reasons that Ivan Pavlov’s “theory of higher nervous activity” was so attractive to Bolshevik leaders was that Pavlov and his students claimed to have done exactly what Bolshevik intellectuals like Lenin had expected the physiologists to do: use the

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<sup>8</sup> For an overview of the realism/anti-realism debate, see Samir Okasha, *Philosophy of Science: A Very Short Introduction* (Oxford: Oxford University Press, 2002), 58-76; Antonio Damasio, *The Feeling of What Happens: Body and Emotion in the Making of Consciousness* (San Diego, CA: Harcourt, Inc., 1999), 320-321; Kandel, *In Search of Memory*, 202-203.

<sup>9</sup> Joravsky, *Russian Psychology*, 190-191; Loren R. Graham, *Science, Philosophy, and Human Behavior in the Soviet Union* (New York: Columbia University Press, 1987), 42-43.

<sup>10</sup> *BSE*, 1<sup>st</sup> ed. (M: 1940), s.v. “psikhika.”

experimental methods of the laboratory to figure out the physical laws governing the reflection of reality in the brain. Until the early twentieth century Pavlov had devoted his laboratory to the study of digestion, and he was awarded a Nobel Prize for this work in 1904. In the process of doing this research, however, he (or rather, one of his lab workers) had discovered that dogs could be trained to salivate copiously in anticipation of food.<sup>11</sup> Pavlov published his first paper on conditional reflexes in 1903, and in the years that followed he devoted himself and his considerable scientific organization to studying conditional reflexes and the laws governing their establishment, their extinction, and the complex regularities of their interaction. His international prestige and his materialist research earned him praise and support from the Bolshevik regime, despite Pavlov's own vocal objections to Communism and the Bolsheviks.<sup>12</sup>

Pavlov believed that conditional reflexes were the fundamental units on which all complex behavior was based. In his classic model, a dog is trained to salivate at the sound of a bell. The dog salivates naturally when it sees food – an unconditional reflex. But when the researcher consistently rings a bell before giving the dog its food, the dog begins to salivate at the ringing of the bell regardless of whether food is present or not. This discovery proved to be of lasting importance for psychological science in the twentieth century, and was taken up by many scientists outside of Pavlov's own lab. "Behaviorism" was born when contemporaries like the American Karl Lashley focused on the observable effects of behavioral conditioning. Later neuroscientists ignored Pavlov's own neurological explanations, but did use conditioning as a tool for physiological experimentation. In his research into the neuronal correlates of learning, for instance, physiologist Eric Kandel used Pavlovian conditioning techniques to design his

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<sup>11</sup> Todes, *Pavlov's Physiology Factory*, 216-254.

<sup>12</sup> Daniel P. Todes, "Pavlov and the Bolsheviks," *History and Philosophy of the Life Sciences* 17, no. 3 (1995): 379-418.

experiments on the neurons in sea slugs. Such research suggests that Pavlovian conditioning can take place at the level of synaptic connections even in creatures with extremely simple cellular structures, and helped win Kandel the Nobel Prize in 2000.<sup>13</sup> Both behaviorism and modern neuroscience, however, used Pavlov's ideas in ways that he himself considered to be ignoring "the essence of his doctrine as he conceived it," as David Joravsky writes.<sup>14</sup> Conditional reflexes, Pavlov believed, could explain complex human thought as well as simple reactions in dogs, and thus conditional reflexes could be used as a tool to probe the laws of the mind without the need for introspection or subjective reporting. Simply by measuring the dog's production of saliva in response to a variety of stimuli under experimental conditions, the researchers could make precise measurements of mental processes, and thus build up a scientific understanding of the fundamental laws of the mind, the "theory of higher nervous activity."<sup>15</sup>

Like many neurophysiologists in the late nineteenth century, Pavlov conceived of the central nervous system as a hierarchical system of parts that had developed at different points in human evolution: the oldest, most evolutionarily ancient parts were the "lowest" in the hierarchy, and they were responsible for inborn, instinctual behaviors – unconditional reflexes.<sup>16</sup> The newest, most evolutionarily recent parts were in the cortex of the brain and had no inborn function: this, Pavlov believed, was where conditional reflexes were formed. Their role was to

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<sup>13</sup> Eric R. Kandel, *In Search of Memory: The Emergence of a New Science of Mind* (New York: W. W. Norton & Company, 2006), pp. 158-159, 160-161; Luis Aguado, "Neuroscience of Pavlovian Conditioning: A Brief Review," *The Spanish Journal of Psychology* 6, no. 2 (2003): 155-167. "All Nobel Laureates in Medicine," [http://nobelprize.org/nobel\\_prizes/medicine/laureates/](http://nobelprize.org/nobel_prizes/medicine/laureates/) (accessed 31 July 2008).

<sup>14</sup> Joravsky, *Russian Psychology*, 386.

<sup>15</sup> Joravsky, *Russian Psychology*, 138-145, 277, 293-297.

<sup>16</sup> In psychiatry and neurology, the most influential source of this idea seems to have been J. Hughlings Jackson, who in turn had been directly influenced by Herbert Spencer's mid-century writings on psychology. A. R. Luria, *The Making of Mind: A Personal Account of Soviet Psychology*, ed. Michael Cole and Sheila Cole (Cambridge, Mass.: Harvard University Press, 1979), 122-123; Boris Petrovitch Babkin, *Pavlov: A Biography* (Chicago: University of Chicago Press, 1949), 293-301; Mary A. B. Brazier, *A History of Neurophysiology in the 19th Century* (New York: Raven, 1988), 158-160.

respond to the changing environment, and part of this response meant controlling and guiding the action of the lower, automatic parts of the nervous system.<sup>17</sup> Reflexes were subject to two basic processes: excitation and inhibition. These terms were common in nineteenth century and twentieth physiology, and they had a wide range of meanings and usages. Roughly speaking, Pavlov used the term “excitation” to describe the stimulation of a reflex, and he used the term “inhibition” to describe what happened when a reflex ceased to operate. He conceived them as “nervous processes” that spread through the brain and the nervous system in “waves,” and wrote of a healthy nervous system as a zone of conflict between these two processes, “ending normally in a certain equilibrium between them, in a certain balance.”<sup>18</sup> These processes could explain a broad variety of behavior, the nerve “center” that responded to a bell, to the soldier who suppressed his fear in face of battle, to the nightly experience of sleep. The brain was a “canvas” on which an ever-changing pattern was projected by the external world. External stimuli resulted in “centers” of inhibition or excitation, some of them quite strong, others weak. Excitation and inhibition would “irradiate” toward strong centers, thus establishing the links between “centers” that were key to conditional reflexes. The canvas thus turned from a “mosaic” of stimulated centers into a complex and shifting lattice of interconnected nodes. Complex behaviors, he argued, were developed over time by the simultaneous stimulation of many different “centers” which became associated with one another. Pavlov referred to this type of formation as a “dynamic stereotype,” a constellation of blazing lights on the “great mosaic” of the brain.<sup>19</sup>

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<sup>17</sup> George Windholz, "Pavlov's Concept of Schizophrenia as Related to the Theory of Higher Nervous Activity," *History of Psychiatry* 4, no. 16 (December 1993): 515-516.

<sup>18</sup> Pavlov, quoted in Roger Smith, *Inhibition: History and Meaning in the Sciences of Mind and Brain* (Berkeley: University of California Press, 1992), 200.

<sup>19</sup> Douglas L. Grimsley and George Windholz, "The Neurophysiological Aspects of Pavlov's Theory of Higher Nervous Activity: In Honor of the 150th Anniversary of Pavlov's Birth," *Journal of the History of the Neurosciences* 9, no. 2 (2000): 152-163.

In the simple outlines of this theory, Bolshevik leaders felt that they recognized the scientific realization of their hope for an objective science of the mind. In Pavlov's theory, "behavior at any level could be explained by reflexes," from the simplest to the most complex.<sup>20</sup> Objective science could at last show how external reality was "reflected" in the cortex of the brain in Pavlov's "grand mosaic." "Inhibition" in this schema became a key component in human culture because it enabled humans to direct or suppress the inchoate, automatic impulses that came from the lower parts of their nervous systems.<sup>21</sup> Personality could be accounted for by positing different inborn individual tendencies toward inhibition (inward looking, controlled, unspontaneous) or excitation (emotional, impulsive, uninhibited). Neuroses likewise could be conceptualized as a pathological relationship between higher and lower parts of the nervous system.<sup>22</sup> When Pavlov died in 1936 at the age of 87 his theory was hailed as the natural sciences explanation of Lenin's theory of reflection.<sup>23</sup>

Taken in their most basic terms, "The Theory of Higher Nervous Activity" and the "Theory of Reflection" were both radically reductive versions of realism, insisting that the minds of humans are purely reactive, "mirrors" responding to their environment. As David Joravsky points out in his probing examination of Russian psychology, this vision of humans as machines

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<sup>20</sup> Joravsky, *Russian Psychology*, 165.

<sup>21</sup> Physiologists working after the French Revolution were concerned with issues of command and obedience, and, as Roger Smith shows, their anxieties about natural hierarchies exerted significant influence over how they conceptualized and described the body. "Scientific theories of inhibition," he writes, "reexpressed ways of thought already embedded in the culture. In doing so, however, they lent an authority based on the prestige of observational scientific methods. Inhibition became part of a language characterizing regulation as a natural process, thereby confirming conceptions of ordered life that people already possessed. But this return re-presented those conceptions as objective descriptions of nature." Smith, *Inhibition*, 10.

<sup>22</sup> Paul Calloway, *Russian/Soviet and Western Psychiatry: A Contemporary Comparative Study* (New York: John Wiley, 1993), 176-177.

<sup>23</sup> As Joravsky usefully points out, "In Russian Pavlov's reflexes (*refleksy*) and Lenin's reflection (*otrazhenie*) are not cognates, as they are in English, but the metaphorical resonance is very strong anyhow." Joravsky, *Russian Psychology*, 388.



subject to the strict laws of the material world existed in tension with Marx's belief in man as a creative force, an agent of his own destiny capable of shaping the world around him. Lenin himself continued to grapple with this problem after he published his realist polemic, and in the notebooks that he kept during the First World War he showed a much more subtle awareness of the problems of agency and human consciousness. As Joravsky writes, some of the ideas in these notebooks were those that "the author of *Materialism and Empiriocriticism* had denounced as utter idealism. For example: 'The consciousness of man not only reflects the objective world but also creates it.'"<sup>24</sup> This later Lenin went so far as to recognize that there is not a 1:1 correspondence between reality and mental reflection, and even that there is an element of "fantasy" in our perception of the surrounding world.<sup>25</sup> These "philosophical notebooks" were published in the Soviet Union in the late 1920s, and in full form in 1933, and they provided a text that scientists and philosophers could draw on when they wanted to make arguments that acknowledged the ambiguities and complexities of the mind, or when they wanted to imply that not all human behavior can be explained as reactions to prior events.<sup>26</sup>

Pavlov too provided some room for vague acknowledgement of will and choice. He speculated at times that there was a "second signal system" that explained higher order thought in humans. He called the conditional reflexes related to most external stimuli "the first signal system," but he suggested that human language was different because words were abstract symbols whose significance was not rooted in the intrinsic physical properties of the sounds (the thing itself) but rather in the collectively agreed upon meaning of the sounds. As a result, he thought, these stimuli created conditional reflexes in the cortex that constituted a "second signal

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<sup>24</sup> Joravsky, *Russian Psychology*, 191.

<sup>25</sup> Graham, *Science, Philosophy, and Human Behavior*, 45.

<sup>26</sup> Graham, *Science, Philosophy, and Human Behavior*, 42-45; Joravsky, *Russian Psychology*, 187-191.

system,” a system that he sometimes described as “the physiological foundation of thought.” Mental illness in humans, Pavlov claimed, might be caused by anything that disrupted the second signal system, and the functional psychoses (those not caused by any obvious lesions in the brain) were caused by disordered relationships between the two signal systems, or between the cortex and the subcortex. To treat these psychoses, then, one should try to reestablish normal balanced functioning of the signal systems.<sup>27</sup>

Most Soviet psychiatrists received Pavlov’s ideas with interest, cited him from time to time, but found little in his theory that they could use in their day-to-day work. In an article commemorating Pavlov in 1936, Vasilii Giliarovskii described Pavlov’s main contribution to psychiatry as the introduction of objective laboratory methods to clinical practice, and in a 1945 review of reflex theory he called the conditional reflex method “of little use in the study of humans.”<sup>28</sup> A few psychiatrists, however, did try to figure out how to apply Pavlov’s ideas in psychiatric hospitals, and the most significant of these was a Leningrad psychiatrist named Anatolii Ivanov-Smolenskii. Born in St. Petersburg in 1885, Ivanov-Smolenskii graduated from the Military-Medical Academy in 1917, and served as a division medical doctor in the army in 1917-1918. From 1919 to 1927 he studied under Vladimir Bekhterev at the Leningrad Psychoneurological Institute and with Bekhterev’s protégé Viktor Osipov at the Military Medical Academy. In 1921 he defended his doctoral dissertation under Osipov’s direction, “The

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<sup>27</sup> L. A. Orbeli, "Vtoraia signal'naia sistema," *NiP* 18, no. 5 (September-October 1949): 8-18.

<sup>28</sup> Giliarovskii credited Pavlov with having a knack for comforting the mentally ill, many of whom apparently wrote to Pavlov hoping for a cure. V. A. Giliarovskii, "I. P. Pavlov i psikhiairiia," *Nevropatologiia, psikhiairiia, psikhogigiena* 5, no. 6 (1936): 907-908; idem., "Kontsepsiia refleksa na razlichnykh etapakh razvitiia psikhiairiia," *NiP* 14, no. 1 (1945): 6. Mikhail Gurevich went so far as to write that psychiatrists who had wanted to apply Pavlov’s theory had been “intellectually sterile.” In the twenty years since the Revolution, Gurevich claimed, not a single work had been written from that perspective that had received any sort of recognition as an achievement. The notion that humans are merely passive, acted upon by their world, was not compatible with the Marxist concept of human psyche. M. O. Gurevich, "20 let sovetskoi psikhiairiia," *NiP* 6, no. 10 (1937): 19-20.

development of the theory of psychasthenia and the experience of experimental psychophysiological research on psychasthenics.” He received the title of “professor” in 1923.<sup>29</sup>

During these years Ivanov-Smolenskii was heavily involved with Bekhterev’s institute, serving as its deputy director from 1918-1921. In 1921, however, Ivanov-Smolenskii began to work with Pavlov, Bekhterev’s colleague and rival, first in Pavlov’s laboratory at the Military Medical Academy and later in Pavlov’s laboratory at the Institute of Physiology. In 1924 Ivanov-Smolenskii helped organized the first university department for the study of higher nervous activity, and he headed this department (at the A. G. Herzen Pedagogical Institute) until 1931.<sup>30</sup> In 1931, Pavlov invited Ivanov-Smolenskii to come to work for him and to organize a psychiatric clinic where they could study higher nervous activity.<sup>31</sup> There Ivanov-Smolenskii pursued a number of projects which attempted to apply the theory of higher nervous activity to mental patients. One of these projects involved adapting new methods of active therapy, especially prolonged sleep. (See Chapter Six.) What Ivanov-Smolenskii was most known for, however, was his efforts to operationalize Pavlov’s idea of the “second signal system.” To do this, he tried to

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<sup>29</sup> "A. G. Ivanov-Smolenskii (K 60-letiiu so dnia rozhdeniia)," *Zhurnal nevropatologii i psikhatrii im. S.S. Korsakova* 55, no. 4 (1955): 315; "Anatolii Georgievich Ivanov-Smolenskii (K 50-letiiu nauchnoi deiatel'nosti)," *ZhNiP* 67, no. 12 (1967): 1880; *BME*, 3<sup>rd</sup> ed., s.v. "Ivanov-Smolenskii," and "Anatolii Georgievich Ivanov-Smolenskii (K 50-letiiu nauchnoi deiatel'nosti)," *ZhNiP* 67, no. 12 (1967): 1880; I. V. Strel'chuk and V. K. Faddeeva, "A. G. Ivanov-Smolenskii (K 90-letiiu so dnia rozhdeniia)," *ZhNiP* 85, no. 11 (1985): 1721-1722; "Protokol #4 rasshirenogo zasedaniia Prezidiuma UMS NKZ SSSR, sovместno sovместno s predsedateliami i sekretariami nauchnykh med. ob-v i Komitetom pomoshchi invalidam i rannym OV," 21 February 1946, GARF, f. r-8009, op. 2, d. 868, l. 46.

<sup>30</sup> It is likely that Ivanov-Smolenskii lost his job at the Herzen Institute in the wake of the discussion of pedology there in 1931. Ivanov-Smolenskii’s work in the late 1920s focused particularly on children, and he also seems to have flirted with Freudian theory. It is likely that in inviting Ivanov-Smolenskii to head a psychiatry lab, Pavlov was in fact saving the man’s career. For Freudian work being done at Ivanov-Smolenskii’s lab, see T. V. Kovsharova, "Opyt eksperimental'nogo issledovaniia analiticheskoi psikhoterapii," *Nevropatologiya, psikhatriia, psikhogigiena* 5, no. 7 (1936): 1149-1162; *BME*, 2<sup>nd</sup> ed., s.v. "Ivanov-Smolenskii," and "A. G. Ivanov-Smolenskii (K 60-letiiu so dnia rozhdeniia)," *Zhurnal nevropatologii i psikhatrii im. S.S. Korsakova* 55, no. 4 (1955): 315,

<sup>31</sup> *BME*, 2<sup>nd</sup> ed., s.v. "Ivanov-Smolenskii"; "A. G. Ivanov-Smolenskii (K 60-letiiu so dnia rozhdeniia)," *ZhNiP* 55, no. 4 (1955): 315; I. V. Strel'chuk and V. K. Faddeeva, "A. G. Ivanov-Smolenskii (K 90-letiiu so dnia rozhdeniia)," *ZhNiP* 85, no. 11 (1985): 1721-1722.

show that under laboratory conditions spoken words could act as stimuli for conditional reflexes. These spoken-word reflexes, Ivanov-Smolenskii believed, still followed the same laws of excitation and inhibition that governed all conditional reflexes, even though were based on complex symbolic information. Like the dogs that were shown a ringing bell or a light before every feeding, Ivanov-Smolenskii's experimental subjects were shown a light before being given a command to touch a telegraph button. Eventually the subject would touch the button in response to the light even without the spoken command. Ivanov-Smolenskii claimed that these "second signal system" reflexes could then be used as tools to probe the functional condition of the human mind, just as Pavlov had used conditional reflexes to probe the regularities in the minds of his dogs.<sup>32</sup> The information gained in this way could be used to help the psychiatrist decide what treatment to give, whether to encourage excitation or inhibition, for how long, and to what degree. In short, Ivanov-Smolenskii hoped to use Pavlov's theory of higher nervous activity as a tool that would open the way to a truly rational biological psychiatry.

### **Leon Orbeli, Konstantin Bykov, and the Vegetative Nervous System**

Ivanov Smolenskii's work stands out because he particularly insisted that Pavlov was right about the central importance of the cortex in regulating all the functions of the body. Some of Pavlov's other students were not so sure, however. Even during his lifetime, several of Pavlov's most prominent protégées began to question his claims that conditional reflexes were properties of the cortex of the brain, and even his claim that behavior was strictly determined by past experience. Pavlov's theory of higher nervous activity was based on a strictly determinist model of reflex action in the cortex of the brain. All complex behaviors, he believed, were

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<sup>32</sup> A. G. Ivanov-Smolenskii, "Ob izuchenii sovместnoi raboty pervoi i vtoroi signal'nykh sistem mozgovoï kory," *Zhurnal vysshei nervnoi deiatel'nosti imeni I. P. Pavlova* 1, no. 1 (1951): 57.

responses to past experiences: a dog that salivated at the sight of meat was not salivating because it anticipated getting food in the future; it was salivating because it associated the sight with past feedings. “Higher nervous activity” could be understood as strictly determined by cause (past stimuli) and effect (future behavior).<sup>33</sup>

One of the physiologists who questioned these dogmas was Leon Orbeli, an Armenian physiologist who had trained with Pavlov at the Military Medical Academy, and who Pavlov tapped to succeed him as director of his institute. In the 1920s and 1930s Orbeli shifted his research focus from the cortex of the brain to the sympathetic nervous system. He was interested in the basic physiological problem of how the body maintains a stable internal environment. Even single-celled organisms devote a great amount of energy to maintaining a stable internal environment. If an amoeba suddenly finds itself surrounded by water that is high in sodium, it needs some mechanism to maintain the right level of sodium inside its cell wall. For an animal as complex as a human being, maintaining a constant internal environment becomes much more difficult. Like any creature, a complex animal like a human must monitor the changing world around the body and respond to it. Unlike the single-celled amoeba, however, the human has a vast number of bodily systems that need to be kept in working order. To adjust the body’s internal state to changing conditions, then, the human must have some idea at any given moment of what state the body is in. This phenomenon had been recognized since the mid-nineteenth century, and was commonly referred to using the term *milieu interior* coined by one of the great founders of experimental physiology, French scientist Claude Bernard. Orbeli’s research showed how the sympathetic nervous system interacted with the brain stem and other subcortical

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<sup>33</sup> Pavlov’s approach contrasted sharply with the procedure adopted by American behaviorist psychologists who were inspired by his work. They let their lab rats loose in mazes with food as a reward at the end of the course. The rats were put into a much more complex situation than Pavlov’s dogs, and clearly had active choices to make in running through the maze. Joravsky, *Russian Psychology*, 294-296.

structures, especially the cerebellum and the hypothalamus, and that not all of this interaction involved impulses sent through nerve cells. In fact, the sympathetic nervous system and the subcortical structures of the brain were in constant interaction, and much of this interaction was done using biological chemicals that were released into the blood stream and communicated information through so-called “neurohumoral means.”<sup>34</sup>

Pavel Anokhin, another of Pavlov’s students, was also interested in the issue of the regulation of the body’s internal environment. Anokhin had come to believe that Pavlov’s reflex theory needed to be seriously modified in order to explain how animals could cope with novel situations where past experience was no guide. How, in other words, did animals make choices? In 1935 he published a paper in which he proposed that the nervous system was made up of what he called “functional systems” which operated on a feedback principle. Pavlov had conceived of a reflex as a one-directional unit, where stimuli traveled along a “reflex arc” from the sense organ to the cortex and then on to an “effector.” Anokhin proposed a final stage in which the “effector” sent a signal back to a central location indicating that an action had been carried out. At the simplest level, his functional system would act on a principle similar to a thermostat, with the organism continuing to carry out an action until some equilibrium level was reached, like the furnace that continues to heat until the room reaches a predetermined temperature.<sup>35</sup> “In his view,” writes historian Slava Gerovitch, “each functional system worked in a closed loop:

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<sup>34</sup> V. L. Sviderskii, N. P. Veselkin, and Iu. V. Natchin, "Shkola L. A. Orbeli," in *Fiziologicheskie nauchnye shkoly v SSSR: Ocherki*, ed. N. P. Bekhtereva (Leningrad: Nauka, 1988), 94-107; V. V. Fanardzhian, "L. A. Orbeli i sovremennyye predstavleniya o funktsiyakh mozghechka," in *Fiziologicheskie nauchnye shkoly v SSSR: Ocherki*, ed. N. P. Bekhtereva (Leningrad: Nauka, 1988), 107-112; N. A. Grigorian, "L. A. Orbeli - Outstanding Physiologist and Science Leader of the Twentieth Century," *Journal of the History of the Neurosciences* 16 (2007): 181-193.

<sup>35</sup> K. V. Sudakov and V. A. Makaraov, "Shkola P. K. Anokhina: Istoki, nastoiashchee i budushchee," in *Fiziologicheskie nauchnye shkoly v SSSR: Ocherki*, ed. N. P. Bekhtereva (Leningrad: Nauka, 1988), 113-124; Galina G. Egiazaryan and Konstantin V. Sudakov, "Theory of Functional Systems in the Scientific School of P.K. Anokhin," *Journal of the History of the Neurosciences* 16 (2007): 194-199; Slava Gerovitch, *From Newspeak to Cyberspeak: A History of Soviet Cybernetics* (Cambridge, Mass.: MIT Press, 2002).

signals from peripheral organs ‘sanctioned’ those patterns of excitation in the center that caused favorable effects ... and thus facilitated the restoration of damaged functions.” Anokhin shifted the focus from the cortex of the brain to the relationship between center and periphery.<sup>36</sup>

These ideas attracted Giliarovskii, and he made the relationship between “center and periphery” the focus of his approach to psychiatry. Giliarovskii cited Orbeli, Anokhin, and also Konstantin Bykov, another student of Pavlov’s, who was interested in how internal organs established conditional reflexes with the cortex of the brain. In his programmatic essays in the early 1940s, however, Giliarovskii made clear that he saw himself in a broader of European neurophysiology going back to French physiologist Claude Bernard, who had originally coined the term *milieu interior* to describe the body’s ability to maintain a stable internal environment.<sup>37</sup> Giliarovskii argued that psychiatrists should try to understand the interaction between body and mind in order to better understand and treat mental illness. He saw the subcortical parts of the central nervous system, and especially the autonomic (vegetative) nervous system, as key elements in the creation of what might be called “proto-consciousness,”<sup>38</sup> and which Giliarovskii called “the somatopsyché.”<sup>39</sup> In Giliarovskii’s conceptual model, “Processes in the periphery, somatic processes, can strongly affect mental function,” just as “the brain, as the center, influences the soma, the periphery.”<sup>40</sup>

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<sup>36</sup> Slava Gerovitch, "Love-Hate for Man-Machine Metaphors in Soviet Physiology: From Pavlov to 'Physiological Cybernetics'," *Science in Context* 15, no. 2 (2002): 345.

<sup>37</sup> V. A. Giliarovskii, quoting Claude Bernard, in "Voprosy teorii i praktiki nevro-psikhiatricheskoi pomoshchi v poslevoennoe vremia," *Sovetskaia meditsina*, no. 7 (1946): 1. On Claude Bernard see Mary A. B. Brazier, *A History of Neurophysiology in the 19th Century* (New York: Raven, 1988), 50-56.

<sup>38</sup> Damasio, *The Feeling of What Happens*, 133-159.

<sup>39</sup> V. A. Giliarovskii, *Starye i novye problemy psikiatrii* (Moscow: Medgiz, 1946), 106.

<sup>40</sup> "...imeet mesto vliianie mozga, kak tsentra, na somu, kak na periferiiu." V. A. Giliarovskii, "O vzaimootnosheniakh somaticheskogo i psikhicheskogo v meditsine," *Vrachebnoe delo* 27, no. 8 (August 1947): 625-262.

Giliarovskii choice of the term “somatopsyche” was itself a deliberate allusion to the work of German neurologist Carl Wernicke, who had coined the term in 1892.<sup>41</sup> It was also an obvious and deliberate reversal of the term “psychosomatic,” which in the 1940s was becoming increasingly popular in America and was closely identified by Soviet psychiatrists as a form of Freudianism. Giliarovskii claimed that his work was building on the latest discoveries of neuroscience and showed that Freud had things exactly backwards. Freud, he claimed, believed that traumatic experiences were repressed by being pushed out of the conscious mind and into the subconscious. Once repressed, the conflict still had to be expressed somehow and thus found outlets in the body where it produced the physical symptoms of the neurosis. In fact, Giliarovskii argued, Freud had things exactly backwards. The “entry point” for trauma was in fact the sympathetic nervous system and the brain stem, the non-conscious mind. Any physical or mental symptoms were then caused by changes in the “somatopsyche” which affected how the body was enervated but also could impinge on the cortex of the brain, perhaps producing delusional thoughts or feelings.<sup>42</sup>

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<sup>41</sup> In the introduction to his edited volume, Giliarovskii discusses Wernicke’s concept of the “somatopsycheic.” *Somato-psikhicheskie rasstrostva. Sbornik trudov Instituta psikhatrii AMN* (Moscow: Izd-vo AMN SSSR, 1946), 3-4. In English-speaking countries, the term “somatopsychic” was generally used as an antonym for “psychosomatic.” “Somatopsychic” problems were those in which physical problems caused mental disorders, while “psychosomatic” problems were psychological problems that were expressed as physical disorders. In Giliarovskii’s usage, the domain of “somatopsychic” medicine was significantly broader. As he put it in the introduction to his 1946 edited volume, Giliarovskii was interested in the “interrelationships [vzaimootnoshenii] of the somatic and the psychic. These interrelationships are understood not only in the sense of psychic reactions to somatic disorders, or true somatogenic disorders [sobstvenno somatogenii], but also [in the sense of] explaining in general the role of somatic components in psychoses, as well as the influence of psychic factors on somatic processes.” V. A. Giliarovskii, “Predislovie,” in *Somato-psikhicheskie rasstrostva. Sbornik trudov Instituta psikhatrii AMN* (Moscow: Izd-vo AMN SSSR, 1946), 4. For usage of the term “somatopsychic” in English, see OED online, s.v. “somatopsychic.”

<sup>42</sup> V. A. Giliarovskii, "O sushchnosti istericheskikh rasstrostv v svete novykh dannykh v uchenii o vegetativnoi nervnoi sisteme," *NiP* 11, no. 6 (1942): 27. In his pre-war clinical lectures, Giliarovskii endorsed Freud’s concept of conversion, though he thought Freud had been wrong about infant sexuality. V. A. Giliarovskii, *Psikhatriia: Klinicheskie lektsii* (Moscow: 1942), 310-312.



Though Giliarovskii framed his approach as a main-stream application of contemporary Pavlovian physiology, his model of “mutual influence” was in fact a serious break from the orthodox Pavlovian dogma of cerebral control of the body.<sup>43</sup> As he explained in his 1946 monograph, “Soviet pathologists hold to nervism, I. P. Pavlov’s point of view that all processes taking place in the organism depend on central and nervous systems [*ot tsentral’noi i nervnoi sistemy*]. Not limiting this general principle to the dependence of somatic processes on the brain, soviet researchers have established corrections between concrete processes on the periphery and changes in certain systems of the brain. It can be considered established that each organ has a particular representation not only in the subcortical systems, but in the cortex of the brain.”<sup>44</sup> As Giliarovskii put it ...sometimes it is difficult to say where the *primum movens* is located – on the periphery or in the center?<sup>45</sup>

### **Pavlovian Physiology and The Neuron Doctrine**

By the time of Pavlov’s death in 1936, other physiologists were beginning to grow impatient with Pavlov’s neurological explanations for conditional reflexes, and Ivanov-Smolenskii’s approach to psychiatry drew more criticism than praise. At issue were two key parts of Pavlov’s theory: the idea that all conditional reflexes passed through the cortex (“cortical dogmatism”) and the idea that conditional reflexes were the fundamental unit of all mental activity. Pavlov had continued to insist on these principles even as his peers began to follow other lines of research. When Pavlov had studied digestion in the late nineteenth century, he had

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<sup>43</sup> In his articles and books, Giliarovskii paid lip service to the notion that the brain was ultimate locus of control in the body, affirming, for instance, “that the brain is not just the organ of thought, action, and feeling, but also regulation of vegetative [i.e. autonomic] function.” But the basic concept of his work contradicted this top-down regulatory scheme, as the rest of the article in this example shows. Giliarovskii, "O vzaimootnosheniakh somaticheskogo i psikhicheskogo," 625.

<sup>44</sup> Giliarovskii, *Starye i novye problemy*, 108.

<sup>45</sup> Giliarovskii, "O vzaimootnosheniakh somaticheskogo i psikhicheskogo," 627.

focused his attention on the level of whole organs, grounding his explanations in the theory of “nervism,” the idea that all physiological processes were ultimately governed by signals conveyed by nerves. The discovery early in the twentieth century that digestion was in part controlled by signals conveyed by chemical processes upset this picture, and it was one reason that Pavlov shifted his focus to conditional reflexes, which he saw as a way to reassert the primacy of nervous processes in the body.<sup>46</sup> His investigations of the brain were “conceived and approached as a form of organ physiology (the physiology of the brain and sensory organs),”<sup>47</sup> and sought to establish the regularities governing these organ systems much as he had sought to establish the regularities governing the digestive system, and he extended the theory of “nervism” to suggest that all non-instinctual behavior was controlled by conditional reflexes that were established in the cortex of the brain.

Pavlov posited the conditional reflex as the basic unit of analysis in the study of “higher nervous activity,” the key to understanding the physiological rules that governed thought and behavior. He recognized, of course, that the brain is composed of myriad individual cells, each with its own internal structure, and that these cells form discrete formations in the brain – involutions, lobes, hemispheres, and so forth. These parts, Pavlov argued, were necessary but not sufficient for understanding higher nervous activity. They were the physical substrate of the true unit of mind: the conditional reflex. Just what a conditional reflex looked like, where it was located – these were not questions that Pavlov pursued.<sup>48</sup> He probed the laws of higher nervous activity relying “almost entirely on one source of data: saliva drops....Using the quantitative

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<sup>46</sup> Todes, *Pavlov's Physiology Factory*, 240-241.

<sup>47</sup> *Ibid.*, 351.

<sup>48</sup> Joravsky, *Russian Psychology*, 295.

patterns of salivation during tens of thousands of experiments, Pavlov built an edifice of interpretive judgments about higher nervous processes....”<sup>49</sup>

Little was understood about neurons in the late nineteenth century when Pavlov did his pathbreaking research on the enervation of the digestive system, but in the 1920s and 1930s neuron theory developed rapidly, and in the West physiologists studying phenomena similar to those that interested Pavlov and began to focus on neurons and their bioelectrical processes to understand how nerve cells worked. Pavlov treated this work as basically unimportant to his own research: he was studying a higher order of phenomenon.<sup>50</sup> The processes in nerve cells were of course important, but they could not explain higher nervous activity which was a “whole brain” phenomenon. Pavlov could afford to make these claims in part because physiologists were deeply divided over the structure of neurons and how they communicated. The classical “neuron theory” had been formulated in the late nineteenth century by Spanish physiologist Santiago Ramon y Cajal, who argued that the fibers of one nerve cell did not actually make contact with the nerve cells adjacent to it: the fibers were divided by a gap, and the neurons communicated by sending signals across this gap. The hypothetical gap between nerve cells came to be referred to as a “synapse,” a term coined by English physiologist Charles Sherrington in 1897. Ramon y Cajal’s theory was opposed by some of the leading physiologists of the day, including Italian physiologist Camillo Golgi, the man who had invented the method of staining nerve tissue that made it possible to look at these structures under the microscope. Golgi held that nerve fibers *were* connected to one another in a single continuous system, and that there was no gap across which signals would have to be passed. Ramon y Cajal and Golgi were awarded a joint Nobel

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<sup>49</sup> Todes, *Pavlov’s Physiology Factory*, 353.

<sup>50</sup> Joravsky, *Russian Psychology*, 295.

Prize in Physiology or Medicine in 1906, two years after Pavlov. Even in their acceptance speeches, however, the two men continued to argue over whether nerve fibers were connected or not. In a tribute to Cajal in 1932, Soviet neuropathologists Pavel Snesev concluded that Cajal's theory would probably not be vindicated, and that his proponents "do not look like the victors."<sup>51</sup> No definitive images of a synapse were produced until 1954, when the invention of the electron microscope finally settled the old debate by distinctly showing the gap between nerve fibers.<sup>52</sup>

Even among the growing number of physiologists who accepted Ramon y Cajal's "neuron doctrine," however, there was disagreement about the nature of the signal that neurons used to signal across synapses. In the early part of the century physiologists who studied the peripheral nervous system amassed a significant body of evidence that suggested that chemical substances (acetylcholine, adrenaline) were involved in the stimulation and inhibition of nerve cells,<sup>53</sup> and several Nobel Prizes were awarded for this research in the 1930s. Even after this recognition, however, most neurophysiologists rejected the idea that "neurohumoral transmission" was capable of explaining brain activity. They "were convinced that only electrical transmission is fast enough to activate skeletal muscles, and for them the possibility that nerve impulses at brain synapses might be transmitted chemically was not worth thinking about...."<sup>54</sup> For the electrical transmission theory, however, inhibition and excitation remained crucial

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<sup>51</sup> "Odnako mnogie iz nikh [otkrytyia Kakhalia] povidimomu ne voidut v istoriiu v tom vide, kak ikh predstavliaet sebe sam Kakhal. Voz'mem, khotia by ego spor s retikuliaristami v voprose o neironnoi structure nervnoi tkani. Istina ne vsia povidimomu na storone Kakhala, i ego protivniki ne imeiut vida pobezhedennykh." P. E. Snesev, "Sant'iago Ramon-i-Kakhal: Zhizn' i nauchnaia deiatel'nost'," *Sovetskaia nevroptologiya, psikhiairiia i psikhogigiena* 1, no. 12 (1932): 715.

<sup>52</sup> Elliot S. Valenstein, *The War of the Soups and the Sparks: The Discovery of Neurotransmitters and the Dispute Over How Nerves Communicate* (New York: Columbia University Press, 2005), 4.

<sup>53</sup> Important initial discoveries of chemical neurotransmission were made by John Langley (1852-1925) and Walter Gaskell (1847-1914), two physiologists studying the nerves that innervate viscera. Valenstein, *War of the Soups and the Sparks*, 10.

<sup>54</sup> Valenstein, *War of the Soups and the Sparks*, 120.

problems: why did some neural impulses excite neighboring neurons while others impeded their neighbors from functioning? The chemical theory of transmission dealt with this by claiming that some synapses released chemicals that had an “excitatory effect,” while other synapses released different chemicals that had an “inhibitory” effect.”<sup>55</sup> Strong evidence for the chemical theory of transmission came in the early 1950s, when a new type of microelectrode was invented that could be used to measure voltage inside a single nerve cell. (Until then only “extracellular” electrodes had been used.) This method enabled neurophysiologists to show that chemical transmission was fast enough to explain observed facts. Still, the general community of neurophysiologists did not accept the theory that chemical transmission took place in the brain until the early 1960s.<sup>56</sup>

In remaining above the fray in the 1920s and 1930s, then, Pavlov had been able to portray himself as rising above scientific controversy rather than just ignoring scientific consensus, and his followers could continue to make such claims into the 1950s, though their grounds for doing so became increasingly untenable after the breakthrough discoveries that came the 1950s. Some Soviet scientists, however, including a few of Pavlov’s students, were interested in neuron theory and exciting about the new discoveries in biochemistry. In the 1930s their research began to implicitly challenge two of Pavlov’s central claims: the claim that the reflex was the fundamental unit of the mind, and the claim that all conditional reflexes (and thus all non-instinctual behavior)

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<sup>55</sup> This continues to be the way in which the concepts of inhibition and excitation are used in neuroscience. When an action potential arrives at an axon terminal, it causes the depolarization of the synapse membrane, causing Na<sup>+</sup> ions to come into the cell. The depolarization causes neurotransmitter chemicals to be released into the synaptic cleft. They travel across and bind with proteins on the membrane of the other side (the post-synaptic side), which leads to either a depolarization (excitation) or hyperpolarization (inhibition) of the postsynaptic cell. If the cell is another neuron this can lead to an action potential event (if depolarization is the result), or increased resistance to action potential (if it is a hyperpolarization). If the cell across the cleft is a muscle cell, the result is muscle contraction (or resistance to contraction). Michael S. Gazzaniga, Richard B. Ivry, and George R. Mangun, *Cognitive Neuroscience: The Biology of the Mind* (New York: W. W. Norton, 1998), 39-40.

<sup>56</sup> Valenstein, *War of the Soups and the Sparks*, 129-160.

were governed by the cortex of the brain. It was in these two areas that psychiatrists developed new theoretical models in the 1940s that brought them into conflict with other psychiatrists who saw their ideas as a threat to Pavlov's theory of higher nervous activity.

### **Chemical Mediators: Nikolai Grashchenkov, Synapse Theory, and Medical Research in the 1930s**

Orbeli dominated many of the physiological research laboratories in Leningrad in the 1930s, but in the mid-1930s scientific research in physiology and medicine was increasingly concentrated in Moscow, and the man who was in charge of this system was Nikolai Grashchenkov. A neurologist by training, Grashchenkov was a major proponent of the chemical theory of synaptic transmission, and had a long history of criticism of Pavlov's neurophysiological explanations for higher nervous activity. He had joined the party at a very young age during the Civil War, and then trained in medicine at Moscow University. In 1931, Grashchenkov was still a very young man, as David Joravsky points out, "just turning thirty ... and still a postgraduate at the Institute of Red Professorship." That year, however, the man who had dominated the "psychoneurological front," psychologist Aron Zalkind, was ousted for his views on education,<sup>57</sup> and Grashchenkov was chosen to replace him. He began by giving a fiery speech denouncing psychiatrists like Giliarovskii and Gannushkin for their theories of "Soviet exhaustion" [*Sovetskaia iznoshennost'*] and "affirmative action neurosis" [*nevroz vydvizhenchestva*].<sup>58</sup>

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<sup>57</sup> Zalkind was one of the leading theorists of "pedology." He committed suicide in 1936 around the time that the Central Committee declared pedology to be an anti-Party discipline. Some leaders of pedology who were closely associated with Zalkind, like I. N. Shpilrein, the founder of Soviet psychotechnics, were arrested, sent to camps, and/or shot. Nikolai Kurek, *Istoriia likvidatsii pedologii i psikhotehniki* (St. Petersburg: Aleteia, 2004), 96-97; Joravsky, *Russian Psychology*, 279. For criticisms of the ideological deviations of Zalkind and others on the "psychoneurological front," see also D. E. Stolbun and A. S. Shmar'ian, "Pis'mo t. Stalina i zadachi nevropsikhiatricheskogo fronta," *Sovetskaia nevroptologiya, psikhiatriia i psikhogigiena* 1, no. 1-2 (1932): 9-24.

<sup>58</sup> Kurek, *Istoriia likvidatsii pedologii i psikhotehniki*, 96-97; Joravsky, *Russian Psychology*, 340, 383.

In 1933 Grashchenkov became one of the top administrators for an important new institute, the All-Union Institute of Experimental Medicine, usually known by its Russian acronym, "VIEM." In fact VIEM was an umbrella organization that brought together many different research institutes and laboratories, based on a core group that had been the Institute of Experimental Medicine in Leningrad. Grashchenkov oversaw the creation of new VIEM institutes and laboratories in Moscow, and this made him into a man of great influence in scientific medicine. From this position he helped to advance the careers of several associates from the Institute of Red Professors/Communist Academy, including psychiatrist Mikhail Gurevich, who became the head of the psychiatry department at the First Moscow Medical Institute in 1937, and in 1938 became the first chairman of the psychiatry commission at the newly created All-Union Commissariat of Public Health (Narkomzdrav USSR).<sup>59</sup> Grashchenkov also helped advance the careers of two other Communist Academy alumni, Pavel Posvianskii and Aleksandr Shmar'ian, who became Director and Deputy Director of the Central Institute of Psychiatry, also in 1937. In 1940 Grashchenkov became editor-in-chief of the *Nevropatologiya i psikhiatriya*, one of the two remaining journals that focused on neurology and psychiatry. (After 1941 it became the only journal of its kind.) He chose Shmar'ian to be his deputy editor, putting him in a position of great influence over what psychiatrists and psychiatric ideas could find their way into print; in 1942 Shmar'ian replaced Gurevich as the head of psychiatry at Narkomzdrav USSR. Through World War Two and well into the 1940s, Grashchenkov remained the most powerful figure in psychiatry or neurology, and acted as an important patron to psychiatrists like Shmar'ian and Gurevich.

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<sup>59</sup> "M. O. Gurevich (Nekrolog)," *ZhNiP* 54, no. 2 (1954): 203.

Just as Grashchenkov's career as a medical science administrator was taking off he was sent abroad on a tour of the most important neurophysiology laboratories in the West. He spent the winter of 1935-1936 in Cambridge working with English physiologist Edgar Adrian, who in 1932 had shared a Nobel Prize with Charles Sherrington for work on the functions of neurons.<sup>60</sup> In Cambridge Grashchenkov also met other scientists who were part of the community researching the problem of how nerve signals are transmitted, including Henry Dale and John Eccles, both of whom would go on to win Nobel prizes for their work.<sup>61</sup> Grashchenkov spent the next winter (1936-1937) working with another pioneer of neurophysiology, Herbert Gasser at Rockefeller University in New York.<sup>62</sup> Grashchenkov also visited Walter Cannon, who studied the autonomic nervous system and chemical mediators at Harvard, and John Fulton, who was doing fine-grained studies of brain function at Yale.<sup>63</sup> All three eminent physiologists had recently visited the USSR for the for the fifteenth International Congress of Physiology, and Grashchenkov's trip may well have been something of a reciprocal visit intended to demonstrate

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<sup>60</sup> "All Nobel Laureates in Medicine," [http://nobelprize.org/nobel\\_prizes/medicine/laureates/](http://nobelprize.org/nobel_prizes/medicine/laureates/) (accessed 31 May 2008).

<sup>61</sup> A. M. Vein and N. A. Vlasov, *Nikolai Ivanovich Grashchenkov, 1901-1965* (Moscow: Nauka, 1985), 15-16. Dale shared the 1936 Nobel Prize for medicine with German physiologist Otto Loewi for their discovery of the chemical acetylcholine. In the 1930s John Eccles was the most outspoken opponent of the chemical theory of synaptic transmission, but in the 1950s he disproved his own hypothesis and became an outspoken proponent of the chemical transmission theory. He was one of three recipients of the 1963 Nobel Prize in medicine for "discoveries concerning the ionic mechanisms involved in excitation and inhibition in the peripheral and central portions of the nerve cell membrane" "All Nobel Laureates in Medicine," [http://nobelprize.org/nobel\\_prizes/medicine/laureates/](http://nobelprize.org/nobel_prizes/medicine/laureates/) (accessed 31 May 2008). On the history of neurotransmitters and the controversy about chemical transmission, see Valenstein, *War of the Soups and the Sparks*.

<sup>62</sup> According to his biographers, while in the Soviet Union Gasser gave a paper to the Georgian Academy of Sciences, an event that might have been connected to Georgian psychiatrist Avlipi Zurabashvili's interest in synapse research. Gasser shared the 1944 Nobel Prize in Medicine with Joseph Erlanger "for their discoveries relating to the highly differentiated functions of single nerve fibers." Merrill W. Chase and Carlton C. Hunt, "Herbert Spencer Gasser: July 5, 1888 - May 11, 1963," *Biographical Memoirs* 67 (1995): 160-161; "All Nobel Laureates in Medicine," [http://nobelprize.org/nobel\\_prizes/medicine/laureates/](http://nobelprize.org/nobel_prizes/medicine/laureates/) (accessed 31 May 2008).

<sup>63</sup> Vein and Vlasov, *Nikolai Ivanovich Grashchenkov*, 15-17.



the engagement of the Soviet Union with international physiology.<sup>64</sup> Grashchenkov gave Fulton a copy of a textbook he had co-authored, and inscribed it, “To Mr. John A. Fulton, with complements and deep respect. N. I. Propper. New Haven. November 30.”<sup>65</sup>

When Grashchenkov returned to the Soviet Union in the spring of 1937 the Great Terror was reaching its peak, and Grashchenkov was unexpectedly thrust into the position of acting Commissar of Health. The man in charge of Narkomzdrav USSR was Grigorii Kaminskii, an old Bolshevik who had headed the Moscow health department and then Narkomzdrav RSFSR during the height of Stalin’s industrialization drive. At a Central Committee plenum in June 1937, according to Chris Burton, Kaminskii “allegedly questioned the course of the Terror,” and “disappeared before the second half of the plenum.” Grashchenkov became acting commissar in his stead, and presided over Narkomzdrav USSR from mid-1937 until a new commissar was appointed in 1939.<sup>66</sup> It was as acting head of Narkomzdrav USSR that Grashchenkov played a role in one of the most notorious episodes of the Terror, the July 1937 “mass operations” against “former kulaks, criminals, and other anti-Soviet elements.”<sup>67</sup>

In this tense atmosphere a controversy broke out at VIEM over the role of Pavlovian theory in psychiatry. The psychiatric laboratory that Pavlov had founded in Leningrad was still

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<sup>64</sup> Elin L. Wolfe, A. Clifford Barger, and Saul Benison, *Walter B. Cannon, Science and Society* (Cambridge, MA: Boston Medical Library, 2000), 348.

<sup>65</sup> Fulton’s copy of this textbook is now held in the collection of the National Library of Medicine in Bethesda. M. B. Krol’, M. S. Margulis, and N. I. Propper, *Uchebnykh boleznei. Tom 1: Obshchaia chast’* (Moscow: Gosmedizdat, 1933), NLM Unique ID: 41410180R.

<sup>66</sup> Chris Burton, “Medical Welfare During Late Stalinism: A Study of Doctors and the Soviet Health System, 1945-1953” (Ph.D., University of Chicago, 2000), 77-78; Vein and Vlasov, *Nikolai Ivanovich Grashchenkov*, 18.

<sup>67</sup> As the acting head of Narkomzdrav USSR, Grashchenkov was instructed to send physicians and fel’dshers to GULAG camps to help with the mass operations. “Vypiska iz protokola No. 51 zasedaniia Politbiuro TsK,” 31 July 1937, in Mark Iunge and Rol’f Binner, *Kak terror stal 'bol'shim'. Sekretnyi prikaz No. 00447 i tekhnologiiia ego ispolneniia* (Moscow: AIPO-XX, 2003), 94-96. For an English translation of this document see J. Arch Getty and Oleg V. Naumov, *The Road To Terror: Stalin and the Self-Destruction of the Bolsheviks, 1932-1939* (New Haven: Yale University Press, 1999), 478.

run by Ivanov-Smolenskii, but it was now a part of VIEM. At the same time, VIEM had created another psychiatry laboratory in Moscow, this one headed by Vasili Giliarovskii and staffed by some of the psychiatrists who had been affiliated with the Communist Academy. In June 1937 Ivanov-Smolenskii gave a paper on the study of higher nervous activity and its application in psychiatry at a meeting held at Giliarovskii's Moscow clinic. Details of the meeting are sketchy,<sup>68</sup> but Ivanov-Smolenskii's paper was apparently attacked by Anatolii Aleksandrovskii, one of the psychiatrists who had studied at the Institute of Red Professors in the 1920s. Aleksandrovskii had taken on important leadership positions in the world of Moscow psychiatry during the Cultural Revolution in the early 1930s, and in 1937 he headed Narkomzdrav USSR's Directorate of Medical Services. Strong criticism from a man with Aleksandrovskii's institutional clout evidently rattled Ivanov-Smolenskii, and he tried to defend himself. Giliarovskii, however, spoke in support of Aleksandrovskii, and other psychiatrists from the Moscow branch quickly published an article in VIEM's in-house newspaper declaring Ivanov-Smolenskii's approach to psychiatry "methodologically incorrect."<sup>69</sup> Giliarovskii followed two days later with an article in which he again defended his staff and where he referred to Ivanov-Smolenskii's work as "conditional reflex hair-splitting."<sup>70</sup> Ivanov-Smolenskii protested to Grashchenkov, the

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<sup>68</sup> The fullest account I have of this episode comes from the anonymous "spravka" written during the planning of the 1951 session in psychiatry. Unsigned, "Spravka," undated (December 1950), GARF, f. r-9120, op. 2, d. 1201, ll. 216-217.

<sup>69</sup> A. B. Aleksandrovskii and A. S. Shmar'ian, unknown title, in *Gazeta VIEM*, 7 June 1937, cited in "Za pavlovskuiu psikhatriiu i nevropatologiu," *NiP* 20, no. 4 (1951): 4. I have not yet found a library that holds *Gazeta VIEM*, VIEM's in-house journal, and have relied on bibliographical references and passing comments to piece together what I can of their content.

<sup>70</sup> V. A. Giliarovskii, A. S. Shmar'ian, and L. P. Lobova, "Novaia psikhiairiia Ivanova-Smolenskogo," *Gazeta VIEM*, 9 April 1937, cited in "Spisok nauchnykh rabot V. A. Giliarovskogo," in *V. A. Giliarovskii: Izbrannye trudy* (Moscow: Meditsina, 1973). For the "conditional reflex hair-splitting" comment, see Giliarovskii's 1951 apology to Ivanov-Smolenskii in V. M. Banshchikov *et al.*, eds., *Fiziologicheskoe uchenie akademika I.P. Pavlova v psikhiairii i nevropatologii: materialy stenograficheskogo otcheta obedinennogo zasedaniia rasshirennogo Prezidiuma AMN SSSR i plenuma Pravleniia Vsesoiuznogo obshchestva nevropatologov i psikhiatrov. 11-15 okt., 1951 g* (Moscow: Medgiz, 1952), 77.

Secretary of VIEM's Party cell, and to the VIEM's Director, Lev Fyodorov, a physiologist who had spent many years working in Pavlov's laboratory. Both Fyodorov and Grashchenkov supported Giliarovskii.<sup>71</sup> Ivanov-Smolenskii appealed to other potential patrons, including Leon Orbeli, one Pavlov's main institutional successor, but to no avail. In October 1937 the psychiatry clinic in Leningrad was closed, and over the next two years VIEM closed two more of Pavlov's laboratories, leaving Ivanov-Smolenskii without a base of operations.<sup>72</sup> When VIEM was transformed into the Academy of Medical Sciences in 1944, it was Giliarovskii's laboratory that became the prestigious new Academy of Medical Sciences Institute of Psychiatry.

In 1939 Grashchenkov left Narkomzdrav USSR and took on two important posts. He replaced Fyodorov as the Director of VIEM, a position he held until 1944 when VIEM was reorganized as the USSR Academy of Medical Sciences. He continued to head his own division of VIEM, the Department of the Physiology and Pathology of Sense Organs [*otdel fiziologii i patologii organov chuvstv VIEM*], but now he also took on VIEM's clinic of nervous illnesses.<sup>73</sup> He used these positions to further develop Soviet research into the physiology of the synapse and the biochemical transmission of neuronal signals. He had returned from his trip abroad with new

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<sup>71</sup> L. Fedorov had studied under Pavlov, and after he entered the government he became Pavlov's patron. Todes, "Pavlov and the Bolsheviks." For Grashchenkov's Party cell role, see Vein and Vlasov, *Nikolai Ivanovich Grashchenkov*, 18.

<sup>72</sup> See "Na soveshchaniia aktiva VIEM," *Pravda*, 7 June, 1941, cited in Joravsky, *Russian Psychology*, 394, 399. For the roles of Grashchenkov and Fedorov, see especially Ivanov-Smolenskii's comments at the 1950 Pavlov Session, E. Sh. Airapet'liats *et al.*, eds., *Nauchnaia sessiia posviashchennaia problemam fiziologicheskogo ucheniia akademika I. P. Pavlova, 28 iunია - 4 iulia 1950 g.: Stenograficheskii otchet* (Moscow: Izd. Akademii Nauk SSSR, 1950), 608. See also Grashchenkov's reluctant apology at the 1951 session, "Stenogramma ob'edineogo zasedaniia rashirennogo Prezidiuma AMN SSSR i Plenuma Pravleniia Vsesoiuznogo ob-va nevropatolgov i psikiatrov, t. 2," 13 October 1951, GARF, f. r-9120, op. 2, d. 1203, 322-324.

<sup>73</sup> Vein and Vlasov, *Nikolai Ivanovich Grashchenkov*, 19. This clinic had been previously been headed by M. B. Krol', who died in 1939. Krol' was influential in his own right, directing the Kremlin Policlinic from 1934-1938. He was also held top posts in the All-Union Society of Neuropathologists and Psychiatrists and was the editor of *NiP* from 1932 until his death. Grashchenkov took over not only his university post, but also his editorship. Both men were from Minsk, and it is likely that the two helped one another, though who was patron to whom is unclear to me. Iu. S. Mart'ynov and N. A. Shuvakhina, "Mikhail Borisovich Krol' (K 100-letiiu so dnia rozhdeniia)," *ZhNiP* 78, no. 12 (1978): 1857-1858.

foreign equipment and pharmaceuticals, including electroencephalography equipment that was the first equipment of its kind imported into the USSR.<sup>74</sup> Grashchenkov also imported a new drug, prostigmin, that a British doctor had recently found was a remarkably effective treatment for myasthenia gravis, a degenerative neuromuscular disease. Neurologists were excitedly discussing this discovery in 1935 when Grashchenkov was working in Cambridge, and after his return to the Soviet Union Grashchenkov began testing prostigmin in his neurology clinic.<sup>75</sup> He and his research staff used it to develop a model of the “role of the neuro-muscular peripheral synapse in the pathogenesis of myasthenia,” and by 1942 they had tentatively concluded that prostigmin worked by acting on the chemical mediators present in the synaptic cleft, helping to break down acetylcholine. They hypothesized that some neurological conditions like myasthenia developed when cells did not produce enough acetylcholine to transmit a signal across the synaptic cleft. They called this condition “functional asynapsia.”<sup>76</sup>

Grashchenkov continued this research even after war broke out in 1941. During the war Grashchenkov was put in charge of organizing care for soldiers who had brain injuries, spinal injuries, and injuries of the peripheral nervous system. To do this he established a chain of

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<sup>74</sup> Vein and Vlasov, *Nikolai Ivanovich Grashchenkov*, 18. A Russian physiologist, Pravdich-Neminsky, was apparently the first to apply encephalography to humans (19212). By the 1930s, encephalography in humans was a quickly developing field throughout the world, and it was one of the most frequently published on topics in the Soviet neurology and psychiatry journal during the war. The first International EEG congress was held in 1947. Barbara E. Swartz and Eli S. Goldensohn, "Timeline of the History of EEG and Associated Fields," *Electroencephalography and Clinical Neurophysiology* 106, no. 2 (February 1998): 173-176.

<sup>75</sup> The woman who discovered prostigmin treatment, Dr. Mary Walker, “reasoned correctly that if the patient’s symptoms were similar to curare poisoning then the antidote, physostigmine salicylate, should be helpful.” The results were published in *The Lancet* in June 1934. Arthur H. Keeney and Virginia T. Keeney, "Mary B. Walker, M.D. and the Pioneering Use of Prostigmin to Treat Myasthenia Gravis," *Documenta Ophthalmologica* 93, no. 1-2 (1997): 128.

<sup>76</sup> The research on prostigmin in traumatic brain injuries cited by Grashchenkov was done by Iakov Ratner at the Institute of Neurology before the war, and by Lev Perel’man at the Kisegach evacuation hospital during the war. N. I. Grashchenkov, "Funktsional'naia asinapsiia," *NiP* 15, no. 1 (1946): 53-66; N. I. Grashchenkov, "Sovremennoe uchenie o sinapsakh v patologii nervnoi sistemy," in *Trudy tret'ego vsesoiuznogo s"ezda nevropatologov i psikiatrov. Moskva, 25-31 maia 1948 g.*, ed. V. A. Giliarovskii (Moscow: Medgiz, 1950), 32.

special medical units in front-line hospitals, in Moscow, and in the deep rear. Soldiers with the most serious injuries were evacuated to a village in the Ural Mountains near Chelyabinsk called Kisegach, where a neurosurgical hospital was created on the base of a former sanitarium. The hospital was officially a filial of VIEM, and it became the center of some of the most important neurology, psychology, and neurophysiology research to come out of the Soviet Union during the war. The man that Grashchenkov chose to run the hospital was Alexander Luriia, a psychologist and physician who had worked closely with Lev Vygotskii in the 1920s and 1930s and who already had a major profile in the world of Soviet psychology. In the wake of the pedology scandal Luriia had retrained as a physician, and he spent the late 1930s working in the Institute of Neurosurgery under Nikolai Burdenko.<sup>77</sup> He used his appointment to Kisegach to bring together a high-caliber group of experts in physiology, neurology, and psychology, many of whom were colleagues from Luriia's days with Vygotskii in Moscow and Kharkov.<sup>78</sup> After the war Grashchenkov continued to support Luriia and his research, and together they published a series papers in which they proposed a theory of consciousness based on what they referred to as "functional systems." These functional systems, they argued, were made possible by the chemical transmission of nerve impulses: the synapse, not the reflex, was the basic constitutive unit of the mind.

Research done during the war at the Kisegach hospital gave support to the asynapsia theory, and showed that prostigmin had potential as a treatment for conditions other than myasthenia gravis. Lev Perel'man, a professor of neurology from Moscow University who

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<sup>77</sup> A. R. Luria, *Etapy proidennogo puti: Nauchnaia avtobiografiia* (Moscow: Izd. MGU, 1982), 122.

<sup>78</sup> Vein and Vlasov, *Nikolai Ivanovich Grashchenkov*, 24-25; A. R. Luria, *Etapy proidennogo puti: Nauchnaia avtobiografiia* (Moscow: Izd. MGU, 1982), 129-131; Elena Luriia, *Moi otets A.R. Luriia* (Moscow: Gnozis, 1994), 89, 100-105.

worked at the Kisegach hospital (and who also led the team that studied deaf-mute syndrome), gave prostigmin injections to over 900 soldiers suffering from paralysis and found that within 30 minutes of the injection 84% of his patients showed “noticeable improvement in movement,” and that many of them were able to quickly get up and walk around. (Over two-thirds of these soldiers had been paralyzed for over six months, and 17% for more than one year.) In most cases the recovery was lasting.<sup>79</sup> Grashchenkov concluded that prostigmin’s effects were proof of the chemical transmission of neural signals, and the importance of this discovery for medical therapeutics.<sup>80</sup> In his exposition of the Kisegach group’s research, Aleksandr Luriia agreed. “Precisely through this action of prozerin [the Soviet name for prostigmin],” he wrote, “the processing of the mediator in the disturbed synapse could be normalized and its temporarily suppressed conductivity could be restored.”<sup>81</sup>

### **Emergent Qualities: Mikhail Gurevich and the Synapse Theory of Psychoses**

Grashchenkov and his researchers presented the concept of “asynapsia” at conferences and meetings throughout the war, and so they were already fairly well known to psychiatrists even before Grashchenkov began publishing his work in 1944.<sup>82</sup> The psychiatrist who most

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<sup>79</sup> Grashchenkov, "Funktsional'naia asinapsiia," 58.

<sup>80</sup> Prostigmin acted, he wrote, by “... directly eliminating functional asynapsia . . . establishing the correct chemical processes in the transmission of excitation and inhibition from neuron to neuron, including the establishment of a correct relationship between cholinesterase and acetylcholine, which leads to the establishment of conductivity and, as a result, to the reestablishment of the functions that were lost because of the group of neurons that were in states of functional inactivity or functional asynapsia.” Grashchenkov, "Funktsional'naia asinapsiia," 63-64.

<sup>81</sup> A. R. Luria, *Vosstanovlenie funktsii mozga posle voennoi travmy* (Moscow: Izd. Akademii Meditsinskikh nauk SSSR, 1948), 16-18. Luriia later recalled that L. B. Perel'man's work “gave excellent results, often leading to significantly sped up synaptic conductivity and recovery of dynamic inhibitory function.” A. R. Luriia, "Sovetskie psikhologi v gody Velikoi otechestvennoi voiny," *ZhNiP* 75, no. 5 (1975): 759. For a brief summary of this research, see also Albert R Gilgen, *et al*, *Soviet and American Psychology During World War II* (Westport, Connecticut: Greenwood Press, 1997), 37-38.

<sup>82</sup> See, for instance, V. K. Khoroshko, "O posledstviakh vozduzhnoi kontuzii na voine," *NiP* 11, no. 5 (1942): 9; comments by M. O. Gurevich in P. B. Posvianskii and T. I. Gol'dovskaia, "Khronika: Vserossiiskaia konferentsiia

enthusiastically embraced the idea was Mikhail Gurevich, the chairman of the psychiatry department at the First Moscow Medical Institute and, after 1944, the Deputy Director of the Serbsky Institute of Forensic Psychiatry. Gurevich believed that synaptic connections could help explain what went wrong in mental illness. The “asynapsia” concept was particularly attractive to him because its image of broken connections seemed to harmonize with his own observations of the symptoms of schizophrenia, many of which could be described as “disconnected.” Furthermore, his own observations suggested that there was no physical damage to brain cells that could account for the changes in behavior observed in the clinic. Before he became a professor, Gurevich had spent many years doing autopsies on deceased mental patients and, as he explained in a 1945 paper, he had examined brain tissue from well over 1,000 patients who had been diagnosed with schizophrenia. He found that patients who had suffered from schizophrenia had obviously dead nerve cells in some parts of their brains, but that in patients with relatively fresh cases of schizophrenia there were no consistent or obvious problems in brain tissue. Some brain specialists were inclined to think that scientists would eventually develop more advanced microscopes and more advanced staining techniques that would enable them to see the problems that were causing schizophrenia.<sup>83</sup> Gurevich, however, had concluded that looking for structural damage in nerve cells was simply the wrong approach. Schizophrenia, Gurevich hypothesized, was caused “by the disruption of connections (that is, synapses), which are capable of being reestablished.”<sup>84</sup>

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po voprosam psikhiatrii," *NiP* 13, no. 5 (1944): 72; and comments by P. K. Anokhin in M. S. Sheiman, "Nauchnye zasedaniia o travmaticheskikh reflektornykh sindromoakh," *NiP*, no. 6 (1945): 78.

<sup>83</sup> Gurevich particularly singled out the histology work of leading Soviet psychiatrist Pavel Sensarev and the work of German psychiatrist Franz Nissl. M. O. Gurevich, "K voprosu o sushchnosti shizofrenicheskogo protessa," *NiP* 14, no. 5 (1945): 10-11.

<sup>84</sup> M. O. Gurevich and G. E. Sukhareva, "Dostizheniia sovetskoi psikhiatrii za gody otechestvennoi voiny," in *Trudy tsentral'nogo instituta psikhiatrii MZ RSFSR*, ed. P. B. Posvianskii and A. S. Shmar'ian (Moscow: 1947), 57.

He particularly pointed to the reversibility of schizophrenia as evidence that these “functional” problems were caused by the disruption of some essential process in the brain. Sometimes patients recovered altogether, but at other times their behavior simply changed very quickly from one state to another, from catatonia, for instance, to extreme agitation. Such quickly changing symptoms, he argued, suggested a malfunctioning system, not a system that was fundamentally broken. None of this made sense, Gurevich argued, if the patient’s brain tissue was undergoing lasting and destructive changes. But all of these symptoms made sense if psychiatrists thought of these symptoms as the results of broken connections, bad connections, or reestablished connections. “Schizophrenia,” Gurevich concluded, “is a disease of the synapses, the structures that establish connections and integration of mental function.”<sup>85</sup> Psychiatric researchers who wanted to understand schizophrenia should stop looking for damaged cells and start studying synapses. He believed that insulin therapy, electroshock, and other methods of active therapy that had been pioneered in the 1930s worked because they “are based on the reestablishment of normal synaptic connections,” and that therefore psychiatrists who wanted to heal schizophrenia should start looking for treatments that could help them reestablish correct synaptic connections.<sup>86</sup>

In his more sober moments, Gurevich acknowledged that research on the synapse hypothesis was still too poorly developed to fully support his theory of psychoses. But he defended his claim by pointing out that leading Soviet physiologists like Leon Orbeli and Ivan Beritashvili, as well as American physiologists like John Fulton, had begun to base their work on the synapse. Some physiologists continued to object that signals could not travel across synapses

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<sup>85</sup> Gurevich, "K voprosu o sushchnosti shizofrenicheskogo protessa," 13.

<sup>86</sup> Ibid., 11-13; M. O. Gurevich, *Nervnye i psikhicheskie rasstroistva pri zakrytykh travmakh cherepa* (Moscow: Medgiz, 1945), 50-51.



fast enough to explain brain activity, but Gurevich pointed to recent research that had shown the delay between nerve impulses in the central nervous system to be much shorter than the delay in the peripheral nervous system, suggesting that synapse theory could adequately explain the observed rate of electrical transmission in the brain.<sup>87</sup> Drawing on nearly a half-century of research on synapses, he argued that Soviet psychiatrists should assume that the chemical transmission theory was a scientific fact because physiologists had shown that “their function changes depending on humoral [i.e. biochemical] influence, on the functional state of the corresponding neurons and the surrounding tissue and, apparently, also on the release of particular substances in the synapses themselves.” As a result, Gurevich concluded, even Pavlov’s conditional reflexes were now thought to be dependent on the still more basic connections created by synapses. Pavlov had resisted the idea that there might be some more basic unit that could explain the physiological regularities of the mind, but so far as Gurevich was concerned, the synapse had replaced the reflex as a basic unit of analysis in the brain: “The conditional reflex, of course, cannot be understood other than as the creation of new connections by means of synapses.”

Not only did Gurevich see synapse theory as a challenge to Pavlovian orthodoxy on the nature of the reflex, he also thought that synapse theory could help explain the complexity of consciousness in a way that conditional reflexes simply could not. Gurevich described Pavlov’s basic processes of “nervous activity,” inhibition and excitation, as useful concepts, but concepts

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<sup>87</sup> Gurevich cited recent work by John Eccles and Rafael Laurente de No. M. O. Gurevich, *Nervnye i psikhicheskie rasstroistva pri zakrytykh travmakh cherepa* (Moscow: Medgiz, 1945), 50-51. When an action potential reaches the synapse there is a delay caused by the time it takes neurotransmitters to be released, to travel across the synaptic cleft, and to bind to the receptors on the other side of the gap. This is referred to as “synaptic delay.” There is a further delay while potassium ions are pumped into the neuron, enabling it to undergo another action potential event. Michael S. Gazzaniga, Richard B. Ivry, and George R. Mangun, *Cognitive Neuroscience: The Biology of the Mind* (New York: W. W. Norton, 1998), 31-40.

that could not explain many of the symptoms seen in psychoses. Excitation and inhibition, Gurevich wrote, described only quantitative changes in function – the signals in the nervous system got stronger or weaker, or were extinguished. But in psychoses regular psychological functions were not attenuated or heightened. Instead, “... in pathology, complex psychic changes ... give pathological productions, new phenomena that are not characteristic of a normal psyche (for example, delusional ideas, hallucinations).<sup>88</sup> In its forms of pathology, then, the human psyche had qualities that could not be studied anywhere else. “From this,” Gurevich concluded, “it is clear just how naïve is the outlook of those authors who think it is possible to draw direct conclusions about the human psyche based on animal experiments.”<sup>89</sup>

Building on the idea that synapse theory could explain qualitative changes in the mind that could not be explained by inhibition and excitation, Gurevich argued that synapse theory could actually provide a more robust foundation for a materialist theory of consciousness. Gurevich saw Pavlov’s theory of higher nervous activity, at least in its simplified version, as providing an explanation only for a “photograph-like” reflection of the world.<sup>90</sup> Though he did not say so explicitly, Gurevich implicitly suggested that the same was true for the theory presented by Lenin in *Materialism and Empiriocriticism*. In his papers on psychiatric theory from the mid-1940s he always began with an extended analysis of Lenin’s theory of reflection, and always drew almost exclusively on the Lenin of the “Philosophical Notebooks.” Lenin’s theory of reflection, in Gurevich’s presentation, was subtle and multi-layered. There were many

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<sup>88</sup> M. O. Gurevich, "K postroeniiu teorii psikiatrii," in *Trudy psikiatricheskoi kliniki im. S. S. Korsakova*, ed. M. O. Gurevich and A. O. Edel'shtein (Moscow: 1 MOLMI, 1945), 14-15.

<sup>89</sup> M. O. Gurevich, *Nervnye i psikhicheskie rasstroistva pri zakrytykh travmakh cherepa* (Moscow: Medgiz, 1945), 45.

<sup>90</sup> Gurevich used the “photograph-like-act” example in most of his papers on psychiatric theory, but for an instance where he explicitly attributed this mistaken view to Pavlovians, see M. O. Gurevich, "Sovetskaia psikiatriia za 25 let posle velikoi oktiabr'skoi sotsialisticheskoi revoliutsii," *NiP* 11, no. 6 (1942): 3-10.

different “levels” of perception, beginning with simple sensations and proceeding through more complex levels of awareness from perception to concepts to concrete thought and on through abstract thought and dialectics. Perception, though was not a passive “photographic act,” it was a “goal-oriented” act. The “things in themselves” were not the same as the “things in us.” Indeed, neurologists had shown that nerve fibers ran not only from the eyes to the cortex, but from the cortex to the eyes, suggesting that the individual “has the ability to actively influence the thing that is perceived.” The information coming into the brain might not even be a correct representation of the outside world: only “practice” could verify it.<sup>91</sup>

To account for these properties of consciousness, Gurevich argued, psychiatrists needed to look beyond the two-dimensional “canvas” of Pavlov’s theory and start thinking about emergent properties that could result from the “integration” of neurons. The qualitative properties of mind could be accounted for, he said, if one used the concept of integration, where neurological structures were built up both gradually through addition of more units, and suddenly, when already existing networks were linked together into a new “integrated” system. The simplest psychological functions, he argued, were based in particular anatomical structures in the brain. These were then connected to one another to form more complex systems, and these systems had qualities and abilities that were not present in their constituent parts. Systems operated differently and reacted differently to stimuli; they were not just different in terms of their intensity or their magnitude, they had different qualities, just as the theory of reflection suggested that they should. These systems involved both awareness of the body at any given

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<sup>91</sup> M. O. Gurevich, *Nervnye i psikhicheskie rasstroistva pri zakrytykh travmakh cherepa* (Moscow: Medgiz, 1945), 46-47; M. O. Gurevich, "K postroeniiu teorii psikiatrii," in *Trudy psikiatricheskoi kliniki im. S. S. Korsakova*, ed. M. O. Gurevich and A. O. Edel'shtein (Moscow: 1 MOLMI, 1945), 6-8.

moment (synchronic awareness) and awareness of the state of the body over time (diachronic awareness). The result was the most complex of integrated system of all, consciousness itself.<sup>92</sup>

Gurevich readily acknowledged that this idea had a long history. Most obviously, and probably most pertinently, English physiologist Charles Sherrington had titled his famous 1906 book “The Integrative Action of the Nervous System,” and Gurevich (mis)quoted him saying that the nervous system was the “integrative system par excellence.”<sup>93</sup> Reaching further back, however, Gurevich traced the concept of integration in the nervous system to the social philosopher and psychologist Herbert Spencer, whose ideas about integration and evolution had been applied to the nervous system by English physiologist J. Hughlings Jackson. According to Jackson (drawing on Spencer), the many qualitative levels of the psyche were the result of the process of evolution, the result of simple organisms developing neurological structures which in later organism were “integrated” into new, more complex systems.

This evolutionary conception of the hierarchy of function had an important corollary: if the most complex, most evolutionarily recent structures were somehow damaged, the result could be “disinhibition,” or the “liberation [*osvobozhdenie*] of the lower mechanisms,” which, having been “dis-integrated” then “lose their new qualities of the higher functions . . . and begin to react to stimuli as did the original simple functions.”<sup>94</sup> The phenomenon of “dis-integration,”

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<sup>92</sup> M. O. Gurevich, "K postroeniiu teorii psikhiiatrii," in *Trudy psikhiatricheskoi kliniki im. S. S. Korsakova*, ed. M. O. Gurevich and A. O. Edel'shtein (Moscow: 1 MOLMI, 1945), 10, 14; M. O. Gurevich, *Nervnye i psikhicheskie rasstroistva pri zakrytykh travmakh cherepa* (Moscow: Medgiz, 1945), 47.

<sup>93</sup> M. O. Gurevich, "K postroeniiu teorii psikhiiatrii," in *Trudy psikhiatricheskoi kliniki im. S. S. Korsakova*, ed. M. O. Gurevich and A. O. Edel'shtein (Moscow: 1 MOLMI, 1945), 16. Gurevich's version seems to be a misquote. The passage in Sherrington's book actually reads, "In the multicellular animal . . . it is nervous reaction which par excellence integrates it, welds it together from its components, and constitutes it from a mere collection of organs an animal individual." Charles S. Sherrington, *The Integrative Action of the Nervous System* (New Haven: Yale University Press, 1906), 2.

<sup>94</sup> M. O. Gurevich, "K voprosu teorii ostrykh psikhozov," in *Voprosy sotsial'noi i klinicheskoi psikhonevrologii*, vol. 8, ed. E. K. Krasnushkin (Moscow: 1946), 10-11. For a brief overview of Jackson's work and ideas see Mary A. B. Brazier, *A History of Neurophysiology in the 19th Century* (New York: Raven, 1988), 158-

Gurevich argued, could explain sudden changes in the mental faculties of the insane. Those complex systems might be restored through “re-integration,” but this “re-integration” might go awry, a process that he thought could explain the “qualitatively different” properties of mind observed in the mentally ill. These people had neural structures that were simply not present in the healthy brain, and thus they had patterns of thought that were the unique domain of psychiatry.<sup>95</sup>

### **A Materialist Theory of Consciousness? Aleksandr Luriiia and “Systemic Localization”**

Among psychiatrists Gurevich was the most articulate advocate of a theory of psychoses based on the new findings about synapses and the chemical transmission of nerve impulses. His ideas about integration and consciousness, however, were developed at a time when a great deal of thought and research was being put into this by physiologists and neurologists. The most fully developed theory was presented in 1944 in a paper co-authored by Nikolai Grashchenkov and Aleksandr Luriiia. As the director of VIEM, Grashchenkov was listed as first author, but the ideas were clearly Luriiia’s. Like Gurevich, whom they cited in their paper, Grashchenkov and Luriiia presented a model of the psyche based on the “integration” of brain systems. Unlike Gurevich, however, they adapted Anokhin’s concept of the “functional system” and applied it to the cortex of the brain. They proposed that most psychological functions were not “localized” in any single brain structure, as some physiologists had assumed, but that did not mean that all structures in the brain were interchangeable, as others had argued. Using electroencephalography,

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160. For an interesting account of Hughlings Jackson’s concept of integration (and an attempt to use it in psychiatry) that is contemporary to Gurevich’s work, see Walther Riese, "The Principle of Integration: Its History and Its Nature," *The Journal of Nervous and Mental Disease* 96, no. 3 (September 1942): 296-312.

<sup>95</sup> M. O. Gurevich, "K postroeniiu teorii psikiatrii," in *Trudy psikiatricheskoi kliniki im. S. S. Korsakova*, ed. M. O. Gurevich and A. O. Edel'shtein (Moscow: 1 MOLMI, 1945), 15; M. O. Gurevich, "K voprosu teorii ostrykh psikhozov," in *Voprosy sotsial'noi i klinicheskoi psikhonevrologii*, vol. 8, ed. E. K. Krasnushkin (Moscow: 1946), 9; Gurevich, "K voprosu o sushchnosti shizofrenicheskogo protessa," 11-12.

physiologists could see that when patients did simple tasks areas all over their brains were simultaneously activated: no single area was responsible for their mental activity. Similarly, two patients with damage to different parts of their brains might lose the very same cognitive function. Complex psychological functions were not tied to single anatomic structures in the brain. This did not mean, however, that all parts of the brain were equal or interchangeable. The patients with damage to different parts of the brain might lose the same mental function, but they lost that function in *different ways* depending on which structure was damaged. Complex psychological functions *were* localized in the brain, Grashchenkov and Luriiia argued, but they were not localized in anatomical structures. Rather, anatomical structures were organized into “functional systems” that were responsible for different psychological tasks. Every structure played a specific role in producing the given cognitive function, and damage to any of the structures could disrupt the overall function. But the patient would show specific deficits depending on which component of the function was damaged. Grashchenkov and Luriiia called their idea of brain structures linked together into systems “horizontal integration.”<sup>96</sup>

Grashchenkov and Luriiia also posited something that they called “vertical integration.” In their model of the mind, some “functional systems” were responsible for simple psychological functions like sensing the environment or controlling muscles, while a higher-order group of “functional systems” were responsible for coordinating these simple activities, and a still higher level was involved in analyzing and synthesizing the information in the lower-level systems. Grashchenkov and Luriiia called the low-level systems “primary areas,” and noted that a person who suffered damage to one of these parts of the brain would lose some basic ability, like the

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<sup>96</sup> N. I. Grashchenkov and A. R. Luriiia, "O sistemnoi lokalizatsii funktsii v kore golovnogo mozga," *NiP* 14, no. 1 (1945): 14.

ability to move a hand or to see.<sup>97</sup> These “primary areas,” they argued, were “integrated” into higher order systems that enabled a person to coordinate multiple cognitive functions, like locating picking up a pencil. A soldier who was wounded in one of these “secondary” areas of the brain might not lose the ability to see or to move his hand, but he *would* lose the ability to accurately reach out and pick up the pencil. Without the “secondary” area of the brain, the complex system broke down, producing a qualitative change in cognitive ability.<sup>98</sup>

Finally, Grashchenkov and Luriiia argued that some specific parts of the brain were involved in “higher functions” involving knowledge and goals. These “tertiary” areas were connected with specific secondary and primary brain systems, and thus a person who suffered damage to a tertiary area of the brain might lose motor control, while another with damage to different tertiary area might lose the ability to make sense of sight. Grashchenkov and Luriiia were careful to note that these “tertiary” brain systems should not be understood as the localized “seats of consciousness,” but they affirmed that these higher integrating functions were the “necessary precondition” for consciousness to arise.<sup>99</sup>

Though Grashchenkov and Luriiia claimed accurately that their paper represented an emerging consensus in neuroscience, their paper was nevertheless important for the way in which it conceptualized systemic cognitive function in the brain, particularly because it was grounded in a large and rigorous body of empirical research. Though much more sophisticated and empirically grounded than Gurevich’s theory, their work, like his, provided a model of consciousness that was anything but a “canvas” or a “photographic” reflector of the surrounding world. In their model, the mind was multi-dimensional, and this enabled processing of

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<sup>97</sup> Ibid., 15.

<sup>98</sup> Ibid., 16.

<sup>99</sup> Ibid., 18-19.

information to happen simultaneously at different levels and in different areas. Lurii's concept of three "functional systems" proved to be enduring, and has been particularly important in shaping how modern neuroscientists conceptualize the function of the brain. In the late-twentieth century Aleksandr Lurii remained the most cited Russian psychology scholar in North America.<sup>100</sup>

In the Soviet Union, Grashchenkov and Lurii's paper was remarkable not only for its ideas, but for the intellectual allegiances declared by its authors. Grashchenkov and Lurii did not cite Lenin's theory of "reflection" *at all*, nor did they mention Ivan Pavlov, two omissions that were practically unheard of in a paper that dealt with how the brain formed a dynamic response to the world around it. Marx was cited only for his observation that a musician can hear tones that are not accessible to the untrained ear.<sup>101</sup> The influences that the authors did cite suggest that they saw the end of World War Two as a time when they might reengage with world science and rehabilitate Soviet psychologists who had been semi-officially forbidden since the 1930s. They acknowledged that they had been influenced by the thought of western physiologists like J. Hughlings Jackson, Charles Sherrington, John Fulton, Otto Pötzl, and Karl Lashley.<sup>102</sup> Their main inspiration, however, they attributed to Lev Vygotskii. Indeed, they presented their own ideas as unoriginal and derivative, simply further developing "a series of propositions" that

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<sup>100</sup> "Although obviously simplified," David Tupper writes, "this conceptualization helps students and practitioners utilize a simple brain-behavior model in clinical and research work, and it provides the type of functional behavioral geography system that can incorporate specific findings from diverse neuropsychological perspectives. Such a simplified model is useful, for example, in teaching the difference between patients with classic focal neuropsychological deficits (agnosia, apraxia, etc.) from a circumscribed stroke and patients with more generalized behavioral control difficulties from head-injury-generated frontal dysfunction." David E. Tupper, "Introduction: Alexander Luria's continuing Influence on Worldwide Neuropsychology," *Neuropsychology Review* 9, no. 1 (1999): 2.

<sup>101</sup> Grashchenkov and Lurii, "O sistemnoi lokalizatsii funktsii," 15.

<sup>102</sup> In 1948, Lurii published a book-length exposition of this theory and the data that supported it. In the book he did cite Ivan Pavlov, and he gave primary credit for the distributed cognition theory to one of Pavlov's students, Russian physiologist Pavel Anokhin. Luria, *Vosstanovlenie funktsii mozga*, 5.



Vygotskii had proposed in the 1930s. He had been, they wrote, a “wonderful Soviet psychologist who died before his time.”<sup>103</sup>

Grashchenkov and Luriiia’s defense of Vygotskii was remarkable because Vygotskii had been persona-non-grata in the world of Soviet science since 1936. Vygotskii himself had died of tuberculosis in 1934, two years before the ban on pedology and psychotechnics, but he had been strongly associated with pedology, and his ideas were forcibly denounced as anti-Soviet.<sup>104</sup> Now Grashchenkov and Luriiia provided an overview of Vygotskii’s theory for their readers, explaining how he thought that as a child aged its brain developed in complexity, both in terms of structure and function. Vygotskii’s approach, they claimed, provided the foundations for a truly dialectical-materialist theory of brain localization, one that avoided the pitfalls of vulgar materialism, while also avoiding the anti-dialectical-materialist trap of divorcing the mind from the physical brain. Using Vygotskii’s theory, they could develop a view of the brain as a complex system whose physiological structure was the result of the individual’s own historical development in the context of a given place and time.<sup>105</sup> For Grashchenkov and Luriiia to prominently credit Vygotskii with the ultimate Soviet theory of brain organization was a bold attempt to put the 1930s behind them and to use the victory in World War Two as a new beginning for cognitive sciences. It was also a shot across the bow of orthodox Pavlovian theory.

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<sup>103</sup> Grashchenkov and Luriiia, “O sistemnoi lokalizatsii funktsii,” 21. On Anokhin’s controversial revisions to Pavlov’s theory, see Joravsky, *Russian Psychology*, 393-398; Slava Gerovitch, *From Newspeak to Cyberspeak: A History of Soviet Cybernetics* (Cambridge, Mass.: MIT Press, 2002), 121-122.

<sup>104</sup> As his various biographers have argued, there is some reason to think that, had he survived his illness, Vygotskii would have perished in the Great Terror. Several other prominent spokesmen for pedology and psychotechnics were arrested in 1937-1938, though others, like Luriiia himself, escaped unscathed. Iu. S. Savenko, “1937’ 70-letie bol’shogo terrora i psikhiiatriia,” *Nezavisimyi psikhiatricheskii zhurnal*, no. 3 (2007). <http://www.npar.ru/jouranl/2007/3/1937.html> (accessed 12 May 2008).

<sup>105</sup> Grashchenkov and Luriiia, “O sistemnoi lokalizatsii funktsii,” 21-22.

## **Medical Holism and Institutional Politics**

In 1944 All-Union Institute of Experimental Medicine (VIEM) was disbanded, and its laboratories, divisions, and departments became the core institutes of the new USSR Academy of Medical Sciences (referred to hereafter by its commonly used Russian acronym, AMN, or *Akademiia meditsinskikh nauk*). Since 1939 Nikolai Grashchenkov had been the director of VIEM, and he had been one of its founders and Party leaders since its creation in 1934. He participated in early planning for an All-Union Academy of Medical Sciences before the war, and in 1944 he was a member of the small group of influential men who served on the Academy's organizational committee. He became the director of the newly created AMN Institute of Neurology, but he was not among the top leaders of the Academy's Presidium. He remained an influential and well-connected man, but the creation of the AMN appears to have diminished his significance in the hierarchy of medical research institutions.

Vasilii Giliarovskii and Mikhail Gurevich were two of the relatively small group of medical scientists who were made full members of the AMN from the very beginning, and both played active roles in the organization of Academy's Department of Clinical Medicine. It was Giliarovskii, however, who became the director of the newly created AMN Institute of Psychiatry. Gurevich remained influential as the chairman of the most prestigious university psychiatry program in the USSR, a consultant to the Soviet military, and, after 1944, the research director for the Serbsky Institute of Forensic Psychiatry. But he was not a director of an Academy Institute, and this difference may have been one of the things fueling an increasingly public rivalry between him and Giliarovskii.

From a distance, Lurii's "systemic localization," Gurevich's "theory of integration," and Giliarovskii's "somatopsyche" all seem basically compatible. Giliarovskii was focusing on the

interaction between body and brain and the creation of a proto-consciousness, while Gurevich and Lurii were focusing on the cortex of the brain and the construction of what has been referred to as “core consciousness.” Both were interested in pursuing a more subtle approach to the problem of perception and agency, and were attracted by ideas like Anokhin’s notion of feedback loops and Cannon’s (and Orbeli’s) idea about homeostasis.<sup>106</sup>

And yet, the two men were very critical of one another and of their ideas, and they were frequently placed in positions of authority over one another where these opinions had real weight. Gurevich objected to Giliarovskii’s claim that disturbances of the sympathetic nervous system could explain hysteria. “The essence of the later [hysteria] is psychogenic,” he wrote, “and vegetative disorders are not always very clear and, in any case, in themselves they do not explain the essence of the illness.” He compared Giliarovskii’s theory of the “somatopsyche” to an attempt in the 1920s to reduce all mental phenomena to endocrine disorders. Like that “endorinological exaggeration,” Gurevich thought, Giliarovskii’s theory would be disproven through practice. When psychiatrists had attempted to use endocrinology to treat major mental illness, their attempts failed. “It is characteristic that now they do not even try to prove the correctness of their theory with attempts to find corresponding treatment.”<sup>107</sup> As one of the only other psychiatrists who were full members of the AMN, Gurevich was asked to chair the

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<sup>106</sup> Damasio usefully differentiates between what he calls the “proto-self,” “core consciousness,” and “extended consciousness.” Damasio, *The Feeling of What Happens*, 82-106.

<sup>107</sup> Gurevich and Sukhareva particularly criticized neuropathologist Nikolai Chetverikov, who had praised Giliarovskii’s theory because he thought it would help get psychiatry out of “the vicious circle of psychic concepts and terms that are close to idealist concepts.” The suggestion that psychiatrists should do without “mental concepts and terms,” Gurevich and his coauthor concluded, was not even worthy of discussion. Simply mentioning it was enough to discredit it. Gurevich and Sukhareva, “Dostizheniia sovetskoi psikhiiatrii za gody otechestvennoi voyny,” 56-57.

committees that reviewed the research plans and work at Giliarovskii's institute,<sup>108</sup> and in 1947 he was a member of the commission assigned to vet the professional qualifications of Giliarovskii's staff ("attestation").<sup>109</sup>

Giliarovskii was equally critical. In a 1946 report to the AMN, Giliarovskii wrote that "Many Soviet psychiatrists, following the example of the West, think that the primary [thing] in a psychosis ... consists of a process of intrapsychic ataxia, disintegration, in the unbinding of individual more elementary mechanisms which are said to remain whole. The institute considers his hypothesis more than ~~strange~~ questionable. [strike through original]".<sup>110</sup> At the Academy and Minzdrav USSR Giliarovskii was placed in positions that allowed him to make official reports on Gurevich and his work. As part of a 1947 inspection of the Serbsky Institute, for instance, Giliarovskii concluded that the institute was overly dependent on "psychological analysis" and was "still not doing enough to introduce laboratory and complex tests" into their research.<sup>111</sup>

Other psychiatrists and medical authorities, however, were receptive to Giliarovskii's ideas. Contemporaries were certainly aware of the rivalry between Giliarovskii and Gurevich, in part from their scathing critiques of one another's work, but also from petty complaints scattered

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<sup>108</sup> This was true for at least the 1948 review. V. A. Giliarovskii, in Ognev (Chairman), "Rashirenniy protokoll No. 23 zasedaniia Biuro OKM AMN SSSR," 31 August 1948, GARF, f. r-9120, op. 2, d. 562, l. 144. The April 1946 review was done by neuropathologist Sergei Davidenkov, Zelenin (Chairman), "Protoikoll no. 12 zasedaniia biuro OKM AMN SSSR," 2 April 1946, GARF, f. r-9120, op. 2, d. 188, ll. 19-24.

<sup>109</sup> I. G. Rufanov, "Protokoll No. 30 Zasedaniia Biuro AMN SSSR," 14 October 1947, GARF, f. r-9120, op. 2, d. 353, l. 125.

<sup>110</sup> "Soviet psychiatrists," Giliarovskii continued, "stand before the task of completing the construction of Soviet psychiatry – the construction of a system of views on the basis of studying the material substrate of psychoses not just in the sense of brain changes, but also somato-vegetative disruptions and disruptions of metabolism." "Godovoi otchet Instituta psikiatrii AMN za 1946 god," GARF, f. r-9120, op. 2, d. 250, l. 10.

<sup>111</sup> Giliarovskii, in N. N. Priorov (Chairman), "Stenogramma zasedaniia Preziudma UMS MZ SSSR," 26 February 1948, GARF, f. r-8009, op. 2, d. 1150, l. 21.

through their work about perceived slights to their own priority in research.<sup>112</sup> In at least one case Minzdrav officials even attempted to use their rivalry to political advantage, sending to Gurevich a doctoral thesis that Giliarovskii had already evaluated negatively. (They evidently hoped that Gurevich would deliberately give the thesis a positive review; he did not.)<sup>113</sup> But Giliarovskii's research agenda was praised by prominent psychiatrists and physiologists for being both progressive and Pavlovian. Ukrainian psychiatrist Evgenii Popov, one of the most prominent practitioners of self-consciously "Pavlovian" psychiatry, praised Giliarovskii 1946 edited volume *Somato-psikhicheskie rasstrostva: Sbornik trudov Instituta psikhiatrii* [*Somato-Psychic Disorders: A Collection of the Works of the Institute of Psychiatry*], and seconded Giliarovskii's call for psychiatrists to create a unified dialectical-materialist theory of the mind, a "Soviet psychiatry in the full sense of the word."<sup>114</sup> Konstantin Bykov, an increasingly prominent Pavlovian physiologist, also positively reviewed Giliarovskii's work. "The orientation of the Institute is entirely correct," he told the AMN Department of Clinical Medicine in 1946. "We, students of I. P. Pavlov, have some acquaintance with psychiatry. Ivan Petrovich himself was interested in these questions, and the clinic was one of the areas of that work."<sup>115</sup> He praised Giliarovskii for his "clearly expressed effort to use the achievements of modern physiology and adapt the newest methods of research to resolve important questions of the origins and

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<sup>112</sup> In his major postwar monograph, for instance, Giliarovskii accused Gurevich of having ignored Giliarovskii's theory that vascular disorders were caused by disruptions in the vegetative nervous system. Giliarovskii, *Starye i novye problemy*, 116.

<sup>113</sup> The doctoral dissertation in question was Andrei Snezhnevskii's thesis on old-age psychosis. According to Portnov (who clearly had an axe to grind with Snezhnevskii), Gurevich's assessment was even more negative than Giliarovskii's had been. The person who was trying to play the two off one another was Dmitrii Fedotov, then a top official at Minzdrav USSR. A. A. Portnov, "Vospominaniia o razvitii otechestvennoi psikhiatrii," in *Voprosy sotsial'noi i klinicheskoi psikhiatrii i narkologii*, ed. B. D. Tsygankova (Moscow: 2000), p. 294

<sup>114</sup> E. A. Popov, "Retsenziia: 'Somato-psikhicheskie rasstrostva. Sbornik trudov Instituta psikhiatrii AMN pod redaktsiei V. A. Giliarovskogo.'" *Vrachebnoe delo* 27, no. 8 (August 1947): 719.

<sup>115</sup> K. M. Bykov, in V. F. Zelenin (Chairman), "Protokol no. 12 zasedaniia biuro otdeleniia klinicheskoi meditsiny AMN SSSR" (2 April 1946), GARF, f. r-9120, op. 2, d. 188, l. 40ob.

mechanisms of the development of various mental disruptions.”<sup>116</sup> Bykov himself was very interested in the relationship between “center and periphery” in physiology, and he and Giliarovskii collaborated on a January 1948 conference on “problems of psychosomatics.”<sup>117</sup>

The tension between Giliarovskii and Gurevich in the early 1940s illustrates how leading psychiatrists critically positioned their work in relation to contemporary physiology even before the infamous Pavlov Sessions of 1950-1952. In their often uneasy interactions, leading psychiatrists judged one another by the physiological authorities they cited, by the ways they used the “newest laboratory tests” in their research. During World War Two and the early post war these transactions were conducted largely (though not solely) in terms that might impugn a rival’s scientific acumen or professional judgment, but not in terms that cast the rival’s scientific interpretations as signs of insufficient patriotism, philosophical immaturity, or an anti-Soviet worldview. Bad theory was not yet equated with political deviation as it would be at the end of the decade.

Indeed, the war and early postwar years were particularly auspicious times for scientists who wanted to develop new approaches to their work. During the war Soviet scientists were able to openly reengage with Western ideas and to reestablish personal ties with Western scientists. The largest single conduit for Western medical research into the USSR was the American-Soviet Medical Society, an organization created in 1943 by Henry Sigerist.<sup>118</sup> By 1947 the American-

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<sup>116</sup> K. M. Bykov, “Zakluchenie po rassmotreniiu plana institute psikhiiarii AMN na 1946 god,” undated, GARF, f. r-9120, op. 2, d. 223, ll. 1-2.

<sup>117</sup> Though Bykov was listed as the books editor, the publication information makes clear that the actual work was done by Leon Rokhlin, a senior psychiatrist at Giliarovskii’s institute. Psychiatrists from Giliarovskii’s institute were the single biggest group of contributors to the conference, with 1/3 of all the papers (11 out of 33). K. M. Bykov, ed., *Problemy kortiko-vistseral'noi patologii: Trudy nauchnoi konferentsii po problemam psikhosomatiki (ianvar' 1948 g., Leningrad)* (Moscow: Izd-vo AMN SSSR, 1949).

<sup>118</sup> Henry E. Sigerist, "On American-Soviet Medical Relations," *American Review of Soviet Medicine* 5, no. 1 (December 1947): 5-8.

Soviet Medical Society was providing 47% of the foreign journal titles received by the State Medical Library in Moscow, and 63% of the American medical journals.<sup>119</sup> For psychiatrists like Giliarovskii who were interested in the role of the autonomic nervous system, the exchange with the Society proved to be a boon not only because of the number of journals and books that the society provided, but also because the Society's president was eminent physiologist Walter B. Cannon, the American neurophysiologist who had coined the term "homeostasis," and who was actively involved in studying the chemical transmission of nerve signals and their role in regulating the internal environment of the body. Cannon had travelled to the Soviet Union for the fifteenth International Congress of Physiology in Leningrad in 1935 and he considered himself a personal friend of Pavlov and Orbeli.<sup>120</sup> His status as an officially recognized "friend of the Soviet Union" made him an acceptable Western scientist to cite in Soviet publications.<sup>121</sup>

Even in this relatively relaxed environment for scientific inquiry, however, arguments like those between Gurevich and Giliarovskii mattered because funding for psychiatric research was so hard to secure. The early 1940s were a historical low point for publication of psychiatric

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<sup>119</sup> In 1947 the State Medical Library was receiving 389 foreign medical journal: 286 titles were from the United States, where the two single largest sources of journals were the American-Soviet Medical Society (181 titles) and the Army Medical Library (64 titles). Most of these exchanges were halted in 1948. P. L. Shupik (Deputy USSR Minister of Health) to TsK KPSS, 3 March 1955, GARF, f. r-8009, op. 1, d. 1201, ll. 23-58. The Society's declared purpose was to establish international scientific exchange with the USSR in the hope that "reciprocal undertakings will serve to strengthen in time the natural ties of fellowship of physicians ... and thereby will help to promote mutual acquaintance and to lessen ignorance and misjudgment among the citizens of two great and powerful nations." Walter B. Cannon, "Foreword," *American Review of Soviet Medicine* 1, no. 1 (October 1943): 6. The inaugural issue included a statement by the Representative of the Russian Red Cross in the United States, who wrote about his shock on coming to the United States and finding that American scientists were ignorant of the "achievements of Soviet medicine." He wished the journal well, and hoped that it would help "enrich the life of man after the plague of fascism has been cleansed from the earth." Vladimir V. Lebedenko, "Greetings from the U.S.S.R.," *American Review of Soviet Medicine* 1, no. 1 (October 1943): 7-8.

<sup>120</sup> For a fascinating account of Cannon's trip to the USSR, see Wolfe, Barger, and Benison, *Walter B. Cannon, Science and Society*, 333-337, 343-353.

<sup>121</sup> In 1945 Vasilii Parin, the man in charge of the Academy of Medical Sciences, began work on a translation of Cannon's book, "The Wisdom of the Body." Parin's translation was never completed. "'Vvedenie' knigi U. Kennona 'Samoregulatsiia zhiznennykh protsessov' (Perevod V.V. Parina)," 23 Dec. 1945, in N. A. Grigori'an, ed., *Akademik Vasilii Vasil'evich Parin: K 100-letiiu so dnia orzhdeniia* (Moscow: Nauka, 2003), 118-130.

literature in the USSR, and just getting access to new literature could be very difficult. Before the war there had still been two journals devoted to psychiatry, *Nevropatologiia i psikhiaetriia*, published in Moscow, and *Sovetskaia psikhonevrologiia*, published by Ukrainian Psychoneurological Institute in Kharkov. The latter ceased publication in 1941, and never resumed, leaving the Soviet Union with a single journal for psychiatrists.<sup>122</sup> During the war *Nevropatologiia i psikhiaetriia* was reduced from 12 to 6 issues per year and its print-run [*tirazh*] was also reduced, from 4,200 copies per issue in 1941 to 1,300 in 1948.<sup>123</sup> As the director of *Medgiz* [The State Medical Publishing House] explained in a 1948 letter to the Party Central Committee, there were over 5,500 neuropathologists and psychiatrists in the USSR, and there was no way that 1,300 copies of the journal could get to all of them, not to mention the medical schools, research institutes, and libraries that were interested in subscribing.<sup>124</sup>

Psychiatrists working in psychiatric hospitals and medical institutes outside the USSR's main cities were at particular disadvantage. Many complained that they simply could not get

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<sup>122</sup> Until 1930 the Bekhterev Institute of the Brain and the Bekhterev Psychoneurological Institutes in Leningrad had published two additional journals, *Voprosy izucheniia i vospitaniia lichnosti* and *Obozrenie psikhiaetriia, nevrologii i refleksologii im. Bekhtereva*. The former ceased publication in 1932, and the latter in 1930. The Ukrainian Psychoneurological Institute's journal *Sovetskaia psikhonevrologiia* was published from 1925-1941. During this period the Moscow journal went through several different titles and publishers. It had been founded in 1900 by the Moscow Society of Neuropathologists and Psychiatrists as *Zhurnal nevroptologii i psikhiaetrii im. S. S. Korsakova* (1900-1917, 1925-1930). It then became simply *Zhurnal nevroptologii i psikhiaetrii* (1931), *Sovetskaia nevroptologiia, psikhiaetriia, i psikhogigiena* (1932-1935), *Nevropatologiia, psikhiaetriia, i psikhogigiena* (1935-1936), and finally simply *Nevropatologiia i psikhiaetriia* (1937-1951). In 1952 it was renamed *Zhurnal nevroptologii i psikhiaetrii im. S. S. Korsakova*, and its volume number was changed to suggest that publication had been continuous since 1900 (i.e., 1951 no. 6 was issued as volume 20, and 1952 no. 1 was issued as volume 52). *Periodich. Pechat'*, *Periodicheskaia pechat' SSSR, 1917-1949. Zhurnaly, trudy iulleteni po zdavookhraneniui, meditsine, fizicheskoi kul'ture i sportu*, (Moscow: Glavizdat, 1956), 84-85.

<sup>123</sup> The number of copies available to psychiatrists in the USSR would have been even lower than 1,300, since some issues were sent abroad. In 1949 the *tirazh* was raised to 5,000 copies, but 1,500 of those were reserved for export literature organization *Mezhdunarodnaia kniga*. E. Smirnov (Ministr Zdrav. SSSR) to M. A. Suslov (Sek. TsK VKP(b)), 17 January 1950, GARF, f. r-8009, op. 1, d. 821, l. 4.

<sup>124</sup> V. M. Banshchikov (Direktor MedGIZa), "Ob"iasnitel'naia zapiska po voprosu uvelicheniia tirazha, ob"ema i periodichenosti riada izdavaemykh medgizom zhurnalov na 1949," undated, GARF, f. r-8009, op. 1, d. 654, ll. 137-145, esp. 141.



copies of *Nevropatologiia i psikhiatriia* for months at a time. To cope, they developed practices such as reading abstracts out loud at conferences.<sup>125</sup> The lack of literature did not end with periodicals, however. Textbooks, monographs, and every other sort of scientific literature were also in short supply. At a 1948 conference in Moscow, a psychiatrist from an *oblast'* psychiatric hospital in Gor'kii complained that his hospital had not received a single copy of the journal in 1947, that they could not get a single copy of a standard psychiatric textbook (Gurevich and Sereiskii).<sup>126</sup> Some provincial psychiatrists resorted to putting together their own small pamphlets summarizing the basics of psychiatric practice so that local psychiatrists and physicians would at least have some reference material to turn to.<sup>127</sup>

The lack of literature not only made it hard to read about psychiatric research, it also made it hard to publish psychiatric research. Most of the articles selected for publication by the editors of *Nevropatologiia i psikhiatriia* were produced by people who worked in Moscow and Leningrad, particularly people who worked at the institutions that the editorial board members controlled.<sup>128</sup> Getting a monograph published was very difficult; Medgiz only published a

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<sup>125</sup> Pashchenko (Gl. vrach psikh b-tsa, Kiev), cited in D. D. Fedotov (Chairman), "Stenogramma zasedaniia vrachei-psikhiatrov po obsluzhdeniiu dekadnika glavnykh vrachei psikhiatricheskikh bol'nits," 14 May 1951, GARF, f. r-8009, op. 33, d. 398, l. 11.; GARF, f. a-482, op. 47, d. 8454, l. 23ob; GARF, f. a-482, op. 48, d. 3512, l. 7.

<sup>126</sup> I. M. Sheikin (Zam. po med chasti Gor'kovskoi oblastnoi psikh. b-tsy), cited in "Protokol nauchnoi konferentsii, posviashchennoi voprosam noveishikh metodov lecheniia psikhicheskikh zabol'evanii," 13 April 1948, GARF, f. a-482, op. 47, d. 8454, l. 23ob.

<sup>127</sup> See, for instance, V. M. Belous and V. M. Chugreeva, *Pamiatka po psikhiatriia uchastkovomu vrachu Kryma* (Simferopol': Krymskii oblast'noi psikhonevrologicheskii dispenser, 1947), typed page proofs, GARF, f. 482, op. 47, d. 846, ll. 11-41. The material in Belous and Chugreeva's thirty page pamphlet was primarily drawn from the standard textbooks written by Mikhail Gurevich and Mark Sereiskii and by Vasilii Giliarovskii. They included sections on how to detect symptoms of mental illness, how to give first aide, how to treat various specific disorders (manic depressive psychosis, epilepsy, etc), a summary of legal procedures for sending patients to local psychiatric institutions and finding them work, and an appendix of formulas for mixing up various pharmaceutical tranquilizers.

<sup>128</sup> From 1945-1948 the editor was Nikolai Grashchenkov, director of the Institute of Neurology AMN SSSR; Shmar'ian, the deputy editor, was the deputy director of the Central Institute of Psychiatry MZ RSFSR and head psychiatrist MZ SSSR. The secretary was N. S. Chetverikov [not sure where he worked]. Members of the editorial

handful of books on psychiatry in the postwar, and virtually all of them written by the directors of major research institutes or people closely associated with them. For most psychiatrists the only viable avenues for publication were conference volumes and collections of “works” [*trudy*] published by medical schools, research institutes, or even hospitals. The key was having a capable scientific administrator who could figure out how to get the paper, how to get the book to the head of the queue at the printer, and who would thus be able to get his staff members access to publication.<sup>129</sup> The Director of the RSFSR Central Institute of Psychiatry, Pavel Posvianskii, went so far as to sell copies of a volume of his institute’s research papers in advance in order to secure the funds he needed to finance and publish the book.<sup>130</sup>

In this context, having a competent and well-connected institute director was crucial. Publication, of course, was just one small, though important, part of the picture. Researchers needed to have lab space, technical equipment like x-ray machines (modern or otherwise), chemicals, medicines, and all the other paraphernalia necessary for medical research. To a large extent, being a research institute director meant acting as a broker within one’s profession, helping cultivate researchers and at the same time maintaining contacts with powerful people in the state and the party who could help approve research budgets, procure paper for books, obtain

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board were V. A. Giliarovskii (Director of the Institute of Psychiatry AMN SSSR), M. O. Gurevich (Director of the psychiatry clinic at 1 MMI), and E. K. Sepp (Director of the Neurology clinic at 1 MMI).

<sup>129</sup> "Otchet Leningradskogo Gosudarstvennogo nauchno-issledovatel'skogo psikhonevrologicheskogo instituta po nauchno-issledovatel'skoi rabote za 1960 g.," undated, GARF, f. a-482, op. 48, d. 3512, l. 7.

<sup>130</sup> Sheikin was complaining about the lack of textbooks, and suggested that Minzdrav RSFSR follow Posvianskii’s example. Posvianskii, he said, had raised money for the publication of his textbook by sending out a notice asking for pre-publication orders. The volume in question was probably P. B. Posvianskii and A. S. Shmar’ian, eds., *Trudy tsentral'nogo instituta psikiatrii MZ RSFSR* (Moscow: 1947). I. M. Sheikin (Zam. po med chastii Gor'kovskoi oblastnoi psikh. b-tsy), cited in “Protokol nauchnoi konferentsii, posviashchennoi voprosam noveishikh metodov lecheniia psikhicheskikh zabolevanii,” 13 April 1948, GARF, f. a-482, op. 47, d. 8454, l. 23ob.

permissions to travel abroad to conferences.<sup>131</sup> Making an intellectual argument in the field, much less challenging the existing conceptualization of core problems of the field, was simply not possible without access to institutional clout. Institutional politics and the politics of knowledge could not be untangled.

### **“Psychiatry is Deeply Concerned with Theory”: Pavlovian Theory and the Status of Psychiatry in the Soviet Hierarchy of Medical Specialties**

One of the psychiatrists who had been excluded from the new Academy of Medical Sciences system was Anatolii Ivanov-Smolenskii, the psychiatrist who had worked closely with Pavlov in the 1930s. In 1937 his clash with Giliarovskii had resulted in the closing of his laboratory at VIEM. Had it not been closed, the laboratory might well have been turned into an institute when the AMN was created in 1944. As it happened, though Ivanov-Smolenskii was left to find some place to do his research, while Giliarovskii’s laboratory was turned into an AMN institute. Ivanov-Smolenskii was an ambitious man and a man who held grudges, and he spent much of the 1940s and early 1950s attempting to establish himself as the director of an independent institute. After a series of failed attempts, including an abortive denunciation of Orbeli in 1948,<sup>132</sup> Ivanov-Smolenskii ultimately succeeded. With the patronage of Party science chief Iurii Zhdanov, the son of Andrei Zhdanov, Ivanov-Smolenskii managed to turn his own laboratory into an independent institute, become a member of the Academy of Medical Sciences, and, ultimately, its Vice President. For a brief time in the early 1950s, Ivanov-Smolenskii was one of the most influential power brokers in both physiology and psychiatry.

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<sup>131</sup> On patronage in Russian and Soviet science see D. A. Alexandrov, "Istoricheskaia antropologiia nauki v rossii," *Voprosy istorii estestvoznaniia i tekhniki*, no. 4 (1994): 9-14.

<sup>132</sup> According to Kremmentsov, “The institutional dimension of the attack on Orbeli was clearly articulated in the commissions’ proposal to separate the Moscow branch of the institute, then directed by Ivanov-Smolenskii.” Nikolai Kremmentsov, *Stalinist Science* (Princeton: Princeton University Press, 1997), 269-272

In 1944 Ivanov-Smolenskii became the head of a laboratory at the Moscow branch of the Institute of Evolutionary Physiology, a research institute that was directed by Orbeli.<sup>133</sup> Ivanov-Smolenskii was once again able to do research, but he did not publish in *Nevropatologiya i psikhiatriia*, and he does not seem to have participated in the small world of Moscow psychiatry, the conferences, professional association boards, government commissions, and so forth that constituted a sort of “psychiatric public” where ideas were exchanged, decisions were made, and personal connections were maintained. Ivanov-Smolenskii’s few publications from this period appear to have been in edited volumes produced by Orbeli. His low status, lack of an effective patronage, and inability to command respect of his peers was demonstrated when he was recommended as a possible candidate for the honorary title of “Honored Scientist” [*zasluzhenyi deiatel’ nauki*], a rank that provided special access to goods and higher pay in addition to prestige. The nominating commission recommended Ivanov-Smolenskii’s candidacy by a vote of 4 in favor to 2 against. In a secret ballot vote in early 1946, however, the Presidium of Minzdrav USSR’s Scientific Medical Council voted 5 to 2 *against* awarding making him an “honored scientist.”<sup>134</sup>

In the summer of 1946, however, the political and ideological situation in Soviet science began to change rapidly as a series of Party resolutions attacked “the pernicious influence of bourgeois culture” and “servility and slavishness before Western culture.” In the increasingly tense atmosphere of the early Cold War, Ivanov-Smolenskii sought to recast his history of personal grievances and professional exclusion as an important front in the ongoing struggle of

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<sup>133</sup> According to Joravsky, Orbeli “smiled benignly” when Ivanov-Smolenskii secured this institute for his work. Joravsky, *Russian Psychology*, 394.

<sup>134</sup> In addition to the recommendation of the nominating commission, Ivanov-Smolenskii’s candidacy was supported by a letter written by the psychiatrist V. Protopopov. I. Rufanov (Chairman), “Protokol #4 rasshirennogo zasedaniia Prezidiuma UMS NKZ SSSR, sovместno sovместno s predsedateliami i sekretariami nauchnykh med. ob-v i Komitetom pomoshchi invalidam i rannym OV,” 21 February 1946, GARF, f. r-8009, op. 2, d. 868, ll. 46-47.

dialectical-materialism and idealism. He himself represented a continuation of Pavlov's progressive, iconoclastic materialism. His failure to earn the respect of his peers and his exclusion from professional resources and positions of influence was a sign that the forces of idealism, the enemies of progressive soviet science, had long ago taken control of the commanding heights in psychiatry and were holding back the truth.

Ivanov-Smolenskii's attack on other psychiatrists (and on Giliarovskii in particular) came against the background of the crackdown against contact with Western science by medical researchers, an intervention that made Ivanov-Smolenskii's accusations against Giliarovskii particularly potent. This crackdown at Minzdrav and the AMN, however, was also closely related to a series of administrative reforms that were intended to rationalize the USSR's health care and medical systems. As part of these reforms, and just before Ivanov-Smolenskii's intervention, the Academy of Medical Sciences recommended removing Giliarovskii's institute from the Academy and transferring it to Minzdrav USSR, a move that was potentially a major blow to Giliarovskii's institutional and professional power. Archival sources are disappointingly unclear on the reasoning behind the AMN's decision to remove the Institute of Psychiatry from the Academy. On the face of it, the decision was made based on fairly major problems like the institute's lack of independent buildings (they shared space with Giliarovskii's university department), and their major focus on clinical treatment. The discussion of the decision, however, revealed major disagreement about the validity of the recommendation to transfer, and there were some suggestive hints that behind the scenes someone had made a decision to remove Giliarovskii's institute, and that this decision had more to do with the psychiatry as a discipline than the quality of this particular institute.

The ideological crackdown in the medical sciences came in 1947, when Soviet cancer researchers Nina Kliueva and Grigorii Roskin were accused of passing information about their research to the Americans. This scandal came to be known as the “KR Affair,” named after the “KR substance” that that Kliueva and Roskin (K and R) were developing to fight cancer. As a result of this “affair” several very senior administrators at Minzdrav USSR were fired, including the Minister himself, and the man in charge of the USSR Academy of Medical Sciences, Academician-Secretary Vasili Parin, was arrested as an American spy. Stalin ordered a special “honor court” to be convened by Minzdrav in order to subject those involved to a demonstrative condemnation in front of their peers, and to orchestrate this he chose Efim Smirnov, the military physician who had headed the Red Army Medical Service during the war.<sup>135</sup> In February 1947 Smirnov was appointed as the new Minister of Health, and his first order of business was to script the case against Kliueva and Roskin.<sup>136</sup>

Smirnov was also given a broad mandate to reform the way the public health system operated, and in some ways his ideological crackdown at the Ministry became entwined with his organizational reforms. Chris Burton examines these reforms at length in his dissertation and concludes that Smirnov wanted to change the administrative culture that had become entrenched at Minzdrav, to regularize procedures and force officials to think more like administrators. Smirnov, Burton writes, “regarded his immediate task as ‘breaking the psychology of a significant part of the leadership of medical organs and institutions.’ The administrators still thought in the hasty improvisations of wartime rather than the more considered terms that peace

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<sup>135</sup> Nikolai Kremontsov, *The Cure: A Story of Cancer and Politics from the Annals of the Cold War* (Chicago: University of Chicago Press, 2002), 102-109, 112-113. For Smirnov’s own account of his appointment see E. I. Smirnov, *Meditsina i organizatsiia zdavookhraneniia, 1947-1953* (Moscow: Meditsina, 1989), 5-8.

<sup>136</sup> E. I. Smirnov, *Meditsina i organizatsiia zdavookhraneniia, 1947-1953* (Moscow: Meditsina, 1989), 6-9.

enabled.<sup>137</sup> Smirnov began to implement his administrative reforms the week after he organized the “Court of Honor” for the KR Affair, and one of his first efforts was an important but little known effort to reorganize the Academy of Medical Sciences. Smirnov created a commission which he himself chaired to investigate the Academy’s institutes. The Academy’s institutes were to be high-prestige organizations, and Smirnov thought that this should mean institutes that did basic research to advance fundamental medical theory. Academy research institutions should not be teaching students, doing clinical treatment, or duplicating work that was being done elsewhere. The Academy was intended to do “in depth scientific research directed at solving major central problems [*krupnykh uzlovykh problem*] that have undoubted importance for the development of medical science, having particularly important significance from the point of view of the health care needs of our country.”<sup>138</sup>

Coming immediately on the heels of the KR Affair and the arrest of the Academy’s senior administrator, this inspection had at least the appearance of a check on researchers’ political loyalty and ideological orthodoxy. This impression was reinforced by instructions to inspectors to check staff members’ level of education, age, membership in the Party, and

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<sup>137</sup> Burton adds, “The political leadership had found Miterev too disengaged for their requirements for a senior health administrator. They wanted a micro-manager: Smirnov, bustling, assertive, perhaps even over-engaged, fitted that bill. An era of very tight control over the ministry ensued.” Burton, “Medical Welfare,” 96-97.

<sup>138</sup> N. N. Anichkov (Chairman), “Stenogramma zasedanii kollegii MZ SSSR,” 17 October 1947, GARF, f. r-8009, op. 1, d. 617, ll. 10-11. The commission would be chaired by Smirnov himself, and included Nikolai Anichkov (the president of the Academy), Lev Fëdorov (a leading physiologist and former director of VIEM), and Semyon Sarkisov (the director of the Institute of the Brain and Academic Secretary of the Academy) Fëdorov was also head of laboratory of higher nervous activity at the Institute of Neurosurgery and head of kafedra of VND at MGU. The other two members of the commission were Anatolii Strukov (a leading pathologist at the Institute of Normal and Pathological Anatomy) and Leonid Smirnov (a leading neuromorphologist at the Burdenko Institute). Prikaz MZ SSSR No. 130, “V tseliakh podvedenii itogov raboty AMN SSSR za vremia ee deiatel’nosti i pomoshchi v dal’neishem razvitii,” 14 April 1947. GARF, f. r-9120, op. 2, d. 350, l. 1; N. Semashko, in “Stenograficheskii otchet k protokolu #27-111 zasedanii Prezidiuma AMN SSSR,” 3 October 1947, GARF, f. r-9120, op. 2, d. 325, l. 79.

“Marxist-Leninist education.”<sup>139</sup> If this was the goal, however, it was not at all explicit, and it was not the only purpose of the inspections. Officially, the inspection was justified on the grounds that the Academy’s creation during the war had been too rushed and, as a result, some relatively minor laboratories and even hospitals had been turned into Academy institutes “accidentally [*sliuchaino*], sometimes through personal connections.” The inspection was intended to weed out this type of undeserving, leaving behind a core body of truly elite medical research organizations. The inspectors’ reports suggest that these practical concerns were foremost in their minds. They highlighted the condition of lab equipment, the publication record of staff, the condition of buildings, and, of course, the institutes’ “fulfillment of plan, prospects, and accomplishments.” They praised institutes that were efficient and economical, those that were properly maintaining their buildings, and those that were producing good work.<sup>140</sup> They found Giliarovskii’s Institute of Psychiatry wanting by all of these standards.

The inspectors described the Institute of Psychiatry as “a major institution of the hospital type that does not have its own [clinical] base, with quite shabby laboratory equipment, occupied primarily with treatment work. The research topic of the institute, extremely wide-ranging, relates to various areas of psychiatry.” The institute, in other words, was not a streamlined, well-managed, tightly focused, or highly theory-oriented research establishment. It was an eclectic operation that included the treatment of actual patients and focused on no single aspect of

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<sup>139</sup> “Plan obsledovaniia institute (proekt),” undated, GARF, f. r-9120, op. 2, d. 350, l. 6.

<sup>140</sup> For instance, L. A. Orbeli’s Institute of the Comparative Physiology of High Nervous Activity was found to “fully meet the profile of academic institutes” and to be “undertaking major research on important problems of biology and medicine.” The recommendation was “to retain the institute basically without changes, carrying out only a few simplifications of its internal structure.” The N. N. Burdenko Institute of Neurosurgery was similarly praised for “meeting the profile of a clinical institute,” though in this case the institute was found to have “a somewhat exaggerated structure and personnel, and should be reduced.” The Institute of Neurology was praised, but the commission recommend that several of its divisions be removed or reorganized so that the Institute could focus on its primary task of solving major problems in neurology. Unsigned, “Dokladnaia zapiska [po obsledovaniuu deiatel'nosti AMN SSSR],” undated (mid-1947), GARF, f. r-9120, op. 2, d. 350, ll. 15-25.



psychiatry in particular. By the commission's own criteria, the Institute of Psychiatry was not Academy material.<sup>141</sup> The recommendation also included another rationale for transferring the institute, however, and this rationale had little to do with Giliarovskii's institute itself, and everything to do with the nature of psychiatry as a medical science and its place in the emerging hierarchy of Soviet medical specialties. According to the recommendation, "the importance of psychiatry in modern medicine is not so great as to warrant a special institute in the given discipline within the Academy of Medical Sciences."<sup>142</sup>

The inclusion of this phrase in the recommendation provoked a something of a scandal at the AMN's Department of Clinical Medicine. Giliarovskii reported that he had protested the inclusion of this phrase in the recommendation and had been given assurances that it would be rewritten. "I cannot understand," he said, "how it could happen that it came to be accepted when it was unanimously rejected. I will say again now: if they propose to have me work in the Ministry system I will not protest, I will do good work there too. But this formulation is incomprehensible to me.... psychiatry is not only connected with practice – it is connected with theory as well, and quite deeply connected with theory."<sup>143</sup>

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<sup>141</sup> Ibid., 24-25.

<sup>142</sup> Ibid., ll. 24-25.

<sup>143</sup> I. G. Rufanov (Chairman), "Stenogramma zasedanii Biuro OKM k protokle #26," 16 September 1947, GARF, f. r-9120, op. 2, d. 355, l. 158. The Academy Institutes were each assigned to one of three "departments" within the Academy: The Department of Clinical Medicine, The Department of Medical-Biological Sciences, and the Department of Hygiene, Microbiology, and Epidemiology. Each department would have discussed the recommendations regarding its constituent institutes.

<sup>143</sup> N. I. Grashchenkov (Acting Chairman), "Protokol zasedanii Biuro AMN SSSR #24," 2 September 1947, GARF, f. r-9120, op. 2, d. 353, ll. 93-95. There is no indication in the protocol of who voted against the transfer, but Khoroshko's comments at a later meeting indicate that he spoke against it at the first meeting. See I. G. Rufanov (Chairman), "Stenogramma zasedanii Biuro OKM k protokle #26," 16 September 1947, GARF, f. r-9120, op. 2, d. 355, l. 157.

<sup>143</sup> I. G. Rufanov (Chairman), "Stenogramma zasedanii Biuro OKM k protokle #26," 16 September 1947, GARF, f. r-9120, op. 2, d. 355, ll. 157.

In the autumn of 1947 the acting secretary of the Department of Clinical Medicine was none other than Nikolai Grashchenkov. He was the only person at the meeting who spoke in defense of the decision to transfer Giliarovskii's Institute to Minzdrav, though he supported Giliarovskii's proposal to remove the offensive language about the value of psychiatry from the official decision. Other ranking members of the Academy strongly disagreed. Others at the meeting supported Giliarovskii's position. Neurologist V. K. Khoroshko succinctly articulated a common opinion among the participants at the meeting when he declared, "This is absurd. I think that the Institute of Psychiatry is one of the most successful [institutes]." Vladimir Zelenin, director of the Academy's Institute of Internal Medicine [*terapii*] and one of Giliarovskii's long-time colleagues at the Second Moscow Medical Institute, asked that the Academy reconsider the whole thing. "Today's decree should first of all be used to remove this discrimination, namely: we need to appeal to the Presidium [of the Academy] and the Commission [appointed by Smirnov to inspect the institutes] and point out that this formulation does not at all accord with reality, and that all the members of the Bureau protest against it, and protest in the most categorical manner."<sup>144</sup> When the issue came to a vote, those present voted nearly unanimously for the recommendation that Giliarovskii's institute remain in the Academy system, and in support of the motion that the Presidium reexamine the question. Only one person voted in favor of the Institute's transfer to the Ministry of Public Health. The majority of the members were for the proposal that the Presidium of the AMN reexamine the question, and for the recommendation that they leave Giliarovskii's institute in the AMN system.<sup>145</sup>

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<sup>144</sup> Ibid., 157-159.

<sup>145</sup> Ibid., 158-159.

The Presidium agreed to reexamine the transfer of Giliarovskii's institute, and they met to discuss the issue three weeks later. By this time Giliarovskii was reportedly feeling "very insulted" and had submitted a long memorandum detailing his institute's scientific achievements.<sup>146</sup> Unlike Giliarovskii's peers at the Department of Clinical Medicine, however, the members of the Presidium agreed in principle that Giliarovskii's institute should be removed from the Academy system. Some did express discomfort with wording of the original decision. One of the Academy's Vice Presidents, for instance, wondered aloud how they could justify the claim that psychiatry was not as important as some other medical disciplines. "Why is psychiatry less important?" he wondered. "Does that not sound like discrimination against science [*kak diskriminatsiia nauki*]? I would not write that. And if that were not there, I would be satisfied [with the language in the decision]."<sup>147</sup> Most Presidium members, however, were less concerned with insulting psychiatry per se and more concerned about insulting Giliarovskii himself. As one presidium member put it "We are insulting an old man [*starik*] who has simply not earned [this kind of treatment]."<sup>148</sup> They agreed that the language of the decision should be changed: they would not refer to the institute as a "hospital institution," and they would acknowledge the institute's high quality of research. Giliarovskii himself would remain a member of the Academy. But the institute would still be transferred to the Ministry of Public Health.<sup>149</sup>

However, Nikolai Anichkov, the President of the Academy, reiterated that the fundamental reason for the institute's transfer was not the quality of the work being done by this particular institute, but the quality of psychiatry itself as a medical discipline:

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<sup>146</sup> N. N. Anichkov (Chairman), "Stenograficheskii otchet k protokolu #27 zasedanii Prezidiuma AMN SSSR," 3 October 1947, GARF, f. r-9120, op. 2, d. 325, ll. 80-81

<sup>147</sup> Ibid., 80

<sup>148</sup> Ibid., 80.

<sup>149</sup> Ibid., 81

“After all, the basic position is that the Academy cannot include every one of the many divisions of medicine, we would have to have about 50 institutes. Only those institutes are included in the Academy that have the most significance for the development of medicine and clinical medicine. . . . Is psychiatry such a discipline? That is the question that needs to be set. The study of higher nervous activity from a physiological point of view is very widely represented [in the Academy]. Besides, our physiologists are constantly in contact with the clinic; in that regard, we even have the clinical base of the Institute of Higher Nervous Activity in the form of Ivanov-Smolenskii’s department. It follows that psychiatry, modern physiological psychiatry, is represented very solidly in the Academy.”<sup>150</sup>

Giliarovskii’s institute was perfectly adequate, Anichkov said, and the Academy would of course continue to support his research just as it supported all of its members. But his institute was doing “treatment and organizational work,” not “modern physiological psychiatry.” Ivanov-Smolenskii, on the other hand, was doing precisely the type of work that the Academy wanted to see. Ivanov-Smolenskii could not have agreed more. Just two months later he published a review in the AMN’s journal of Giliarovskii’s most recent book. Ivanov-Smolenskii reported that Giliarovskii’s ideals did not match his practice. Giliarovskii told readers that to modernize the study of psychiatry they should adopt methods that were “anatomical, deeply pathophysiological,” but Giliarovskii’s own methodology was primarily “descriptive-clinical.”<sup>151</sup>

The Academy’s decision to transfer Giliarovskii’s institute to Minzdrav USSR was made final in October 1947, but it took over a year for the transfer to be fully processed by the government, and the USSR Council of Ministers officially completed the transfer in July 1948. , In February 1949 Minzdrav USSR finally issued an edict investing Giliarovskii’s institute with responsibility for “organizational, methodological, and scientific leadership for the affairs of

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<sup>150</sup> Ibid., 79.

<sup>151</sup> A. G. Ivanov-Smolenskii, "Review of *Starye i novye problemy psikhii* by V. A. Giliarovskii," *Vestnik Akademii Meditsinskikh Nauk SSSR*, no. 1 (1948): 59.

psychiatric services in the USSR.”<sup>152</sup> By this time, Giliarovskii’s tenure at the institute was increasingly under siege. He was ultimately removed from his position as director after the “Pavlov Session” in psychiatry in October 1951, an event which is discussed in some depth in Chapter Six.

Anichkov’s decision to single out Ivanov-Smolenskii as the exemplar of “modern physiological psychiatry” was quite suggestive, particularly in light of Ivanov-Smolenskii subsequent rise to the top of the profession, but there is no substantive evidence to suggest that Ivanov-Smolenskii was working with Anichkov behind the scenes, or that pressure was being put on Anichkov by someone associated with Ivanov-Smolenskii. In any case, Ivanov-Smolenskii was the real beneficiary of Giliarovskii’s difficulties. He was singled out as the new representative of modern psychiatry at the Academy, and he was clearly given support from someone at the Academy who allowed his scathing review of Giliarovskii’s work to be published. Other psychiatrists were put on the defensive, and in late 1947 and 1948 they sought to redefine and clarify their ideas in relation to the ideal of “modern physiological psychiatry.” What this meant in practice was justifying their work in light of Pavlov’s theory of higher nervous activity.

### **Pavlov’s Theory in Psychiatry**

According to Ivanov-Smolenskii’s review of Giliarovskii’s 1946 book *Starye i novye problemy psikiatrii* [Old and New Problems of Psychiatry], Giliarovskii had failed to use Pavlovian concepts in the way that Pavlov had intended. As a result his book was something worse than gibberish: it was gibberish posing as an authoritative guide for psychiatrists who

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<sup>152</sup> The same edict also officially changed the institute’s name to the “Scientific Research Institute of Psychiatry of the USSR Ministry of Public Health.” “*Prikaz MZ SSSR no. 79*,” 4 February 1949, GARF, f. r-8009, op. 1, d. 807, l. 386. The Council of Ministers decree (no. 2521) was issued on July 10, 1948.

wanted to apply physiological concepts in their own work. Substantively, Ivanov-Smolenskii said, Giliarovskii had simply misunderstood many of Pavlov's basic ideas. Much of the book was spent arguing that wartime neuroses like deaf-mute syndrome could be explained by studying the sympathetic nervous system and the subcortical parts of the brain. This was the basis for Giliarovskii's concept of the somatopsyché, and his argument that Soviet soldiers and civilians might suffer "nervous demobilization" long after the traumatic experiences of the war. Wrong, Ivanov-Smolenskii concluded. Giliarovskii had seriously misunderstood Pavlov, and had ignored Pavlov's doctrine of "cortical dominance." Giliarovskii's argument about the causes of deaf-mute syndrome and hysteria "fundamentally contradicts Pavlov's theory of 'breaks' [syrvy]." Giliarovskii had gotten Pavlov's concept of the "second signal system" wrong too. He had claimed that the second signal system (the conditional reflexes formed by language) produced the qualities of the personality, and explained most of the phenomena that people usually referred to when they talked about the "psyche proper." Wrong again, Ivanov-Smolenskii said. Pavlov believed that the "individual qualities of the personality" were the product of the "dynamic interrelationship of the first and second systems," not of the second signal system by itself. Giliarovskii's clearly had only an "extremely superficial acquaintance with this [Pavlov's] doctrine," and the result of his clumsy attempts to apply Pavlov's ideas to his clinical observations produced "mistaken conclusions, incorrect interpretation, and, at times, direct perversion [izvrashcheniui] of I. P. Pavlov's pathophysiological conceptions." Ivanov-Smolenskii found that much of the book was filled with "statements by the author that are simply incomprehensible." The only positive quality that he could find was the book's "numerous clinical observations." The raw data might be useful to someone else who would understand how to interpret it properly. The book itself, however, was harmful. It "cannot serve as a handbook on

how psychiatrists should ‘use the findings of physiology of the nervous system to solve psychiatric questions,’ [because] in this regard it will only serve to disorient the reader [*sposobna lish’ disorientirovat’ chitatelia*].”<sup>153</sup>

Ivanov-Smolenskii’s attack on Giliarovskii’s book did not end with a critique of Giliarovskii’s use of Pavlovian theory. The rhetoric of his review drew obviously on the language of the *Zhdanovshchina*, the campaign led by Party ideology chief Andrei Zhdanov against foreign influence in Soviet culture. One of the most obvious allusions to the Party campaign was his phrase “disorient the reader,” which was drawn from one of the foundational texts of the *Zhdanovshchina*, the Party decree on the magazines “Zvezda” and “Leningrad,” where the works of writer Mikhail Zoshchenko’s were said to be “... apolitical, intended to disorient our youth and poison their consciousness.” Zoshchenko and poet Anna Akhmatova were accused of “bowing before the modern bourgeois culture of the West.”<sup>154</sup>

Ivanov-Smolenskii made a similar charge against Giliarovskii, complaining that Giliarovskii had cited “a number of foreign authors who have examined neuroses from a Pavlovian position (Love, Futterman, Goldstein) but surrounds with complete silence all the works of national authors [*otechestvennykh avtorov*] who have worked from the postulates of I. P. Pavlov ... In fact, this does not apply only to neuroses: all of the fairly broad national literature on the question of the application of I. P. Pavlov’s theories in the psychiatric clinic have not received any reflection in Professor Giliarovskii’s book.” As a result the reader got the “false impression” that Giliarovskii was the first person in the Soviet Union to introduce Pavlovian

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<sup>153</sup> Ivanov-Smolenskii, “Review of *Starye i novye problemy psikiatrii*, 58-59.

<sup>154</sup> Postanovlenie Orgbiuro TsK VKP(b), “O zhurnalakh ‘Zvezda’ i ‘Leningrad’ (14 avgusta 1946 g.),” *Pravda*, August 21, 1946. Republished in A. N. Iakovlev, A. N. Artizov, and O. V. Naumov, eds., *Vlast’ i khudozhestvennaia intelligentsiia. Dokumenty TsK RKP(b) - VKP (b), VChK - OGPU - NKVD o kul’turnoi politike. 1917-1953* (Moscow: Mezhdunarodnyi fond “Demokratiia”, 1999).

ideas into psychiatry, and that the ideas of foreign authors with obviously Jewish names were more valuable than the Soviet books on the subject. Giliarovskii, Ivanov-Smolenskii implied, was perhaps not entirely patriotic, and was certainly not on the side of progressive Pavlovian science. The same could be said for many other leading psychiatrists. They were divided into two camps: those who were “followers of I. P. Pavlov’s project” and those, like Giliarovskii, who were ignorant of Pavlov and felt affinity with foreigners.<sup>155</sup>

Ivanov-Smolenskii’s 1948 review of Giliarovskii’s book marked the beginning of the Late Stalin Period in Soviet psychiatry, a period when psychiatrists used citations to Pavlov’s work to show that they were patriotic materialists who understood the new rules of the game. In chapters 5 and 6 I will examine the infamous Pavlov Sessions in 1950 and 1951 when psychiatrist joined physiologists and others in criticizing themselves and their peers, swearing to adhere to the doctrine of Higher Nervous Activity as set down by Pavlov and interpreted by Bykov and Ivanov-Smolenskii. Historians have tended to portray the Pavlov Sessions as egregious examples of political intervention in science, the imposition of pseudoscience by ideological hacks. Reading the secondary literature, one could easily come to the conclusion that when psychiatrists were denounced at the Pavlov Session for failing to properly use Pavlovian physiology in their work they were being held to a standard that simply had no place in psychiatry. David Joravsky, whose short history of Soviet psychiatry is arguably the best available, describes the 1950 as “largely irrelevant” to the “substantive disagreements within psychiatry.”<sup>156</sup> My reading is different. As I have tried to show in this chapter, psychiatrists,

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<sup>155</sup> Ivanov-Smolenskii included a footnote in which he attacked Mikhail Gurevich for his derisive evaluation of the sterility of Pavlovian theory in his 1937 and 1942 assessments of the state of the field. Ivanov-Smolenskii, "Review of *Starye i novye problemy psikhiiatrii*, 57-59.

<sup>156</sup> Joravsky, *Russian Psychology*, 414.



particularly those involved in elite research science, were deeply engaged with physiological theory long before the Pavlov Sessions. Even during the war and early postwar years they had to use physiological theory to consolidate their own institutional and scientific prestige. Ivanov-Smolenskii's attack on the way that Giliarovskii used physiological terminology politicized psychiatric discourse in a new way, but Ivanov-Smolenskii was hardly the first to have used physiological concepts in psychiatry, or to have attacked a rival for the way he used physiological terms.

In the face of Ivanov-Smolenskii's attack, a group of Moscow's leading psychiatrists, physiologists, and neurologists gathered to discuss how Pavlov's theory ought to be used in psychiatry. The conference was officially a meeting of the All-Union Society of Neuropathologists and Psychiatrists, and it was held on December 23-24, 1947, just weeks *before* Ivanov-Smolenskii's review was published, but after it had been sent to press. Giliarovskii was well connected at the Academy, and he and others at the conference certainly knew that Ivanov-Smolenskii's review was coming and had probably even read it. Giliarovskii gave the keynote address to the meeting, and his speech was published in the issue of *Nevropatologiia i psikhiatriia* that came out at the beginning of 1948, almost simultaneously with Ivanov-Smolenskii's review.

The speech Giliarovskii delivered was a polemic that was clearly aimed at Ivanov-Smolenskii and at anyone who wanted to insist on a narrow reading of how psychiatrists should use Pavlov's theory in their work. As Giliarovskii saw things, there were two ways that Pavlov's ideas could be applied in psychiatry. The first would be to simply do what Pavlov had done - study conditional reflexes, study inhibition, study excitation. This approach led nowhere, Giliarovskii warned. "If we go down this path, then we can speak only of gathering clinical

facts." The second option was for psychiatrists to base their research on the same principles that Pavlov used for his own work. Psychiatrists should "not just take physiological conceptions, but [they should] also rework them in light of the findings that as it happens are better known to them [psychiatrists], namely clinical symptoms (subjective) and localization in the brain (objective)."<sup>157</sup>

Giliarovskii warned that there were certain researchers in the Soviet Union who believed that psychiatrists should be using conditional-reflex methods and that they should "dogmatically apply the findings of physiologists as if they were conclusive." Psychiatrists should beware of these dogmatists, Giliarovskii said. Physiology was important, and was rapidly advancing medical knowledge, but physiologists simply did not understand everything, and could not even agree about many fundamental questions. If psychiatrists were to mechanically apply physiologists' findings to their own work the only result would be bad science. "Using physiological concepts for psychiatric purposes," Giliarovskii said, "requires care because they are too general in character and allow multiple interpretations." The most valuable thing about Pavlov's work was the example that Pavlov set for others of how one could describe mental disorders using physiological terminology. Psychiatrists could and should borrow from physiological thought, but they would only benefit from it only if they understood clearly what physiological thinking was good for.<sup>158</sup>

Contrasted to Ivanov-Smolenskii's crude attack Giliarovskii's speech was strikingly levelheaded. He acknowledged the limitations of current knowledge and pleaded for toleration of a multiplicity of methodology. He praised Pavlov and his ideas but refused to treat Pavlov's

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<sup>157</sup> Giliarovskii, "Puti proniknoveniia," 5.

<sup>158</sup> Ibid., 4-5, 12.

ideas as infallible or perfected. His speech looks even more striking if one reads in conjunction with the Pavlovian screeds that he himself published in 1950 and 1951. A closer reading of his text, however, leaves one with a more ambiguous picture. Like Ivanov-Smolenskii, Giliarovskii framed his piece with the jingoistic slogans of Stalinist patriotism, and criticized his colleagues for being overly in thrall to foreign ideas. “Russian psychiatry,” he stated at the outset, “has in its essence always been unique and original,” and the great Russian psychiatrists of the nineteenth century had all been materialists and they had all been great clinicians.<sup>159</sup> This opening clearly served to indicate that Giliarovskii understood the new political climate. No longer would he be an advocate for Western ideas or an internationalist view of science. In his paper, however, the rhetoric of Soviet patriotism did more than serve as a content-less nod to current politics. He immediately moved to castigate other leading psychiatrists for their excessive fixation on foreign authorities. He did not give the names of the scientists he had in mind, but Gurevich was clearly one of them, and perhaps Luriia and Grashchenkov as well.

According to Giliarovskii, “some of our researchers” had been writing about a great deal recently about the hierarchy of functions in the central nervous system, and they had been focusing in particular on the role of synapse in the integration and disintegration of this hierarchy of mental functions. Russian physiologists had written a rich body of literature on hierarchy of function and on integration and disintegration, Giliarovskii said, but “our researchers” did not look to this national literature for their concepts and inspiration. Instead they filled their articles with overly long discussions of the work of foreign scientists, especially English neurologists J. Hughlings Jackson. This was unnecessary and even harmful because Jackson’s ideas were overly mechanistic and were derivative of the work of Herbert Spencer. Such ideas could not provide an

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<sup>159</sup> Ibid.,”3.

adequate foundation for a dialectical materialist theory of the mind. Giliarovskii himself had suggested using Pavlov's concept of hierarchy in his book *Starye i novye problemy psikhiiatrii*.<sup>160</sup> For Giliarovskii's audience, the message would have been entirely clear: Mikhail Gurevich was not sufficiently patriotic, and his ideas were based on flawed, mechanistic, foreign theory.

Giliarovskii spent the bulk of his speech laying out the ways that new findings in Soviet physiology might be useful for psychiatrists. Like his discussion of patriotism, his selection of physiologists and ideas was very strategic. In essence, he made a plea to the community of elite physiologists and psychiatrists to find common ground, to tolerate pluralism, to seek to develop new knowledge rather than confining themselves to the dogmas of the past. At the same time, he explicitly depicted the current state of the field as empirically supporting his own "somatopsychic" approach.<sup>161</sup> The key discoveries and research projects that he singled out were those that were pointing to the complex mechanisms that the body used to maintain homeostasis, to signal between the periphery of the nervous system and the center of the brain. Leon Orbeli, Konstantin Bykov, A. D. Speranskii: all of them were producing research that supported Giliarovskii's own approach. These physiologists were showing that the concept of "nervism" was key to understanding the integration of the body and the brain, and psychiatrists should make sure that they had a profound understand these concepts so that their work could help move forward the common task of building a truly scientific medical theory.<sup>162</sup>

Finally, at the end of his speech Giliarovskii moved beyond attacking rivals like Ivanov-Smolenskii and Gurevich, and addressed the problem raised by the Academy of Medical

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<sup>160</sup> Ibid., "4-5.

<sup>161</sup> Ibid., "6.

<sup>162</sup> Giliarovskii also discussed the work of Leon Orbeli, A. A. Ukhotomskii, Vvedenskii. Giliarovskii, "Puti proniknoveniia dostizhenii fiziologii v psikhiiatriiu," 6-11.

Sciences. Was psychiatry a significant branch of medical science? Or was it primarily a clinical discipline, useful and important in its own right, but unlikely to contribute to fundamental medical theory. Psychiatry, Giliarovskii claimed, was indeed a distinct medical science. It *was* capable of making important contributions to medical theory, and it *could not* be replaced by “the physiology of higher nervous activity.” Rather than deny psychiatry’s connection with clinical practice, though, Giliarovskii chose to emphasize this as a strength. Physiological theory was similarly impoverished compared to psychiatric reality. While physiologists worked in laboratories and focused on simplified animal models, psychiatrists worked with the messy reality of human madness, meeting regularly with human patients who were suffering from a bewildering array of symptoms. The phenomena that psychiatrists saw in the clinic were “much richer, much broader than what physiological theories can propose to explain them.” Even key ideas from physiology like inhibition and excitation were not much help in establishing the essence of psychiatric symptoms, much less establishing boundaries between different symptoms. Diagnosis, one of the key disciplinary activities of psychiatry, remained beyond the reach of physiologists. The trained eye of the psychiatrist was still better than the most sophisticated physiological test because no physiologist had yet developed a laboratory test that could reliably detect psychosis. Forcing psychiatrists to strictly diagnose mental illnesses by using “neuro-dynamic physiological methods” would seriously compromise psychiatric science.<sup>163</sup>

Giliarovskii’s speech, then, made three important moves. He challenged the premise of Ivanov-Smolenskii’s critique of his work, and argued that psychiatrists needed to be free to adapt and extend Pavlov’s ideas. He further argued that, implicitly, the Academy of Medical Sciences

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<sup>163</sup> Giliarovskii, “Puti proniknoveniia dostizhenii fiziologii v psikhatriiu,” 5.

had made a serious mistake: psychiatry *was* a legitimate theory-producing science in its own right, and the task of doing scientific research on disorders of the mind could not be delegated to “physiologists of higher nervous activity” like Ivanov-Smolenskii. Finally, Giliarovskii continued to press long-standing arguments with Mikhail Gurevich and other psychiatrists who were critical of Giliarovskii’s theory of the somatopsyché, and he reframed this argument in terms of the patriotic discourse of the *Zhdanovshchina*. When arguing about the significance of synapses, the nature of perception, or the interaction of higher and lower, center and periphery, Soviet psychiatrists should defend their arguments by using evidence taken only from the work of Soviet physiologists, and from Pavlov particularly.

Other physiologists and psychiatrists at the December 1947 conference followed Giliarovskii’s lead. Leon Orbeli gave a speech in which he defended Giliarovskii’s claim that psychiatry was an independent scientific discipline. Pavlov had always tried as much as possible to understand the processes in the brain in objective terms, but “this does not mean that Pavlov denied subjective experience.” The study of mental disorders should not be reduced to the study of the brain alone.<sup>164</sup> Moscow psychiatry professor Akim Edel’shtein extended Orbeli’s (and Giliarovskii’s) critique. Using the rhetoric of political struggle, he, wrote viciously in *Nevropatologiya i psikiatriia* about “immoderate adepts of Pavlov’s doctrine” whose “lack of understanding of the regularities of the human psyche” had led them to announce “the creation of an apsychological clinic.” These unnamed “adepts” were not only mistaken in their scientific methodology and their theoretical claims, they were guilty of a “curious deviation” that had “compromised this young theory.” Edelshtein’s use of the terms “deviation” [zagyb] and

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<sup>164</sup> Orbeli, quoted in A. Edel'shtein, "Uchenie I.P. Pavlova v nevroptologii i psikiatrii," *NiP*, no. 2 (1948): 71.

“compromised” clearly evoked denunciations of “deviationists” in Soviet political life, and thus analogized from scientific mistakes to ideological and political errors.<sup>165</sup>

Like Giliarovskii, Mikhail Gurevich used the conference to restate the case for his own theory of psychoses, the “theory of disintegration.” This theory, he claimed, was totally in keeping with Pavlov’s ideas about the physiology of the brain. Pavlov had spoken of “temporary connections” as being the fundamental physiological processes in the brain. Conditional reflexes were one *example* of temporary connections, Gurevich said, but this should not be taken to mean that Pavlov thought conditional reflexes were the only possible category of temporary connection. Contemporary physiology was showing that important structural features of neurons, the synapses, also operated according to the principle of temporary connections. “The anatomical substrate of the temporary connection,” Gurevich concluded, “should be considered the synapse, where communication [between neurons] is realized, where excitation is exchanged, and where functions of elements of the nervous system are connected.” If psychiatrists were to study Pavlov’s theory in depth, they would be convinced of the truth of what Gurevich was saying.<sup>166</sup>

## Conclusion

Five months after Ivanov-Smolenskii’s review of Giliarovskii, the All-Union Society of Neuropathologists and Psychiatrists held a congress, the first all-union congress of psychiatrists since 1936, and only the third since the founding of the Soviet Union. The Congress was held in Moscow at the Red Army Theater, and was attended by 2,200 people.<sup>167</sup> Vasilii Giliarovskii was

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<sup>165</sup> A. Edel'shtein, "Uchenie I.P. Pavlova v nevropatologii i psikiatrii," *NiP*, no. 2 (1948): 70.

<sup>166</sup> Gureivch, quoted in A. Edel'shtein, "Uchenie I.P. Pavlova v nevropatologii i psikiatrii," *NiP*, no. 2 (1948): 72.

<sup>167</sup> Nearly 1,800 of them filled out a questionnaire asking about their demographics and education, and some of this data was published in the professional journal. Of these, 900 were neuropathologists and 826 were psychiatrists, but journal did not publish any information that was specific to either discipline. Nearly 40% of these participants

the chairman, and he opened the congress with a speech thanking Stalin for the Soviet victory in World War Two and urging psychiatrists and neuropathologists to make serious study of Party decisions on the “ideological front.” Psychiatrists had done a good job of criticizing the “anti-scientific, reactionary concepts of bourgeois scientists,” but the job was not yet done. “It needs to be said,” Giliarovskii told the audience, “that we have culled the flowers of the foul smelling plants brought here from abroad, but not all their roots have yet been torn out.” He then went on to stress the importance of using the modern discoveries of Soviet physiology to advance psychiatric knowledge, and in particular the importance of discoveries about the sympathetic nervous system. For psychiatrists, he claimed, these discoveries would have “enormous importance” for explaining mental illness.<sup>168</sup>

The most prominent psychiatrists and physiologists of the day started off the congress with programmatic speeches that explained their own research agendas for the field. Leon Orbeli spoke about the second signal system. Nikolai Grashchenkov spoke about “the modern theory of synapses in the pathology of the nervous system.” Gurevich laid out his “theory of disintegration.” Aleksandr Shmar’ian talked about his theory of “brain pathology,” an attempt to conceptualize mental illness in terms of the interaction between local brain lesions and “the whole brain.” (His theory and the controversies that surrounded it will be discussed in detail in Chapter 5.) And Giliarovskii spoke in depth about his theory of the somatopsyche and how the

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came from Moscow and Leningrad, with another 15% coming from Ukraine. Fourteen percent had finished medical school before 1920, but most had begun their professional careers after the revolution, 50% of them in the 1920s, 24% in the 1930s, and 12% in the 1940s. One-third of the participants (593) were members of the Communist Party, though only 11 of 88 presidium members were Party members (13%). A. O. Edel'shtein, "III vsesoiuznyi s"ezd nevropatologov i psikhiatrov (Kratkaia khronika s"ezda)," *NiP*, no. 4: 78-80.

<sup>168</sup> V. A. Giliarovskii, “Vstupitel’naia rech’ predsedatelia Organizatsionnogo komiteta,” in V. A. Giliarovskii, ed., *Trudy tret'ego vsesoiuznogo s"ezda nevropatologov i psikhiatrov. Moskva, 25-31 maia 1948 g.* (Moscow: Medgiz, 1950), 6-7.



physiology of the sympathetic nervous system and the subcortical parts of the brain could help psychiatrists understand and treat schizophrenia.

Ivanov-Smolenskii did not attend the congress, and in the discussion period his approach to psychiatric research was belittled. One Georgian psychiatrist was recorded attacking Ivanov-Smolenskii by name. “Unfortunately,” he said, “there are researchers among us who put the words “consciousness” and “psyche” in quotes, thus denying their existence (Ivanov-Smolenskii). This is a clear vulgarization of the theory of the psyche.”<sup>169</sup> The congress, in short, offered psychiatrists and neuropathologists from all over the Soviet Union a chance to hear about how the newest discoveries in physiology were changing the way psychiatrists thought about the mind. It gave them a snapshot of the different theories that were competing for dominance in the profession, and put on display the ongoing melodramas between the leaders of the field.

Elite Soviet psychiatrists thought of themselves as part of a broader community of Soviet neuroscientists. They read extensively in physiology literature, they socialized with eminent physiologists and neurologists, and they organized joint conferences and publications with physiologists like Orbeli and neuropathologists like Grashchenkov. Many in the older generation of psychiatrists had even been trained in brain science. Indeed, as young men both Gurevich and Giliarovskii had spent many years in laboratories dissecting brains and looking at stained tissue through microscopes. Psychiatrists hoped that, like surgeons who could use x-rays to study broken bones, psychiatrists would soon be able to use laboratory methods to study the disordered parts of the brain that produced the symptoms of mental illness. In their research reports to the officials who set their budgets, they wrote at length about their engagement with physiology,

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<sup>169</sup> V. A. Giliarovskii, ed., *Trudy tret'ego vsesoiuznogo s'ezda nevropatologov i psikhiatrov. Moskva, 25-31 maia 1948 g.* (Moscow: Medgiz, 1950), 87. Cited in Joravsky, *Russian Psychology*, 87, fn. 43.

using this as a way to show that they were at the cutting edge of materialist science. When they criticized institutional rivals, they did so in part by attacking their use of physiological concepts: their rivals interpreted the data improperly, used inappropriate concepts, ignored the bigger picture. As the Cold War began, leading psychiatrists added to their repertoire attacks the Western borrowings of their rivals, real or imagined. A competition began to justify research agendas on the grounds that one was more Russian, more dialectical-materialist, more Pavlovian, than all the others.

By engaging so closely with physiological research, however, psychiatrists opened their field to criticism by physiologists. Some, like Orbeli and Bykov, were willing to acknowledge their lack of specialist knowledge in psychiatry and happily accept the role of prestigious keynote speakers at psychiatric conferences and muses to psychiatric researchers. Ivanov-Smolenskii, however, was trained as both a psychiatrist and a physiologist and he spoke with the authority of someone who had trained under Pavlov. In his attack on Giliarovskii in 1948, Ivanov-Smolenskii made the argument that psychiatrists should not just look to physiology for inspiration. If they wanted to use the methods and insights of physiology, and they should, then psychiatrists would have to undergo more rigorous training in physiological theory and methods. For Ivanov-Smolenskii, of course, this meant training in *his* methods. But his critique raised a legitimate question about the status of psychiatry as a scientific discipline. If psychiatrist seriously believed that the mind could be explained in biological terms, then shouldn't they look to brain scientists for that knowledge? Was their profession reliant on physiologists for the conceptual apparatus that clinicians used in their daily work? Would diagnostic categories, lab tests, and treatment methods all be developed by brain scientists, by "pathophysiologists of higher nervous activity"? If so, then the term of "psychiatrist" would in essence be redefined to

refer specifically to the doctors who worked with the mad. By definition, the science of the mind would be studied by scientists who were not psychiatrists. As Soviet psychiatrists entered the late 1940s, these were the dilemmas that they faced. Would psychiatry continue as a research science? Or would the body of theory that psychiatrists used be produced by a separate group of brain scientists?

## CHAPTER 5

### THE SOVIET BAN ON LOBOTOMY: PROFESSIONAL POLITICS, STATE-SPONSORED ANTI-SEMITISM, AND THE ETHICS OF PSYCHIATRIC TREATMENT, 1944-1950

“Only when they have mastered all the riches of the modern physiology of higher nervous activity and physiology of receptor systems will our clinicians be able to overcome the numerous harmful idealistic conceptions that are still held in our psychiatry, conceptions which need to be decisively vanquished because they hinder the successful development of the materialist theory of the nature of mental illness, a theory which makes possible the successful prevention and treatment of these illnesses.”

-- Nikolai Grashchenkov, “Toward the One-Hundredth Anniversary of the Birth of Academician I. P. Pavlov,” 1949<sup>1</sup>

#### Introduction

In this chapter I trace the intellectual, institutional, and ideological developments that led to the ban on lobotomy. I argue that the ban was the result of a professional conflict over the appropriate use of active treatment, a conflict that was closely connected to a struggle for control of resources and power within the public health system. The psychiatrists on both sides of this conflict drew on the rhetoric of Soviet patriotism and national science to portray their approach as the only truly Soviet approach to psychiatry. Disagreements that had been relatively cordial were transformed into ad hominem attacks on one another’s character, loyalty, morality, and

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<sup>1</sup> N. I. Grashchenkov, “K stoletiiu so dnia rozhdeniia Akademika I. P. Pavlova,” *Nevropatologiya i psikiatriia* 18, no. 4 (July-August 1949): 9.

philosophical worldview. As a result, the discussion that ultimately decided the fate of lobotomy also ended the careers of several of the leading psychiatrists of day.

### **Lobotomy or Electrosleep?**

The ban on lobotomy was the most dramatic outcome of two important institutional conflicts that took place between psychiatrists in the Soviet Union in the post- World War Two period. These institutional conflicts were particularly important in reshaping the profession because the psychiatrists attacked one another on philosophical grounds. What was at stake was therefore not just which psychiatrist would sit on Minzdrav committees, but what sort of knowledge would govern psychiatric practice and how mental disease would be conceptualized. As if the conceptual and institutional stakes were not high enough, these polemics were carried out at the same time as several very important ideological campaign, including the campaigns against “cosmopolitanism” and “kow-towing before the west and the campaign for party-mindedness in Soviet science. The already heated scientific and philosophical debate was therefore infused with the language and practices of political denunciation, as each side tried to portray the other as ideologically un-soviet.

The first institutional conflict was between two powerful research institute directors, Aleksandr Shmar’ian and Vasilii Giliarovskii. Their conflict was not so much personal as it was institutional and ethical. Shmar’ian had held very influential posts in Narkomzdrav RSFSR and Minzdrav SSSR, and he was also the deputy editor in charge of psychiatry at *Neuropathology and Psychiatry*, the fields only remaining academic journal.<sup>2</sup> What brought Shmar’ian into institutional conflict with Giliarovskii was the 1937 creation of the All-Union Commissariat of

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<sup>2</sup> Unsigned, “Zakliuchenie o deiatel’nosti Instituta psikiatriia MZ RSFSR,” undated [before 4 January 1951], GARF, f. r-8009, op. 33, d. 463, l. l. 56.

Public Health (Narkomzdrav SSSR). As I discuss in my introduction, the creation of this institution disrupted the existing institutional hierarchy in psychiatry. The Central Institute of Psychiatry where Shmar'ian worked as Deputy Director played a major role in formulating psychiatric policy in the RSFSR. This had made the institute the single most influential in Soviet psychiatry – until the creation of the All-Union Commissariat of Public Health created a new set of committees and research institutes.

The RSFSR's Institute was effectively demoted to dealing with parochial issues, and its prestigious "leading role" was taken by a new institute headed by Giliarovskii. Tension developed between Giliarovskii and Shmar'ian because although Giliarovskii was the director of the new Academy of Medical Sciences Institute of Psychiatry, Shmar'ian was in charge of the psychiatry committee at the All-Union Ministry.<sup>3</sup> Perhaps conflict could have been avoided if the two men had seen eye to eye on the direction they wanted psychiatry to take. As it was, however, as the 1940s advanced they found themselves increasingly at odds over basic questions of psychiatric practice.

Shmar'ian had a longstanding interest in neurosurgery and its applications in psychiatry. Indeed, he had a research position at the Institute of Neurosurgery in Moscow and had worked with Nikolai Burdenko and other leading Soviet neurosurgeons.<sup>4</sup> Shmar'ian hoped to use the

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<sup>3</sup> As "head specialist," Shmar'ian served as a member of the *Gospital'nyi sovet*, NKZ SSSR's commission to oversee the evacuation hospitals that were under its jurisdiction, and also as chairman of the "Commission on Neurosurgery, Neuropathology, and Psychiatry." "Otchet o rabote UMS NKZ SSSR v 1943," undated, GARF, f. r-8009, op. 2, d. 580, ll. 4, 19. On the origins of the "head psychiatrist" position see L.A. Koreisha (Chairman), "Protokol no. 24 zasedaniia Biuro Prezidiuma UMS MZ SSSR," 24 May 1949, GARF, f. r-8009, op. 2, d. 1305, ll. 27-27ob.

<sup>4</sup> A. Dobrokhotova, "K Istorii psikhiatricheskoi sluzhby v institute neirokhirurgii imeni Akademika N. N. Burdenko RAMN," *Voprosy neirokhirurgii*, no. 1 (2000): 34-37; available from <http://www.nsi.ru/psycho/history.htm> (accessed 22 September 2005); A. S. Shmar'ian, "K patofiziologii opticheskikh psikhosenzornykh rasstroistv," *Sovetskaia nevropatologiya, psikhiatriia i psikhogigiena* 4, no. 5 (1935): 23-36; GARF, f. r-8009, op. 1, d. 1407, l. 227.

tools of neurosurgery to help him uncover the physical causes of mental illness. To do this he used patients with brain tumors as subjects, closely studying their mental symptoms and then dissecting their brains after they died. As best he could he hoped to correlate mental symptoms with particular structures and disorders in the brain. As he put it at a 1942 psychiatric conference in Tomsk, psychiatrists “need to move away from a phenomenological and symptomological approach” and instead “make use of modern achievements in general [pathology] and brain pathology.”<sup>5</sup>

Shmar’ian’s approach was fundamentally oriented toward a laboratory model of science, one in which the classification and diagnosis of psychiatric illness would be done on the basis of knowledge generated under the controlled conditions of the laboratory. In addition, Shmar’ian’s focus on brain structures led him to adopt a basically ontological approach to disease. Mental illness, in this understanding, was caused by “broken parts” in the brain, and could hopefully be cured by figuring out how to fix those broken parts or prevent them from being broken in the first place. “The further progress of psychiatry as a science,” he wrote in a 1944 research proposal, “depends on the adaptation and use in the psychiatric clinic of the findings and methods of the mixed disciplines – neuro-physiology, neurology, neurosurgery, and others.”<sup>6</sup>

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<sup>5</sup> A. S. Shmar’ian, "Osnovnye voprosy kliniki travm golovnogo mozga," in *Biulleten' nauchnoi konferentsii Tsentral'nogo Instituta Psikhatrii po voprosam nevropatologii i psikhatrii voennogo vremeni: 30 maia - 1 iunia 1942*, ed. A. S. Shmar’ian and P. B. Posvianskii (Tomsk: 1942), 17-18. For other early instances of Shmar’ian’s ‘brain pathology,’ see I. I. Lukomskii, "Rabota Moskovskogo obshchestva nevropatologov i psikhiatrov v period Velikoi otechestvennoi voiny," *NiP* 11, no. 5 (1942): 61; idem., "Sessia Moskovskogo obshchestva nevropatologov i psikhiatrov," *NiP* 12, no. 2 (1943): 76; and A. S. Shmar’ian, "Obshchie i chastnye zakonomernosti psikhopatologii travmy golovnogo mozga," *NiP* 12, no. 6 (1943): 3-16.

<sup>6</sup> “Ob’iasnitel’naia zapiska k planu nauchno-issled. raboty Tsentral'nogo Instituta Psikhatrii NKZ RSFSR na 1945 god,” undated, GARF, f. a-482, op. 48, d. 202, ll. 6-7. In 1944, at the first major psychiatry conference since before the war, RSFSR Central Institute of Psychiatry director Pavel Posvianskii declared that this approach should be the model of all psychiatrists in the USSR. “The general path [*general’nyi put’*] for the development of psychiatric science is connected in the closest way with the further development of general and brain pathology, with the successes of neurophysiology, neuropathology, and internal medicine. P. B. Posvianskii and T. I. Gol’dovskaia, "Khronika: Vserossiiskaia konferentsiia po voprosam psikhatrii," *NiP* 13, no. 5 (1944): 64.

Giliarovskii himself had a background in pathological anatomy, but his inclination was to use the tools of anatomy and physiology as ancillary methods of observation in the clinic. What is more, as we have seen in chapters 3 and 4, in the mid-1940s Giliarovskii was attempting to rehabilitate a holistic approach to mental illness. In this view, mental illness could not be reduced to a single broken part. It was understood instead as a process of adjustment to one's situation in life, finding ways of living and coping that were best suited to one's physical and mental capabilities. Giliarovskii's disciplinary goals were therefore sometimes in conflict with Shmar'ian, which made it difficult for the two men to work together. By 1949 he was lobbying the USSR Minister of Health that rationalizing the system logically should mean eliminating Shmar'ian position at Minzdrav. "Under such conditions," he concluded, "the existence of the psychiatric commission chaired by head psychiatrist A. S. Shmar'ian seems like extraneous parallelism, when Minzdrav USSR's Scientific Medical Council can refer to its Scientific Research Institute of Psychiatry or to the institute's scientific council, which consists of 12 professors and doctors of medical science."<sup>7</sup>

The issue that crystallized their conflict was lobotomy. Not surprisingly, Shmar'ian's enthusiasm for neurosurgery attracted him to lobotomy. Shmar'ian was by no means the only medical scientist in the Soviet Union who performed lobotomies, but he was the most visible psychiatrist to be associated with the method.<sup>8</sup> Giliarovskii, for his part, spoke out quite early in favor of caution in the use of lobotomy, and in the late 1940s he spearheaded a crusade to get the practice banned in the Soviet Union.

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<sup>7</sup> V. A. Giliarovskii (Director NII Psikhiiatrii MZ SSSR) to E. I. Smirnov (Ministr Zdrav. SSSR), 18 March 1949, GARF, f. r-8009, op. 2, d. 1305, ll. 27-27ob.

<sup>8</sup> Their collaborators included psychiatrist/histologist Pavel Snesev, psychiatrists Sof'ia Gol'denberg and Iurii Rozinskii, and neuroscientist Aleksandr Lurii. Egorov, *et al*, "Khirurgicheskoe lechenie shizofrenii metodom lobnoi leikotomii," 395-398.



Lobotomy was first tried in 1935 by a Portuguese psychiatrist named Egaz Moniz.<sup>9</sup> These early attempts were reported in the Soviet Union in 1936,<sup>10</sup> and psychiatrists at first reacted skeptically. No one was quite sure why cutting the brain might help cure mental illness, nor were they sure what the long term consequences might be. The Soviet reviewers highlighted reports of serious post-operative neurological complications and concluded that these were "insurmountable obstacles" to recommending such intervention for use in psychiatric practice in the USSR.<sup>11</sup>

Lobotomy was first used on psychiatric patients in the Soviet Union in Shmar'ian's clinic in 1944,<sup>12</sup> and the RSFSR Central Institute of Psychiatry made it a central part of the next Five-Year Plan (1946-1950) for psychiatric research.<sup>13</sup> The actual lobotomy operations were done by a surgeon who made several small holes in the skull, then used the holes to reach the brain and cut

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<sup>9</sup> Elliot S. Valenstein, *Great and Desperate Cures: The Rise and Decline of Psychosurgery and Other Radical Treatments for Mental Illness* (New York: Basic Books, 1986), 62-76.

<sup>10</sup> The first review appeared in 1936, and was followed by subsequent articles in 1937. A. S. Peitsik, "Review of E. Moniz and A. Lima, 'Simatomy prefrontal'noi doli'. Revue Neurolog., t. 65, no. 3, str. 582, 1936.," *Nevropatologiya, psikhiiatriia, psikhogigiena* 5, no. 7 (1936): 1233-1234; L. Shevderov, "Review of Egaz Moniz. Psikhokhirurgiiia. Der Nervenarzt, H. 3. 1937," *NiP* 6, no. 11 (1937): 175; V. Ia. Strazhevskii, "Review of James W. Watts and Waltes Freeman. Psikhokhirurgiiia (vliianie khirurgicheskogo pereyva putei v lobnoi dole na nekotorye psikhicheskie simptomty). The Journ. of Nerv. a. Ment. disease, vol. 48, No. 5, 1938," *NiP* 7, no. 7 (1939): 81-82.

<sup>11</sup> Iu. Rakhal'skii, "Review of Watts I. a. Freeman W. Psikhokhirurgiiia. The Journ. of Nervous and Mental Dis. 88, 5, 1938," *NiP* 7, no. 9-10 (1939): 88.

<sup>12</sup> "Ob"iasnitel'naia zapiska k planu nauchno-issled. raboty Tsentral'nogo Instituta Psikhiiatrii NKZ RSFSR na 1945 god," undated, GARF, f. a-482, op. 48, d. 202, l. 7. Who first prescribed this operation is unclear: that dubious honor was later attributed to physicians working in the cities of Moscow, Leningrad, and Gork'kii. The head psychiatrist at the Medical Institute in Gor'kii, a man named M.A. Gol'denberg, was an early enthusiast, and may have been doing leucotomies as early as 1944, aided by the prominent neurosurgeon Kh. I. Garkavi. Gol'denberg's priority was apparently contested by psychiatrist I. F. Sluchevskii. V. M. Banshchikov et al., eds., *Fiziologicheskoe uchenie akademika I.P. Pavlova v psikhiiatrii i nevropatologii: materialy stenograficheskogo otcheta obedinnogo zasedaniia rasshirennogo Prezidiuma AMN SSSR i plenuma Pravleniia Vsesoiuznogo obshchestva nevropatologov i psikhiatrov. 11-15 okt., 1951 g* (Moscow: Medgiz, 1952), 253-55.

<sup>13</sup> A. N. Sysin (Chairman), "Stenogramma rasshirennogo zasedaniia Prezidiuma UMS MZ SSSR: Obsuzhdenie osnovnykh printsipov postroeniia nauchno-issleodval'tel'skoi raobty v oblasti meditsiny na IV piatiletku," 27 September 1946, GARF, f. r-8009, op. 2, d. 879, l. 77; Joseph Wortis, *Soviet Psychiatry* (Baltimore: Williams & Wilkins, 1950), 259-60.

the “white matter” that connected the frontal lobes of the brain to the rest of the cortex.<sup>14</sup> From 1946 to 1950, lobotomy, or, rather, “leucotomy” as it was most often called in Soviet practice,<sup>15</sup> was used on mental patients in as many as 23 different research institutes, medical schools, and psychiatric hospitals around the Soviet Union.<sup>16</sup> Probably not many more than 1,000 people were given lobotomies in the USSR in that time, though this is a very rough estimate based on the published journal literature and available archival reports.<sup>17</sup> Compared to the United States, where many times this number were lobotomies, lobotomy was used relatively little in Soviet psychiatry. Even so, it proved to be of crucial importance to the politics of Soviet psychiatry.

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<sup>14</sup> In the Soviet Union the method of lobotomy was the topic of an ongoing debate between neurosurgeons from Leningrad and Moscow. Moscow neurosurgeon Boris Egorov, preferred an “open” method of operation. Unlike the infamous “ice pick lobotomy” used in the United States, Egorov preferred to actually open up the patient’s skull so he could see what he was doing. Leningrad neurosurgeon Isaac Babchin argued for a quicker and easier “closed” lobotomy operation using a method that was much closer to the one in use in the United States. This “closed” method seems have been the preferred method for most Soviet surgeons working in provincial hospitals, particularly because it did not require a fully outfitted operating room. Egorov described his “open” method at some length in the published proceedings of the 1948 Congress of Neuropathologists and Psychiatrists. B. G. Egorov, et al, "Khirurgicheskoe lechenie shizofrenii metodom lobnoi leikotomii," in *Trudy tret'ego vsesoiuznogo s'ezda nevropatologov i psikhiatrov (Moskva 25-31 maia 1948 g)*, ed. V. A. Giliarovskii (Moscow: Medgiz, 1950), 395-398; For a detailed description of Babchin’s “closed method” of leucotomy, see I. S. Babchin, "Opyt khirurgicheskogo lecheniia nekotorykh form psikhicheskikh zabolevanii," *Voprosy neirkhokirurgii* 12, no. 2 (1948): 3-11. Babchin had been the head neurosurgeon for the Leningrad front during WWII. *Bol'shaia meditsinskaia entsiklopediia*, 3<sup>rd</sup> ed., s.v. “Babchin, I. S.”

<sup>15</sup> The terms “leucotomy” and “lobotomy” were loosely interchangeable in Soviet usage, but in a medical context “leucotomy” was by far the most frequently used. “Lobotomy” was sometimes used to refer to a specific method of surgery, while at other times it was used as a synonym for “leucotomy” – usually with a pejorative connotation. I have followed the practice of refereeing to the operation as “leucotomy” except where someone I am quoting referred to it as “lobotomy.”

<sup>16</sup> At the discussion of lobotomy on 30 November 1950, V. M. Banshchikov said that in 1950 there were thirteen locations actively practicing leucotomy. S. A. Sarkisov, director of the Institute of the Brain, suggested that the figure was “as many as 23.” G. V. Vygodchikov (Chairman), "Stenogramma zasedaniia Prezidiuma UMS MZ SSSR," 30 November 1950, GARF, f. r-8009, op. 2, d. 1498, ll. 80, 90.

<sup>17</sup> These are rough estimates based on two pieces of information: the number of patients who passed through USSR psychiatric hospitals in 1949, and the percentage of patients in RSFSR psychiatric hospitals who were given insulin therapy and electroshock in 1949 ( 7.8% and 4.8% respectively). If USSR psychiatric hospitals gave these treatments in the same proportion as RSFSR hospitals, the result would have been 11,034 patients given insulin therapy, and 6,790 given ECT. But reports suggest that non-RSFSR hospitals gave significantly lower rates of treatment, so I have based my estimates on a guessed-at rate of 6.8% and 3.8% respectively, which yield 9,619 and 5,375 patients. Adapted from A. A. Portnov (Nach. Otdela psikhonevrologicheskoi pomoshchi MZ SSSR, “Otchet o rabote psikhonevrologicheskogo otdela MZ SSSR za 1950 g.,” undated [after 9 December 1950], GARF, f. r-8009, op. 33, d. 263, l. 9.

Vasilii Giliarovskii was by no means a stranger to using biological therapy on psychiatric patients. He himself had coauthored a handbook on the subject in 1939.<sup>18</sup> In the 1940s, however, his holistic theory of the “somato-psyche” led him to argue that psychiatric treatments should rely as much as possible on the body’s own defense mechanisms. He personally began to avoid using shock therapies like Cardiazol and electroshock, and in 1946 he began to call for others to abandon them as well:

... The methods used in psychiatry fall into two main groups: shock (insulin, Cardiazol, electroshock) and sedative, which includes sleep therapy, prolonged and fractional. ... At the present time shock methods are broadly propagandized, in particular so-called electroshock. The Institute considers this method, taken from the experience of the USA, to be inappropriate for Soviet conditions [*malo sootvetstvuiushchim sovetskim ustanovkam*]. Convulsive fits, even those which are not very serious, as sometimes happens in electroshock, cause hemorrhaging in the brain, and sometimes lead to diminished memory. If such complications can be accepted for serious schizophrenics, since it removes from them still more serious symptoms, then they should be considered inadmissible in cases of manic-depressive psychosis and reactive conditions....<sup>19</sup>

Giliarovskii believed that mental illness was the product of interactions between the brain, the body, and the environment. If this was so, he reasoned, then injuring the brain could hardly be expected to do the patient good. Psychiatrists needed to consider the harm they were doing before they adopted these methods too enthusiastically.

Giliarovskii was particularly uncomfortable with the idea of cutting the brain. At the first postwar congress of the All-Union Society of Neuropathologists and Psychiatrists he publicly voiced his opposition to lobotomy, using his position of Chairman of the Congress to speak to the assembled members of his profession. Giliarovskii admitted that his caution about lobotomy was not based on any research findings, he simply felt uneasy about intentionally causing brain

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<sup>18</sup> V. A. Giliarovskii and P. B. Posvianskii, eds., *Metodika i tekhnika aktivnoi terapii psikhicheskikh zabolevanii* (Moscow: 1939).

<sup>19</sup> V. A. Giliarovskii, “Godovoi otchet institute psikhatrii AMN SSSR za 1946 g.,” GARF, f. r-9120, op. 2, d. 250, ll. 8-9.

damage. "I am not drawing conclusions," he told his colleagues, "simply stating my own opinion that this method should be seen as experimental, a method that gives [researchers] a great deal of data about general psychopathology. As a method of therapy it requires great care. In any case, it may not be used in the beginning stage of the illness, but only when there is already a significant decrease of its acuteness. One should keep in mind that such an operation may have bad consequences after two-three years, or even later."<sup>20</sup> As a result of Gilairovskii's intervention, the delegates to the congress agreed that the issue of whether or not lobotomy could be used should be examined by a special plenum of their professional organization.<sup>21</sup>

As an alternative to electroshock and lobotomy, Giliarovskii proposed a method of his own devising that he called "electrosleep." Sleep therapy, he argued in his 1946 report, was less damaging than the various forms of "shock therapy." Giliarovskii worried, however, that drugged sleep did not provide the same therapeutic effect as "true" sleep, and thought that the drugs themselves might have toxic effects on the body. He therefore championed methods of sleep therapy that induced sleep without drugs, and which gave patients an experience that was as similar as possible to "physiological" sleep. In 1946 he and his staff experimented mainly with hypnotherapy and suggestion,<sup>22</sup> but they also started to test the effects of a mild electrical current, and found that they could use electricity to induce sleep. After starting with experiments on dogs they built a prototype "electrosleep machine, and in 1946 they began experimenting on patients

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<sup>20</sup> The bulk of Giliarovskii's concluding statement was devoted to electroshock, which he worried was causing damage to the vasculature of the brain. *Trudy tret'ego vsesoiuznogo s"ezda nevropatologov i psikhiatrov*, ed. V. A. Giliarovskii (Moscow: Medgiz, 1950), 436-437.

<sup>21</sup> *Trudy tret'ego vsesoiuznogo s"ezda nevropatologov i psikhiatrov*, 447-449; A. O. Edel'shtein, "Khronika: III Vsesoiuznyi S"ezd Nevropatologov i Psikhiatrov (Kratkaia khronika s"ezda)," *NiP*, no. 4: 78-80.

<sup>22</sup> *Ibid.*, 9.

in their clinic.”<sup>23</sup> Minzdrav’s Scientific Medical Council was sufficiently impressed by his results to recommend electrosleep for clinical trials.<sup>24</sup>

The “electrosleep” device that Giliarovskii developed used a mild electrical current that passed through electrodes into a patient’s head. The electrical current was constant, but was modulated so that the brain periodically received short impulses, up to 10,000 per second, a frequency that Giliarovskii had been advised could induce a rhythm in a person’s brain waves.<sup>25</sup> In October 1947 Giliarovskii reported to Minzdrav USSR that he had tried the method on 40 dogs and on 34 patients with schizophrenia, and that all the dogs and most of the humans had fallen asleep. (Though some of the patients had merely been anesthetized, while a few had not been affected at all.) The results, he admitted, were preliminary, and it was still too early to judge whether electrosleep would be effective as a method of treatment. But he had great hopes for electrosleep. “... we have found something new,” he claimed, “perhaps even something that is new in principle [*printsipial’no novoe*].” Not only was his method a native Russian scientific breakthrough, it was also based on Soviet ethical principles. “... I think,” he said at the conclusion of his speech, “that from this [principle of electrosleep] may develop a method of treatment that is in principle Soviet, one that is Soviet in principle of humaneness [*sovetskii po*

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<sup>23</sup> From a letter in which Giliarovskii defended his electrosleep from a pair of “inventors” who had usurped his patent. V. A. Gilarovskii to “redactor” [journal unnamed, probably to the editor of *Meditsinskaia gazeta*], undated [late 1958], GARF, f. r-9592, op. 1, d. 193, l. 16.

<sup>24</sup> N. N. Priorov (Chairman), “Protokol No. 18 zasedanii prezidiuma UMS MZ SSSR,” 9 October 1947, GARF, f. r-8009, op. 2, d. 1048, l. 2; V. A. Giliarovskii, et al, *Elektrosion (Kliniko-fiziologicheskoe issldovanie)* (Moscow: Medgiz, 1953), 133-134.

<sup>25</sup> Giliarovskii traced his method back to Stéphane Leduc, a Frenchman who in 1902 had demonstrated a method he called “electronarcosis” at a congress in Bern. Giliarovskii differentiated his machine from Leduc’s based on the latter’s use of constant, non-impulse current. V. A. Giliarovskii, in N. N. Priorov (Chairman), “Protokol No. 18 zasedanii prezidiuma UMS MZ SSSR,” 9 October 1947, GARF, f. r-8009, op. 2, d. 1048, l. 13; V. A. Giliarovskii, et al, *Elektrosion* (Moscow: Medgiz, 1953), 14.

*printsipu metod lecheniia, sovetskii po printsipu gumannosti*].”<sup>26</sup> Giliarovskii hoped to define medical holism as a synonym of “soviet values.”

Pavel Posvianskii, the director of the RSFSR Central Institute of Psychiatry, lauded Giliarovskii for trying to make sleep therapy “a bit more humane,” and he recommended full support for the research. But he doubted that electrosleep would become a valuable treatment precisely because it was so mild. In Posvianskii’s experience, the less brutal the method, the less effective it was at healing the patient. “Unfortunately,” he said, “all of our attempts to make our method of treatment gentler and more humane lead to diminished effectiveness. I think that all psychiatrists will agree with that.”<sup>27</sup>

#### *“Justified and Humane”: The First Lobotomy Discussion*

At their 1948 Congress, the All-Union Society of Neuropathologists and Psychiatrists agreed that their directorate should examine the effectiveness of lobotomy and make a recommendation about its use. This discussion took place in February 1949 at an All-Union Society Plenum. In the eight months since the Congress, however, the world of Soviet science had been rocked by Stalin’s intervention in genetics in August 1948. His support of “Michurinism,” Trofim Lysenko’s neo-Lamarckian theory of acquired traits, sent a strong signal about the role of ideology in scientific life, and in the months that followed every scientific institute in the USSR held its own in-house meeting to discuss the lessons of the “August Session.” There were two types of science, according to the worldview of Lysenko’s speech:

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<sup>26</sup> V. A. Giliarovskii, in N. N. Priorov (Chairman), “Protokol No. 18 zasedanii prezidiuma UMS MZ SSSR,” 9 October 1947, GARF, f. r-8009, op. 2, d. 1048, l. 31.

<sup>27</sup> Posvianskii, in N. N. Priorov (Chairman), “Protokol No. 18 zasedanii prezidiuma UMS MZ SSSR,” 9 October 1947, GARF, f. r-8009, op. 2, d. 1048, l. 28.

progressive Soviet science and reactionary western science. The task of each scientific discipline was to make sure that they were on the right side.<sup>28</sup>

The February 1949 discussion of lobotomy was held in the context of this newly charged atmosphere of ideological vigilance. Indeed, the first item on the agenda was not lobotomy but rather the reassessment of Soviet psychiatry in light of the discussion in genetics. The Plenum declared that they would fight against the “vulgarization” of Michurinist theory, and that they spend more of their time researching the influence of the environment on mental illness. They would be vigilant for suspicious foreign inventions and foreign ideas, and they would stress the achievements of Soviet and Russian national scientists. And they took the opportunity to demonstrate their patriotic zeal by claiming that lobotomy was in fact a Russian invention. Though lobotomy was commonly believed to have been invented in Portugal in 1936, it had in fact been first proposed in 1908 by Ludwig Pussep, who, though technically Estonian, had trained and worked in St. Petersburg under Vladimir Bekhterev. Lobotomy was thus *not* an example of bowing before Western science.<sup>29</sup>

Psychiatrists from Moscow, Leningrad, and Gor’kii all presented data from their own research, and argued that lobotomy was indeed an effective form of treatment for schizophrenia. They all struck a conservative tone, agreeing that lobotomy should be strictly limited to cases of

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<sup>28</sup> Nikolai Kremmentsov, *Stalinist Science* (Princeton: Princeton University Press, 1997), 158-183.

<sup>29</sup> Born in Kiev to Estonian parents in 1875, Pussep studied under Vladimir Bekhterev at the Military-Medical Academy in St. Petersburg. After serving as a neurologist in the Russo-Japanese War, he returned to St. Petersburg and became a professor at the Military-Medical Academy. In 1920 he emigrated to Estonia, where he taught neurology and neurosurgery at Tartu University until his death in 1942. Boleslav L. Likhterman, *Neirokhirurgii: Stanovlenie klinicheskoi distsipliny* (Moscow: 2007), 57-59. Contrary to the indignant claims of these Soviet psychiatrists, Pussep’s early experiment with ‘psychosurgery’ has in fact been generally acknowledged outside Russia. See, for instance, Walter Freeman, James W. Watts, and Thelma Hunt, *Psychosurgery: Intelligence, Emotion and Social Behavior Following Prefrontal Lobotomy For Mental Disorders* (Springfield, Ill.: Thomas, 1942), 10-11. See also George A. Mashour, Erin E. Walker, and Robert L. Martuza, "Psychosurgery: Past, Present, and Future," *Brain Research Reviews* 48 (2005): 411.

schizophrenia which had lasted for a long time, were getting progressively worse, and did not respond to any other forms of treatment. Perhaps most importantly, however, lobotomy was again given a personal stamp of approval by Leon Orbeli. "The effect that is achieved in this operation is great enough," he said, "that [the operation] may be considered not only permissible, but entirely indicated in certain cases of mental disease." He suggested that follow-up studies should be done to determine if the operation was truly justified, and suggested this should be done by the government, not by individual treating physicians<sup>30</sup>

The members of the All-Union Society's Directorate were hardly neutral in the matter of lobotomy. The meeting was chaired by Semyon Sarkisov, the director of the Institute of the Brain, a man who was himself sympathetic to the use of lobotomy, and Shmar'ian himself was one of five Deputy Chairmen. Other members of the Presidium included Raisa Golant and Pavel Emdin, both of whom ran active lobotomy programs. It was not surprising, then, that the group issued a resolution declaring that lobotomy was "a relatively effective and comparatively safe method of treatment for several serious forms of schizophrenia," and therefore could be considered a "justified and humane attempt, with the help of surgical methods, to relieve and return to life and labor these permanent residents of psychiatric hospitals." The resolution called on Minzdrav to develop a list of institutions where the operation could be done, as well as a list of specialists who would be allowed to do it.<sup>31</sup>

Approval in the professional society in 1949 was followed by official from public health officials. Late in 1949, the Scientific Medical Council of Minzdrav RSFSR read and approved

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<sup>30</sup> S. V. Kurashev, "Nauchnye zasedaniia: II plenum Vsesoiuznogo obshchestva nevroptologov i psikiatrov," *NiP*, no. 3 (1949): 72-73.

<sup>31</sup> N. N. Priorov (Chairman), Protokol #18 zasedanii prezidiuma UMS MZ SSSR, 9 October 1947, GARF, f. r-8009, op. 2, d. 1048, ll. 14-15; 130-132.



the Institute of Psychiatry's research report, noting with interest that they had found that patients recovered more quickly after lobotomy than foreign literature had led them to believe. This, the reviewer speculated, was probably because of the superior method of operation that had been developed by Boris Egorov. They also noted with approval that the director of the psychosurgery ward had reported that 33% of operations produced "lasting improvement, including a case of virtual recovery." The Ministry approved the institute's plan for further studies on lobotomy in 1950.<sup>32</sup>

### **"Compromised Our Science": The Second Lobotomy Discussion**

After the 1949 discussion at the All-Union Society, Giliarovskii took his concerns to Minzdrav USSR. Addressing the Ministry's Scientific Medical Council, he said that lobotomy was unjustified and harmful, even as a treatment of last resort. "I consider it proven," he told them, "... that if it would be possible not to touch the frontal lobes it would be for the best."<sup>33</sup> As a result of this meeting Minzdrav asked Giliarovskii to carry out an investigation of the use of lobotomy.<sup>34</sup> Early in 1950 he and staff members from his institute inspected psychiatric hospitals in Leningrad, Gor'kii, and Moscow, did interviews with doctors, examined patients, and studied case histories. They concluded that lobotomy seriously harmed the health of patients, even those who were able to leave the hospital after the operation. They also found that psychiatrists were not following the strict guidelines set down by the Directorate of the All-Union Society at its

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<sup>32</sup> "Zakliuchenie Prezidiuma UMS MZ RSFSR po otchetu Tsentral'nogo instituta psikhiiatrii za 1949 g., (kopiia)," 14 June 1950, GARF, f. a-482, op. 48, d. 871, ll. 27-28ob.

<sup>33</sup> L. A. Koreisha (chairman), "Stenogramma zasedaniia biuro prezidiuma UMS MZ SSSR," 30 November 1949, GARF, f. r-8009, op. 2, d. 1368, 14-18.

<sup>34</sup> A. A. Portnov (Nach. Otdela psikhonevrologicheskoi pomoshchi MZ SSSR, "Otchet o rabote psikhonevrologicheskogo otdela MZ SSSR za 1950 g.," undated [after 9 December 1950], GARF, f. r-8009, op. 33, d. 263, l. 2; S. A. Sarkisov (Pred. pravleniia vsesoiuznogo ob-va NiP), "Rehsenie plenuma pravleniia vsesoiuznogo ob-va nevropatologov i psikhiatrov: O primenenii elektorsudorozhnoi terpaii, kak metoda lecheniia dushevnykh zabolovani," 24 June 1950, GARF, f. r-8009, op. 2, d. 1498, l. 133; G. V. Vygodchikov (Chairman), "Stenogramma zasedaniia Prezidiuma UMS MZ SSSR," 30 November 1950, GARF, f. r-8009, op. 2, d. 1498, l. 17.

1949 plenum. Instead of reserving lobotomy for patients with chronic schizophrenia, psychiatrists were in fact using it on people who had recently fallen ill, who had dubious diagnoses of schizophrenia, or who were suffering from some other form of illness altogether. Worse still, they were using lobotomy on young people, even on children as young as 12.<sup>35</sup>

These infractions were at best a matter of bending the rules; at worst, they involved going against explicit orders from other physicians and writing falsified reports. Giliarovskii and his inspectors gave examples which were calculated to tug at the emotions of their listeners. Gor'kii psychiatrist Mark Gol'denberg was singled out as having perpetrated particularly egregious offences. His theoretical justifications for lobotomy, the inspector concluded, had “compromised our science” and the operation itself had affected patients in ways that were “totally scandalous.”<sup>36</sup>

In May 1950 Giliarovskii presented these findings to the All-Union Society of Neuropathologists and Psychiatrists and the members of the Society's Directorate discussed his report on 23-24 June 1950. At the meeting Giliarovskii argued that the All-Union Society should reconsider its decision to permit lobotomy. Breaking the rules was not the only problem, or even the main problem. Patients, he argued, were damaged by lobotomy regardless of whether or not the operation was done according to the All-Union Society's guidelines, and psychiatrists were

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<sup>35</sup> S. A. Kurashov (Sek. Vsesoiuznogo ob-va NIP), “O rezul'tatakh obsuzhdeniia na Plenumakh pravleniia vsesiouznogo ob-va nevropatologov i psikhiatrov voprosov primeneniia leikotomii v lechebnykh psikhonevrologicheskikh uchrezhdeniakh,” 30 November 1950, GARF, f. r-8009, op. 2, d. 1498, ll. 16-17; M. V. Solove'va (Kand. med nauk, Institut psikh. SSSR), “Shiozfreniia i leikotomiia,” corrected manuscript, undated [probably May 1950], GARF, f. r-8009, op. 2, d. 1498, l. 146. In published articles on lobotomy I have found references to lobotomy being performed on children as young as 9 I. S. Babchin and A. Ia. Sal'man, “O frontal'noi leikotomii v khirurgii bolei,” *Voprosy Neirkhokhirurgii* 14, no. 4 (1950): 7.

<sup>36</sup> This was Galach'ain's opinion, voiced at the November 1950 discussion of lobotomy. G. V. Vygodchikov (Chairman), “Stenogramma zasedaniia Prezidiuma UMS MZ SSSR,” 30 November 1950, GARF, f. r-8009, op. 2, d. 1498, l. 37

causing great harm to their patients. Even patients who were hailed as success stories were suffering from obvious signs of brain damage.

“Our comrades showed us 8 such patients, and all of them had one or another defect: they had a degree of *oRGANic* diminishment [*oRGANicheskoie snizhenie*]. . . . But the most materially significant result, as the head physician of the hospital said, is that the patients are made “passive,” that is, agitated patients become calm and don’t require special observation or any particular chores. But the most significant thing is that . . . surgeons and psychiatrists do the operation, and then they transfer the patients to other medical institutions, and thus don’t see the consequences of the operation.”<sup>37</sup>

The other psychiatrists at the June meeting seem to have taken Giliarovskii and his findings seriously. They agreed to forbid using leucotomy on any patients who were not “chronic,” forbid giving the operation to children, and to forbid giving it to patients with diagnoses other than schizophrenia. They also created a short list of medical schools and research institutes that the society would allow to practice lobotomy; other institutions in the USSR would not be allowed to use the operation. Finally, the psychiatrists at the plenum readily acknowledged that leucotomy was far from their ideal method of treatment, and they reiterated an earlier plea for researchers to seriously search for the underlying physiological causes of schizophrenia. If the biological underpinnings of the disease were understood, the reasoning went, then a truly effective therapy could be developed to target the actual cause.

Although they acknowledged Giliarovskii’s concerns and tightened their restrictions, they did not ban lobotomy, and they did not accept Giliarovskii’s more fundamental critique of the operation. Their final decision explicitly stated that lobotomy was recognized as a useful and justified method of last resort, to be used “in cases where all other methods of treatment have not given a therapeutic action.” They asked Minzdrav USSR to publish an official set of legal

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<sup>37</sup> S. A. Kurashov (Sek. Vsesoiuznogo ob-va NIP), “O rezul’tatakh obsuzhdeniia na Plenumakh pravleniia vsesoiuznogo ob-va nevropatologov i psikiatrov voprosov primenenii leikotomii v lechebnykh psikhonevrologicheskikh uchrezhdeniakh,” 30 November 1950, GARF, f. r-8009, op. 2, d. 1498, l. 18.

indications and counterindications that would govern the use of the operation and regularize its use in medical practice.<sup>38</sup> The decision was approved by 28 of the 30 members present.<sup>39</sup> In the protocol of the meeting, Giliarovskii had the final word: “I do not consider leucotomy a method of treatment which can be recommended for psychiatric institutions.”<sup>40</sup>

Giliarovskii’s aggressive opposition to lobotomy in the autumn of 1949 and the spring of 1950 took place in a very particular context, a time when the Party was organizing a highly charged discussion of Pavlov’s physiological theory, and a time when both Shmar’ian and Giliarovskii were being investigated for nepotism and cosmopolitanism. Giliarovskii’s opposition to lobotomy, of course, predated these misfortunes, but the way in which he now prosecuted his campaign against it was important. Not only did he portray Shmar’ian in a strongly negative light, he built an argument that implied that his own holistic theory of the mind was synonymous with good science and humane Soviet values.

### **Ideology and Anti-Semitism**

The conflict between Shmar’ian and Giliarovskii stemmed in part from the structural changes in the Soviet government and in part from their divergent conceptions of the mind and how it should be healed. The second line of institutional conflict, however, pitted Giliarovskii and Shmar’ian both against Anatolii Ivanov-Smolenskii. As I discuss in chapter 4, this conflict

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<sup>38</sup> S. A. Kurashov (Sek. Vsesoiuznogo ob-va NIP), “O rezul’tatakh obsuzhdeniia na Plenumakh pravleniia vsesoiuznogo ob-va nevropatologov i psikiatrov voprosov primeneniia leikotomii v lechebnykh psikhonevrologicheskikh uchrezhdeniakh,” 30 November 1950, GARF, f. r-8009, op. 2, d. 1498, ll. 16-17; S. A. Sarkisov (Chairman), “Reshenie plenuma pravleniia vsesoiuznogo ob-va nevropatologov i psikiatrov: O primeneniia frontal’noi leikotomii kak metoda lecheniia dushevnykh zabolevanii,” 24 June 1950, GARF, f. r-8009, op. 2, d. 1498, l, 128.

<sup>39</sup> S. A. Kurashov (Sek. Vsesoiuznogo ob-va NIP), “O rezul’tatakh obsuzhdeniia na Plenumakh pravleniia vsesoiuznogo ob-va nevropatologov i psikiatrov voprosov primeneniia leikotomii v lechebnykh psikhonevrologicheskikh uchrezhdeniakh,” 30 November 1950, GARF, f. r-8009, op. 2, d. 1498, ll. 16-17.

<sup>40</sup> S. A. Sarkisov (Chairman), “Reshenie plenuma pravleniia vsesoiuznogo ob-va nevropatologov i psikiatrov: O primeneniia frontal’noi leikotomii kak metoda lecheniia dushevnykh zabolevanii,” 24 June 1950, GARF, f. r-8009, op. 2, d. 1498, ll. 128-129.

was in part institutional and in part personal. Ivanov-Smolenskii had longstanding grievances against both Giliarovskii and Shmar'ian. He saw himself as carrying on Pavlov's true work in the psychiatric clinic, and bridled against the fact that he did not have an institute of his own.

Ivanov-Smolenskii was particularly adept at using the rhetoric of the anti-cosmopolitanism campaign against his professional opponents. In 1948 he published a harsh attack on Giliarovskii's work, calling it incoherent and un-Pavlovian. What is more, he managed to get himself noticed by people in positions of power. When the status of Giliarovskii's institute came up for discussion in the Academy of Medical Sciences, the recommendation to transfer it to the Ministry of Health was based on the claim that Ivanov-Smolenskii's institute was already doing fundamental research on the physiology of mental disease.<sup>41</sup>

In 1949 when the Soviet government began to mobilize popular anti-Semitism, both Giliarovskii and Shmar'ian found themselves under attack. Shmar'ian was himself Jewish, while Giliarovskii, though Russian, presided over an institute where the staff was about twenty percent Jewish.<sup>42</sup> An analysis of hiring information for Giliarovskii institute suggests that by early 1949 he was under intense pressure to fire Jewish staff members. In the space of just a few months, the number of Jewish staff dropped from 25 to 22 to 14, or from 46% of the staff to 36% and then to 25%. (See Table 5.1.) In the autumn of 1949 both of Giliarovskii deputies were removed from their posts and replaced by Russians, one of whom was Vasilii Banshchikov, a

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<sup>41</sup> N. N. Anichkov (Chairman), "Stenograficheskii otchet k protokolu #27 zasedanii Prezidiuma AMN SSSR," 3 October 1947, GARF, f. r-9120, op. 2, d. 325, l. 79.

<sup>42</sup> This proportion was about in line with most other All-Union medical research institutes, though other psychiatric research institutes in Moscow had much higher percentages of Jewish staff. Chris Burton, "Medical Welfare During Late Stalinism: A Study of Doctors and the Soviet Health System, 1945-1953" (Ph.D., University of Chicago, 2000), 374-375; Kovanov (Zav. Sektorom Admin. otдела TsK) and Larionov (Otv. Kontroler KPK pri TsK) to P. K. Ponomarenko (Sek. TsK) and M. F. Shkiriatov (Pred. KPK pri TsK), 11 October 1949, RGANI, f. 6, op. 6, d. 1556, l. 7; "Personal'nyi spisok spetsialistov po sostoianiiu na 1 okt. 1949 goda po psikiatricheskoi bol'nitse im. Kashchenko," RGANI, f. 6, op. 6, d. 1556, ll. 20-23ob; "Shtaty NII psikiatrii MZ SSSR po sostoianiiu na 1/IX-49g," RGANI, f. 6, op. 6, d. 1556, ll. 26-29.

politically well-connected psychiatrist who had spent the postwar years working as the director of Medgiz, the State Medical Publishing House. Giliarovskii's position in the profession began to seem increasingly insecure.

Giliarovskii's job, however, was far more secure than Shmar'ian's. In December 1949 Aleksandr Shmar'ian was abruptly removed from his post as head psychiatrist for Minzdrav USSR. The orders for his removal actually came from the Central Committee of the Communist Party.<sup>43</sup> This was in 1949 in the midst of the Party's thinly veiled campaign to remove Jews from positions of influence.

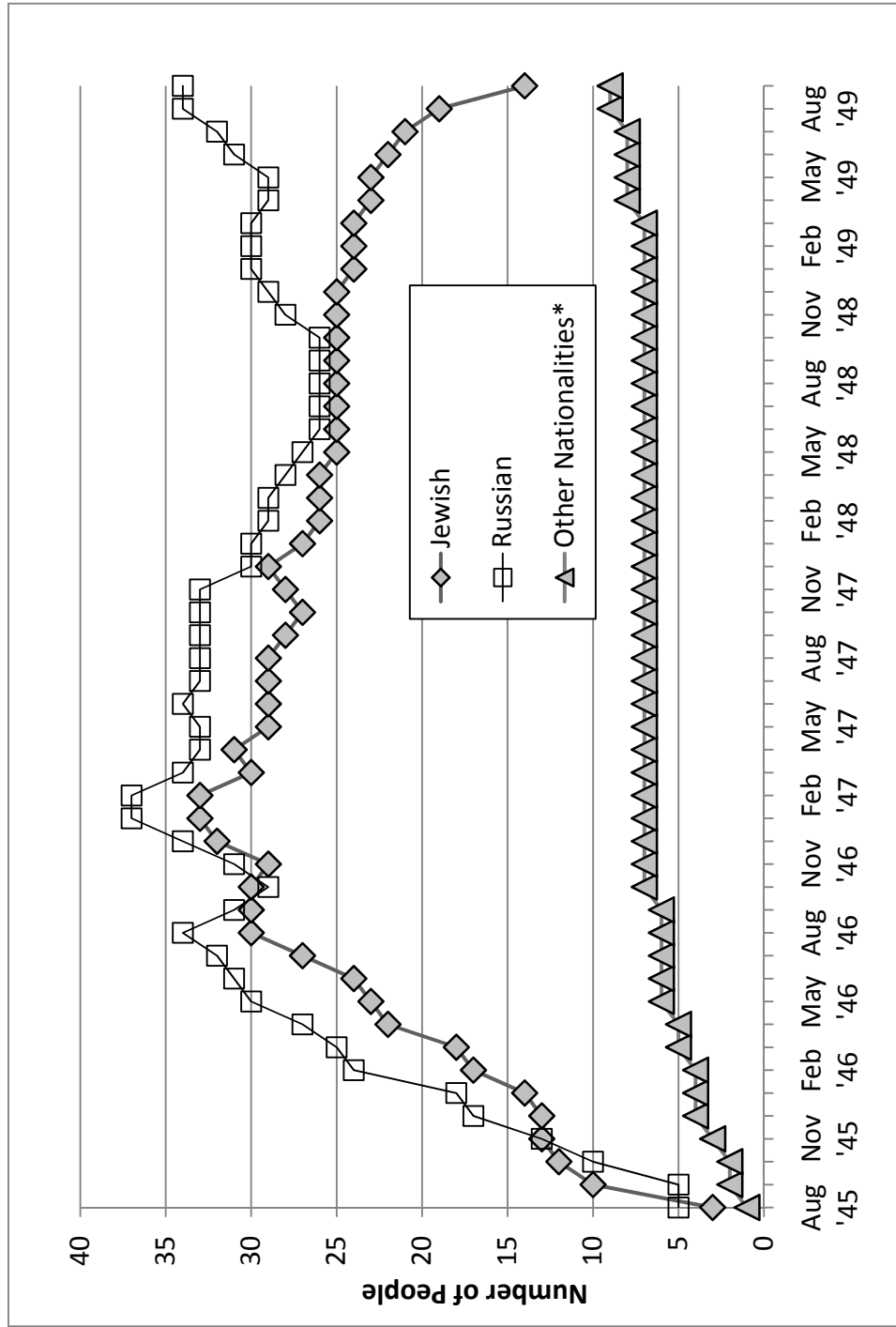
The Party's intervention came after an investigation that began after the Central Committee was sent a letter by an anonymous author who claimed to be a disgruntled provincial psychiatrist. In June 1949, the author claimed, he had come to Moscow from the provinces for a conference at the USSR Institute of Psychiatry. There he had been shocked to find that "the tone in the sciences of neuropathology and psychiatry" was being "set almost exclusively by Jews." "Involuntarily," he asked himself, "Why? What are the causes? The cause turns out to be fairly simple: over the course of many years (20-25 yrs), all the neuro-psychiatric institutions in the capital, the center of science, of have been 'occupied' exclusively by Jews."<sup>44</sup> He went on to denounce leading Jews by name and to ask the Party for help. "We ask for intervention [*vmeshatel'stva*] and to make the central and Moscow neuro-psychiatric intuitions accessible to Russians, Ukrainians, Georgians, Armenians, Kazaks, and others, and to put an end,

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<sup>43</sup> According to Snezhnevskii, Posvianskii and Shmar'ian were apparently able to get the commission's membership altered and the new commission absolved their institute. The implication was that they had pulled strings at the Ministry, using their "family" connections to protect themselves. M. D. Kovrigina (Chairman), "Stenogramma zasedanii Kollegii MZ RSFSR," 4 January 1951, GARF, f. a-482, op. 49, d. 3041, ll. 24, 35.

<sup>44</sup> "Occupied": the word used in the Russian is '*okkupirovany*', implying "occupation" in a military sense. The author(s) of the anonymous letter used quotation marks to highlight the figurative use of the word.

Figure 5.1. Nationality of Staff Members at the USSR Institute of Psychiatry, 1945-1949



\* Other Nationalities: Ukrainian, Georgian, Armenian, Latvian.

Source: Adapted from "Spiski nauchnykh sotrudnikov i vrachei priinytykh na rabotu i uvolennykh po institutu psikhiatrii AMN, 1945-1949," 4 October 1949, RGANI, f. 6, op. 6, d. 1556, ll. 30-47.

finally, to the insolent [*nagloe*] use of the best institutions in the country only in the interests of one nation. It is time, finally, to liquidate this disturbing monopoly [*vozmutil'naia monopoliia*].”<sup>45</sup>

The Party took this complaint seriously enough to launch an investigation and the outcome was the removal of Shmar'ian and other very prominent Jewish psychiatrists.<sup>46</sup> Along with Shmari'an, the Party removed the head psychiatrist of Minzdrav RSFSR and the head psychiatrist of the Moscow City Health Department. They ordered psychiatric research institutes to undertake a review of their staff's professional and political qualifications (*attestatsiia*), and told the Ministry to fire anyone who was found to be “inactive or without prospects.” Such people were to be replaced with “capable, well-prepared youths.”<sup>47</sup> Finally, after an investigation,<sup>48</sup> the director of the Serbsky Institute was also fired.<sup>49</sup> This was surprising because the director, Tsetsilia Feinberg, was well connected in the world of the NKVD and Ministry of

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<sup>45</sup> Ibid., 12-13

<sup>46</sup> Though the report includes analysis of personnel from all these institutions, the KPK archive has retained only the reports sent to the KPK by the Kashchenko psychiatric hospital and the Institute of Psychiatry Minzdrav SSSR. Kaganovich (Glav. vrach Psikhiatricheskoi b-tsy im. P. P. Kashchenko) to Minzdrav SSSR, Uprav. Kadrov, 5 October 1949, RGANI, f. 6, op. 6, d. 1556, ll. 16-24; “Shtaty Nauchno-issled. Institute psikhii MZ SSSR,” “Spisok uvolennykh nauchnykh sotrudnikov i vrachei po institute psikhii AMN,” “Spisok priinyatykh na rabotu v Institut psikhii AMN,” 4 October 1949, RGANI, f. 6, op. 6, d. 1556, ll. 15, 26-47.

<sup>47</sup> In particular, among “young capable scientific cadres working on the periphery,” the TsK investigators singled out Oleg Kerbikov, [?] Shevelev, Igor Sumbaev, and V. A. Glazov. P. V. Kovanov (Zav. sektorom Administrativnogo otdela TsK VKP/b/) and Larionov (Otvetstv. kontroler KPK pri TsK VKP/b/) to P. K. Ponomarenko (Sekretar' TsK) and M. F. Shkiriakov (Zam. pred. KPK pri TsK), 11 October 1949, RGANI, f. 6, op. 6, d. 1556, ll. 10-11. A partial publication of this document can be found in G. V. Kostyrchenko, *V plenu u krasnogo faraona: Politicheskie presledovaniia evreev v SSSR v poslednee stalinskoe desiatiletie*. (Moscow: Izd. "Mezhdunarodnye otnosheniia", 1994), 295, or in the English translation, pp. 253-254.

<sup>48</sup> At the 16 June meeting, Fedotov told the collegium that he formed the commission to inspect the institute after Smirnov summoned him on 1 February. When asked if there “some sort of signal,” another collegium member, Belousov, replied, “There were signals to the directing organs and Efim Ivanovich also had signals.” A. N. Shabanov (Acting chairman), “Stenogramma zasedaniia kollegii MZ SSSR,” 16 June 1950, GARF, f. r-8009, op. 1, d. 864, l. 12.

<sup>49</sup> For the 26 January meeting of the party cell, see N. E. Sazonov, “Spravka o rezul'tatakh kompleksnoi proverki raboty TsNII sudebnoi psikh. im. Serbskogo MZ SSSR za vremia s 5 fevralia 1950 goda po 13 fevralia 1950 goda,” undated [February 1950], GARF, f. r-8009, op. 1, d. 850, l. 119.



Justice, and in the course of the investigation she attempted to call in these favors to save her career.<sup>50</sup> It did not work. She was replaced at the Serbsky institute by Andrei Snezhnevskii, an example of the sort of person the Party considered to be a “capable, well-prepared youth.”

As director, Snezhnevskii almost immediately set about purging the institute of workers who were “without prospects.”<sup>51</sup> His background is worth dwelling on briefly because of his later status as the most influential psychiatrist in the USSR. Snezhnevskii had begun his career as a psychiatrist managing the psychiatric hospital in his home city, Kostroma, and he had gained a reputation by taking a failing and overcrowded rural psychiatric hospital and turning it into a well functioning institution.<sup>52</sup> In 1933, Snezhnevskii’s hospital was visited several times by Lev Rozenshtein, the director of Moscow’s Institute of Neuro-Psychiatric Prophylactics Psychiatry, who was apparently impressed with Snezhnevskii’s work, and invited him to come to Moscow to work at his institute.<sup>53</sup> Though he was quite young, Snezhnevskii appears to have gained some influence in Moscow, and collaborating on some of the early active biological therapy research, and appearing as an author of the 1938 official instruction on insulin therapy.<sup>54</sup> In the late 1940s he served as a member of Narkomzdrav USSR’s Psychiatry Commission, which put him into contact with important decision makers in the profession, institute directors and university

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<sup>50</sup> E. I. Smirnov (Chairman), “Stenogramma zasedaniia kollegii MZ SSSR,” 10 March 1950, GARF, f. r-8009, op. 1, d. 850, ll. 90, 95; G. V. Morozov, D. R. Lunts, and N. I. Felinskaia, *Osnovnye etapy razvitiia otechestvennoi sudebnoi psikhiiatrii* (Moscow: Meditsina, 1976), 174.

<sup>51</sup> “Prikaz MZ SSSR No. 846,” 6 October 1950, GARF, f. r-8009, op. 1, d. 907, l. 124.

<sup>52</sup> Snezhnevskii was head physician at the Kostroma hospital from 1925-1938. “Andrei Vladimirovich Snezhnevskii: K 100-letiiu so dnia rozhdeniia,” *ZhNiP*, no. 5 (2004): 4. A. V. Snezhnevskii, “Oblastnaia psikhiatricheskaia bol'nitsa v g. Kostrome,” *Sovetskaia nevroptologiya, psikhiiatriia i psikhogigiena* 2, no. 10 (1933): 149-154; Joravsky, *Russian Psychology*, 421-422.

<sup>53</sup> Iu. S. Savenko, “120-letie L'va Markovicha Rozenshteina (1884-1934),” *Nezavisimyi psikhiatricheskii zhurnal*, no. 3 (2004).

<sup>54</sup> “Instruksii po insulinoterapii Terapevticheskoi sektiis Psikhiatricheskoi komisii UMS pod redaktsiei profess. M. Sereiskogo, doktora Zak P.K., Morozova D.A., Grombakha V.A., Zhislina S.G., Konstorm S. I., Snezhnevskii A.V. (proekt),” 1938, GARF, f. r-8009, op. 5, d. 164, ll. 121-147

department chairs like Mikhail Gurevich, Vasilii Giliarovskii, Tsetselia Feinberg. By 1941 he had become Deputy Director of the Gannushkin Institute (later called the Moscow Psychiatric Research Institute).<sup>55</sup>

During the war Snezhnevskii served as a military physician, and later as an army psychiatrist, ultimately directing a front-line psychiatric hospital, for which he was awarded a Red Star.<sup>56</sup> In 1945 he returned to Moscow and joined the Party.<sup>57</sup> He taught at the Institute of Advanced Medical Study, lectured and did research at the Central Institute of Psychiatry, and served on the Psychiatry Commission of Minzdrav RSFSR.<sup>58</sup> He finished a doctoral dissertation under Mark Sereiskii in 1949.<sup>59</sup> He was a capable, well connected young researcher. He was also Russian. When the Party proposed that he take over the job of Serbsky Institute Director he initially refused, but, according to Genadii Kostrychenko, his refusal was not accepted.<sup>60</sup> Why the Central Committee singled him out is not altogether clear, though his connections to highly placed officials in Minzdrav like Dmitrii Fedotov and Sergei Kurashov may have played some role.

In 1949 Ivanov-Smolenskii was able to make use of the ongoing campaign for the purity of Russian culture and Russian science. He met privately with the young Party science chief, Iurii Zhdanov, and they discussed what Ivanov-Smolenskii saw as major problems in the way

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<sup>55</sup> "Andrei Vladimirovich Snezhnevskii: K 100-letiiu so dnia rozhdeniia," *ZhNiP*, no. 5 (2004): 4. M. O. Gurevich (Chairman), "Stenogramma zasedanii psikh. komissii pri Upr. gorodskikh bol'nits NKZ SSSR," 19 June 1941, GARF, f. r-8009, op. 5, d. 212a., ll. 4-5ob; M. O. Gurevich (Chairman), "Stenogramma zasedanii psikh. komissii pri Upr. gorodskikh bol'nits NKZ SSSR," 12 June 1941, GARF, f. r-8009, op. 5, d. 212a., ll. 8-18.

<sup>56</sup> "Andrei Vladimirovich Snezhnevskii: K 100-letiiu so dnia rozhdeniia," *ZhNiP*, no. 5 (2004): 4.

<sup>57</sup> *BME*, 3<sup>rd</sup> ed., s.v. "Snezhnevskii, Andrei Vladimirovich."

<sup>58</sup> In 1945, Snezhnevskii seems to have served on the Psychiatry Commissions of both NKZ RSFSR and SSSR. "Otchet o nauchno-issled. rabote za 1945 god Tsentral'nogo in-ta psikhiiatriia," undated [1946], GARF, f. a-482, op. 47, d. 3412, l. 10.

<sup>59</sup> *BME*, 3<sup>rd</sup> ed., s.v. "Snezhnevskii A.V.."

<sup>60</sup> Kostyrchenko, *V plenu u krasnogo faraona*, 294.

that physiologists were handling Pavlov's legacy.<sup>61</sup> Zhdanov became convinced that Pavlov's scientific legacy was not being properly developed by soviet physiologists, and that Pavlov's successor, Leon Orbeli, had concentrated too much institutional power in his own hands. In September 1949 Zhdanov sent Stalin a long report titled, "On the development of Academic Pavlov's doctrine," in which he wrote at length about how physiologists were ignoring, perverting, or outright attacking Pavlov's theories, particularly his theory of "higher nervous activity." Zhdanov proposed a four-step solution to the problem, beginning with a "meeting of physiologists at which to smash [*raznesti*] the enemies of Pavlov," including "liquidating the monopolistic position of Academic Orbeli in the leadership of physiological institutions," reworking medical school curriculums along Pavlovian lines, and "connecting scientific work more closely with medical practice, beginning with the psycho-neurological clinic."<sup>62</sup> Stalin responded positively to Zhdanov's suggested, and wrote back to him with advice on how to most effectively carry out the struggle against Orbeli.<sup>63</sup>

With Stalin's blessing, Zhdanov planned a discussion for June 1950 where Pavlov's theories could be discussed. This 1950 discussion helped Ivanov-Smolenskii become a key arbiter of what was and was not Pavlovian in psychiatry. With Zhdanov's help, Ivanov-Smolenskii was appointed to be one of the two main speakers at the event. Ivanov-Smolenskii used this platform to attack his institutional rivals, settle old scores, and advance his own views on physiology and psychiatry. As Zhdanov and Stalin had planned, the event was primarily devoted to removing Leon Orbeli from his position of influence in the biological sciences, and to

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<sup>61</sup> Iu. A. Zhdanov, *Vzgliad v proshloe: Vospominaniia ochevitdsa* (Rostov-na-Donu: Feniks, 2004), 277.

<sup>62</sup> Iu. A. Zhdanov (Zav. Sektora nauki Otelom propagandy i agitatsii TsK VKP(b)) to I. Stalin, cc. to G. M. Malenkov (Sek. TsK VKP(b)), 28 September 1949, *RGASPI* f. 17, op. 132, d. 177, ll. 144-162.

<sup>63</sup> D. G. Nadzhafov and Z. S. Belousova, eds, *Stalin i kosmopolitizm: Dokumenty Agitpropa TsK KPSS, 1945-1953*, ed. A. N. Iakovlev, *Rossiia XX Vek: Dokumenty* (Moscow: Materik, 2005), 515-517.

establishing “Pavlov’s doctrine” as a general framework for all the Soviet life sciences.<sup>64</sup> The main speech at the session was given by physiologist Konstantin Bykov, who criticized Orbeli for focusing too many resources on studies of the autonomic nervous system. For his part, Orbeli defended himself vigorously, justified the legitimacy of his research, and questioned whether or not the session was a genuine discussion. He later apologized and acknowledged some mistakes.<sup>65</sup>

For psychiatrists, though, the most important speech was Anatolii Ivanov-Smolenskii’s. Ivanov-Smolenskii narrated the history of psychiatry as an escalating conflict between idealism and dialectical-materialism, linking his 1930s conflicts with Shmar’ian, Gurevich, Giliarovskii, and others with the world-historical clash between progress and reaction, socialism and capitalism. “One cannot remember without sorrow,” Ivanov-Smolenskii said, “that for a long time and even quite recently all attempts to apply Pavlovian theory to the tasks of psychiatry were unfailingly met “in arms” [*v shtiki*].”<sup>66</sup> He attacked virtually all of the USSR’s leading psychiatrists, and he singled out Giliarovskii and Shmar’ian in particular. Giliarovskii’s work showed only “declarative acknowledgment of Pavlov’s theory” and demonstrated a “failure to master even basic physiology and pathophysiology of higher nervous activity” and “a superficial acquaintance with I. P. Pavlov’s theory.”<sup>67</sup> (Giliarovskii was reportedly shaken deeply by

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<sup>64</sup> For other accounts of the 1950 Pavlov Session, see David Joravsky, *Russian Psychology: A Critical History* (Oxford: Basil Blackwell, 1989), 379- 414; Kremontsov, *Stalinist Science*; 272-275; Pollock, *Stalin and the Soviet Science Wars*, 150-158.

<sup>65</sup> Joravsky, *Russian Psychology*, 407-409; Pollock, *Stalin and the Soviet Science Wars*, 150-158.

<sup>66</sup> A. G. Ivanov-Smolenskii, "Puti razvitiia idei I. P. Pavlova v oblasti patofiziologii vysshei nervnoi deiatel'nosti," in *Nauchnaia sessiia posviashchennaia problemam fiziologicheskogo ucheniia akademika I. P. Pavlova, 28 iunია - 4 iuliia 1950 g.: Stenograficheskii otchet* (Moscow: Izd. Akademii Nauk SSSR, 1950), 49-51.

<sup>67</sup> Elsewhere in the speech Ivanov-Smolenskii named both Shmar’ian and Gurevich as propagandists of the “psychomorphological trend,” but he never explicitly named Giliarovskii. Instead he discussed the lack of understanding of Pavlov’s theory demonstrated in “Monographs that have come out in the past few years about old and new problems in psychiatry, or more specific issues, like mental disorder in brain tumors”: Giliarovskii’s most

Ivanov-Smolenskii's speech, and interpreted the attack on him as a sign that he was to be "ostracized" from the profession.<sup>68</sup>) Shmar'ian was attacked for what Ivanov-Smolenskii called "the psychomorphological trend," a term of abuse that he used to describe psychiatrists who had attempted to correlate symptoms of mental illness with anatomical structures in the brain. He turned the title of Shmar'ian's own book, *Mozgovaia patologiia i psikhiatriia* [*Brain Pathology and Psychiatry*] into a synonym for all that was unpatriotic, un-soviet, and anti-Pavlovian.

. . . the infamous "brain pathology" (Shmar'ian) has been pitted against Pavlov's doctrine, supposedly created, in the words of Prof. Shmar'ian, by the joint work of a few of the leading Moscow and Leningrad psychiatrists . . . it actually must be considered the creation of the English physiologist Sherrington and the Moscow psychiatrist Gurevich. Unfortunately, our psychiatry has still not outlived this sort of tendency right up to the present day!<sup>69</sup>

Ivanov-Smolenskii did not say directly that lobotomy should be banned, but he did mention the widespread use of lobotomy in America, and he talked about Pavlov's own studies on dogs whose brains had been operated on. "These experiments," he said, "are of particular interest because in recent years attempts have been made, in particular in America, but also in a few Soviet psychiatric institutions, to use lobotomy to treat certain psychoses. . . . The studies by [Pavlov's student] Usievich . . . signal the need to observe extreme care when deciding the

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recent monograph was titled, "Old and New Problems in Psychiatry," while Shmar'ian's recent book was "Brain Pathology and Psychiatry: Brain Tumors and the Theory of Localization." Ibid., 51.

<sup>68</sup> In an autobiographical speech, Aleksandr Portnov recalled ridding home with Giliarovskii after the 1950 session. According to Portnov, Giliarovskii turning to him in the car and told him not to say anything to his (Giliarovskii's) wife. "What do you mean," Portnov responded, to which Giliarovskii shot back: "Come on, I've just been ostracized." [*Nu kak, ia zhe podvergsia ostrakizmu.*] Portnov: "I said: 'I didn't hear that.' - 'Don't try to pretend.' He was shocked, sang to himself 'Oh-ho-ho, okho-honiushki-ho-ho,' not noticing me." When they arrived at his flat, Giliarovskii's wife had already heard the news from someone else, and burst out "Vasya! What happened? What sort have your enemies turned out to be? [*Kakie u tebia vrugi okazalis?*]" A. A. Portnov, "Vospominaniia o razvitii otechestvennoi psikhiatrii," in *Voprosy sotsial'noi i klinicheskoi psikhiatrii i narkologii*, ed. B. D. Tsygankova (Moscow: 2000), 295.

<sup>69</sup> Ibid., 51.

question of the therapeutic value of lobotomy.”<sup>70</sup> His suggestion that lobotomy was first and foremost a *foreign* method of treatment was potentially dangerous for proponents of the operation, but Ivanov-Smolenskii did not declare outright that lobotomy was anti-Pavlovian.

Giliarovskii himself addressed the Session on the fourth day (July 1st), and clearly recognized that he was expected to engage in self-criticism, not self-defense. He abandoned any claim that psychiatry might be able to produce its own body of theory, and went so far as to say that psychiatry had “not yet become a fully scientific discipline.” It could only do so with the help of Pavlovian theory as interpreted by Bykov and Ivanov-Smolenskii. The fundamental processes nervous activity, inhibition and excitation, could help explain all mental phenomena, and Pavlov’s discovery of the laws governing excitation and inhibition could and should transform how psychiatrists thought about mental disorders. Giliarovskii also accepted Ivanov-Smolenskii’s criticisms of his 1946 book. He saved face, however, by reminding the audience that he, Giliarovskii, had taken courses with Ivan Sechenov, the father of Russian neurophysiology. In the hagiography of great Russian scientists, Sechenov was commonly hailed as the author of one of the key texts of nineteenth century Russian materialism, “Reflexes of the Brain,” and the source for the concepts that Pavlov had worked out experimentally in the laboratory. Giliarovskii’s connection to this legendary figure gave him at least some claim to honor, if not authority, among physiologists.<sup>71</sup>

Having conceded his own mistakes and accepted Ivanov-Smolenskii’s criticisms of him and his work, Giliarovskii focused the remainder of his on the evils of shock therapy and

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<sup>70</sup> Ibid., 56.

<sup>71</sup> V. A. Giliarovskii in *Nauchnaia sessiia posviashchennaia problemam fiziologicheskogo ucheniia akademika I. P. Pavlova, 28 iunია - 4 iulia 1950 g.: Stenograficheskii otchet* (Moscow: Izd. Akademii Nauk SSSR, 1950), 304-305, 308-309.

lobotomy. Pavlov, he pointed out, had proposed sleep as a form of treatment for mental illness. “Unfortunately,” he said, “it [sleep] is used ten times less than so-call electrical shock [*elektricheskii shok*].” Worse yet, “so-called prefrontal leucotomy has recently become more and more widespread among psychiatrists.” Giliarovskii described how his institute had inspected the use of lobotomy in psychiatric hospitals, and how they had come to the conclusion that it should not be used. “Leucotomy,” he declared, “is a crude operation which causes great damage, and the consequence of it is a significant mental decline [*psikhicheskoe snizhenie*].”

Giliarovskii singled out Shmar’ian as a supporter of lobotomy, and implied that Shmar’ian’s reductionist theory of disease was in itself a symptom of his flawed thinking. People like Shmar’ian, he concluded, “think that local changes in the system of fibers can heal schizophrenia, though schizophrenia is really a disease of the entire *organism*. This operation is theoretically unjustified.”<sup>72</sup> A condensed version of Giliarovskii’s speech appeared in *Pravda* the next week along with the other speeches at the session, and it included the section of his speech where he condemned lobotomy. The conflict over lobotomy had escalated and careers were on the line.

It was Shmar’ian’s career that was most in danger of being snuffed out. After the June 1950 discussion of Pavlov’s theory, Shmar’ian’s use of lobotomy became an easy shorthand for the malign influence of foreign ideas in Soviet psychiatry. Shmar’ian himself became a symbol of the alleged linkage between scientific theory, philosophical worldview, political ideology, patriotism, and perhaps biological ethnicity. Shmar’ian tried to defend his ideas when his institute called an emergency conference to discuss the 1950 Pavlov Session. According to the conventions of Soviet political culture, this was the wrong thing for him to have done. He should

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<sup>72</sup> Ibid., 306-307.

have done his utmost to demonstrate “comprehensive and strictly principled criticism” that might have set an example for the collective and helped them to restructure their work on Pavlovian principles.<sup>73</sup> Instead he had chosen to deny the allegations against him. By November 1950 the RSFSR Central Institute of Psychiatry was being investigated by the Ministry of Health and the Communist Party,<sup>74</sup> and Shmar’ian’s career was in deep trouble.

### “Social Recovery”: The Therapeutic Rationale for Radical Treatments

Meanwhile, lobotomy was still being used in Soviet psychiatric hospitals. Why did some psychiatrists still think that lobotomy made sense? Were they simply self-serving and unprincipled, as their opponents later claimed? Or did they think that what they were doing actually might benefit their patients? These questions have been explored in some depth by historians of lobotomy in the American context.<sup>75</sup> Here I argue that the “therapeutic rationale” used by Soviet psychiatrists was very similar to that used in America. In the real world conditions of Soviet psychiatric hospitals, lobotomy was deemed by some psychiatrists to be highly effective because it had a real impact on the symptoms that psychiatrists looked at to determine how sick a patient was.

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<sup>73</sup> Unsigned (leadership of the Central Institute of Psychiatry, almost certainly P. B. Posvianskii), untitled response to inspection report (“Spravka k dokladu na kollegii MZ RSFSR o rabote TsNII psikhiiatriia RSFSR”), undated [before 7 December 1950], GARF, f. a-482, op. 48, d. 871, l. 11.

<sup>74</sup> There are two different investigation reports, one in the archive of Minzdrav RSFSR, the other in the archive of Minzdrav SSSR. The first is signed by a Minzdrav RSFSR inspector, and was prepared for the 7 December 1950 collegium meeting, probably before the lobotomy discussion, since the discussion is not mentioned. O. D. Kolybina (Nach. GU lechprofpom MZ RSFSR), “Spravka k dokladu na kollegii MZ RSFSR o rabote TsNII psikhiiatriia RSFSR,” undated [before 7 December 1950], GARF, f. a-482, op. 48, d. 871, ll. 34-43; Unsigned, “Zakliuchenie o deiatel’nosti Instituta psikhiiatriia MZ RSFSR,” undated, GARF, f. r-8009, op. 33, d. 463, ll. 54-73.

<sup>75</sup> Joel Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley: University of California Press, 1997); Jack D. Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge: Cambridge University Press, 1998).



In his study of biological therapies, historian Joel Braslow makes a useful distinction between “efficacy” and “effectiveness.” “Efficacy” is used to describe the effects that a treatment has under ideal laboratory conditions, where every variable is controlled under double-blind conditions. The question being asked is “*can* it work?” In the real world outside this hypothetical laboratory, however, treatments are done under conditions in which an unknown number of uncontrollable variables may be involved in producing (or hindering) whatever effect is observed. The question under real-world conditions is not whether a treatment shows a statistically valid result under double-blind conditions. The question is not *can* it work, but “*does* it work?” A treatment is *effective* if it produces the desired effect, but just because it works in the real world does not necessarily mean that it would have *efficacy* in the lab.<sup>76</sup> Braslow refers to this as a “therapeutic rationale,” the reasoning that clinicians use to evaluate and justify a treatment.

Braslow does not argue that the effects of a therapy are socially constructed; treatments like lobotomy, electroshock, or warm baths all clearly have some biological effect on the body. Braslow’s argument, rather, is that the effects of a given treatment (biological or otherwise) are themselves important factors in shaping how psychiatrists understand *what* they are treating. When a treatment was found to eradicate a particular type of behavior, that behavior came to define the essence of the disease. Psychiatrists, he writes, develop “a kind of rough-and-ready

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<sup>76</sup> Before a treatment is recommended for wide use, epidemiological studies are undertaken to determine the effectiveness of the treatment, since a treatment that has been proven efficacious will not necessarily be effective under real-world conditions. Milos Jenicek, *Foundations of Evidence-Based Medicine* (New York: Parthenon Publishing Group, 2002).

‘therapeutic rationale’ through which they can interpret their patients’ signs and symptoms in the context of the proposed intervention.’<sup>77</sup>

To understand why psychiatrists found lobotomy effective, it is important to remember that most Soviet psychiatric hospitals were terribly overcrowded. Psychiatrists frequently wrote about the problem of beds that were “immobilized” or “silted up” by patients whose illness never improved enough for them to be checked out. These “chronics” took up more and more beds each year, making it harder to keep order on the wards and harder to take in patients who had recently fallen ill, and who thus were likely to be more responsive to active treatment. Psychiatrists knew that if they were truly going to turn psychiatric hospitals into institutions that were seen by other physicians as respectable places of scientific medicine, then they would have to solve the problem of immobilized beds and chronic patients. Lobotomy was seen as a useful addition to the “arsenal” of treatments precisely because it helped many “chronics” who had never responded to any other treatment.

Psychiatrists, of course, did not always explicitly articulate their therapeutic rationale for using lobotomy. In their written reports they based their decisions to operate on the textbook theory of lobotomy. The operation was described much like fixing a clock: the mechanic/surgeon opened the device and fixed the specific broken part. If the intervention was successful, the mechanism was returned to something like working order. For his part, Shmar’ian believed that lobotomy worked by ending a disordered relationship between “the personality and actual reality.”<sup>78</sup> The key area was actually the orbito-frontal cortex, Shmar’ian thought, the area that

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<sup>77</sup> Braslow, *Mental Ills and Bodily Cures*, 173. On “effectiveness” and “efficacy,” see the discussion in *ibid.*, 4-5. Jack Pressman develops a similar approach in his discussion of “clinical frames.” Pressman, *Last Resort*, 432-437.

<sup>78</sup> A. S. Shmar'ian, *Mozgovaia patologii i psikiatriia. Opukholi golovnogo mozga i uchenie o lokalizatsii psikhicheskikh rasstroistv*, vol. 1 (Moscow: Medgiz, 1949), 136.

he believed to be responsible for the integration of emotion. (Shmar'ian advocated the "orbital leucotomy," as opposed to the classical prefrontal lobotomy operation proposed by Moniz.) Like fixing a broken mechanism, cutting connections between the prefrontal cortex and the rest of the brain could bring order to a schizophrenic patient's mind.<sup>79</sup>

In practice, of course, the psychiatrists did not know why cutting the fibers in the front of the brain had an effect or what caused schizophrenia. But they could see that it did *have* an effect: it made patients easier to manage in the overcrowded psychiatric hospitals. Virtually all the psychiatrists who wrote about lobotomy described their patients before the operation as *disorganized*, disorderly, and often violent. After the operation, the patients' behavior was described as becoming much more orderly, less violent, and less *disorganizing* to hospital life. The Leningrad neurosurgeon Isaak Babchin described the phenomenon as "the restructuring [*perestroika*] of the mental life of the patient." The operation, he wrote, may "reduce his emotional stress and agitation, eliminate aggressiveness and elevated activity, liquidate delusions and hallucinations, annihilate anxiety."<sup>80</sup> Iurii Rozinskii, a neurosurgeon on staff at the Central Institute of Psychiatry, echoed this analysis. "In the post-operative conditions of our subjects, the most notable thing was the way that their pronounced tension and affect vanished, as did their former depersonalization [*otchuzhdennosti*], their bothersome fears, and the way the patients focused on them. . . . Their autism and negativism are replaced by an orientation toward reality, . . . they become simple, natural, and accessible"<sup>81</sup>

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<sup>79</sup> Babchin, "Opyt khirurgicheskogo lecheniia," 4.

<sup>80</sup> The verbs that Babchin uses are notably violent: ". . . *oslabit' ego emotsional'noe napriazhenie i vzbuzhdenie, ustranit' agressivnost' i povyshennuiu aktivnost', likvidirovat' bred i galliutsinatsii, unichtozhit' bespokoistvo.*" Babchin, "Opyt khirurgicheskogo lecheniia," 4.

<sup>81</sup> Iu. B. Rozinskii, "Dinamika galliutsinatorno-paranoidnogo sindroma pri prefrontal'noi leikotomii," *NiP* 17, no. 2 (1948): 36.

For many patients who were suffering from advanced cases of schizophrenia, social interaction was virtually impossible. After the operation, the doctors were struck to find that patients became accessible to social contact. As psychologist Bliuma Zeigarnik observed, “Even in the early post-operative stage, the ability of the patient to interact with the external world was striking.” The interaction was not always easy or always perfect, they hastened to add, but it was possible, and this was a qualitatively different circumstance from the patient’s pre-lobotomy condition.<sup>82</sup> This openness to the external world made it possible for patients to be reintegrated into social relationships, and the degree to which this social reintegration was possible seems to have been used as a rough measure of the operation’s effectiveness.

A patient’s accessibility to social contact determined where the patient could live: the least sociable patients were kept on psychiatric hospital wards for agitated patients, while those that were less difficult were kept in the wards for calm patients. The highest functioning patients lived at home. Lobotomy’s success was made visible in the movement of patients from one locale to another. Patient G— was an example of this type of success story. Notes from his case were published by Rozinskii as an illustration of a good outcome, and I quote at length from it because the case illustrates the basic narrative of the clinical rationale behind lobotomy. Patient G— had been wounded during the Second World War and had been given the status of “invalid.” In August 1945, at age 21, he suddenly developed a “psychotic condition.” Nothing could be found that was physically wrong with him, but his thoughts and behavior were extremely disordered. Wrote Rozinskii:

Delusional ideas of persecution, auditory hallucinations. Totally inaccessibility. Angry, periodically agitated, foolish, endlessly screaming something. Disoriented: says that he is

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<sup>82</sup> B. V. Zeigarnik and P. Ia. Gal'perin, "Psikhologicheskie izmeneniia posle leikotomii u shizofrenikov," *NiP*, no. 4 (1948): 67.

in Warsaw. . . . Negative, extremely monotonous, answers have an awkward character. Operation prefrontal leucotomy under general narcosis. . . .

Two days later: aggressive, agitated, cynical, threatens personnel, struck a physician. Periodic changes of condition in the course of the day: at times calm, controlled, well intentioned, at other times agitated, negative, aggressive.

Two and a half weeks later behavior has become ordered [*uporiadochennoe povedenie*], disciplined, no sign of aggression. Cheerful, helpful, sociable, simple, natural. Remembers his condition before the operation. Is embarrassed when remembering a few outbursts. Says: "It was all as if in a fog, now it isn't." . . . Is more critical, active. One notes a certain good humor, emotional flattening, ease of judgment . . . Answers no longer foolish, now simple and concrete. No hallucinations or delusions. Has gone home. Is working well.<sup>83</sup>

Studies of lobotomy patients showed that, like G—, many patients were able to leave the psychiatric hospital for the first time in years and go to live with their family, though fewer were able to return to work. Patients were not restored to a pre-illness state of health, but these outcomes were still judged to be successful. As Leningrad neurosurgeon Isaac Babchin explained, "We present the results of the operation . . . not in the usual form of evaluating outcomes of treatment by dividing patients into cured, improved, and so forth, but rather [by evaluating them] from the point of view of social recovery [*sotsial'nogo vyzdorovleniia*], and the patient's adjustment to the conditions of his surrounding environment." From this point of view, Babchin could point with pride to the fact that 32 of the 89 subjects in his study were now living at home, among them people who had been seriously ill for up to 22 years.<sup>84</sup>

Patient's families seem to have adopted this approach to evaluating the effectiveness of lobotomy as well. Boris T. fell ill with schizophrenia in 1938. Everything was tried, and in 1947 he was transferred to the Troitskaia Psychiatric Hospital for chronic patients outside Moscow. There his condition deteriorated, and he was transferred to a psychiatric hospital in Moscow,

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<sup>83</sup> Rozinskii, "Dinamika galliutsinatorno-paranoidnogo sindroma pri prefrontal'noi leikotomii," 36-37.

<sup>84</sup> Only 12 of Babchin's 89 subjects (13%) had returned to work. I. S. Babchin, "Opyt khirurgicheskogo lecheniia," 9.

“where he was in an extremely excited state and had to be kept tied to the bed; his body was covered in welts.” In April 1948, the family asked that their son be transferred to the Tenth Ward of the Gannushkin Hospital, “where he was given the ‘lobotomy’ operation.” In the two years since the operation he had lived at home and worked under the supervision of the local psychiatric clinic. “He is very calm, orients fully in the household, has become more emotional, reads sometimes, loves to go to the theater and to the cinema, and is noticeably developing a critical attitude toward concrete events. . . . With feeling we thank the physicians of the Tenth Ward for giving the help that made it possible for our son to be useful, even a little bit, to society.”<sup>85</sup>

Another mother echoed this story. She agreed to have a leucotomy performed on her daughter, Evelina P—, “only because the doctors had sentenced my daughter to life in the colony [for the chronic mentally ill].” The results of the operation had been positive: “It seems to me that the improvement in her condition happened immediately after the operation: she lives at home, she does housework, sews, works in the garden, . . .reads. She worked in an *artel*’ for invalids for three months as a gluer [*skelishchitsa*] and made about 300 rubles per month. She quit that job because of the distance. After the operation she was in the hospital twice, but not in the ward for serious cases, but in the sanatorium. Of course, she is a sick person, the operation has not made her altogether well, but partially and significantly there was improvement.”<sup>86</sup>

The criterion of “social adjustment” could also be used to determine when an operation had been a failure. In 1950, a member of the raikom in a town in Moscow oblast’ wrote to the

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<sup>85</sup> Otets i mat’ B. Tauba to 10-oe otdelenie bol’nitsy im. Gannushkina, testimonial letter, undated, GARF, f. r-8009, op. 2, d. 1498, l. 152.

<sup>86</sup> E. Petrova to Bol’nitsa im. Gannushkina, testimonial letter, 18 November 1950, GARF, f. r-8009, op. 2, d. 1498, l. 150.

Deputy Chairman of the Supreme Soviet of the RSFSR to ask for intervention. His brother, Anatolii, had fallen ill with schizophrenia in 1936 when he was 21 years old. The family had a history of mental illness: Anatolii's sister had been sent to the Troitskaia Psychiatric Hospital where, according to her family, she had died of starvation. Anatolii himself had been in and out of psychiatric hospitals for the past ten years. Psychiatrists had given him electro-shock therapy and malaria therapy but "without any particular effect." In January 1947, he was given a "two-sided frontal leucotomy operation in Professor Shmar'ian's clinic."<sup>87</sup> Anatolii lived at home after the operation, but by 1950 the situation had become untenable. He was violent, and incessantly beat his 61-year-old mother. His mother refused to let her son go back to the psychiatric hospital, fearing that he would meet the same fate as her daughter. Anatolii's brother, the raikom chairman, wrote to the Supreme Soviet requesting that legal guardianship over Anatolii be transferred to himself so that he would have the legal authority to put his brother away. The Deputy Ministry of Health agreed. In a letter sent to the Supreme Soviet, he noted that Anatolii had been given "the most modern, newest methods of treatment, right up to operative. . . . Improvement in his condition has not occurred." Since Anatolii could not be reintegrated into the household, the only course of action was to send him to a rural psychiatric hospital where he would have "the possibility of being involved in labor processes."<sup>88</sup>

### **"Is it Wise to Cut the Brain?": The Final Discussion of Lobotomy**

Giliarovskii's vocal opposition to lobotomy in the medical press increased pressure on the Minzdrav USSR. The editors of *The Medical Worker* followed up on Giliarovskii's article

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<sup>87</sup> I. M. Temkin (Starshii nauchnyi sotrudnik Ts. Inst. psikhiiatrii MZ RSFSR) to G. G. Karanovich (Nach. otdela nevropsikh. uchrezhdenii MZ RSFSR), 25 February 1950, GARF, f. a-482, op. 49, d. 1405, ll. 79-81.

<sup>88</sup> V. Stapnov (Zam. Ministra Zdrav. RSFSR) to A. M. Safronov (Zam. Pred. SM RSFSR), 4 and 30 March 1950, GARF, f. a-482, op. 49, d. 1405, ll. 59-62, 75-84.

with a letter to the Minister of Health asking him to report on any measures being taken to rectify the situation depicted by Giliarovskii.<sup>89</sup> Whether Minzdrav replied to them or not is unclear, but when November came and Minzdrav had still taken no action to stop the use of lobotomy, more “signals” arrived, this time from *Pravda*, a much more authoritative source. In the letter, two provincial psychiatrists complained that lobotomy was still being used and that Shmar’ian and others had “still not disarmed.” “In our country,” they wrote, “lobotomy is undoubtedly an accidental, imported phenomenon, and it should be judged decisively.” Across the front of *Pravda’s* memorandum the Minister of Health scrawled a note in pencil to one of his deputies: “Why are you going so slow with instructions on this?”<sup>90</sup>

The next day, November 30, Minzdrav convened what was to prove the decisive meeting about the use of lobotomy. The coincidence of these events suggests that, at the very least, the Ministry of Health was under pressure to ban lobotomy. Unfortunately no archival documentation has come to light that might clarify whether the Party ordered the discussion to take place and, if so, why. It seems unlikely that the meeting was actually planned overnight, though Smirnov’s marginal note to his deputy could be interpreted to suggest this.<sup>91</sup> Rumors later circulated among Moscow physicians that the daughter of a senior party official had been lobotomized, perhaps even without the approval of her parents, and that this had set the Party

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<sup>89</sup> The editors of *Medrabotnik* asked Minzdrav to reply by 10 October. S. Skoblov (Medrabotnik) to V. I. Pshenichnikov (UMS MZ SSSR), 30 September 1950, GARF, f. r-8009, op. 2, d. 1498

<sup>90</sup> *Pravda* never published the letter. The editor’s note accompanying the letter to the editor simply said, “We’re sending you the material that *Pravda* has on lobotomy.” A. Portnov and V. Pakhomov, “Protiv odnogo lzhenachnogo metoda lecheniia (Pis'mo v redaktsiiu),” undated [1950], GARF, f. r-8009, op. 2, d. 1498, l. 12.

<sup>91</sup> The Likhtermans’ take Smirnov’s comment and the speed with which Minzdrav oRGANized the discussion of lobotomy to indicate that they were receiving ‘signals’ that they felt were of the highest priority – from some authoritative office or individual in the Party. Leonid Likhterman and Boleslav Likhterman, “Kak v SSSR zapreshchali psikhokhirurgiiu,” *Meditinskaia gazeta*, 1 September 2000, 12-13.



against lobotomy.<sup>92</sup> There is also some evidence to suggest that Iurii Zhdanov, the Party's science boss, was orchestrating the "signals" being sent to *Pravda*.<sup>93</sup>

If someone in the Party did intend to ban lobotomy, however, that someone had not shared their intention with all the members of Minzdrav's Scientific Medical Council. From the outset of the Council's meeting on November 30 there was confusion about what they were there to do. The agenda called for them to discuss the decision about lobotomy made by the Plenum of the All-Union Society of Neuropathologists and Psychiatrists in June 1950.<sup>94</sup> One member of the Council, Semyon Sarkisov, wanted to know if the Scientific Medical Council was intended to simply rule on whether that decision was right or wrong, or if they supposed to examine the parts of the decision. Vasilii Banshchikov, Giliarovskii's deputy, told Sarkisov that the members of the Council were intended to make their own decision about lobotomy. At the end of the meeting, after five hours of discussion, the chairman moved to essentially reaffirm the Society's June 1950 decision. His draft language called on psychiatrists to "refrain from wide usage of leucotomy as a method of treatment." So while a ban may well have been the desired outcome, the five hour meeting that took place on November 30 turned into an earnest discussion, with little of the stilted, most-holds-barred quality of most public "discussions" during this era. The

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<sup>92</sup> B. L. Lichterman, "On the History of Psychosurgery in Russia," *Acta Neurochirurgica* 125 (1993): 3.

<sup>93</sup> The letter forwarded by *Pravda* to Minzdrav was written by two psychiatrists from the city of Gor'kii, and both men stand out for the significant roles they went on to play in psychiatric policy making. The first author was Anatolii Portnov, the head physician at the Gor'kii Psychiatric Hospital. Within weeks after the lobotomy discussion he was appointed to head the psychiatry section at Minzdrav USSR, and later in his career he went on to become the Director of the RSFSR Central Institute of Psychiatry. The second author was Vladimir Pakhomov, a psychiatrist from Gor'kii, but also a long-time family friend of the Zhdanov family. Ia. Kalashnik (Nachal'nik otdela p/nev pomoshchi MZ SSSR) to D. D. Fedotov (Nachal'nik GU Gorodskikh lech.-prof. uchrezhdenii MZ SSSR), "Plan otdela psikhonevrologicheskoi pomoshchi MZ SSSR na 1951 g.," 20 December, 1950, GARF, f. r-8009, op. 33, d. 263; and M. D. Kovrigina (Chairman), "Protokol no. 1 zasedanii kollegii MZ RSFSR," 4 January, 1951, GARF, f. a-482, op. 49, d. 3040; Portnov, "Vospominaniia," 298-299.

<sup>94</sup> The meeting began with a presentation by the secretary of the All-Union Society's directors, Sergei Kurashov. G. V. Vygodchikov (Chairman), "Stenogramma zasedanii Prezidiuma UMS MZ SSSR," 30 November 1950, GARF, f. r-8009, op. 2, d. 1498, ll. 14-17.

lobotomy discussion became quite heated, and the participants ended up calling into question not only the scientific and ethical status of lobotomy, but the scientific and ethical status of psychiatric medicine as a whole.

Thirty-three people gathered at the Ministry of Health for the discussion of prefrontal lobotomy. The meeting was chaired by microbiologist Grigorii Vygodchikov, and was attended by other members of the Scientific Medical Council. These men were top specialists in their fields (surgery, cardiology, physiology, orthopedics), and all of them held important posts at research institute, universities, and the Ministry of Health. In addition to the seven members of the Scientific Medical Council, two large groups of psychiatrists were present, one from Giliarovskii's Institute of Psychiatry, and the other from Shmar'ian's RSFSR Central Institute of Psychiatry. Finally, there were individual representatives of other Moscow psychiatric hospitals and institutes, Ministry of Health administrative departments, and university departments. Notably absent were Raisa Golant and Mark Gol'denberg, the psychiatrists from Leningrad and Gor'kii who were frequently named as the most prolific practitioners of lobotomy.

Giliarovskii began the meeting by presenting a version of his report on lobotomy, and he was followed by several members of the team that had helped him do the investigation.<sup>95</sup> They questioned the therapeutic rationale used to justify lobotomy, and claimed that patients with allegedly good outcomes from lobotomy were actually suffering from serious and irreversible brain damage. When examined objectively, they claimed, the facts showed that lobotomy did not heal.<sup>96</sup> The proponents of lobotomy failed to see this because they were "carried away by

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<sup>95</sup> V. A. Giliarovskii (Direktor instituta psikiatrii MZ SSSR) in Vygodchikov (Chairman), "Stenogramma," ll. 17-27.

<sup>96</sup> On this point see "Stenogramma," ll. 18-19 (Giliarovskii), l. 36 (Galachian), ll. 40-43 (Soloveva), ll. 48-49 (Pakhomov), and ll. 67-68 (Nikolaev).

enthusiasm” and personally “interested” [*zainterestovan*] in finding a beneficial result. As a result, either they simply could not see the truth, or they had convinced themselves that they had not seen it. In either case, the pro-lobotomy psychiatrists were *not* objective. They had failed to adopt the properly detached stance that was appropriate for a Soviet scientist.<sup>97</sup>

In response, Aleksandr Shmar’ian and his assistant Iurii Rozinskii defended their clinical judgment and accused Giliarovskii and his team of using the wrong criteria to judge the value of the operation. Like all Soviet physicians, Shmar’ian and Rozinskii claimed, they were personally dedicated to giving patients the most humane possible medical treatment. How could Giliarovskii possibly think that patients would be better off living out their lives in an overcrowded, under-funded, poorly-maintained psychiatric hospital instead of living at home with their families, even if they did have to live with life-long brain problems?<sup>98</sup> Iurii Rozinskii made this case passionately. Lobotomy was certainly not a panacea, Rozinskii told the Scientific Medical Council. In two thirds of the lobotomies that he had done the patients had been no better off afterward than they had been before the operation. But in the other third of his operations, Rozinskii had seen dramatic results:

“Among our patients were some who were animals, not people: these were finished people [*konchennye liudi*], all the psychiatrists said that nothing could help them. And now a few of those patients are, first of all, working, and second, they are living, helping their families, making money. They are people in the true sense of that word [*...iavliaiutsia liud’mi v nastoiashchem smysle etogo slova*]. So excuse me, comrades, but what else could the criteria for judging the leucotomy operation possibly be?”

Rozinskii admitted that the operation had some long-term consequences – the brain was being cut, after all. But compared to the effects that years of schizophrenia had on the brain, the effects

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<sup>97</sup> See, for instance, “Stenogramma,” ll. 35-39 (Galachian), l. 67 (Nikolaev), and l. 103 (Giliarovskii). Galachian speculated that Rozinskii’s “loose summation of the facts” was motivated by the interest he had in the approval of his doctoral dissertation.

<sup>98</sup> Other proponents of leucotomy followed the same line of argument as Rozinskii. “Stenogramma,” l. 65 (Sakaian), ll. 71-73 (Egorov), ll. 75-78 (Shmar’ian), and ll. 99-102 (Koreisha)

of lobotomy were relatively minor, “a post-operative defect that cannot be differentiated from the ruin of the personality [*ruinirovaniia lichnosti*]” caused by the schizophrenia.<sup>99</sup>

Later in the afternoon Rozinskii returned to demonstrate three patients to the group, all of whom had suffered from schizophrenia for years before being given lobotomies. Rozinskii brought them out one at a time, and asked them questions to demonstrate their mental acuity to the audience. He particularly stressed the fact that these patients now had perspective on their former madness, a sign that the surgery had helped them recover. “Was it hard for you,” he asked one man. “Not just for me,” the man replied, “but I was very unpleasant to those around me too.” Rozinskii highlighted this answer: “You heard – he recognizes that he was unpleasant for us, for those around him.”<sup>100</sup> Giliarovskii was skeptical of the demonstration. He called the diagnosis of schizophrenia into doubt in one case, and told the members of the Council that he simply had not been shown enough to make an informed judgment. “To make a judgment about their condition, it is not enough to give them two or three questions, a more detailed examination is needed, but we have information that suggests that we can’t talk about any sort of recovery.”<sup>101</sup>

The idea that lobotomy could restore a patient’s humanity provoked a strong response by the psychiatrists opposed to lobotomy. Aram Galachian, one of the psychiatrists who had investigated lobotomy earlier in the year, spoke immediately after Rozinskii, and took Rozinskii to task for suggesting that people with chronic schizophrenia were less than human. “... Comrade Rozinskii characterizes [these patients] as animals – an expression entirely unsuitable for a psychiatrist and characteristic of that group [the proponents of lobotomy], who forget the

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<sup>99</sup> Iu. Rozinskii (TsNII Psikhiatrii MZ RSFSR) in “Stenogramma,” ll. 29-33.

<sup>100</sup> Ibid., 57-62.

<sup>101</sup> V. A. Giliarovskii (Direktor instituta psikiatrii MZ SSSR) in “Stenogramma,” l. 62.

most elementary principles of Russian psychiatry – forget about Korsakov.”<sup>102</sup> In fact, patients were not animals – they were human beings, and therefore, Galachian concluded, “we need to categorically ban the leucotomy operation as a method of treatment, precisely to preserve the personalities of the mentally ill who are entrusted to us.”<sup>103</sup>

Giliarovskii’s assistant M. V. Solov’eva suggested that lobotomy actually did precisely the opposite of what Rozinskii claimed: rather than restoring them, lobotomy actually destroyed something integral to their humanity. As an example she offered the example of patient K., a 32 year old man who was lobotomized in 1948. “In this case the patient, thanks to leucotomy, took on deeply *oRGANic* characteristics [brain damage], mentally he is an automaton [*avtomat*], he can work for whole days, he never complains of fatigue, never expresses feelings of satisfaction or dissatisfaction. From the point of view of the leucotomists this outcome is considered an improvement, but is this not the ideal of the American imperialists who are searching for ‘robots’? [*robotov*]”<sup>104</sup>

The case against lobotomy was restated by another member of Giliarovskii’s staff, this time in the language of Pavlovian physiology. Iudif Segal’ explained that, according to Pavlov, the brain worked as an integrated unit: specific cognitive operations and functions did not strictly take place in particular localized brain structures. Cutting the brain, therefore, was ill advised even in cases that did not involve schizophrenia, because it could produce long-term and unforeseeable changes in the whole body.<sup>105</sup> Furthermore, according to Segal’, Pavlov’s theory suggested that many people could recover from schizophrenia, if only their brains were given a

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<sup>102</sup> A. G. Galachian (Institut psikiatrii MZ SSSR) in “Stenogramma,” I. 35.

<sup>103</sup> Ibid., I. 39.

<sup>104</sup> M. V. Soloveva ((Institut psikiatrii MZ SSSR) in “Stenogramma,” II. 41-42.

<sup>105</sup> Iu. E. Segal’ (II Mosk. med. institut) in “Stenogramma,” II. 53-55.

chance to defend themselves. Pavlov believed that the brain had a built-in defensive mechanism he called “protective inhibition,” and that when brain cells were threatened, they reacted by going into a sort of stasis that prevented damage to themselves and gave the body a chance to fight off the problem and recover. In principle, he believed, the brain cells themselves were still capable of recovery, and under the right conditions the person suffering from schizophrenia might return to a normal life. The surgeon’s knife would disrupt this natural defense mechanism, Segal’ warned. No recovery was possible after the operation because the brain cells had now been irreversibly destroyed by the surgeon. The ‘treatment’ was worse than the ‘disease.’<sup>106</sup> Her analysis also undermined one of the key arguments used in favor of lobotomy, the idea that lobotomy was as a last resort to be used on chronic patients. According to Segal’, the category of ‘chronic patient’ was itself flawed from a Pavlovian perspective, and thus could not be relied on as a criterion for judging who should be given the operation.<sup>107</sup>

Segal’s analysis was aimed at lobotomy, but the neurosurgeons and brain scientists in the group saw her comments as a direct attack on their discipline. As the discussion began to heat up, a voice from the floor called out, “Is it wise [*razumno*] to cut the brain?” To this the director of the Institute of the Brain, Semyon Sarkisov, shot back: “If you are going to reason that way, I promise you that tomorrow we’ll need to close the Institute of Neurosurgery.”<sup>108</sup> Boris Egorov, director of the Burdenko Institute of Neurosurgery and chairman of the newly-formed All-Union Society of Neurosurgeons,<sup>109</sup> challenged Segal’s interpretation of Pavlovian theory. In fact,

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<sup>106</sup> Ibid., I. 51-52.

<sup>107</sup> Ibid., I. 51. See also “Stenogramma,” II. 74-75 (Lukomskii), II. 103-105 (Giliarovskii).

<sup>108</sup> S. A. Sarkisov (Direktor Instituta mozga AMN SSSR) in “Stenogramma,” II. 93-94.

<sup>109</sup> The society of neurosurgeons gained ‘all-union’ status in 1950; a provisional directorate had been in place from 1936-1948, and had been reorganized in ’48. B. G. Egorov (Direktor Instituta Neirokhirurgii AMN SSSR) in “Stenogramma,” I. 40.

Egorov reminded them, Pavlov had shown that the brain was remarkably adaptable, and precisely because of its inherent flexibility it was quite capable of compensating for brain damage, even after an operation like lobotomy. Egorov assured everyone that he was not suggesting that brain surgery should be taken lightly – to the contrary, operations such as lobotomy should be used only as a last resort. But he insisted that there *were* circumstances in which operating on the brain was justified, and these were cases in which surgery could save the brain from even more damage. Though Segal’ had suggested that patients with schizophrenia had normal brains that could recover, Egorov said that in his experience this was not the case. When he operated on them he found that they nearly always had abnormal swelling in their brains, particularly of the blood vessels. So he did not think that lobotomy was disrupting an otherwise normal brain. At the least, lobotomy was saving the brain from further damage; at best it was opening up the possibility that the patient could go back to something like a normal life.<sup>110</sup>

Vladimir Pakhomov, the Gor’kii psychiatrist who had written the letter about lobotomy to *Pravda*, shifted the terms of the debate from medical practice to professional politics, and introduced a large measure of rhetoric taken from the campaign against cosmopolitanism. For Pakhomov, the question was why lobotomy had been allowed to take root in Soviet psychiatric practice in the first place. As he saw it, the theory behind lobotomy was not far removed from the “medieval” views of Freeman and Watts, the American popularizers of lobotomy. By giving voice to these American views, Soviet psychiatrists like Shmar’ian and Gol’denberg were guilty of spreading the worst of Anglo-American psychiatry, the “crudest form of the localizationist

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<sup>110</sup> B. G. Egorov (Direktor Instituta Neurokhirurgii AMN SSSR) in “Stenogramma,” ll. 71-73. Koreisha reiterated and expanded on a number of the same points made by Egorov, esp. the point that neurosurgery DOES do harm, and all other treatments should be tried first, but that surgery to the central nervous system does more than just destroy, it also is used to reestablish equilibrium to a disordered system, help the brain regenerate pathways. L. A. Koreisha (Institut neurokhirurgii) in “Stenogramma,” l. 97.

mechanistic perspective,” the belief that in order to affect a specific system of the brain “one has only to pick up a knife.”<sup>111</sup> Shmar’ian and Gol’denberg had been able to get away with it because they held positions of inordinate power in the profession, positions that enabled them to quash any protest from below. Pakhomov knew what to call this situation: “Involuntarily, the thought occurs to me, inspired by comrade Stalin’s work of genius on linguistics, that like those around Academic Marr, a group of psychiatrists headed by professors Shmar’ian, Gurevich, and others, have created an Arakhcheev regime in psychiatry.”<sup>112</sup>

The accusation that Shmar’ian might be running an “Arakhcheev regime” potentially carried consequences that went far beyond a mere restriction on lobotomy. Pakhomov’s accusation provoked an interruption by neurosurgeon Leonid Koreisha: “And what about professor Giliarovskii – doesn’t he have an Arakhcheev regime?” Pakhomov responded that he thought Giliarovskii’s views on lobotomy were “entirely correct, and ... capable of breaking up the dangerous theory of the proponents of leucotomy.” Koreisha’s outburst, however, was indicative of a mood at the meeting which came through in several other places, a feeling that this meeting was as much about institutional rivalries as it was about science or ethics. The chairman, however, ultimately dismissed Pakhomov’s accusation that Shmar’ian was running an Arakhcheev regime, declaring in the concluding speech, “That is an unsuccessful claim.”<sup>113</sup>

For his part, Shmar’ian tried to address his critics on all counts: scientific, ethical, and patriotic. He began by trying to show that lobotomy could be justified in terms of Pavlov’s scientific theory, because according to Pavlov, “intellect and personality are not narrowly localized in the frontal lobes.” The opponents of lobotomy were actually making an anti-

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<sup>111</sup> V. M. Pakhomov (Psikh. bol’nitsa, Gor’kii) in “Stenogramma,” l. 47.

<sup>112</sup> Ibid., l. 50.

<sup>113</sup> G. V. Vygodchikov (Zam. direktora Mosk. gorodskogo bakteriologich. in-ta) in “Stenogramma,” l. 106.



Pavlovian argument, Shmar'ian suggested. "It follows that if you think that cutting a certain fiber causes dementia and defect, then you actually are taking a localizationist stance..."<sup>114</sup> Shmar'ian argued that lobotomy was ethically acceptable as a treatment of last resort, and was intended to stop mental disease from destroying what was left of the patient's brain. "Of course," he agreed, "first we need to treat the patient with psychotherapy, the most delicate methods. Then move to physiological treatments, then to prolonged sleep. If it doesn't work – go to narcotic forms of sleep, use insulin therapy, and only then, where this doesn't work, and the process is moving inexorably . . . and cells begin to be destroyed due to the irritation of the cortex. And then to stop the irradiation process in this phase we need to operate, and apparently this causes a break between the subcortical and intercortical, and causes the stimuli that give us this effect."<sup>115</sup> If a less drastic method of treatment were to be found effective, he would be the first to embrace it. But to date there was no cure for schizophrenia.

Furthermore, Shmar'ian told them, lobotomy had to be understood in the context of the real world of the mentally ill in the Soviet Union. There were 2,700 patients in the psychiatric hospital at Troitskaia Psychiatric Hospital outside Moscow, and, according to Shmar'ian, 80% of those patients had schizophrenia. (This estimate drew angry noise from the crowd, and Shmar'ian allowed that the number might be 70%.) Many patients had been there for decades, and had been given all known treatments. Shmar'ian posed a question that brought the discussion back once again to the existing therapeutic rationale: "If leucotomy could help even ten percent

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<sup>114</sup> A. S. Shmar'ian (Zam. direktora TsNII psikhiatrii MZ RSFSR) in "Stenogramma," ll. 75-76.

<sup>115</sup> Ibid., 77-78.

of such patients return to life, return them to labor – isn't that humane? I personally think that if a patient becomes calmer, that is better ...”<sup>116</sup>

Shmar'ian also tried to defend lobotomy against charges that it was an unpatriotic western import. He reminded everyone that St. Petersburg neurologist Ludwig Pussep had experimented with something like lobotomy in 1909, so it could be claimed as a home-grown achievement. He also argued that lobotomy should be seen as ideologically neutral even if it was connected with the corrupt idealist West. Like Pakhomov, Shmar'ian borrowed his logic from Stalin's recent discussion of linguistics. Language, Stalin had argued, was not affected by historical changes in the mode of production. Like language, Shmar'ian argued, schizophrenia was outside history. “There was schizophrenia under feudalism, it existed under capitalism, and to our great shame we are going into communism having not defeated a number of illnesses, schizophrenia among them.” The audience was skeptical, interrupting him with cries of “That is crude mechanism,” and asking whether he believed that sterilization was independent of the base-superstructure relationship as well. Shmar'ian insisted that lobotomy was “a biological problem, just like penicillin.”<sup>117</sup>

Vasilii Banshchikov, Giliarovskii's deputy, brought the discussion back to lobotomy's scientific justification, and blasted Shmar'ian for trying to claim that it might be justified on Pavlovian grounds. In fact, Banshchikov said, the actual mechanism of lobotomy remained wholly unstudied, and thus anything that Shmar'ian or anyone else might say could only be speculation.<sup>118</sup> Banshchikov was echoed by Stefan Pavlenko, a member of the Scientific Medical

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<sup>116</sup> Ibid., ll. 79.

<sup>117</sup> A. S. Shmar'ian in “Stenogramma,” 5

<sup>118</sup> V. M. Banshchikov (Zam. direktora Instituta psikiatrii MZ SSSR) in “Stenogramma,” ll. 81, 84.

Council.<sup>119</sup> Pavlenko told the group that he was astounded by the lack of scientifically grounded arguments on either side of the debate, particularly the reliance on anecdotal cases instead of systematic study. In the absence of any thorough scientific study proving or disproving the effects of lobotomy, the continued use of the operation amounted to ‘empiricism’ – just trying different interventions to see what would work without first establishing a theoretical rationale for the intervention. Pavlenko admitted that there were instances in medical practice where empiricism was to be tolerated. This case, however, was different: “If you go into the brain with a knife and cause serious changes to the connecting fibers, forgive me, but such a method requires very serious justification, and if you don’t have that sort of serious justification, then you have no right to go into the brain – that is what the patho-physiologists tell us!” This declaration earned him applause from the audience.<sup>120</sup>

The neurosurgeons, however, were not amused. Leonid Koreisha was also a member of the Scientific Medical Council, and he had recently served as the Deputy Director for the Soviet medical services in occupied Germany.<sup>121</sup> In his professional life Koreisha was a neurosurgeon, and he himself had performed lobotomies in Moscow. The real problem, Koreisha claimed, was that psychiatrists lacked any clear criteria for determining who had schizophrenia or how it should be treated. Koreisha addressed the psychiatrists in the group:

“In the case of schizophrenia, should the pathways be severed or not? Do you have any thoughts on that question? You don’t have an opinion, because you yourself don’t understand what schizophrenia is, all you have are different diagnoses. When it is established which type of schizophrenia needs to be operated on, when indications are firmly established, then we won’t need to talk about this anymore.<sup>122</sup>

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<sup>119</sup> S. M. Pavlenko was also the country’s leading pathophysiologicalist and head of Minzdrav’s directorate for medical schools. *BME*, 3<sup>rd</sup> ed., s.v. “Pavlenko, Stefan Makarovich (1900-1981).”

<sup>120</sup> S. M. Pavlenko in “Stenogramma,” ll. 86-87.

<sup>121</sup> *BME*, 3<sup>rd</sup> ed., s.v. “Koreisha, Leonid Aleksandrovich (1896-1973).”

<sup>122</sup> L. A. Koreisha, in “Stenogramma,” ll. 97-99.

What is schizophrenia? The question struck at a very sore spot for Soviet psychiatrists. Soviet researchers had been unsuccessful in their attempts to identify either the etiology or the pathology of the disease. As a result, they could not say with certainty what the underlying cause of schizophrenia was, or even if their patients with schizophrenia all had the same underlying physiological problems. If Soviet psychiatrists had rigorously held themselves to their own ideal of a natural sciences model of medical treatment, then they should have stopped treating people for schizophrenia altogether, because they did not understand how or why *any* of their methods of treatment worked.

This point was illustrated near the end of the meeting, when the value of insulin therapy was questioned by Larisa Lobova, one of Shmar'ian's co-workers and a long-time editor at *Meditsinskii rabotnik*.<sup>123</sup> "We see that this method [lobotomy] gives 30% improvement," she said. "(Voice: Not 30%). Even if it's 20%. And what rate [of improvement] does insulin give? And is insulin a [theoretically] grounded method today? Voice from the floor: It is harmless."<sup>124</sup> At the time, insulin therapy was the most widely used biological treatment for schizophrenia both in the USSR and in the West.<sup>125</sup> Insulin therapy seemed to help, and it was "harmless." Lobotomy should be used only based on a rigorous understanding of the underlying pathology of schizophrenia, Banshchikov and Pavlenko were in effect setting the bar so high that virtually none of psychiatry's "active treatments" could be justified. In practice, psychiatrists evaluated all their methods of active therapy using the same instrumental logic that they used to decide if

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<sup>123</sup> "Nekrolog: Larisa Pavlovna Lobova," *ZhNiP* 80, no. 2 (1980): 304.

<sup>124</sup> Anonymous in "Stenogramma," GARF, f. r-8009, op. 2, d. 1498, l. 115.

<sup>125</sup> Like leucotomy, insulin therapy was a drastic physiological intervention which was thought to have a positive effect on patients with schizophrenia. Patients were given high doses of insulin until they slipped into a coma, and while in the coma they experienced seizures. Afterwards their symptoms seemed to improve, and patients became much calmer. On the history of insulin coma therapy, see Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley, 1997), 210-213.

lobotomy was justified: Did it help more people than not? Did its value to those it helped outweigh the harm that it did?

No one at the meeting could provide clear answers to these questions, nor could they agree on the standards by which benefits should be measured. (This lack of agreement, as Pavlenko pointed out, could be seen as reason enough for banning lobotomy.) But in addition to these disagreements about how costs and benefits could be measured, the discussion had exposed a deeper problem, the question of whether costs and benefits *should* be measured. The brain should not be cut, according to this interpretation of Pavlovian principles, because the personality of the patient would be changed forever, and the core task of the Soviet psychiatrist was to protect and restore the personality. In this view, cutting the brain could not be justified regardless of the outcome, because the personality would be irreversibly damaged.

Psychiatrists like Galachian and Solov'eva who tried to articulate this view, however, seemed to have no clear reasons for their argument. Why was the personality inherently valuable? If some people really did live fuller lives after lobotomy, why should the psychiatrist prefer their pre-operation state? Other than a sense of unease about the outcome, these psychiatrists had great difficulty finding a language with which to articulate their reasons. The fact that they *had* this sense of unease, a sense that there were moral sources beyond instrumental utilitarianism, suggests a more complicated picture of the moral world of Soviet psychiatrists. When they thought about their patients, apparently, their decisions were informed by more than just the instrumental logic found in textbooks and regulations.<sup>126</sup>

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<sup>126</sup> On the implicit values of instrumental utilitarianism, see Charles Taylor, *Sources of the Self: The Making of the Modern Identity* (Cambridge, Mass.: Harvard University Press, 1989), ch. 19, esp. 330-336.

## **Banning Lobotomy**

Despite five hours of speeches, the discussion of lobotomy did not produce a clear consensus among the members of the Scientific Medical Council. When Grigorii Vygodchikov, the chairman, brought the meeting around to formulating the language of their decision, he proposed that the first point of the resolution should be “refrain from wide usage of leucotomy as a method of treatment.” Sarkisov, the director of the Institute of the Brain, reminded him that in their professional society the psychiatrists had allowed for circumstances in which lobotomy would be acceptable, and that this was a good idea, because it would “broaden the possibilities of the psychiatric clinic.” Vygodchikov agreed that this was desirable, and suggested that research institutes should be allowed to continue experimenting with lobotomy.<sup>127</sup>

At this point Vasilii Banshchikov spoke out against this approval of the status quo. Banshchikov suggested that instead the first point of the resolution should read, “The Scientific Medical Council considers it necessary to refrain from the method of leucotomy as a therapeutic method.” He was supported by Stefan Pavlenko, who was a voting member of the Council. Pavlenko suggested that for clarity’s sake they should use the word “forbid,” rather than “refrain.” Alexander Portnov, one of the two psychiatrists who had complained to *Pravda* about lobotomy, spoke up to agree that the “attitude of the Scientific Medical Council ... should be expressed precisely in that the Council considers leucotomy principally inadequate as a therapeutic method.”<sup>128</sup>

Proponents of lobotomy were upset by this move to establish an outright ban, and they urged the members of the Scientific Medical Council not to allow themselves to be dominated by

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<sup>127</sup> Sarkisov in “Stenogramma,” l. 111.

<sup>128</sup> Banshchikov in “Stenogramma,” l. 111.

a minority view. Larisa Loboza suggested that the Council should simply develop guidelines for the use of lobotomy as the All-Union Society had suggested. The specialists who took part in that decision, she argued, were “our greatest scientists, students of Pavlov,” and should be trusted. She accused Giliarovskii and his colleagues of disrespecting Soviet neurosurgery and of acting in bad faith. “Surely,” she said, “you don’t think that the Soviet neurosurgeons who use the method of neurosurgery in the area of psychiatry are acting inhumanely. I think that this is incorrect.” Pavlenko, the Council member who was most outspoken in favor of banning lobotomy, responded by calling Loboza’s speech “demagoguery.” An angry and telling exchange followed in which Loboza suggested that Giliarovskii was being used to the detriment of the profession:

Loboza: I think that you have long been practicing demagoguery, and I think that you are confusing respected Vasilii Alekseevich [Giliarovskii], our great [*krupnyi*] scientist, because you give him information that doesn’t follow.

Giliarovskii: Please don’t bother about me.

Loboza: I want to bother about you and I will bother about you, because you are our great scientist. I think that you are in such a group and that they are leading you into confusion, even more so since you yourself used to think that leucotomy should be used, you had talks with Professor Koreisha.... You were on the right path. And now it’s as if I don’t know you. . . . Here the biggest scientists were gathered, and I don’t know, why is the opinion of Comrade Pakhomov higher than the opinions of the biggest specialists in our country?

Giliarovskii: I ask for a word – I protest against Comrade Loboza’s statement.

Chairman: I’m not going to let anyone speak. The members of the Presidium have spoken; the final statements have been heard by the chairman ...<sup>129</sup>

Having cut off discussion, the chairman told them that the final language of the decision would be decided on by Scientific Medical Council’s leadership, “the same as we do for other questions.”<sup>130</sup>

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<sup>129</sup> The entire string of exchanges that I translate in this section comes from Vygodchikov (Chairman), “Stenogramma,” ll. 106-117.

Just over one week later, USSR Minister of Health Efim Smirnov issued *Prikaz* No. 1003, which forbade any further use of lobotomy as a treatment for mental illness. Unfortunately, any deliberations that may have happened behind closed doors during that week have not come to light in the archives. The *prikaz*, however, clearly adopted the language of lobotomy's critics: instead of Sarkisov's "refrain from wide usage," or even Banshchikov's simple "refrain," the order instead adopted Pavlenko's more categorical "forbid." Lobotomy, according to the order, caused more harm than good: its benefits were no greater than other methods (like insulin shock), while its costs were very high indeed, because it produced profound brain damage that made further treatment impossible. The *prikaz* also included language that said that lobotomy was unacceptable because it was not based on scientific understanding of the mechanisms of the brain and the nature of schizophrenia. Or, as the *prikaz* worded it, lobotomy was "theoretically ungrounded" and "contradictory to the physiological principles of I. P. Pavlov."<sup>131</sup> According to this foundational text of Pavlovian psychiatry, then, psychiatrists should use treatment methods only if they had a rational basis for doing so.

Also important for Pavlovian psychiatry was what was not in the *prikaz*. In the discussion, psychiatrists like Gala'chian and Solov'eva had argued that the brain and the personality were indelibly linked, that to cut the brain was to forever change the personality, and that this was an immoral act. Minzdrav's *prikaz* made no mention of the personality or its value. Pavlovian psychiatry was humane, but its humanity was grounded on the complete importation of the natural sciences paradigm into psychiatric practice. Psychiatrists would use their new

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<sup>130</sup> V. G. Vygodchikov (Zam. direktora Mosk. gorodskogo bakteriologich. in-ta) in "Stenogramma," l. 117.

<sup>131</sup> E. Smirnov (Ministr Zdrav. SSSR), "Prikaz MZ SSSR No. 1003," 9 December 1950, GARF, f. r-8009, op. 1, d. 908, ll. 200-201. For a published copy of the order, see "Prikaz MZ SSSR No. 1053," *Zhurnal nevropatologii i psikiatrii im. Korsakova* 52, no. 1 (1952): 17-18. A translation of the order can be found in B. L. Lichterman, "On the History of Psychosurgery in Russia," *Acta Neurochirurgica* 125 (1993): 3.



understanding of the understanding laws of the brain to consciously and rationally bring order back to the body-mind.

### **After Lobotomy: Cosmopolitanism, Idealism, and the new Pavlovian Psychiatry**

The lobotomy discussion helped take shape the narrative of what had gone wrong in psychiatry. Until after the lobotomy discussion, psychiatrists had been given little help in figuring out what they could or should be doing to prove themselves sufficiently Pavlovian. Articles published in 1950 in journals like *Meditinskii rabotnik* and *Nevropatologiia i psikhiatriia* were of little help. They shed light on Pavlov and his theories, and provided some suggestive hints about how sleep therapy might be used in psychiatric hospitals, but they offered no clear, black-and-white answer to the question of how Pavlovian psychiatry would differ from what had come before. Now that answer was clearer: Pavlovian psychiatry would not, could not allow the use of lobotomy, and Aleksandr Shmar'ain and other lobotomists were responsible for the profession's failures.

When the first issue of *Neuropathology and Psychiatry* arrived in 1951, its readers found that the tone of the journal had changed. Instead of staid explications of Pavlov's ideas about signal systems and experimental neuroses, the journal was now filled with outraged exposés of lobotomy, "brain pathology," and "militant idealism." In order to create Pavlovian psychiatry, physicians were told, they would not only have to learn new scientific and clinical concepts, they would have to (re)learn how to exercise Bolshevik vigilance in their daily work. As the editors of the journal declared, Soviet psychiatrists would now focus on the significance of Pavlovian physiology for psychiatry and neurology, and they would "pay particular attention to the fight for the scientific purity of our discipline, to the fight with all enemy ideas and their conduits, and to

the unmasking [*razoblachenie*] of capitalist anti-national [*antinarodnoi*] essence of neuropathology and psychiatry of capitalist countries.”<sup>132</sup>

This struggle to unmask the “conduits” of “enemy ideas” had an ugly side: barely concealed anti-Semitism. Public statements issued by Minzdrav after the lobotomy discussion made clear that to create a truly Pavlovian psychiatry, Soviet psychiatrists would have to root out Jewish influence. Jewish psychiatrists were not selflessly dedicated to the purity of national science. They were self-interested, dedicated to their own closed circle of relations, and connected to people and ideas outside the Soviet Union. Jewish psychiatrists were the first place to start in the search for “conduits of enemy ideas,” and the purge of Shmar’ian and his cronies from the Central Institute of Psychiatry provided a model for other psychiatrists and institutions in other medical disciplines.

Aleksandr Shmar’ian was not immediately dismissed from his post at the Central Institute after the lobotomy discussion, though his position was clearly precarious. An investigation report was prepared for the RSFSR Minister of Public Health. It concluded that Shmar’ian dominated the institute and that his research on “brain pathology” had crowded out virtually all other topics. The report found Shmar’ian’s work “unsatisfactory” and ordered that he and the director “restructure all the scientific and practical work on the basis of deep study of the physiological science founded by Sechenov and Pavlov and the classics of national psychiatry.” The report also accused Shmar’ian and his boss of hiring staff members based on personal connections (“*semeistvennost’* [nepotism]”) and “unprincipled-ness.” Both men’s wives worked at the institute and allegedly got special treatment, as did the director’s ex-wife and the wives of

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<sup>132</sup> "Plan raboty zhurnala na 1951 god," *NiP* 20, no. 1 (1951): 6-7.

several department heads.<sup>133</sup> The personnel department of Minzdrav RSFSR was told to hold attestation hearings for all the workers from the institute by January 1, and to fire those who were found to be unqualified.<sup>134</sup>

This report was intended to provide the groundwork for a meeting called by the RSFSR Minister of Health. The meeting was supposed to have been held on December 7, just one week after the lobotomy discussion. In a rather surprising turn of events, however, before this meeting could take place the RSFSR Minister of Health himself was fired for nepotism and embezzlement. According to historian Chris Burton, the Minister's wife, a member of the Party's Central Committee, had been "heavily involved in the embezzlements taking place at the ministry."<sup>135</sup> In the wake of this scandal the Central Committee of the Party declared that it had lost confidence in Ministry's party cell, and the Council of Ministers declared the Ministry's work unsatisfactory. A new minister, Mariia Kovrigina, took office on December 8, and was given the task of reestablishing order.<sup>136</sup> One of the first issues that she heard was the report on problems at the RSFSR Central Institute of Psychiatry.

For Shmar'ian and his colleagues, this could not have been a more unfortunate turn of events. Kovrigina used the opportunity to demonstrate her low tolerance for corruption, nepotism, and cosmopolitanism. When the meeting was finally convened, a report was presented

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<sup>133</sup> O. D. Kolybina (Nach. GU lechprofpom MZ RSFSR), "Spravka k dokladu na kolegii MZ RSFSR o rabote TsNII psikhiatrii RSFSR," undated [before 7 December 1950], GARF, f. a-482, op. 48, d. 871, ll. 34-43.

<sup>134</sup> G. N. Beletskii (Ministr Zdrav RSFSR), "Reshenie kolegii MZ RSFSR (proekt), 7 December 1950, GARF, f. a-482, op. 48, d. 871, ll. 44-47.

<sup>135</sup> Burton, "Medical Welfare," 368.

<sup>136</sup> In her memoir, Kovrigina remembers that she arrived at work on December 7 and was called to the minister's office. There Smirnov informed her that she had been appointed RSFSR Minister of Health. "This was a complete surprise," she wrote, "no one had ever spoken to me about it." She began by launching a week-long process of intense self-criticism in the Ministry's party *o*RGANization. Mariia Dmitrievna Kovrigina, *V neoplatnom dolgu* (Moscow: Politizdat, 1985), 131.

by Andrei Snezhnevskii, the man who had taken over the Serbsky Institute at the Party's behest. Snezhnevskii described the problems at the institute as "no accident." The cause, he said, clearly had "one source, which carries the name cosmopolitanism." He noted that many of the staff had worked at the institute under the old leadership, and had continued to hold the same "cosmopolitan views" after Rozenshtein was dismissed. Referring to Shmar'ian, Snezhnevskii quoted Stalin on the recent linguistics controversy: "If I was not convinced in the honesty of comrade Meshchaninov and other linguists, I would say that such behavior was equivalent to wrecking."<sup>137</sup> Coming in the midst of a litany of details about nepotism and "clannishness" and juxtaposed with Jewish names, Snezhnevskii clearly meant to suggest that these psychiatrists, and perhaps Jewish psychiatrists in general, were not trustworthy in leadership positions.

The Minister left no doubt about what she thought of this state of affairs. "This is shameful, simply shameful," she told the leaders of Minzdrav. "Shameful, embarrassing, and upsetting." The result had been not only the ruin of the institute, but the "complete ruin of psychiatric services in the Federation."<sup>138</sup> Kovrigina used this "disaster" at the Central Institute of Psychiatry to justify a new round of inspections and personnel reviews at other research institutes.<sup>139</sup> Shmar'ian and Posvianskii were both fired, and the staff at the Central Institute of Psychiatry underwent a new round of attestation designed to purge anyone who was found to be

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<sup>137</sup> "Zakliuchenie o deiatel'nosti Int. Psikhiiatrii MZ RSFSR g. Moskva," undated, GARF, f. r-8009, op. 33, d. 463, l. 54-73.

<sup>138</sup> M. D. Kovrigina (Chairman), "Stenogramma zasedanii Kollegii MZ RSFSR," 4 January 1951, GARF, f. a-482, op. 49, d. 3041, l. 42.

<sup>139</sup> As Kovrigina put it, ". . . when such things are going on right under our noses, so to speak, then what is happening in places where we *can't* see! M. D. Kovrigina (Chairman), "Stenogramma zasedanii Kollegii MZ RSFSR," 4 January 1951, GARF, f. a-482, op. 49, d. 3041, l. 41. Kovrigina's deputies and department heads were not soon allowed to forget the scandal at the institute of psychiatry.

politically unreliable.<sup>140</sup> Half of the institute's research staff were forced out as a result of this attestation (23 out of 46), though nine of these left "of their own accord," and two were "promoted" to new jobs at medical institutes in the provinces; the other 12 were fired outright for nepotism, or because they were "not suitable for the position occupied due to technical or political qualifications" [*po delovym i politicheskim priznakam*].<sup>141</sup>

## Conclusion

The Soviet ban on lobotomy was the result of a confluence of factors, some of them scientific, professional, and institutional, others ideological, political, and personal. Even before the war some psychiatrists had been uncomfortable with the "brutality" of some of the new "active biological therapies" for mental illness. In the postwar period lobotomy both came into public view and provided an example of an extremely invasive and "brutalizing" treatment, a method that psychiatrists like Giliarovskii could attack as inhumane. Giliarovskii's scientific and ethical questions about lobotomy were tinged with institutional politics, since lobotomy was primarily advocated by Giliarovskii's rival, Aleksandr Shmar'ian.

Their disputes were politicized, however, by the ideological and political campaigns that were launched by the Communist Party in the late 1940s. Psychiatrists found that their affiliations with scientific powerbroker Leon Orbeli now turned into liabilities. Under pressure from above and from their peers, they began to use the ideologically freighted language of the anti-cosmopolitanism campaign to articulate their professional differences. Attacks that might

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<sup>140</sup> Prikaz MZ RSFSR no. 71, "O rabote Tsentral'nogo institute psikhiatriia," 13 February 1951, *TsAGM*, f. 533, op. 1, d. 1, ll. 3-4. This attestation worked in precisely the politicized manner that Chris Burton describes. Christopher Burton, "Soviet Medical Attestation and the Problem of Professionalisation under Late Stalinism, 1945-1953," *Europe-Asia Studies* 57, no. 8 (December 2005): 1211-1229.

<sup>141</sup> D. E. Melekhov (acting director of the TsNII psikhiatriia MZ RSFSR), "Spravka o rabote po perestroike Gos. NII psikhiatrii MZ RSFSR k zasedaniu kollegii MZ RSFSR," 20 March 1952, GARF, f. a-482, op. 49, d. 4767, l. 120.

have remained collegial became ad hominem attacks, where the philosophical and moral outlook of psychiatrists like Shmar'ian were said to be fundamentally corrupt, leading to corrupt science and corrupt practice. The result was the ban on lobotomy, and the equation of lobotomy with corrupt, anti-Pavlovian science.

The events that led to the ban on lobotomy exemplified “Stalinist science” in action, to borrow a phrase from historian Nikolai Krementsov. Like the better known science discussions in genetics or linguistics, the lobotomy discussion brought together Soviet medical specialists to resolve a problem that was internal to the profession using language and procedures that were borrowed or dictated by the political culture of the time. The result in the lobotomy discussion was striking, however, because in this case the outcome was the result that most early twenty first century readers might hope for: the banning of a medical procedure that we know to be disturbing and destructive.

There is probably some truth in this judgment. The reasoning and evidence that were on display at the lobotomy discussion aired the basic issues quite thoroughly. Minzdrav ultimately rejected the argument that lobotomy was justified as a form of human salvage, and sided instead with the view that physicians should not knowingly inflict brain damage, especially if they were uncertain what they were treating or why. Giliarovskii's argument that the brain should not be cut because the personality has value in itself is intriguing, and raises the possibility that a moral dimension was involved in the decision making that one might not have expected. By insisting on a non-reductionist theory of disease, Giliarovskii seems to have found a way of articulating a concept of human dignity.

The lobotomy debate demonstrates that psychiatrists in the Soviet Union in the 1940s were capable of making the argument against lobotomy, and indeed, against “brutalizing”

treatments per se. But this should not obscure the fact that lobotomy was banned for political and ideological reasons. The politics of the matter were partially internal to the profession: the clash between Giliarovskii and Shmar'ian, and between Ivanov-Smolenskii and everyone. At the same time, there were important political considerations that were external to the system of psychiatric institutions but which still had an enormous impact, including the ouster of Leon Orbeli, the scandal at Minzdrav RSFSR, and the Cold War itself.

The question of ideology was equally complex. There was nothing about lobotomy that was self-evidently non-Marxist or non-Soviet. By 1951, however, lobotomy had become ideologically freighted with a whole range of epithets, from bourgeois idealism to (Jewish) cosmopolitanism. The ban on lobotomy, then, must also be seen as part of the broader campaign against foreignness in Soviet society and in Soviet science. While the ban was probably an unmitigated good for the mental patients who might have been operated on, it represented a new politicization of Soviet psychiatry, something that would have serious long-term consequences. How the ban on lobotomy and the campaign for “purification” of the discipline would affect Soviet psychiatry is the subject of chapters six and seven.

## CHAPTER 6

### THE CAMPAIGN FOR PAVLOVIAN PSYCHIATRY, 1950-1953

“The further progress of clinical psychiatry is possible only on the basis of Pavlov’s theory. The Soviet psychiatric clinic is a principally different kind of clinic and should be based on Pavlovian pathophysiology of higher nervous activity, preserving continuity with the clinical traditions of progressive Russian psychiatry, but on new foundations....”

-- Andrei Snezhnevskii, Vasilii Banshchikov, Oleg Kerbikov, and Ivan Strel’chuk, “The Condition of Psychiatry and Its Tasks in Light of I. P. Pavlov’s Theory,” delivered 11 October 1951.<sup>1</sup>

#### Introduction

In October 1951 psychiatrists held their own “Pavlov Session,” the apex of the tumultuous “restructuring” that gripped the profession from 1950 to 1953. In the years that followed Soviet psychiatrists would look back on the October 1951 Session as a defining event. For some it was the moment when their careers were cast suddenly into doubt by the downfall of a patron; for others the Session was an important step forward, a moment in the spotlight of late Stalinism that led to professional success. Professors and institute directors from an older generation were removed from their posts in disgrace and a new generation of young, Soviet-trained psychiatrists came to the stage to take their place. “Anti-Pavlovians” acknowledged their

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<sup>1</sup> A. V. Snezhnevskii, et al, "Sostoianie psikhiiatrii i ee zadachi v svete ucheniia I. P. Pavlova," in *Fiziologicheskoe uchenie akademika I.P. Pavlova v psikhiiatrii i nevropatologii: materialy stenograficheskogo otcheta obedinennogo zasedaniia rasshirennogo Prezidiuma AMN SSSR i plenuma Pravleniia Vsesoiuznogo obshchestva nevropatologov i psikhiatrov. 11-15 okt., 1951 g* (Moscow: Medgiz, 1952), 29.



guilt and engaged in self-criticism, while other psychiatrists criticized the mistakes of their former leaders, demonstrating their fluency in Pavlovian theory and their political reliability.

In principle, those who were removed from their positions were removed because their ideas were flawed; they had failed to follow the norms of Soviet science. As I have attempted to show in the preceding chapters of this dissertation, this claim was at least partially true. The rivalries and disputes that laid the groundwork for the 1951 Pavlov Session were inextricably connected to specific ideas about how psychiatry should be practiced. Those rivalries, however, were also highly personal. In 1951 personal relationships helped decide who was cast as the “heroes” and the “villains” in the profession. Some were able to negotiate different roles for themselves, others were not so fortunate. Finally, the personal idiosyncrasies of the people involved played a significant role in deciding who took the stage in 1951. The role of keynote speaker was an important one, a role that people assumed would go to the new leader of their field, and so even the planners of the Session were surprised when Anatolii Ivanov-Smolenskii refused to take the job. His decision, however, opened the way for a group of relatively unknown young psychiatrists to take the stage.

In the final analysis, however, the October 1951 Pavlov Session was just one moment in the process through which psychiatrists figured out what “Pavlov’s theory” would mean for psychiatry. This was a process that began in earnest in 1950 with the Pavlov Session in physiology and which lasted at least until 1953. The 1951 Session was important because it helped establish who would control important institutions within the field. These people, however, still had to work out what it would mean for psychiatry to be governed by the Pavlovian laboratory. In this chapter I focus on the public discourse surrounding this question. I argue that Ivanov-Smolenskii’s refusal to speak at the 1951 Session turned the event into a

potentially more radical event than most psychiatrists had anticipated. Using his new institute and his new journal, Ivanov-Smolenskii seemed to be asserting the authority of physiology over psychiatry. In this scheme, psychiatrists would become technicians carrying out the procedures established in the laboratory by Pavlovian physiologists. In public discussion, psychiatrists responded to this threat by arguing for a far more inclusive approach to Pavlov's doctrine.

In the next chapter, I turn away from public discourse to examine how psychiatric hospitals were transformed by the events of 1950-1953. While the rhetoric of the period and the dramatic changes in the leadership created an impression that 1951 represented a fundamental discontinuity in the history of Soviet psychiatry, I argue that it actually served to reinforce long-standing trends in Soviet psychiatric medicine. Pavlovian techniques laid the groundwork for the clinic to become the primary locus of psychiatric science and for psychiatrists to readopt a holistic, bio-social approach to disease.

### **Drawing the Necessary Conclusions in the Aftermath of the 1950 "Pavlov Session" in Physiology**

Anatolii Ivanov-Smolenskii, the psychiatrist who gave one of the two main speeches at the 1950 Pavlov Session, was a dogmatic proponent of the view that science could only be done in the laboratory. To be scientific, he believed, psychiatrists should be leaving the psychiatric hospital and going to a laboratory where they used carefully designed experiments to uncover the basic physical processes that lay at the root cause of mental illness. The knowledge generated under laboratory conditions should be the basis for the classification of mental illness. Mental illness would be diagnosed on the basis of positive knowledge of underlying causes. Before laboratory scientists developed germ theory, diseases like the plague had been diagnosed on the basis of observed symptoms. After germ theory, they were diagnosed only when specific bacteria

were positively identified. As germ theory had transformed medicine, Ivanov-Smolenskii believed, Pavlov's theory of higher nervous activity would transform psychiatry.

In his quest to turn psychiatry into a rigorous science, Ivanov-Smolenskii took an iconoclastic pride in using language that described mental phenomena in a supposedly neutral fashion. The most complex mental events were broken down and described at the smallest level, where the only meaningful terminology described whether or not a part of the brain was "excited" or "inhibited," and to what degree. There was no room here for the idea that thought might occur in the brain because the brain's owner decided to think that thought. Mental events were the product of impersonal physical forces, and these forces were governed by laws that could be quantified and described. For Ivanov-Smolenskii, the idea that a person might consciously cause excitation in his or her own brain was a category error, an attempt to explain one category of phenomena, electrical activity in individual parts of the brain, with another category, individual agency or will.

In his speech at the 1950 Pavlov Session, Ivanov-Smolenskii made purging "psychologism" from the lexicon of psychiatry one of his main goals. He dismissed "the basic concepts of psychology (mind, will, feeling, etc)" as products of a flawed, pre-scientific approach to the mind, an approach that had been developed "exclusively by the descriptive method, without any participation of the morphology and physiology of the brain...."<sup>2</sup> Pavlov offered psychiatrists an alternative:

I. P. Pavlov laid the foundation for a new theory, at the basis of which rests the principle of relating the dynamics of nervous processes to the edifice of the brain, that is, the study of the paths of motion and interaction of nerve processes in the brain both in normal and

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<sup>2</sup> E. Sh. Airapet'liats, *et al*, eds., *Nauchnaia sessiia posviashchennaia problemam fiziologicheskogo ucheniia akademika I. P. Pavlova, 28 iunია - 4 iulia 1950 g.: Stenograficheskii otchet* (Moscow: Izd. Akademii Nauk SSSR, 1950), 49.

in pathological conditions, the study of the constantly changing distribution [tekucheizmenchivogo raspredeleniia] of these processes in the brain mass....<sup>3</sup>

On the page, the effect was to communicate and reinforce a notion of the mind as a purely mechanical object. All mental events could be describing “the balance of irradiating and concentrating excitation and inhibition” and “centers” that were subject to “irradiation of inhibition in the ultra-paradoxical phase.”

This thick, sometimes barely decipherable jargon became one of the most striking features of Soviet psychiatry in the early 1950s. At Moscow’s Kashchenko Psychiatric Hospital, for instance, staff psychologist Roza Epshtein advised her colleagues that “psychological regularities should be scientifically grounded only physiologically, thus approaching the problem of the physiological essence of psychopathological phenomena.”<sup>4</sup> This shift was particularly serious because the Pavlovian terms they were using implied a theory of the underlying causal relationships in the brain. What is more, the psychiatrists were implicitly accepting the authority of the Pavlovian laboratory over the psychiatric clinic. For physicians who wanted to demonstrate that they were competent and dependable soviet specialists, however, the language of Pavlovian theory was not optional.

Many psychiatrists understood Ivanov-Smolenskii’s 1950 speech as a declaration that psychiatry as they had known it was coming to an end. A specialty called “psychiatry” would of course continue to exist, but they would be psychiatric hospital managers or psychiatric nurses, not representatives of a specialty that was also a scientific discipline in its own right. The basic

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<sup>3</sup> Airapet’liats, *et al*, eds., *Nauchnaia sessiia*, 54.

<sup>4</sup> “Meditsinskii otchet psikhiatricheskoi bo’nitsy im. Kashchenko za 1950g.,” undated [1951], TsAGM, f. 389, op. 1, d. 53, ll. 3-9. Roza Il’ichna Epshtein was born in 1902, graduated from medical school in 1932, and had worked at the Kashchenko hospital since 1946. She was not a Party member. “Personal’nyi spisok spetsialistov-vrachcei po sostoianiiu na 1 oktiabria 1949 goda po psikhiatricheskoi bol’nitse im. Kashchenko,” RGANI, f. 6, op. 6, d. 1556, ll. 23-23ob.

terms and concepts that filled psychiatric textbooks, monographs, and research articles were to be replaced by a new set of words and concepts that were grounded in a different body of thought. The abstract, conceptual work done by psychiatrists was to be replaced by people who were expert in the “pathology of higher nervous activity,” and the psychiatrists would become the people who carried out the instructions given to them by this other specialty, these “pathologists of higher nervous activity.”

The impression that “pathology of higher nervous activity” was an upstart new specialty was reinforced by the establishment of a new journal edited by Ivanov-Smolenskii, *Zhurnal vyshchei nervnoi deiatel'nosti imeni I. P. Pavlova* [The Pavlov Journal of Higher Nervous Activity]. The journal began publication in 1951, and its first issue opened with an article by Party science chief Iurii Zhdanov. Ivanov-Smolenskii and his students used the journal to explain how physicians should approach the study of “higher nervous activity,” how they should apply Pavlov’s concepts in hospitals, and how they should use his concepts to treat nervous illness. They also published a series of articles explaining “perversions” of Pavlovian theory, attacking one leading physiologist or psychiatrist after another. The authors of the articles in *Zhurnal VND* presented their work using the thick psycho-physical jargon that Pavlov had developed, and illustrated their material with pages of charts, graphs, illustrations, and accounts of conditioned reflexes.

These “signals” that psychiatry was to be subordinated to Pavlovian physiology were confirmed by events on the ground. Minzdrav’s 1946 psychiatric hospital charter [*polozhenie*] had actually required all large psychiatric hospitals to have a psychology laboratory, and in 1948 a special Minzdrav decision had added more psychologists to the staff of the five largest

Moscow psychiatric hospitals.<sup>5</sup> In 1950 there were still at least ten functioning psychology laboratories in Moscow and Leningrad, with approximately thirty trained psychologists working in them.<sup>6</sup> In 1950 and 1951, however, these laboratories began to close, and by December 1951 only three were left.<sup>7</sup> At the same time, virtually all the major psychiatric hospitals in Moscow and Leningrad opened laboratories of “higher nervous activity” and trained the hospital staff in the new methods of evaluating and diagnosing patients.<sup>8</sup>

The 1950 “Pavlov Session” for physiologists where Ivanov-Smolenskii gave his speech had been a “*diskussiiia*,” a type of meeting where disagreement was allowed, and where “participants were invited to demonstrate polemical skills in a theoretical matter that had not been decided by the authorities.” And indeed, at the 1950 session physiologists actively disagreed with statements made in the opening speeches by Ivanov-Smolenskii and Konstantin Bykov. Leon Orbeli, the physiologist who bore the brunt of their criticism, went so far as to contest the entire premise of the meeting.<sup>9</sup> In contrast, the meetings that followed that 1950 *diskussiiia* fell into a different genre of meeting, the “*obsuzhdenie*” or “consideration.” At these meetings, participants were invited “to discuss and draw conclusions from an authoritative decision or decree.” They were not there to reopen the questions of whether or not Pavlov’s

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<sup>5</sup> “Prikaz MZ SSSR No. 710,” 25 November 1948, GARF f. r-8009, op. 1, d. 727, l. 405.

<sup>6</sup> Until December 1951, there had been psychology laboratories at the Central Institute of Psychiatry RSFSR, the Institute of Psychiatry MZ SSSR, the Serbsky Institute, 1 MMI Psychiatry Kafedra, The AMN Institute of Pediatrics, the AMN Institute of Neurosurgery, the AMN Institute of Neurology, the Bekhterev Institute, the Institute of Labor Expertise, and several Moscow psychiatric hospitals. S. Ia. Rubinshtein (St. nauchnii sotrudnik) to I. G. Kochergin (Zam. MZ SSSR), undated [1952], RGASPI, f. 17, op. 133, d. 261, ll. 34-35.

<sup>7</sup> In 1952, the only institutes that retained psychology labs were the Central Institute of Psychiatry MZ RSFSR, the Serbsky Institute, and the Institute of Neurology. S. Ia. Rubinshtein (St. nauchnii sotrudnik) to I. G. Kochergin (Zam. MZ SSSR), undated [1952], RGASPI, f. 17, op. 133, d. 261, ll. 34-35.

<sup>8</sup> “Otchet MZ RSFSR o deiatel'nosti psikhonevrologicheskikh statsionarov i dispanserov RSFSR za 1952,” GARF f. a-482, op. 49, d. 5772, l. 4.

<sup>9</sup> Joravsky, *Russian Psychology*, 406.

theory was fundamental to Soviet medicine, or whether Leon Orbeli and company were “guilty” of perverting Pavlov’s legacy. They were there to apply the conclusions of the 1950 *diskussia* to their own discipline.<sup>10</sup>

Figuring out just how the results of the 1950 discussion might apply to their own discipline meant closely reading the speeches from that meeting and also reading Pavlov’s own works.<sup>11</sup> Another important source of information about Pavlov’s ideas was the work of Anatolii Ivanov-Smolenskii. Because he had been one of the two main speakers at the 1950 Pavlov Session, Ivanov-Smolenskii was treated as the next best thing to a canonical authority on what Pavlovian psychiatry might mean. Ivanov-Smolenskii himself encouraged this view. He published a popular account of Pavlov’s theory of higher nervous activity that began with Pavlov’s discovery of the conditioned reflex and ended with Ivanov-Smolenskii’s own work. The book won a Stalin prize in 1950 and became something of a handbook for psychiatrists and public health officials alike.<sup>12</sup>

Minzdrav USSR ordered each discipline to hold conferences where they could “creatively develop Pavlov’s great theory on the basis of free scientific criticism and self-

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<sup>10</sup> On the variety of science “discussion,” see Alexei Kojevnikov, *Stalin's Great Science: The Times and Adventures of Soviet Physicists* (London: Imperial College Press, 2004), 199. Kojevnikov argues that the rules of scientific meetings in the late Stalin period were adopted from practices that had developed in intra-Party meetings in the 1920s and 1930s. Alexei Kojevnikov, "Games of Stalinist Democracy: Ideological Discussions in Soviet Sciences 1947-52," in *Stalinism: New Directions*, ed. Sheila Fitzpatrick (London & New York: Routledge, 2000), 142-175.

<sup>11</sup> Pavlov’s complete works had been reissued in 1949, as had an edited volume of his works on psychiatry. I. P. Pavlov, *Psikhopatologiya i psikiatriia: Izbrannye proizvedeniia. Pod redaktsiei i s predisloviem akademika L. A. Orbeli* (Moscow: Izd-vo AMN SSSR, 1949).

<sup>12</sup> A. G. Ivanov-Smolenskii, *Ocherki patofiziologii vysshei nervnoi deiatel'nosti (Po dannym I. P. Pavlova i ego shkoly)* (Moscow: Medgiz, 1949); *BME*, 3<sup>rd</sup> ed, s.v. “Ivanov-Smolenskii Anatolii Georgievich.”

**TABLE 6.1. Plenums Held by All-Union Medical Societies in 1951**

Date	Plenum of the All-Union Medical Society of	Topic(s) of Discussion:
Jan. 30 – Feb. 2	Otolaryngologists	1. “I. P. Pavlov’s Doctrine in the Theory and Practice of Otolaryngology”
Feb. 1–4	Therapists [Terapevty] (with the All-Union Committee for the Study and Treatment of Rheumatism and Bone Diseases)	1. “Rheumatism & the Fight with It.” 2. “Teaching therapy in higher medical schools” 3. “Pavlov’s Doctrine of Higher Nervous Activity in the Internal Medicine Clinic”
March 30-31	Radiologists (Expanded Plenum)	1. “X-ray Diagnostics in Light of I. P. Pavlov’s doctrine” 2. Modern Trends and the Principles of Light Therapy”
June 29 – July 2	Physiotherapists (Expanded Plenum)	1. “Pavlov’s Doctrine and Physical Therapy.” 2. “Physical Methods of Treatment.” 3. “The Consequences of Wartime.” 4. “Teaching Physical Therapy in Medical Institutes.”
Oct. 11- 13	Neuropathologists and Psychiatrists (with the Expanded Presidium of the AMN SSSR)	1. “The Contemporary State of Psychiatry and Neuropathology in Light of I. P. Pavlov’s Physiological Doctrine.”
Nov. 11- 14	Neurosurgeons	1. “The Problem of Pain.” 2. “Organization of Neurosurgical Services in the Union.”
Nov. 29 – Dec. 3	Laboratory workers (Conference)	1. “The Significance of Pavlov’s Ideas for the Restructuring of Laboratory Diagnostic Methods”

*Source:* “Spravka Prezidiuma UMS MZ SSSR o rabote za 1951 g.,” undated [1952], GARF, f. r-8009, op. 2, d. 1670, ll. 21-23.

*Note:* Discussions of Pavlov’s theory are highlighted in grey; the All-Union Society of Neurosurgeons was the only group that did not explicitly discuss Pavlov’s theory at their plenum in 1951.



criticism for the good of the people.”<sup>13</sup> In the second half of 1950 everyone from senior psychiatrists to nurses and nurses’ aides reported that they were gathering in study circles and struggling to draw conclusions from Pavlov’s writings that they could apply to their work.<sup>14</sup> More substantial meetings followed in 1951, when the All-Union Medical Societies held special plenums where they affirmed their dedication to Pavlovian principles. The 1951 meeting of psychiatrists and neuropathologists was the largest and best publicized of these meetings (see Table 6.1). Working out just how these meetings should be conducted was left to specialists in each individual field.

### Settling Scores

From the very first, the “Pavlov Session” in psychiatry was envisioned as an event that would mix ideology, politics and science, but it was also envisioned as an event that would settle personal grudges and redistribute institutional power within the profession. The Session was planned by a committee headed by I. N. Zhukov-Verezhnikov, Vice President of the AMN. Zhukov-Verezhnikov was one of the scientists who had capitalized on the campaign for ideological purity in Soviet science. In 1947 he had helped to promote Ol’ga Lepeshinskaia, the Soviet biologist who claimed to have discovered that cells could develop spontaneously from non-cellular forms of organic matter. In 1950 he had become the Vice-President of the Academy of Medical Sciences, a position that he used, as Chris Burton puts it, “to force Lepeshinskaia’s

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<sup>13</sup> E. Sh. Airapet’liats, *et al*, eds., *Nauchnaia sessiia posviashchennaia problemam fiziologicheskogo ucheniia akademika I. P. Pavlova, 28 iunია - 4 iulia 1950 g.: Stenograficheskii otchet* (Moscow: Izd. Akademii Nauk SSSR, 1950), 527.

<sup>14</sup> All medical workers, were, in fact, ordered to by Minzdrav to discuss Pavlov’s theory and draw conclusions for their own work A. Shabanov (I.o. Ministra Zdrav. SSSR), “Prikaz no. 644 MZ SSSR,” 31 July 1950, GARF f. r-8009, op. 1, d. 905, ll. 23-24. For examples, see “Meditsinskii otchet psikhiatricheksoi bol’nitsy im. Kashchenko za 1950g,” undated [1950], TsAGM, f. r-389, op. 1, d. 53, l. 4; “Protokol no 5 proizvodstvennykh soveshchaniia zavediuiushchikh otdeleniiami i starshikh sester otdelenii pri glavnom vrache bol’nitsy im. Gannushkina,” [day illegible] April 1952, TsAGM, f. 533, op. 1, d. 6, ll. 46-48; “Plan raboty mestnogo komiteta bol’ntisy im. Gannushkina na 1952 god,” TsAGM, f. 533, op. 1, d. 16, ll. 8-9.

ideas on research establishments throughout the USSR.”<sup>15</sup> Zhukov-Verezhnikov, then, was one of the people who was most actively using the political discourse of the anti-cosmopolitanism campaign to change the balance of power within the system of medical specialties.

The planning of details for the session were finalized in extreme haste. The earliest proposal to hold the Session, however, had been sent to Minzdrav USSR from the Academy of Medical Sciences in December 1950, around the time of the lobotomy discussion.<sup>16</sup> Its anonymous authors suggested a “consideration” [*obsuzhdenie*] that would enable leading psychiatrists and neuropathologists to “self-critically uncover their mistakes and to bring themselves into line with the general development of medicine on the basis of I. P. Pavlov’s materialist theory.” This public display of criticism and self-criticism would serve as a means of educating the medical public about the “essence of the concrete mistakes made by a number of psychiatrists,” and it would help specialists understand what was expected of them in restructuring their work based on Pavlov’s ideas. The planners anticipated a “battle of opinions” which would “lead to a decisive unification of experimental research in the area of the study of higher nervous activity with clinical investigations in psychiatry and neuropathology.”<sup>17</sup>

The authors of the December 1950 memorandum devoted less than half of their text to the scientific and pedagogical goals of the session. The majority of their text was devoted to the

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<sup>15</sup> Chris Burton, “Medical Welfare During Late Stalinism: A Study of Doctors and the Soviet Health System, 1945-1953” (Ph.D., University of Chicago, 2000), 85-87.

<sup>16</sup> The draft document was titled simply, “Dokladnaia zapiska,” but someone crossed this out in pencil and wrote “Spravka” in its place. I refer to it generically as “the December 1950 memorandum.” The document was undated, but the author referred to a “recently published sixth issue of ‘Psychiatry and Neuropathology’ [sic], and in particular to an article in that issue which outrageously painted Giliarovskii as the primary representative of Pavlovian theory in psychiatry. This refers to “Vasilii Alekseevich Giliarovskii (K 75-letiiu so dnia rozhdeniia),” *Nevropatologiia i psikhiiatriia* 19, no. 6 (November-December 1950), which was sent to press on 24 November 1950. Further, the memorandum refers to a meeting which is known to have happened in 1950 as having taken place “in June this year,” suggesting that the year was still 1950 at the time of writing. Unsigned, “Spravka,” undated (December 1950), GARF, f. r-9120, op. 2, d. 1201, ll. 219-220.

<sup>17</sup> *Ibid.*, l. 226.

story of the past twenty years and how Anatolii Ivanov-Smolenskii had been repeatedly slighted and offended by other psychiatrists who had taken sides against him. As a result, “the creative use of Pavlov’s theory in psychiatry was long delayed, and a significant number of psychiatrists confirmed their opinion that the theory is not applicable to psychiatry.”<sup>18</sup> As the main offender, the author of the memorandum singled Vasili Giliarovskii, not Aleksandr Shmar’ian, who was mentioned just twice. Giliarovskii was described as a persistent supporter of Ivanov-Smolenskii’s enemies. He had personally disrespected Ivanov-Smolenskii and his research. Once he had even described Ivanov-Smolenskii’s theories as “conditioned reflex hairsplitting.” To the author of the memorandum, Giliarovskii’s continued status as the elder statesman of Soviet psychiatry was galling, particularly Giliarovskii’s new-found role as the authority who instructed everyone else on how to apply Pavlov’s ideas. Giliarovskii’s work served only to “disorient” practicing psychiatrists throughout the country and one of the main goals of the proposed Session was to be putting an end to his influence.<sup>19</sup>

The authority that Giliarovskii had in the profession apparently concerned Party science chief Iurii Zhdanov as well. According to Alexander Portnov, one of the planners of the 1951 Pavlov Session, Iurii Zhdanov wanted Giliarovskii’s to be driven out of psychiatry precisely because Giliarovskii had so much influence over other psychiatrists. In an autobiographical sketch written decades later, Portnov recalled Zhdanov telling him that Giliarovskii needed to be brought down, “precisely because he is so important, so famous, and more so because he is dangerous [*on vreden*], everyone looks to him uncritically, even you [Portnov] clearly look to

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<sup>18</sup> Ibid., ll. 216-217.

<sup>19</sup> Ibid., ll. 219-220.

him without any criticism, and the rest are just the same.”<sup>20</sup> Zhdanov saw Giliarovskii’s influence over other psychiatrists as a dangerous phenomenon, even though Giliarovskii was a Party member and a long-serving member of the “medical public.” Like Leon Orbeli in biology (though on a much smaller scale), Giliarovskii’s institutional power was seen as an impediment to the Science Section’s ability to direct the development of Soviet science.

Giliarovskii and his institute staff continued to publish prolifically even after the publication of the December 1950 memorandum. In their early 1951 articles they wrote scathing polemics that linked lobotomy, “brain pathology,” and opposition to Pavlov. This constellation of practices and beliefs was, they claimed, the essence of “cosmopolitanism” in psychiatry. Giliarovskii presented himself as the most principled defender of Soviet values in psychiatry, the man who had unmasked the alien ideology that led to the use of lobotomy, and who had spearheaded the ban on lobotomy in the USSR. He wrote at length about Pavlov’s concept of “protective inhibition” and its use in sleep therapy, and he highlighted promising new research that he had done on “electrosleep,” a mild new form of active therapy that he hoped would become a mainstay in psychiatric hospitals.<sup>21</sup> Giliarovskii and his supporters, in short, positioned him as the living embodiment of commitment, honesty, and humanism in Soviet psychiatry.

When the 1951 Session finally took place, Giliarovskii was not cast as the main villain. Instead he was described as a leader who had failed to be sufficiently vigilant and who had thus let down his colleagues and his profession. He was removed from his post as Director of the

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<sup>20</sup> A. A. Portnov, "Vospominaniia o razvitii otechestvennoi psikhatrii," in *Voprosy sotsial'noi i klinicheskoi psikhatrii i narkologii*, ed. B. D. Tsygankova (Moscow: 2000), 297-299.

<sup>21</sup> V. A. Giliarovskii, "Razvitie idei I. P. Pavlova v psikhatrii," *Nevropatologiia i psikhatriia* 20, no. 1 (January-February 1951): 8-11.

USSR Institute of Psychiatry, but he remained its Deputy Director for research, and in the 1950s he continued to serve as one of the most prominent psychiatrists in the USSR.

The public relations blitz probably had something to do with this turn of events, but it was not all that saved Giliarovskii's career. Before the session, several highly placed psychiatrists approached Zhdanov and asked him to allow Giliarovskii to end his career with honor. In his memoir, Aleksandr Portnov casts himself as Giliarovskii's savior. He and others involved were "chilled" by Zhdanov's intentions, Portnov recalled, and they sought ways to dissuade him. Ultimately Portnov called in another psychiatrist, Vladimir Pakhomov, who had been a family friend of the Zhdanov's in Gor'kii. Pakhomov came to Moscow and persuaded Zhdanov to abandon the idea of destroying Giliarovskii's career.<sup>22</sup>

### **The Logistics and Difficulties of Staging the "Join Meeting on the Physiological Teaching of I. P. Pavlov in Psychiatry and Neuropathology"**

The people who organized the October 1951 Session in psychiatry wanted to establish as much continuity as possible with the 1950 discussion in physiology and with Pavlov himself. The meeting's venue, Moscow's *Dom uchenykh* [House of Scientists], was the same venue that had been used for the 1950 Pavlov Session in physiology,<sup>23</sup> and both meetings were billed as "unified sessions" of two scientific bodies – though the 1950 session had been a "Unified Session" [*ob'edinennaia sessiia*] of the two most prestigious scientific Academies in the USSR,

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<sup>22</sup> Portnov, "Vospominaniia," 297-298.

<sup>23</sup> The *Dom uchenykh* had also been the venue used for the August 1948 discussion of genetics. The planners of the 1951 session were not at all sure that they would be able to book the *Dom uchenykh* on short notice. The last meeting of the 1951 meeting (Monday, October 15) was actually held at the Second Moscow Medical Academy because the *Dom Uchenykh* had only been booked through Sunday the 14<sup>th</sup>. On previous sessions at the *Dom uchenykh*, see Ethan M. Pollock, *Stalin and the Soviet Science Wars* (Princeton, N.J.: Princeton University Press, 2006), 147.

while the 1951 session was a “Unified Meeting” [*ob’edinennoe zasedanie*] of the Academy of Medical Sciences and the All-Union Society of Neuropathologists and Psychiatrists.<sup>24</sup>

The difficulties started when it came to getting speakers to participate. Konstantin Bykov, the physiologist who had delivered the main address at the 1950 Pavlov Session, refused to even attend, claiming illness.<sup>25</sup> The obvious choice to deliver the main speech was Anatolii Ivanov-Smolenskii. He had worked directly under Pavlov and he had the ear of Iurii Zhdanov. Better still, he was an outsider, and thus could not be blamed for the problems that had continually beset the psychiatric system. Finally, he had given one of the main speeches at the 1950 discussion of Pavlov’s theories in physiology. It was natural, therefore, for the organizers to ask him to headline the event. As the chairman of the organizational committee put it, Ivanov-Smolenskii would provide “a direct transmission belt [*privodnoi remen’*] from Pavlov's doctrine, from Pavlov - that is the central point.”<sup>26</sup>

Ivanov-Smolenskii, however, proved to be a very difficult man. He declined to give the main speech at the 1951 Session on the grounds that, if he did so, he would find himself in the “uncomfortable situation” of citing his own 1950 speech as an authoritative text.<sup>27</sup> The committee pressed him to at least give a short introductory speech and to help them “constitute a certain

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<sup>24</sup> The 1950 session had officially been referred to as “Ob’edinennaia nauchnaia sessiia Akademii Nauk SSSR i Akademii Meditsinskikh Nauk SSSR posviashchennaia problemam fiziologicheskogo ucheniia akademika I. P. Pavlova.” [The Joint Scientific Session of the Academy of Sciences and the Academy of Medical Sciences on the Physiological Teaching of Academician I. P. Pavlov.] The 1951 Session was the “Ob’edinennoe zasedanie Prezidiuma Akademii meditsinskikh nauk SSSR i Pravlenii Vsesiounznoho obshchestva nevropatologov i psikiatrov posviashchennoe fiziologicheskomu ucheniiu I. P. Pavlova v psikiatrii i nevropatologii.” [The Joint Meeting of the Presidium of the Academy of Medical Sciences and Directorate of the All-Union society of Neuropathologists and Psychiatrists on the Physiological Teaching of I. P. Pavlov in Psychiatry and Neuropathology.]

<sup>25</sup> GARF f. r-9120, op. 2, d. 1201, l. 28.

<sup>26</sup> *Ibid.*, l. 201.

<sup>27</sup> *Ibid.*, 199. Portnov confirms that Ivanov-Smolenskii was offered the lead speech, and that he turned it down. Apparently he also declined to appear as a co-author, ceding his place to Strel’chuk. According to Portnov, the lead speech was originally intended for physiologist Aleksei Speranskii, but he got out of it by repeatedly showing up drunk for meetings with Zhdanov. Portnov, “Vospominaniia,” 296.

connection and continuity between the Unified Session and this plenum” by commenting on drafts of the main speeches. He agreed to help, but when the time came to actually give comments, Ivanov-Smolenskii was unavailable, and he remained stubbornly unavailable even when committee members pleaded repeatedly for his cooperation.<sup>28</sup>

At the planning meetings that he attended Ivanov-Smolenskii spoke at considerable length, complaining about “interconnected issues” in long, repetitious, sometimes muddled outbursts. He told the committee that he was unhappy with the constraints that had been put on the main speech: he felt it should do more than just attack anti-Pavlovian trends in psychiatric theory but that he was being asked to write a speech that “somewhat artificially separated this question from a whole series of other issues which are the consequence of the decision of the Pavlov Session.” He did not know what the official line on those “other issues” might be and this put him in a “somewhat difficult situation [*neskol’ko zatrudniaet polozhenie*].”<sup>29</sup> When his colleagues complained that he was not providing comments or help on their drafts, Ivanov-Smolenskii repeatedly asserted that, despite much evidence to the contrary, he “in no way refuse[d] to be useful.”<sup>30</sup> He was, in short, a very difficult person to work with, unpredictable, self-righteous, and perhaps even unstable. Since his colleagues were psychiatrists, rumors

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<sup>28</sup> On September 24, Snezhnevskii, the main author of the speech on psychiatry, told the committee that he and his coauthors could quickly finish the text if only Ivanov-Smolenskii would give them a little time. An exasperated Zhukov-Verezhnikov was reduced to begging: “Therefore we appeal to Anatolii Georgievich [Ivanov-Smolenskii] once more with a humble request: give us your observations on the report, even if only by next Tuesday.” At the next meeting, on October 1, Ivanov-Smolenskii had still not given comments on the text, and was again begged to do so. GARF f. r-9120, op. 2, d. 1201, ll. 190, 193, 200-201.

<sup>29</sup> Zhukov-Verezhnikov (Chairman), “Stenogramma orgkomiteta...,” 24 September 1951, GARF f. r-9120, op. 2, d. 1201, ll. 194-195.

<sup>30</sup> *Ibid.*, ll. 194-195, 199-200.

circulated that Ivanov-Smolenskii himself suffered from some sort of mental illness, and psychiatrists hinted to one another that they knew who was treating him.<sup>31</sup>

With Ivanov-Smolenskii unwilling to participate, the main speech for the Session was written instead by a group of four young, relatively unknown psychiatrists: Andrei Snezhnevskii, Vasilii Banshchikov, Oleg Kerbikov, and Ivan Strel'chuk who had been identified as "reliable communists." All of them had worked as psychiatric hospital directors in the past, and all but one of them (Kerbikov) had run an evacuation hospital during the war. The four men had all been educated after the 1917 Revolution, and all were members of the Communist Party. Banshchikov, the oldest at 53, had participated in the revolution and had made his career in the 1920s as a bureaucrat at Narkompros and Narkomzdrav. In the 1930s he had studied philosophy at the Institute of Red Professors, and after the war had served as the head secretary of the editorial board of Medgiz, the State Medical Publishing House.<sup>32</sup> The youngest, Kerbikov, was a 44 year-old prodigy who had studied at Moscow University during the early 1930s and served as the head psychiatrist for the city of Moscow before the war. After the Second World War Kerbikov had become the head of the psychiatry department at Iaroslavl' Medical Institute, and by 1952 he was the director of institute itself.<sup>33</sup> Strel'chuk had succeeded Kerbikov as Moscow

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<sup>31</sup> Portnov recalls a meeting with psychiatrist Viktor Protopopov where Protopopov said of Ivanov-Smolenskii, "Surely you don't consider him a healthy person?" Portnov recalls replying, "No, I consider him a sick person, and I even know his treating physician." According to Portnov Ivanov-Smolenskii was secretly treated for years by Leningrad psychiatrist K. A. Skvortsov. He adds that this was hardly unique: most psychiatrists went into the field because they wanted to understand or treat the mental illnesses that they or their relatives were suffering. Portnov, *Vospominanie*, 300.

<sup>32</sup> "Vasilii Mikhailovich Banshchikov (K 80-letiiu so dnia rozhdeniia," *Zhurnal nevropatologii i psikhatrii im. S.S. Korsakova* 78, no. 5 (1978): 780-781.

<sup>33</sup> "O. V. Kerbikov (nekrolog)," *ZhNiP* 65, no. 6 (1965): 955-956; M. V. Korkina and I. O. Kalacheva-Kerbikova, "Vospominanie o zhiznennom puti i tvorchestve akademika AMN SSSR Olega Vasil'evicha Kerbikova," in *Vydaiushchiesia psikhiatry Rossii (istoriia i sovremennost')*: *Materialy XVI Kerbikovskikh chtenii*, ed. Tat'iana Borisovna Dmitrieva and Iurii Anatol'evich Aleksandrovskii (Moscow: GNTs SSP im V. P. Serbskogo, 2007), 102-114.



city psychiatrist, and also worked with Ivanov-Smolenskii at the Moscow filial of the Institute of Evolutionary Physiology.<sup>34</sup> Snezhnevskii had known all of these men in Moscow before the war when he too had studied there, served as an institute administrator, and worked on the psychiatry commission at Narkomzdrav. In 1950 he was tapped by the Central Committee to take over the Serbsky Institute, and after the lobotomy discussion it was Snezhnevskii who had led the investigation of cosmopolitanism at the RSFSR Central Institute of Psychiatry. In January Snezhnevskii replaced Shmar'ian as Deputy Editor at *Nevropatologiia i psikhiatriia*. Now he took his place as the lead author on the main speech at the October 1951 Pavlov Session.<sup>35</sup>

These ambitious young psychiatrists were also tapped to take over the three most prestigious psychiatry departments in Moscow, positions that were occupied by the senior psychiatrists who had dominated the field since the 1920s. Snezhnevskii replaced his mentor, Mark Sereiskii, as the head of the psychiatry department at the Central Institute for Advanced Medical Studies. Banshchikov replaced Mikhail Gurevich as the head of the psychiatry department at the First Moscow Medical Institute. And Kerbikov replaced Giliarovskii as head of the psychiatry department at the Second Moscow Medical Institute. In 1952 Kerbikov and Strel'chuk joined Snezhnevskii and Banshchikov as members of the editorial board at *Nevropatologiia i psikhiatriia*.<sup>36</sup> The men that they replaced all been trained in Moscow and St. Petersburg before the First World War, and at least two of the three had spent time studying in

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<sup>34</sup> "Ivan Vasil'evich Strel'chuk (K 70-letiiu so dnia rozhdeniia)," *ZhNiP* 72, no. 1 (1972): 154-155.

<sup>35</sup> "Andrei Vladimirovich Snezhnevskii (nekrolog)," *ZhNiP* 87, no. 10 (1987): 1441-1444; "Andrei Vladimirovich Snezhnevskii: K 100-letiiu so dnia rozhdeniia," *ZhNiP*, no. 5 (2004): 4-7.

<sup>36</sup> E. Smirnov, "Prikaz MZ SSSR No. 2: Ob utverzhdenii redaktsionnoi kollegii zhurnala 'Nevropatologiia i psikhiatriia imeni S. S. Korsakova'," 2 January 1952, GARF f. r-8009, op. 1, d. 1080, l. 6.

the preeminent psychiatry clinics in Europe at the turn of the century.<sup>37</sup> The change in leadership, then, was a generational change as well as an ideological change, a shift from an older generation of psychiatrists who had developed their professional identities as part of a pan-European clinical psychiatry tradition to a younger generation that had never studied abroad and had come of age as professionals during Stalin's revolution from above. These men used their new clout as department chairmen and editorial board members to set the parameters of public discussion about Pavlovian psychiatry.

With very little time to spare, the committee had to scramble to put in place the basic infrastructure of a successful science discussion. The organizers initially expected fewer than 1,000 people to attend,<sup>38</sup> but this figure quickly ballooned to 1,000 "participants" and 2,000 "guests," including practicing physicians, people from other ministries, and members of the press.<sup>39</sup> On such short notice, hotel rooms could only be found for about half of the people; the rest were put up at Moscow psychiatric hospitals and the Serbsky institute.<sup>40</sup> The venue,

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<sup>37</sup> Sereiskii (1886-1957) was the youngest of the three, and had spent some time studying with Kraepelin in Munich. Gurevich (1878-1953) had also studied with Kraepelin, as well as with Arturo Donaggio in Bologna in (1906) and Alois Alzheimer in Munich (1912). Giliarovskii (1875-1959) does not seem to have studied abroad. L. L. Rokhlin, "Mikhail Osipovich Gurevich (K 100-letiiu so dnia rozhdeniia)," *Zhurnal nevropatologii i psikhatrii im. S.S. Korsakova* 78, no. 12 (1978): 1858-1860; I. V. Strel'chuk "K 100-letiiu so dnia rozhdeniia M. O. Gurevicha," *ZhNiP* 90, no. 12 (1990): 81; For details on Gurevich's foreign study, see his personal file at the Academy of Medical Sciences, GARF f. r-9120, op. 8/2, d. 44; "Mark Iakovlevich Sereiskii (Nekrolog)," *ZhNiP* 57 no. 6 (1957): 793-794; P. Zinov'ev, "Vasilii Alekseevich Giliarovskii," *Zhurnal nevropatologii i psikhatrii im. S.S. Korsakova* 46, no. 4 (1956): 358-359; "V. A. Giliarovskii," *Zhurnal nevropatologii i psikhatrii im. S.S. Korsakova* 59, no. 4 (1959): 508; I. I. Lukomskii, "Tvorcheskii put' V. A. Giliarovskogo," *Zhurnal nevropatologii i psikhatrii im. S.S. Korsakova* 61, no. 5 (1961): 755-757; G. K. Ushakov, *et al*, "Vasilii Alekseevich Giliarovskii (1876-1959)," in *V. A. Giliarovskii: Izbrannye trudy* (Moscow: Meditsina, 1973), 3-10.

<sup>38</sup> A note sent to Smirnov around October 1 reported that "over 500" would attend, while Ivanov-Smolenskii expected about 900 people to attend, 500 from Moscow and 400 from outside Moscow. Zhukov-Verezhnikov (Chairman), "Stenogramma zasedanii orgkomiteta ..." 24 September 1951, GARF f. r-9120, op. 2, d. 1201, ll. 200, 223.

<sup>39</sup> *Ibid.*, ll. 134, 178-179.

<sup>40</sup> The organizational committee sent summons to 240 people from outside Moscow, including 20 research institute directors and deputy directors, 70 head physicians of psych. hospitals, and 120 directors of medical institute *kafedras*. They arranged 130 hotel rooms, 40 beds at the Serbsky Institute, and 35-40 beds at hospitals. The protocols do not specify which hotels were reserved, whether the hospitals were psychiatric hospitals, or whether the

Moscow's *Dom uchenykh*, was secured only ten days in advance;<sup>41</sup> the session's program was picked up from the printers only three days in advance, and the main speech was still being revised just two days before the opening of the session. Printed copies of the speech were to be distributed to all the participants at the session, and they were picked up from the print shop on the night of Wednesday, October 10, with the session opening the next morning at 11:00 am.<sup>42</sup> A poorly timed accident at any point in these last weeks might easily have turned the session into a fiasco.

### Criticism and Self-Criticism

The Pavlov Session in psychiatry finally opened on Thursday, October 11, at eleven o'clock in the morning, with 1,307 people in attendance.<sup>43</sup> Audience members were given conference programs and the theses of the main reports, and everyone received a free book, Pavlov's essays on psychiatry.<sup>44</sup> Approximately 850 of the participants were neuropathologists and psychiatrists, or about 10% of the total in the USSR. (Unfortunately, the organizers did not

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guests were to sleep in quarters at the Serbsky usually reserved for the criminally insane. GARF f. r-9120, op. 2, d. 1201, l. 187. In 1950, guests to the physiology session were housed free of charge at Moscow's elite hotels Mosvka, Grand, and Evropa. See Pollock, *Soviet Science Wars*, 150.

<sup>41</sup> On September 24, the organizers were doubtful whether they could book the *Dom uchenykh* at such a late date. They proposed the polytechnic museum and the Institute for Advanced Medical Study as alternative venues. Ivanov-Smolenskii suggested that the *Dom uchenykh* was too large for their projected attendance of 900. (The actual attendance ended up being nearly double that figure.) Zhukov-Verezhnikov (Chairman), "Stenogramma zasedanii orgkomiteta ..." 24 September 1951, GARF, f. r-9120, op. 2, d. 1201, l. 200.

<sup>42</sup> *Ibid.*, ll. 178-208.

<sup>43</sup> Attendance dropped off after the first day, with subsequent sessions drawing between 1,000 and 1,100 people. In all, a total of 1,817 individuals attended at least one session. B. I. Matukhin (Nachal'nik sekretariata Prezidiuma AMN SSSR), "Svedeniia o kolichestve prisutstvuiushchikh na zasedanii," GARF f. r-9120, op. 2, d. 1201, ll. 136-141. According to Kremontsov, the main hall of the *Dom uchenykh* "could hold eight hundred persons." If so, the hall must have been overflowing. Kremontsov, *Stalinist Science*, 273.

<sup>44</sup> The book participants were given was I. P. Pavlov, *Izbrannye stat'i i rechi po voprosam psikiatrii i nevropatologii* (Moscow: Izd-vo AMN SSSR, 1951). On the second and third days of the session (Friday the 12<sup>th</sup> and Saturday the 13<sup>th</sup> of October), the newspaper *Medrabotnik* published the full texts of the main speeches in psychiatry and neurology (respectively), and the organizers reserved 700 copies to be given out to participants. Zhukov-Verezhnikov (Chairman), "Protokol (stenogramma) zasedaniia orgkomiteta..." 1 October 1951, GARF f. r-9120, op. 2, d. 1201, l. 180.

separate the psychiatrists from the neurologists in their counting.) Virtually all of the leaders in the field were present.<sup>45</sup> With just a few exceptions, those who spoke came from elite Moscow research institutes, or were directors of psychiatry departments at medical institutes around the USSR.

The speeches given at the session largely fit into the genre of criticism and self-criticism and repeated the by-now-familiar story of how Ivanov-Smolenskii's enemies had prevented the "creative development of Pavlov's theory." The psychiatrists who were singled out for the most damning criticism were Aleksandr Shmar'ian, Mikhail Gurevich, Raisa Golant, Anatolii Aleksandrovskii, and Larissa Lobova.<sup>46</sup> Giliarovskii was not included in the list of anti-Pavlovian psychiatrists, but he was criticized for his failure to stand up in defense of Ivanov-Smolenskii and Pavlovian principles, and was declared to be "unsound as the leader of the Institute of Psychiatry of the USSR Ministry of Health." In the "discussion" period that followed Giliarovskii was the main target: the first, second, and fourth speakers attacked only Giliarovskii,<sup>47</sup> and the third speaker was Giliarovskii himself. He accepted the criticisms of his work and apologized for calling Ivanov-Smolenskii's work "conditioned-reflex hairsplitting." Then he launched into a speech in which he reminded everyone that he had led the fight against

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<sup>45</sup> Unsigned, "Spravka o sostoianii seti, kadrov i deiatel'nosti psikhonevrologicheskikh uchrezhdenii," undated [1950], GARF f. r-8009, op. 33, d. 265, 5; E. Babaian (Zam. nach. otдела spets. medpomoshchi MZ SSSR), "Spravka o sostoianii psikhonevrologicheskoi pomoshchi v SSSR za 1954 god," 25 August 1955, GARF f. r-8009, op. 33, d. 656, l. 7; B. I. Matukhin (Nachal'nik sekretariata Prezidiuma AMN SSSR), "Svedeniia o kolichestve prisutstviushchikh na zasedanii," 15 October 1951, GARF f. r-9120, op. 2, d. 1201, ll. 136-141.

<sup>46</sup> Cited in Snezhnevskii *et al.*, "Sostoianie psikhiiatrii i ee zadachi v svete ucheniia I. P. Pavlova," 13-14.

<sup>47</sup> The first speaker was Nikolai Ozeretskii, a psychiatrist who had studied in Moscow with Gannushkin before going to work in Leningrad, where in 1951 he was the head of the department of psychiatry at the First Leningrad Medical Institute. The second was Aleksei Buneev, who had done his residency with Giliarovskii before going to work at the Serbsky Institute in the late 1920s. In 1951 he had just become the acting director of the Serbsky Institute. "Aleksei Nikolaevich Buneev," *ZhNiP* 65, no. 1 (1965): 156-157; "Pamiati N. I. Ozeretskogo," *ZhNiP* 55, no. 4 (1955): 318-319.

lobotomy on the grounds that it was anti-Pavlovian, and proceeded to lecture them about how Pavlovian treatments might be developed.<sup>48</sup>

Most of the other psychiatrists who spoke began with self-criticism, then moved on to criticize another psychiatrist, and ended by talking about the successes at their own institution since the 1950 Pavlov Session and how the discipline as a whole should proceed. (Psychiatrists far outnumbered neurologists among the speakers, and psychologists were all but absent from the session.) Some speakers stressed one part of the speech more than others. Psychiatrists who had been named as ideological foes were at one extreme, focusing almost entirely on self-criticism, while a few others devoted their speeches entirely to criticism. Some speakers, most of them directors of provincial medical institutes or hospitals, walked a fine line, engaging in little or no self-criticism and naming no one in particular as an enemy.<sup>49</sup> In a few cases speakers clearly tried to exploit the rhetoric of the session to advance their own careers. One man from the Stalinabad Medical Institute, for instance, used his speech to attack the head of his department, whom he claimed had mismanaged the department, not producing a single dissertation in 11 years. The director had also “propagandized leucotomy and electroshock therapy for schizophrenia,” and only accepted “with great difficulty the harmfulness and anti-scientific-ness of leucotomy.”<sup>50</sup>

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<sup>48</sup>Giliarovskii was followed by Kerbikov, the man who was about to succeed him at the Second Moscow Medical Institute, who accused him of having “not sufficiently defined his position in regard to anti-Pavlovian and cosmopolitan orientations which have been circulating [*imevshikh khozhdenie*] in Soviet psychiatry.” Snezhnevskii *et al.*, “Sostoianie psikiatrii i ee zadachi v svete ucheniia I. P. Pavlova,” 76-85.

<sup>49</sup> The director of the psychiatry department at L’vov State Medical Institute, for instance, focused almost exclusively on the study groups and lectures that his department had organized after the 1950 Pavlov Session, and the problems that they had encountered trying to get their work published in the professional journals. Banshchikov *et al.*, eds., *Fiziologicheskoe uchenie akademika I.P. Pavlova v psikiatrii i nevropatologii*, 120-122.

<sup>50</sup> *Ibid.*, 406-408

Another man took the opportunity to attack Giliarovskii for allegedly plagiarizing his work on “electrosleep.”<sup>51</sup>

Shmar’ian, Gurevich, Sereiskii, and the other psychiatrists who had been accused of anti-Pavlovian activities also spoke at the session. Shmar’ian’s speech was strikingly muddled. Most of the speakers made at least an attempt to make their words flow, but Shmar’ian’s speech read like a list of cliché’s lifted from other speeches. He agreed with the main criticisms of his ideas, apologized for not having recognized Ivanov-Smolenskii’s importance for all these years, and blamed his scientific mistakes on his failure to properly understand Pavlov’s theory. He had thought, he explained, that since he was a dedicated Marxist he would naturally interpret facts from a materialist point of view. Without an explicit theoretical framework, however, idealism and dualism had crept into his research. He also acknowledged that he had used his influence to suppress criticism within the profession, and blamed this on a lack of party-mindedness.<sup>52</sup> The most striking thing about his speech was what he did not mention: lobotomy. After 11 months of being denounced for his role in bringing lobotomy to the USSR, this omission was undoubtedly calculated, and it did not go unnoticed by other speakers.<sup>53</sup>

The organizers of the session were not impressed. Shmar’ian was unreformed, they decided, and they used the editing process to make sure that readers of the stenographic report would get that message. They did this by adding a footnote, which read, A. S. Shmar’ian removed this phrase from the corrected stenogramm: “Before us stands the task of gathering

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<sup>51</sup> Ibid., 359.

<sup>52</sup> Ibid., 134-136. Shmar’ian’s reference to his Marxist beliefs was edited out of the final version, but can be found on the rough uncorrected stenographic report. “Stenogramma ob’edinenogo zasedaniia rashirennogo Prezidiuma AMN SSSR i Plenuma Pravleniia Vsesoiuznogo ob-va nevropatolgovo i psikhiatrov, t. 1,” 1951, *GARF*. f. r-9120, op. 2, d. 1202, l. 167.

<sup>53</sup> See for instance Negovskii in Banshchikov, *et al.*, eds., *Stenogramma ob’edinenogo zasedaniia*, 227.

facts from scratch, of building a theory of pathophysiology of VND from scratch. Eds.” The footnote made it look as though Shmar’ian was still trying to cover up his true beliefs.

The fact that Shmar’ian had edited his text was not actually remarkable, since almost all the speakers had edited their texts for publication. What was unique was that the editors added a footnote to draw attention to an edit: this was the only time they did so. Furthermore, the footnote itself was completely misleading. In fact, Shmar’ian had done more than cut out a single sentence, he had cut out nearly four pages of text in which he had tried to explain the thinking behind his theory of “brain pathology.”<sup>54</sup> The explanation that he had cut out had not been at all clear, and the speech benefited from the cut. Out of context, this footnote seemed to imply that Shmar’ian continued to reject Pavlovian theory and to claim that psychiatrists would need to invent their own theory of higher nervous activity.

### **Controlling the Message**

What the planners of the meeting feared most was that psychiatrists might use the meeting as a forum to vent their frustrations. The planners of the Session wanted to avoid this as much as possible, and in their planning session they discussed what they would do to keep the Session “on message.” As Sergei Kurashov saw it, the biggest threat came from psychiatrists who were from the “very deepest periphery,” people who were likely “to very acutely pose questions about the condition of psychiatric services in the localities”<sup>55</sup> In order to avoid embarrassment, Kurashov suggested, the committee should use reliable Communists to give

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<sup>54</sup> Shmar’ian’s explanation was that, in his work, he had observed that in one patient an injury to a particular part of the brain produced one set of symptoms, while in another patient with the very same type of injury to the very same area of the brain, the symptoms were altogether different. What he should have done was to study the underlying balance of inhibition and excitation, and the way they were affected by constantly changing conditioned reflexes. Instead he had suggested that the differences were caused by swelling brain tissue, which developed differently in different people, and put pressure on various parts of the brain.

<sup>55</sup> Zhukov-Verezhnikov (Chairman), “Stenogramma zasedanii orgkomiteta ...” 24 September 1951, GARF f. r-9120, op. 2, d. 1201, l. 196.

speeches on “the most acute issues of modern psychiatry and neuropathology,” particularly those which led the “discussion” portion of the session. They would ensure that the right criticisms were made of the right people, and they would set the tone of the session for the other psychiatrists in attendance.<sup>56</sup> Another tactic was to tailor the main speech to limit the domain of discussion. As Dmitrii Fedotov put it, “I think that we would act correctly if in our reports we did not talk about that [the “condition of psychiatry” in hospitals], because right now our network does not satisfy demand in any way....”<sup>57</sup> The Session would be best served if its organizers simply did not open the topic to discussion in the first place.

They had good reason to worry. By the early 1950s, overcrowding in psychiatric hospitals had returned to the egregious levels that had been seen before World War Two. Though psychiatric hospitals were legally supposed to have 6.5 square meters of space per patient, by 1951 virtually no psychiatric hospital in the USSR had more than 3 square meters per patient, and some hospitals reported “impossible overcrowding,” with as little as 1.2 square meters per patient.<sup>58</sup> Over the next three years more beds were simply crammed into the back rooms and

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<sup>56</sup> Sarkisov, one of the leaders of the All-Union Society, suggested using the members to make sure the right speeches were made, and criticisms were sufficiently “acute.” Zhukov-Verezhnikov (Chairman), “Stenogramma zasedanii orgkomiteta ...” 24 September 1951, GARF f. r-9120, op. 2, d. 1201, l. 196. Reliable communists, according to a memo sent to Minzdrav, included Oleg Kerbikov (Iaroslav’), Seredina (AMN), Negovskii (AMN), Aleksandr Portnov (MZ SSSR), Ivan Strel’chuk, Sergei Kurashov (TsIUUV), and Nikolai Ozeretskii (Leningrad). Unsigned, AMN to Minzdrav (Smirnov), “Dokladnaia zapiska (Spravka) o provedenii sesii” (undated, probably after 1 October 1951), GARF f. r-9120, op. 2, d. 1201, ll. 223-224. Seredina (marked with an asterisk) did not end up giving a speech at the session.

<sup>57</sup> Zhukov-Verezhnikov (Chairman), “Stenogramma zasedanii orgkomiteta ...” 24 September 1951, GARF f. r-9120, op. 2, d. 1201, l. 198.

<sup>58</sup> The low end reported for Ukraine in 1950 was 1.2 square meters. See Usechev’s speech in E. I. Smirnov (Chairman), “Stenogramma zasedaniia kollegii MZ SSSR,” 22 March 1952, GARF f. r-8009, op. 1, d. 1035, l. 36; Unsigned, “Doklad pravitel’svennoi komissii o sostoianii psikhonevrologicheskoi pomoshchi v RF i merakh po ee uluchsheniiu,” 31 July 1952), GARF f. r-8009, op. 33, d. 399, l. 170.



hallways of existing buildings, and it became commonplace for patients to sleep two to a bed. In some cases hospitals did away with beds altogether and simply put mattresses on the floor.<sup>59</sup>

These facts could be potentially very embarrassing for the Soviet Union. The organizers wanted to hold their session and discuss “problems in psychiatry,” but they did not want to project an image of Soviet psychiatric hospitals in crisis to the rest of the world. This was particularly important to them because American psychiatry had recently suffered from precisely this sort of embarrassment. A 1948 expose by journalist Albert Deutsch, *The Shame of the States*, had described the awful overcrowding and poor conditions of American psychiatric hospitals, and the book had been followed by public outcry in the United States.<sup>60</sup> Soviet psychiatrists were delighted to publish summaries of Deutsch’s work. They contrasted their own approaches to psychiatry with those found in America, depicting Soviet psychiatric hospitals as therapeutic refuges with nothing in common with the horrible prison-asylums found in America.<sup>61</sup> As the resolution issued after the October 1951 Session stated, “Soviet neuropathologists and psychiatrists take pride in the fact that Soviet psychoneurology is characterized by true humanism, in contrast to Anglo- American psychoneurology, which remains in a miasma...”<sup>62</sup>

The organizers of the 1951 Session realized, however, that provincial psychiatrists coming to Moscow would want to make a pitch to Minzdrav: after all, the most influential

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<sup>59</sup> D. D. Fedotov, “Stenogramma soveshchanii vrachei-psikhiatrov,” 14 May 1951, GARF f. r-8009, op. 33, d. 398, 1-17.

<sup>60</sup> Shorter, *A History of Psychiatry*, 277-278.

<sup>61</sup> N. I. Ozeretskii, “Psikhiatricheskaia pomoshch' v SShA,” *NiP* 19, no. 3 (May-June 1951): 61-68; A. N. Rubakin, “Psikhicheskie zabolevaniia i psikhiatricheskaia pomoshch' v anglo-saksonskikh stranakh,” *NiP* 19, no. 3 (May-June 1951): 68-75. Joseph Wortis’s book *Soviet Psychiatry* was also singled out to show the interest and respect paid to Soviet psychiatry by progressive western doctors. See, for instance, Giliarovskii, “Razvitie idei I. P. Pavlova v psikhiatrii,” 11.

<sup>62</sup> V. M. Banshchikov, et al, ed., *Fiziologicheskoe uchenie akademika I.P. Pavlova v psikhiatrii i nevropatologii...* (Moscow: Medgiz, 1952), 317.

people in the profession and the government health administration rarely gathered together, much less with hospital directors in attendance, and psychiatrists from remote parts of the country would be fools not to use the opportunity to plead their case for more resources. To accommodate this, the organizers decided to hold several meetings in parallel to the main Session, and to use these less public gatherings to give people from outside Moscow a chance to vent their frustrations about the problems in their institutions. These closed meetings were to be held on the last day of the Session. The proceedings would not be published.<sup>63</sup>

The separate meeting for hospital directors and university chairmen was held on the final day of the Session before the last general meeting and was attended by 28 hospital directors and university psychiatry department chairmen; only three were from Moscow, and only two had spoken at the main Session.<sup>64</sup> The head of Minzdrav USSR's Department of Psychiatric Services chaired the meeting, and gave a speech about Minzdrav's efforts to "restructure" psychiatric services in light of the 1950 Pavlov Session. General discussion followed. Most hospital directors complained primarily about the difficulties they had providing effective care with too little funding, too little space, and too little respect from state authorities or even from other doctors. Everyone complained about lack of medicine, overcrowded buildings, and a lack of facilities to help people with alcoholism or minor psychiatric problems. Outpatient dispensaries,

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<sup>63</sup> The meetings were both for the directors of psychiatric hospitals, one for directors of hospitals in the RSFSR, the other for directors of hospitals in other republics. "Protokol soveshchaniia glavvrachei psikhonevrologicheskikh bol'nits i zaved. kafedrami Med VUZ'ov v MZ SSSR," 15 October 1951, GARF f. r-8009, op. 33, d. 396, l. 1-7ob; "Stenogramma ob'edinenogo zasedaniia rashirennogo Prezidiuma AMN SSSR i Plenuma Pravleniia Vsesoiuznogo ob-va nevropatolgovo i psikhiatrov, t. 2" [1951]. GARF f. r-9120, op. 2, d. 1203, l. 282.

<sup>64</sup> The two men in attendance at this session who had also given speeches at the Pavlov Session were Al'fred Petrovich Shtess, director of the psychiatry department at the Kazakh Medical Institute in Alma-Ata, and Avlipii Davidovich Zurabashvili, Director of the Georgian Institute of Psychiatry in Tbilisi. There were 123 university department directors at the 1951 Session, 58 in psychiatry, 65 in neuropathology, and 85 hospital directors (glavnie vrachi psikhonevrologicheskikh bol'nits), for a total of 208. The 28 people in attendance at the parallel meeting thus represented 13% of the total. "Spisok prisutstvuiushchikh na soveshchenii Glavnykh vrachei....." 15 October 1951, GARF f. r-8009, op. 33, d. 396, ll. 7-7ob; B. I. Matukhin (Nachal'nik sekretariata Prezidiuma AMN SSSR), "Svedeniia o kolichestve prisutstvuiushchikh na zasedanii," GARF f. r-9120, op. 2, d. 1201, ll. 136-141.

which in theory were the key to the soviet system of mental health care, were not functioning in many parts of the country, and the cause of this was not just lack of funding, they believed, it was also a general incomprehension, or even hostility, toward psychiatry as a discipline. A Ukrainian professor complained that the directors of general hospitals were outright hostile to the idea of opening psychiatry wards in their hospitals.<sup>65</sup> Another psychiatrist complained that in Saratov, “there is still no understanding of the fact that psychiatry is one of the fundamental medical specialties,” and that as a result authorities were trying to close his psychiatric clinic for children and use it as a general hospital.<sup>66</sup>

The psychiatrists were also keen to ask just what, in concrete terms, Pavlov’s theory should mean in their hospitals. Several hospital directors talked about their attempts to use Pavlovian ideas and how they needed specific guidelines. Portnov, the official in charge of psychiatry, addressed the issue directly in his concluding statement. Actual treatments based on Pavlovian theory, he told them, were not yet a reality, though of course they would be coming “in the near future.” For the present, though, Pavlovian psychiatry would not mean using conditioned reflexes to treat mental illness, or using biological treatments that targeted specific types of “higher nervous activity.” Instead, Pavlovian psychiatry would simply mean “changing the culture of patient care [*kul’tura obsluzhivaniia bol’nykh*]” and adopting a “protective therapeutic regime” on the wards. Pavlovian psychiatry meant calm, quiet, and discipline. “From

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<sup>65</sup> A. A. Zaitsev (Zav. kafedroi psikhiiatriia, Vinnitsa) in A. A. Portnov (Chairman), “Protokol soveshchaniia glavvrachei psikhonev. bol’nits i zaved. kafedrami MedVUZov v MZ SSSR,” 15 October 1951, GARF f. r-8009, op. 33, d. 396, l. 1.

<sup>66</sup> M. P. Kutanin (Zav. kafedroi psikhiiatriia, Saratov), in *ibid.*, ll. 1-2.

now on,” Portnov told them, “we cannot advocate the currently existing approaches to patient care.”<sup>67</sup>

Even with careful planning, the organizers of the Session had to accept a certain amount of criticism and unpleasant discussion at the main meeting. In their speeches most psychiatrists used elliptical phrasing to allude to problems in their hospitals and to demand more support from the government, though comments recorded in the original draft of the stenographic report give the impression that they were much freer with their criticisms in the hallways outside the auditorium. “The restructuring of practical psychiatry on Pavlovian principles,” said one psychiatrist, “requires large capital investment in the construction of new hospital buildings, reexamining the entire therapeutic process, the regime in psychiatric institutions, broad introduction of labor therapy, psychotherapy, creation of silence, calm, protective regime for the mentally ill person.”<sup>68</sup> Criticism like this one that avoided specifics and were couched in terms of Pavlovian theory were allowed to go to press, and were included in the published version of the stenographic report. In other cases, however, criticisms became too specific and too negative, and so the organizers of the Session had to resort to the other tool available to them: direct censorship of the stenographic report. One psychiatrist who was annoyed that outpatient dispensaries had not been discussed complained, for instance: “Everyone here talks about hospitals, and, excuse me, whines that they are overcrowded. (Applause). And when will this overcrowding be reduced if there are no psycho-neurological dispensaries? They’re all old monastery hospitals ... out on the edge of the cities. Where is the link to the population?”<sup>69</sup> The

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<sup>67</sup> Ibid., ll. 5-6.

<sup>68</sup> The published text is essentially the same as the uncorrected draft. Banshchikov *et al.*, eds., *Fiziologicheskoe uchenie akademika I.P. Pavlova v psikiatrii i nevropatologii*, 154.

<sup>69</sup> “Stenogramma ob’edinenogo zasedaniia..., t. 1,” GARF f. r-9120, op. 2, d. 1202, l. 257.

speaker got a positive response from the audience, but his comments were too negative for the editors of the stenographic report. The version they sent to print read simply, “Everyone here talks about hospitals. But where is the link to the population?”<sup>70</sup>

The most substantial criticism of hospital conditions came on the first day of the Session in a speech made by M. Ia. Liakhovitskii, the director of Leningrad’s Second Psychiatric Hospital.<sup>71</sup> His assigned role seems to have to discuss “the broad inculcation of I. P. Pavlov’s ideas into our hospital and extra-hospital work,” a nod to psychiatrists that their practical concerns were recognized. Liakhovitskii, however, either did not realize what parameters of self-censorship were expected or did not care, because in his speech he detailed the fundamental problems of psychiatric hospitals in excruciating and specific detail. He talked about catastrophic overcrowding, lack of basic equipment, noise on the wards, crumbling infrastructure, chronic underfunding, and doctors using drugs as a form of restraint. He concluded that the Soviet Union’s psychiatric system was barely functioning and had become fundamentally inhumane. Contrary to the ideals of Soviet psychiatry, patients were being consigned to hospitals that were little better than nineteenth century prisons. “These patients,” he concluded, “should not be packed into the stone buildings of big city hospitals, put under many locks, with the sound of the key, a sound that has an upsetting effect not only on the sick, but also on the healthy.”<sup>72</sup>

Needless to say, the organizers of the Session were not pleased by Liakhovitskii’s performance. After the Session they severely edited his speech before including it in the

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<sup>70</sup> Banshchikov et al., eds., *Fiziologicheskoe uchenie akademika I.P. Pavlova v psikhiiatrii i nevropatologii*, 173.

<sup>71</sup> I know very little about Liakhovitskii or why he was given a place of such prominence on the roster; he was never profiled in *ZhNiP*. He had been the head physician at a Leningrad psychiatric hospital through the wartime blockade. P. B. Posvianskii and T. I. Gol’dovskaia, “Khrionika: Vserossiiskaia konferentsiia po voprosam psikhiiatrii,” *NiP* 13, no. 5 (1944): 65.

<sup>72</sup> “Stenogramma ob’edinenogo zasedaniia..., t. 1,” GARF f. r-9120, op. 2, d. 1202, l. 67.

published stenographic report of the meeting, Liakhovitskii's complaints about government failure to rebuild psychiatric hospitals were entirely eliminated. The rest of his text was reduced to generalities, shorn of emotion, and reconstituted in the dry language of the soviet bureaucracy. Thus in the published version his harangue about "stone buildings" and "the sound of the key" was reduced to a completely bland formulation: "The number of wards for patients with borderline and nervous conditions should be increased, as should the number of colonies for psychiatric patients. Patients with long-lasting and chronic forms of disease should be housed in them."<sup>73</sup>

### **The Laboratory and the Clinic**

The October 1951 Pavlov Session only served to reinforce psychiatrists' sense that a new discipline called "pathology of higher nervous activity" was going to replace traditionally used concepts of psychology and psychopathology. By refusing to accept the role of keynote speaker, Ivanov-Smolenskii seemed to be declaring his intention to work from outside psychiatry to redefine the way psychiatrists classified, diagnosed, and treated mental illness. The main speech at the session did nothing to dispel this notion. In the speech, Snezhnevskii said that psychiatrists would have to master new methods to study mental disorders. Whenever they examined a patient they should establish the relationship between "signal systems" in the brain: "the disturbance of communication between first and second signal system, and between the two signal systems and the brain stem." Their objective findings about disturbances in brain activity (the signal systems) would replace the old, speculative concepts like "will" and "mind." To do this type of analysis, psychiatrists would need to be re-trained in the methods of "pathophysiology of higher nervous

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<sup>73</sup> Banshchikov *et al.*, eds., *Fiziologicheskoe uchenie akademika I.P. Pavlova v psikhiiatrii i nevropatologii*, 92-94.

activity.” As Snezhnevskii explained, special tools for probing higher nervous activity had been developed by Anatolii Ivanov-Smolenskii,<sup>74</sup> particularly his speech-motor method in which he established conditioned reflexes in his patients between spoken words and simple physiological reactions like the dilation of the pupil in the eye.<sup>75</sup>

Other speakers made similar exhortations to purge unobjective methods from the clinic, and the organizers of the Session actually intensified these statements when they edited the stenographic report for publication. For instance, one influential psychiatrist urged participants at the Session to purge “psychologism” from their work, something that he said would require them to “change the style of psychological laboratories; laboratories of higher nervous activity should be established on the basis of these [psychology laboratories].”<sup>76</sup> When the speech was edited for publication, the organizers of the session changed this to read as a much stronger call for the transformation of psychiatry. The relatively mild phrase “change in style” was replaced with a categorical statement: “it is necessary to completely liquidate the psychological laboratories in psychoneurological institutions and replace them with laboratories of higher nervous activity.”<sup>77</sup>

In public, at least, most psychiatrists agreed that their discipline should adopt the methods and explanations offered by Pavlovian science. But not all psychiatrists were happy about what they saw as the impending abolition of their specialty, and they particularly disagreed about whether the language found in traditional psychopathology should be purged of all psychology-laden terms. The forum in which these anxieties were aired was the journal *Neuropathology and*

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<sup>74</sup> Snezhnevskii, *et al.*, "Sostoianie psikiatrii i ee zadachi," 27.

<sup>75</sup> Ibid., A. G. Ivanov-Smolenskii, "Ob izuchenii sovместnoi raboty pervoi i vtoroi signal'nykh sistem," *Zhurnal vysshei nervnoi deiatel'nosti imeni I. P. Pavlova* 1, no. 1 (1951): 55-66.

<sup>76</sup> Zurabashvili in "Stenogramma ob'edinenogo zasedaniia..., t. 1," GARF f. r-9120, op. 2, d. 1202, GARF f. r-9120, op. 2, d. 1202, l. 74.

<sup>77</sup> Zurabashvili in Banshchikov, *et. al.*, *Fiziologicheskoe uchenie akademika I.P. Pavlova v psikiatrii i nevropatologii*, 96-97.

*Psychiatry*. In the two years that followed the session, the editors of the journal published a series of articles on “contested issues [*spornye voprosy*], and particularly on this question of psychology and psychological terminology. This highly controlled “discussion” gave the new editors of the journal, Snezhnevskii and Kurashov, a chance to establish their authority as the new gatekeepers of the discipline. In the process, they articulated an approach to Pavlov’s theory that was significantly broader than Ivanov-Smolenskii’s approach, and reopened the possibility that scientific knowledge could be produced in the psychiatric clinic.

The article in their “contested issues” series that produced the most discussion was an article that defended the value of psychology. The author was Izmail Sluchevskii, the head of the Department of Psychiatry at the Leningrad Institute for Advanced Medical Training. Sluchevskii had studied in Leningrad and worked at a psychiatric clinic that Pavlov frequently visited in the early 1930s.<sup>78</sup> Sluchevskii, then, spoke from personal experience when he discussed the great man’s views. In his 1952 paper, Sluchevskii agreed that Pavlov’s discoveries should be adopted by psychiatrists, but he argued that the old psychological terminology needed to be retained. In their daily work psychiatrists still needed terms and concepts like “sensation,” “attention,” and “memory” to describe what they saw when they examined their patients.

It is entirely obvious that, examining, for example, a patient’s memory, we have every reason to check whether or not he is correctly recalling dates from his past, whether or not he correctly remembers material that he is given, etc. Nor should we refuse such methods as testing attention, for example, asking a patient to subtract 7 from 100.<sup>79</sup>

According to Sluchevskii, Soviet psychology was no longer mired in the errors of idealism. Soviet psychologists believed that all thought was grounded in a “material substrate - nerve processes.” But Soviet psychologists also could see that, as Lenin had written in his

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<sup>78</sup> "Izmail Fedorovich Sluchevskii (nekorolog)," *ZhNiP* 66, no. 11 (1966).

<sup>79</sup> I. F. Sluchevskii, "O nekotorykh aktual'nykh voprosakh psikhiiatrii," *ZhNiP* 52, no. 8 (1952): 4.



Philosophical Notebooks, “Both thought and material are ‘real’, that is, they exist, that is true. But to call thought material is to take a mistaken step toward mixing materialism and idealism.” Therefore, Sluchevskii concluded, “reducing psychology to physiology, to the theory of higher nervous activity, is a crude mistake.” All thought was ultimately grounded in physical processes, but that did not mean that one could understand psychological cause or effect by measuring the ebb and flow of those nerve processes. “Mind facts” could not be explained solely through “brain facts,” and so to do their jobs, psychiatrists would have to continue to study their patient’s minds as well as their brains.<sup>80</sup>

At around the same time (the Autumn of 1952), the head of Minzdrav’s psychiatry department articulated a similar point of view in a letter that he wrote to the Central Committee’s Science Department. He told the Party officials that psychological evaluations were very important in clinical psychiatric practice, but that closing psychology laboratories made sense because psychological evaluations should not be the province of a narrow group of specialists: psychological evaluations should be a part of the everyday practice of every psychiatrist. Evaluating a patient’s mental status was “part of the competence of psychiatrists and cannot be separated from psychiatry as an independent scientific discipline.”<sup>81</sup> Party science boss Iurii

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<sup>80</sup> *Ibid.*, 4-5. The terminology of “mind facts and brain facts” comes from Paul McHugh and Phillip R. Slavney, *The Perspectives of Psychiatry*, 2nd ed. (Baltimore: Johns Hopkins University Press, 1998), 12-14.

<sup>81</sup> Portnov claimed that at best, psychologists duplicate the work of the physician. At worst, they “disorient him in his diagnostic work.” He suggested that more training programs in medical psychology should be set up in Institutes for Advanced Medical Training, and that a special psychology laboratory be established at the Bekhterev Institute to draft guidelines for how psychiatrists should handle psychological evaluation of patients. A. A. Portnov (Nach. Otdela psikhonev. pomoshchi) to A. N. Cherkashin (Otdel Nauki TsK VKP/b/), August 7, 1952, RGASPI f. 17, op. 133, d. 261, ll. 45, 47-48.

Zhdanov agreed with him.<sup>82</sup> Clinicians were to be encouraged to consider the state of a patient's mind, but trained psychologists had no place in a medical clinic.

Several psychiatrists responded supportively to Sluchevskii's argument, agreeing with him that the psyche was "qualitatively different" from reflex actions and molecules.<sup>83</sup> Most of the responses published in *Nevropatologiia i psikhiatriia*, however, were very critical. Several authors attacked Sluchevskii for making grievous philosophical errors; they found fault in his reading of Pavlov, Lenin, and other "classic" texts of dialectical materialism. The strongest attack came from a group of psychiatrists who worked at the Pavlov Institute of Physiology in the laboratory of Andrei Chistovich, a psychiatrist who had trained under Vladimir Bekhterev and who had later worked with Ivanov-Smolenskii.<sup>84</sup> These psychiatrists argued that psychology and psychological terminology *should* be purged from psychiatry, and that psychiatry *should* be replaced by "pathology of higher nervous activity." Psychiatrists should now limit themselves to "objective experimental study" and refrain from "any recidivist subjective-psychological approach." In their clinical work, psychiatrists should seek to establish "brain facts," not "mind facts": "Clinical facts should be analyzed not from the point of view of disturbance of the will, intellect, etc, but from the point of view of a disturbance of certain levels, functional systems, and processes of higher nervous activity."<sup>85</sup>

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<sup>82</sup> Iu. Zhdanov (Otdel Nauki TsK) to M. A. Suslov (Sek. TsK), August 30, 1952, RGASPI f. 17, op. 133, d. 261, ll. 49-50.

<sup>83</sup> N. M. Viazemskii, "Po povodu nekotorykh aktual'nykh voprosov psikhiatrii," *Zhurnal nevropatologii i psikhiatrii im. S.S. Korsakova* 53, no. 12 (1952): 32-29.

<sup>84</sup> "Andrei Sergeevich Chistovich (K 60-letiiu so dnia rozhdeniia i 35-letiiu vrachebnoi i nauchno-pedagogicheskoi deiatel'nosti)," *ZhNiP* 57, no. 4 (1957): 543; Andrei Sergeevich Chistovich (Nekrolog)," *ZhNiP* 81, no. 5 (1981): 786.

<sup>85</sup> L. Ia. Balonov, *et al*, "Po povodu stat'i prof. I. F. Sluchevskogo 'O nekotorykh aktual'nykh voprosakh psikhiatrii,'" *ZhNiP* 52, no. 12 (1952): 40-47. Note that during the 1990s one of the authors of this piece, A. E. Lichko, published an article about the 1951 Pavlov Session.

In their January 1953 response to Sluchevskii, the editors of *Nevropatologiia i psikhiatriia* concluded that mind facts and brain facts were identical, and Sluchevskii was wrong to say otherwise. When a scientist observed changing patterns of inhibition and excitation, he was observing thought; the thought and the “nervous activity” were one and the same. They quoted Pavlov saying that his discovery of “experimental neuroses” showed that subjective psychological experiences and objectively observed patterns of nervous activity were identical. Experimental neuroses were “the best proof that the study of conditioned reflexes is on the right path to studying the higher areas of the brain. In so doing, finally, the functions of this region and the phenomena of our subjective world will have become unified, integrated [ob’edinisils’, otozhdestvilis’].”<sup>86</sup> The editors pointed out that Stalin had argued in his book on linguistics that language and thought were identical. This argument, they claimed, was fully in agreement with Pavlov’s theory of the second signal system: “language and thought find their natural-science foundation in I. P. Pavlov’s theory of human signal systems.” To claim otherwise was to fall into “psycho-physical parallelism.” Pavlov’s genius was to provide a theoretical way of overcoming the fundamental problem of the mind-brain discontinuity.<sup>87</sup>

Having said this, however, the editors hurried to reassure their readers that “this by no means abolishes psychiatry,” and they reproached the more radical psychiatrists for assuming that psychiatrists should restrict their clinical methods to strictly objective Pavlovian measurements of higher nervous activity. Like the government and Party officials cited above, Snezhnevskii and the other editors of *Nevropatologiia i psikhiatriia* argued that psychiatrists

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<sup>86</sup> Pavlov, quoted in "O nekotorykh spornykh i aktual'nykh voprosakh psikhiatrii (Itogi obsuzhdeniia)," *ZhNiP* 53, no. 1 (1953): 14.

<sup>87</sup> "O nekotorykh spornykh i aktual'nykh voprosakh psikhiatrii (Itogi obsuzhdeniia)," *ZhNiP* 53, no. 1 (1953): 15-16.

needed access to the full range of clinical tools that would enable them to evaluate how patients interacted with their surroundings, how they established relationships with the external world, what they said, and what their history of illness was. Objective measurements of brain activity would also be used, of course, along with blood tests, urine analysis, x-rays, and all the other modern tools of the medical laboratory. In fact, simply observing patients in the clinic and even listening to what they said could also yield “objective” knowledge because everything that a person said or did was related to both their subjective experiences and to the nerve processes in their brains and other physiological processes in their bodies. In observing how the patient acted or talked, the clinician was gathering information about the patient’s really existing physical state. Brain facts were not the sole monopoly of experts in Pavlovian “pathology of higher nervous activity”; the traditional tools developed by generations of clinical psychiatrists could also yield objective knowledge about the true material state of the body.

Was this science? The editors were ambiguous on this score. On one hand they were enthusiastic about the possibilities for clinical psychiatry. Using these new tools, psychiatrists could gather much more objective information about their patients, and this “preparatory division and clinical description” would help make possible “true scientific pathophysiological research [*podlino nauchnoe ... isledovanie*].”<sup>88</sup> What the psychiatrists were doing, then, was not “truly scientific research.” Ultimately, psychiatrists would discard the classification schemes that had been developed through careful clinical observation and replace them with new classifications based on the scientific knowledge developed by Pavlovian specialists. “Truly scientific” psychiatry would be based on complete knowledge of the physiological processes that caused

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<sup>88</sup> "O nekotorykh spornykh i aktual'nykh voprosakh psikiatrii (Itogi obsuzhdeniia)," *ZhNiP* 53, no. 1 (1953): 22.

mental illness. “However,” the editors concluded, “to ... create a natural systemization of illnesses, a long period of research will be necessary, both clinical and pathophysiological, etiological and pathogenetic.<sup>89</sup> Surely psychiatry would eventually rest on scientific knowledge of the brain’s physical operation. Until then, however, the objective descriptive research done in the clinic should be considered a crucial component of scientific research.

### *The Demoralization of Soviet Psychiatry*

By 1953, the new leaders of Soviet psychiatry had established a framework for “Pavlovian psychiatry” that gave psychiatrists broad room to pursue their research. This return to something like the status quo, however, did not mean that the experience of the 1951 Pavlov Session had been forgotten. Quite the opposite. Those who participated were in the session were deeply affected by the experience. Moscow University professor Mikhail Gurevich, for instance, took the accusations against himself very hard, according to a memoir written by psychologist Konstantin Platonov. Gurevich had been included as one of the primary group of “anti-Pavlovians,” and blamed for “holding back the growth of national psychiatry.” According to Platonov, Gurevich became wracked with feelings of guilt and self-recrimination [*bred samoobviniia*], muttering “What have I done! I’ve ruined [*pogubil*] psychiatry and all of my students coming in my wake!” It seems plausible that Gurevich would believe that he had really damaged the discipline, but what is particularly striking are his feelings of guilt about the damage done to his students. In a system where careers depended on patronage, the taint of being “anti-Pavlovian” had consequences for ones students and coworkers as well.<sup>90</sup>

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<sup>89</sup> Ibid.

<sup>90</sup> Platonov claims to have learned of Gurevich’s words from the doctor who was treating Gurevich for heart disease in the summer of 1952. Gurevich died the next November. K. K. Platonov, *Moi lichnye vstrechi na velikoi doroge zhizni (Vospominaniia starogo psikhologa)* (Moscow: Institut psikhologii RAN, 2005), 233.

The personnel at the Central Institute of Psychiatry had been under particular pressure because they had worked with Shmar'ian for so long. Minzdrav had subjected the staff at the institute to a special review of credentials ("attestation") even before the October 1951 Session began. This process was supposed to have ended in March 1951, but it ended up dragging on until May, and even then people were left in a state of apprehension because the attestation decisions need to be approved by a higher commission. A year later, in March 1952, that commission had still not reviewed their cases, and there was still talk in the Ministry about closing the institute altogether.<sup>91</sup> Some staff members were slated for dismissal after the attestation, but even in 1952 most of them were still working at the institute because replacements had not been found.<sup>92</sup>

Not surprisingly, the morale at the institute was not very high. According to the secretary of the institute's party cell, work had essentially come to a halt and the staff "lived on rumors" [*zhili slukhami*]. Tikhon Geier, the psychiatrist who headed the labor expertise department at the institute, described the institute as a profoundly depressing place: "You come to the institute, and it's like a cemetery! You say, 'Come on, what is this, let's work!' But why work when they're going to close the institute! I would say that for the first half-year we got virtually no work done, and then we had to make up for it in the rest of the year." Geier himself had had a heart attack, and he blamed it on the stress of working at the institute under these conditions.<sup>93</sup>

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<sup>91</sup> This possibility had been raised at the January 1951 meeting of the MZ RSFSR collegium, and the Minister had allowed it to remain an open question. M. D. Kovrigina (Ministr Zdrav. RSFSR, Chairman), "Stenogramma zasedanii kollegii," 4 January 1951, GARF f. a-482, op. 49, d. 3041, l. 42. The issue of closing the institute was raised again in October at the Joint Session, but didn't seem to gain any traction among the speakers. S.V. Kurashov in Banshchikov, *et al.*, eds., *Stenogramma ob'edinenogo zasedaniia*, 162.

<sup>92</sup> D. E. Melekhov (Acting Director), "Spravka o rabote po perestroike Gos. NII psikhiiatrii MZ RSFSR k zasedaniu kollegii MZ RSFSR," 13 March 1952, GARF f. a-482, op. 49, d. 4767, l. 122.

<sup>93</sup> Zhizhina in V. S. Stepanov (Zam. ministra zdrav. RSFSR, Acting chairman), "Protokol zasedanii Kollegii MZ RSFSR," 20 March 1952, GARF f. a-482, op. 49, d. 4767, ll. 104-105. Geier: "... Ia ot etikh uslovii infarkt poluchil! Prikhodish' v Institut, kak na kladbishche! Govorish', 'davaite rabotat', kak zhe tak! Chto zhe rabotat', kogda Institut zakryvaiut! Ia by skazal, chto polgoda pochni sovsem ne rabotali, vot v ostal'nye polgoda i prikhodilos' vyravnivat'sia." *Ibid.*, l. 108.

There is some evidence to suggest that those participants who denounced their colleagues also had a hard time dealing with their memoirs of the 1951 session. At the session, neurologist Ivan Strel'chuk devoted his speech to denouncing Mikhail Gurevich. In 1990 Strel'chuk published a profile of Gurevich in honor of his one-hundredth birthday. Gurevich's one-hundredth birthday, however, had actually been in 1978, and had been marked at the time by an profile in the same journal. The implication seems to be that Strel'chuk felt that he owed something to Gurevich's memory and still felt guilty about what had happened fifty years earlier.<sup>94</sup>

## Conclusion

The campaign to create a Pavlovian psychiatry was carried out according to a broadly conceived plan. Clearly, the ideology and politics of the time played a large role in formulating the goals of this plan. Removing Jewish psychiatrists from positions of authority was of key importance, as was removing people like Giliarovskii who were perceived by the Party to have too large an influence in the field. The modernization of the psychiatric hospital system was also part of this agenda, however. Practical, clinically-oriented psychiatrists like Sergei Kurashov and Dmitrii Fedotov played major roles in planning the session. The emphasis that they placed on Pavlovian psychiatry was at once ideological and technical. They sought to mobilize psychiatrists to include more technological tools in their day-to-day practice. If Pavlovian psychiatry signified anything, it was medical modernity and materialism.

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<sup>94</sup> I. V. Strel'chuk "K 100-letiiu so dnia rozhdeniia M. O. Gurevicha," *Zhurnal nevropatologii i psikhatrii im. S.S. Korsakova* 90, no. 12 (1990): 81; L. L. Rokhlin, "Mikhail Osipovich Gurevich (K 100-letiiu so dnia rozhdeniia)," *Zhurnal nevropatologii i psikhatrii im. S.S. Korsakova* 78, no. 12 (1978): 1858-1860.

The way that the campaign unfolded was highly contingent on the personalities involved. Ivanov-Smolenskii in particular proved to be unpredictable and unreliable. By refusing to take a lead role in the psychiatry discussion he opened the way for a cohort of younger psychiatrists like Snezhnevskii and Kerbikov. Giliarovskii's actions also seem to have affected the outcome of the campaign. In the original plan that was proposed in 1950, Giliarovskii had been cast as the main villain in the campaign to define Pavlovian psychiatry. By championing the crusade against lobotomy and aggressively imposing his own categories on the debate, however, he made it very difficult for the Party to plausibly cast him in the role of ideological enemy. Giliarovskii's allies also played a significant role, particularly by intervening on his behalf with Iurii Zhdanov.

Finally, the way that this campaign unfolded demonstrate the ambiguities inherent in the project. The psychiatrists implicitly and sometimes openly challenged one another's interpretations of "Pavlov's theory." Even before Stalin's death the new editors of *Neuropathology and Psychiatry* were sketching a "Pavlovian consensus" around the concept of "clinical realism." This approach enabled psychiatrists to claim that eventually their discipline would be strictly grounded in positive knowledge generated by Pavlovian laboratories. At the same time, they could devote themselves to clinical research, using laboratory methods as tools to help them gather clinical data. In the final chapter, I argue that the clinical practices that emerged from the campaign for Pavlovian psychiatry were ultimately its most lasting legacy.



## CHAPTER 7

### SOVIET PSYCHIATRIC HOSPITALS AND PAVLOVIAN MEDICINE, 1950-1953

“Pavlov’s doctrine... is a new path to the unification of psychiatry and somatic medicine and the final liberation of psychiatry from the influence of subjectivist-idealist theory.”

-- Methodological letter on questions of psychoneurological aid to the population under the conditions of a rural medical district, 21 June 1955<sup>1</sup>

In his laboratory, Pavlov used his conditioned reflex method as a tool that enabled him to study the procedural rules of brain processes. In his later years he enjoyed visiting psychiatric hospitals and speculating about similarities he saw between the symptom of mental illness in humans and his model of brain processes in animals.<sup>2</sup> But he had very little to say about how his theory might be translated into medical practices that would be useful to human beings. Some of his work on experimental neuroses seemed to be suggestive of new approaches to the treatment of neuroses and phobias. His speculations during his visits to the psychiatric hospital also offered some hopeful avenues of research, particularly his ideas about the role of sleep as an inborn process that helped the brain heal itself. But this was not much for psychiatrists to go on, and all

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<sup>1</sup> M. Khomutov (Nachal'nik GU lechbeno-prof. pomoshchi MZ SSSR), “Metodicheskoe pis'mo po voprosam psikhonevrologicheskoi pomoshchi naseleniiu v usloviakh sel'skogo vrachebnogo uchastka,” 21 June 1955, GARF f. r-8009, op. 1, d. 1254, l. 89.

<sup>2</sup> V. K. Fedorov, “Poseshcheniia I. P. Pavlovym psikhiatricheskoi kliniki v 1929-1930 gg.,” *Nevropatologiia i psikhiatriia* 20, no. 6 (1951): 13.

of these methods had been tried out in the 1920s and 1930s. Pavlov's ideas had always seemed suggestive of major breakthroughs just in the future, but that future had somehow never arrived.

After the 1950 discussion of Pavlov's physiological theories, however, Soviet medical authorities told practicing psychiatrists to move ahead regardless of the obstacles. All medical specialties were expected to demonstrate that they were adopting Pavlovian methods, which in practical terms meant that in their year-end reports they were at pains to list the forms of Pavlovian treatment used, the number of patients who had been given the treatments, and the results of their treatment. In 1950-1952, Minzdrav organized small conferences to instruct psychiatric hospital directors on how to reorganize their operations. They also sent professors of psychiatry to the provinces to give lectures to local psychiatrists, consult with regional health authorities, and inspect hospitals. Central research institutes and prominent professors were told that their job was to provide a model for others of what Pavlovian looked like in action.<sup>3</sup>

Minzdrav understood how to carry out this type of campaign. Pavlovian techniques were, after all, just particular types of medical technologies. Since its inception, the Soviet public health authorities had considered the adoption of medical technologies as a measure of progress. Modern medicine was understood to be medicine done with the help of x-ray machines, blood tests, urine tests, and pathological anatomy laboratories. The quantity of biological facts was taken as shorthand for quality of psychiatric care.<sup>4</sup> Even before the campaign for Pavlovian medicine, Minzdrav authorities had been frustrated by the slow rate at which psychiatric hospitals were adopting these modern medical technologies. After all, "active therapies" like

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<sup>3</sup> A. Portnov in Dobrodeev (Chairman), "Stenogramma obsuzhdeniia otcheta Tsentral'nogo nauchno-issledovatel'skogo instituta psikhiiatrii MZ SSSR za 1951 g. i plana raboty na 1952 g.," 9 April 1952, GARF f. r-8009, op. 33, d. 463, ll. 41-42.

<sup>4</sup> "Pamiatka Obsledovaniia meditsinskoi raboty psikhiiatricheskoi boln'itsy," GARF f. a-482, op. 47, d. 8454, l. 10.

insulin shock and prolonged sleep simply could not be done unless psychiatric staff had the tools and training needed to carefully monitor their patients' vital signs. Minzdrav administrators like Dmitrii Fedotov and Aleksandr Portnov blamed the slow adoption of active therapy on psychiatric hospital directors' failure to modernize and rationalize their use of technology.

The campaign for Pavlovian psychiatry, therefore, was used to mobilize psychiatric hospital staff to carry through a project of rationalization that went back at least to the 1920s and 1930s. Some, like Ivanov-Smolenskii, seemed to believe that objective tests would self-evidently support a laboratory-based approach to psychiatric knowledge. In this view, medical knowledge was scientific only when it was based on a bottom-up understanding of the physical causes that produced observed symptoms of illness. These physical causes could only be truly established in the laboratory because it was there that the experimenter could actively test his theories under controlled conditions. The introduction of more objective measurements to clinical practice, in this view, would provide a wealth of information that would be carried into the laboratory to help formulate new approaches to diagnosis and treatment. Clinical data is always superficial and descriptive. Scientific knowledge is analytical and experimental, and thus can only be produced under laboratory conditions.

This was not the only possible reading of the role of technology in the hospital, however. In the classical tradition of hospital medicine, physicians work at the bedside using tools like percussion and auscultation to gain insight into which disease a patient has. The disease may present itself in a slightly different way in each patient, but by meticulously recording the symptoms and how they develop over time, physicians eventually build up a picture of what a typical case of the disease looks like. This knowledge can then be used to diagnose new cases and to predict what course an illness will take, and thus to help physicians make critical

decisions about treatments and methods of care. According to this approach, the essence of the disease can be discovered through a natural history approach rather than a natural sciences approach. The hospital physician assumes that there is some essential physical process underlying each disease categories, but he also believes that these categories themselves can only be discerned through research done in the clinic.

The problem for psychiatrists in 1950 was that neither method had provided them with knowledge that could consistently help them accurately diagnose mental illness. In an ideal world, a diagnosis like “schizophrenia” should give the treating psychiatrist a clear idea of how to proceed. Since each disease is assumed to be a natural category, each case of the disease must have an essentially similar underlying cause, and therefore each case should be curable using the same method of treatment. Furthermore, a typical case of the disease should have a predictable course of development. Once a diagnosis is made, the psychiatrist should have a basically clear idea of what to expect and how to manage the patient. This was particularly important when psychiatrists were planning to use “great and desperate cures” like shock therapy. And yet, at the time of the Pavlov sessions, they still found that their diagnostic categories were simply not very useful. Writing in 1950, Moscow psychiatrist M. M. Zak expressed the ideal, and the reality, quite clearly.

One gets the impression that for some patients insulin hypoglycemia fits like a key to a lock, it opens it easily and smoothly; in other cases the key does not seem to fit, and the lock (the illness) does not open; and, finally, in a third set of cases, vigorous attempts to open the lock actually ruin it.<sup>5</sup>

Surely, Soviet psychiatrists assumed, if psychiatry were truly scientific it would be able to fit the right key to the right lock every time.

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<sup>5</sup> Protopopov, Polishchuk and Poznanskii (1939) quoted in M. M. Zak, "Katamnez shizofrenikov, lechennykh razlichnymi metodami," *NiP* 19, no. 4 (July-August 1950): 54.

## Pavlovian Technologies in Psychiatric Hospitals

Minzdrav USSR re-emphasized the importance of laboratory technology for psychiatric hospitals after the 1950 Pavlov Session. Psychiatric hospitals did their best to show progress in their year-end reports by highlighting how much more technology they were using. Their reports were filled with counting: how many new x-ray machines they had acquired, how many laboratories they had opened, how many blood and urine analyses they had done. The number of machines and diagnostic tests was used to measure not only the hospital's quality as a medical institution, but also their success in becoming "Pavlovian." Some psychiatric hospitals, particularly those in Moscow and Leningrad, tried to do something new: they established laboratories for the study of "higher nervous activity."<sup>6</sup>

In 1950 these laboratories were still quite rudimentary. They based their methods on one of Ivanov-Smolenskii's "speech motor" method of establishing conditioned reflex responses to spoken words. Once established, Psychiatrists used those conditioned reflexes to study the underlying patterns in the patient's "higher nervous activity."<sup>7</sup> By 1952, according to a Minzdrav RSFSR report, "higher nervous activity" laboratories had been opened in all the psychiatric hospitals in Moscow and Leningrad and also in the psychiatry departments of medical institutes all around the country. Some psychiatric hospitals that were affiliated with those departments had also opened higher nervous activity labs.<sup>8</sup> Meanwhile, Ivanov-Smolenskii had developed a

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<sup>6</sup> The medical institute psychiatry department in Alma-Ata, for instance, reported opening a higher nervous activity laboratory in September 1951. A. P. Shtess (Chairman of the Society of Neuropathologists and Psychiatrists, Kazakh SSR) to D. D. Fedotov (MZ SSSR), 5 February 1952, GARF f. r-8009, op. 33, d. 399, ll. 6-7.

<sup>7</sup> A. G. Ivanov-Smolenskii, "Ob izuchenii sovместnoi raboty pervoi i vtoroi signal'nykh sistem mozgovoі kory," *Zhurnal vysshei nervnoi deiatel'nosti imeni I. P. Pavlova* 1, no. 1 (1951): 57.

<sup>8</sup> The hospitals listed were Molotov, Gor'kii, Kazan, Riazan', Omsk, Khabarovsk, Sverdovsk; Irkutsk, Crimea, and Smolensk had not had opened VND labs. M. I. Lapidés (i.o. zav. orgmetodotdelom, gos. instituta psikh. MZ RSFSR), "Nekkotorye itogi deiatel'nosti psikhonevrologicheskikh statsionarov i dispanserov RSFSR po godovym statisticheskim i meditsinskim otchetam za 1952 god," undated [archived 8 April 1953], GARF f. a-482, op. 49, d. 5772, l. 4.

prototype machine that he hoped would be mass produced and installed in every hospital, a machine that would enable psychiatrists to more easily use Ivanov-Smolenskii's "speech-action method" to probe the underlying mind-brain of the patient. In 1953 Minzdrav recommended it for preparation (and redesign) for production.<sup>9</sup>

While some hospitals did introduce these strictly Pavlovian laboratories, however, the more significant effect was the boost in the number of other types of laboratories and technologies. Information on the number of these offices is spotty, and can be hard to compare from year to year because standards of reporting and aggregating data changed over time. Table 7.1 presents the available information that shows the level of specialized technical offices and laboratories increasing dramatically from the mid-1930s to the postwar period.<sup>10</sup> During the "Pavlov years," roughly 1950-1953, clinical-diagnostic laboratories became nearly ubiquitous, and the percentage of Soviet psychiatric hospitals with x-ray machines finally grew beyond 50%. Psychiatrists were particularly enthusiastic about their x-ray machines, which they used to screen patients when they were admitted to the hospital, and which they used to make sure patients about to be given insulin shock therapy did not have lung infections. X-rays were also

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<sup>9</sup> I. G. Kochergin (Chairman), "Protokol no. 39 zasedaniia prezidiuma UMS MZ SSSR," 22 September 1953, GARF f. r-8009, op. 2, d. 1902, ll. 43-45.

<sup>10</sup> The exception seems to be physiotherapy offices, which declined abruptly in 1952 from 106 to 11. It is possible that this represents a change in reporting methods (perhaps a method like hydrotherapy was separated out and reported separately). It is also possible that the decline was real. "Physiotherapy" referred to a heterogeneous group of physical interventions that had been state of the art methods at the beginning of the 20th century, including long, warm baths (hydrotherapy), massage, bright light treatment, and various forms of "electrotherapy" (galvanization, d'arsonvalization, faradization, diathermy, and 'franklinization'). Reports in the early 1950s suggested that hydrotherapy was being used much less than in the past, and that physiotherapy laboratories were in decline. On physiotherapy, see M. O. Gurevich and M. Ia. Sereiskii, *Uchebnik psikhiiatrii*, 5th ed. (Moscow: Medgiz, 1946); V. V. Mikheev and A. V. Neiman, *Uchebnik nervnykh i psikhicheskikh boleznei dlia srednikh meditsinskikh shkol*, 3rd ed. (Moscow: Medgiz, 1946). On the declining use of physiotherapy in the early 1950s, see GARF f. r-8009, op. 33, d. 399, ll. 188-189; M. I. Lapidés (i.o. zav. orgmetodotdelom, gos. instituta psikh. MZ RSFSR), "Nekotorye itogi deiatel'nosti psikhonevrologicheskikh statsionarov i dispanserov RSFSR po godovym statisticheskim i meditsinskim otchetam za 1952 god," undated [archived 8 April 1953], GARF f. a-482, op. 49, d. 5772, l. 5.

experimented with as a method of active treatment in their own right. By 1954, 60% claimed to have functioning x-ray offices.<sup>11</sup> The ideal, as Andrei Snezhnevskii articulated it at a 1955 conference, was for hospitals to give each patient a thorough objective analysis. "... it is not the quantity of material that is important," Snezhnevskii explained, "it is the quality, the thorough study of one and the same patient using every method – clinical, biological, physiological."<sup>12</sup>

**Table 7.1. Specialized Offices and Laboratories in USSR Psychiatric Hospitals, 1936, 1949-1953**

Year	Total # of Institutions	X-Ray Offices	Physiotherapy Offices and Wards	Clinical - Diagnostic Laboratories	Pathological Anatomy Offices and Wards	Functional Diagnostic Offices
<i>RSFSR Psychiatric Hospitals (without colonies)</i>						
1936	102	7 (7%)	n/a	42 (41%)	n/a	n/a
<i>USSR Psychiatric Hospitals and Colonies</i>						
1949	188	57 (30%)	94 (50%)	114 (61%)	41 (22%)	3 (2%)
1950	179	65 (36%)	104 (58%)	123 (69%)	45 (25%)	2 (1%)
<i>USSR Psychiatric Hospitals (without colonies)</i>						
1951	151	70 (46%)	106 (70%)	134 (89%)	45 (30%)	5 (3%)
1952	164	82 (50%)	11 (7%)	140 (85%)	48 (29%)	8 (5%)
1953	177	92 (52%)	8 (5%)	150 (85%)	57 (32%)	9 (5%)
1954	187	112 (60%)	n/a	n/a	n/a	n/a

*Sources:* Adapted from D. Shefer, "Mezhkraevaia konferentsiia nevroptologov i psikhiatrov v Rostove N/D," *Nevroptologii, psikhiiarii, i psikhogigiena* 5, no. 6 (1936): 1058; "Osnashchennost' lechebno-profilakticheskikh uchrezhdenii vspomogatel'nyimi spetsial'nyividami pomoshchi (biudzhetye i khozraschetnye uchrezhdeniia) in "Godovoi otchet MZ o seti, deiatel'nosti i kadrakh meditsinskikh uchrezhdenii po SSSR, 1950-1955, RGAE f. 1562, op. 18, dd. 481, 545, 613, 686, 757.

*Note:* Minzdrav USSR began including reports about the number of specialized offices in 1949. In 1951 they stopped reporting the number of offices for psychiatric hospitals and colonies, and instead reported them just for psychiatric hospitals.

<sup>11</sup> X-rays were thought to affect the central nervous system, and to be useful in treating ulcers. One researcher reported finding that exposure to x-rays had an effect on conditioned reflexes in dogs, and that the effect sometimes lasted up to a month. M. I. Nemenov, in L. N. Fedorov (Chairman), "Stenogramma zasedanii prezidiuma UMS MZ SSSR," 17 December 1948, GARF f. r-8009, op. 2, d. 1191, ll. 49-60.

<sup>12</sup> A. V. Snezhnevskii (Chairman), "Stenogramma zasedanii nauchnoi konferentsii po patologicheskoi anatomii psikhozov," 13 April 1955 (evening session), GARF f. r-9592, op. 1, d. 35, ll. 83-84.

## Pavlov's Theory and Prolonged Sleep Therapy

There was one form of medical treatment that Pavlov had specifically advocated: sleep therapy. The idea of using sleep as a method of treatment had been developed and popularized in the early 1920s by Swiss psychiatrist Jakkob Klaesi. Referred to as "prolonged sleep," Klaesi's method used a mixture of barbiturates to put his patients into a deep sleep that lasted for as many as ten days. He reported that "about a quarter to a third improved so greatly that they could be discharged or transferred to wards for less agitated patients."<sup>13</sup> The problem, as one guide to such treatments noted, was that "Great technical skill is required to avoid complications, particularly of a cardiovascular and renal nature."<sup>14</sup> When other psychiatrists studied Klaesi's methods, they found that around 5 percent of patients died. In 1933 one of Klaesi's colleagues developed a safer drug cocktail, the "Cloetta mixture," and in the early 1930s European psychiatrists sleep therapy was "widely adopted for affective, or mood, disorders."<sup>15</sup>

Soviet psychiatrists began to experiment with Cloetta's mixture in 1935, and their first results were reported in January.<sup>16</sup> At a December 1936 congress, the lead researcher reported that the treatment had been successful in 30% of the patients he had given it to, and that this result was even better the outcomes reported in Europe. "We are inclined to judged prolonged narcosis as the best method for treating chronic forms of schizophrenia," he concluded. He

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<sup>13</sup> Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley, 1997), 204-205; V. A. Giliarovskii and P. B. Posvianskii, eds, *Metodika i tekhnika aktivnoi terapii psikhicheskikh zabolevanii* (Moscow: 1939), 18-19.

<sup>14</sup> Lothar Kalinowsky and Paul Hoch, *Shock Treatments, Psychosurgery and Other Somatic Treatments in Psychiatry* (New York: Grune & Stratton, 1952), 291.

<sup>15</sup> Shorter, *A History of Psychiatry*, 205.

<sup>16</sup> "V Moskovskom obshchestve nevropatologov i psikhiatrov," *Nevropatologiya, psikhiaetriia, psikhogigiena* 5, no. 5 (1936): 882-895.



brushed aside the experience of another psychiatric hospital where between 5 and 10 percent of patients had died during prolonged sleep therapy treatment.<sup>17</sup>

Pavlov read some of these early reports about the testing of the “Cloetta Mixture” and he became enthusiastic about the idea that sleep therapy worked because it promoted “protective inhibition” in the brain.<sup>18</sup> Based on his work on experimental neuroses in dogs, Pavlov had developed a theory that nightly sleep was caused by a profound state of inhibition that irradiated over the cortex of the brain. In their inhibited sleep brain cells had a chance to restore themselves. Usually this only happened at night, but in principle the same restorative process might be triggered at any time that the cells of the brain were in danger. If the brain was subjected to toxic chemicals whole areas of the brain might become subject to long-lasting protective inhibition, effectively shutting down certain cognitive functions until the cells could restore themselves and/or the poison stopped its action.

Pavlov believed that many of the symptoms of schizophrenia were caused by this type of pathological protective inhibition, probably a response to poisonous substances produced by malfunctioning metabolic processes in the patient’s own body. This was where Pavlov hoed that prolonged sleep therapy might play a therapeutic role. If a physician induced long lasting sleep, perhaps he could force the brain to engage its own protective inhibition process and ultimately restore proper function to the brain.<sup>19</sup>

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<sup>17</sup> M. Ia. Sereiskii, "Sovremennye problemy lecheniia shizofrenii," in *Trudy 2-go vsesoiuznogo s"ezda nevropatologov i psikhiatrov. 25-29 dekabria 1936 g.*, ed. M. B. Krol' and A. O. Edel'shtein (Moscow: 1937), 570-585.

<sup>18</sup> George Windholz, "Pavlov's Concept of Schizophrenia as Related to the Theory of Higher Nervous Activity," *History of Psychiatry* 4, no. 16 (December 1993): 511-526; For Mark Sereiskii's account of his correspondence with Pavlov about sleep therapy, see M. Ia. Sereiskii, "Znachenie ucheniia I. P. Pavlova dlia problemy aktivnoi terapii psikhozov," *Nevropatologiiia i psikhiatriia* 18, no. 4 (1950): 56-59.

<sup>19</sup> Windholz, "Pavlov's Concept of Schizophrenia," 511-526.

In 1936 Pavlov asked Ivanov-Smolenskii to begin testing his ideas about sleep therapy on psychiatric patients and he found the initial results encouraging. Pavlov, however, died later the same month before the assessment of his concept of “protective sleep” was completed. Ivanov-Smolenskii continued to develop and advocate a Pavlovian concept of sleep therapy, and in the 1940s most psychiatrists seem to have accepted his ideas as valuable insights into why some patients recovered after a course of prolonged sleep.<sup>20</sup> Few Soviet psychiatrists actually adopted sleep therapy as a method of treatment for their patients, however. Dangerous side effects of commonly used drugs continued to be reported, included circulatory collapse, pneumonia, and other “very serious and unexpected complications.”<sup>21</sup> In 1949 only 28 psychiatric hospitals in the USSR (out of 152) were using sleep therapy, about 1% of all psychiatric patients in the USSR, and 7% of those who were receiving active biological therapy.<sup>22</sup> Sleep therapy was far less popular than insulin shock and electroshock, even though the first electroshock machines had only begun to arrive in most provincial psychiatric hospitals in 1947 and 1948.<sup>23</sup>

Overcrowding in psychiatric hospitals was probably the most significant obstacle to the use of sleep therapy. Psychiatrists had a very hard time keeping their wards quiet enough to allow patients to sleep at all, much less for the 12-20 hours advocated by Ivanov-Smolenskii.

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<sup>20</sup> Writing at the end of 1940, Mikhail Gurevich noted that that Pavlov’s theory that prolonged sleep worked through protective inhibition was broadly accepted, and that the Western theory that sleep produced a psychological breakthrough [*perelom v psikhologii*] had gained little traction in the Soviet Union. M. O. Gurevich, “K teorii aktivnoi terapii shizofrenii,” *NiP* 10, no. 1 (1941): 18.

<sup>21</sup> Commonly used drugs referred to were Cloetta’s mixture and sodium amital. V. A. Giliarovskii and P. B. Posvianskii, eds., *Metodika i tekhnika aktivnoi terapii psikhicheskikh zabollevanii* (Moscow: 1939), 22-23, 25.

<sup>22</sup> The figures for 1948 were even lower, with only 16 psychiatric hospitals in the USSR using sleep therapy. The increase in 1949 may have reflected improving access to drugs, or it may have been connected to the 1949 celebration of Pavlov’s 100th birthday and the attendant publicity for sleep therapy. These figures come from a report written by Varvara Eliseevna Galenko, a long-time staff researcher at the USSR Institute of Psychiatry. V. E. Galenko, “O novykh variantakh lecheniia snom psikhicheskii boln’ykh,” *ZhNiP* 53, no. 1 (1953): 58.

<sup>23</sup> M. O. Gurevich (Chairman), “Protokol zasedaniia prezidiuma psikh. komissii,” 24 May 1941, 8009-5-212a, ll. 21-28.

Sleep therapy also required nurses to keep constant watch to make sure nothing went wrong with the sleeping patient, and nursing staff could not easily be spared to keep watch over a small group of sleeping patients.<sup>24</sup>

After the 1950 Pavlov Session in physiology, psychiatrists rapidly began to adopt sleep therapy as a way to demonstrate their active participation in putting Pavlov's theory into practice. From 1949 to 1950 sleep therapy went from being used in 28 psychiatric hospitals to being used in 46 hospitals. Moscow's Kashchenko hospital was reported to have replaced its 5-bed sleep therapy unit with a whole complex of sleep units with a total of 100 beds. Moscow Psychiatric Hospital No. 1 established 45 new beds for sleep therapy, and the Gor'kii Clinical Psychiatric Hospital established 20.<sup>25</sup> One report put the number of patients given sleep treatment in 1950 at around 3,400, which works out to about 2.2% of all patients who passed through Soviet psychiatric hospitals in 1950. To be sure, this was not an enormous portion of the patient population, but it was more than double the proportion of patients given sleep therapy in 1949.<sup>26</sup>

When psychiatrists started to use sleep therapy on a larger scale they discovered that it was by no means a panacea. If the treatment's were judged by whether or not patients recovered from their illness enough to live outside the psychiatric hospital, then sleep therapy was of moderate use at best. Studies found "good remissions" in up to 44% of recently ill patients, but

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<sup>24</sup> V. E. Galenko, "O novykh variantakh lecheniia snom psikhicheski bol'nykh," *ZhNiP* 53, no. 1 (1953): 60.

<sup>25</sup> Minzdrav reported that sodium amital (*amital-natrii*, also known as *barbamil*) was the most popular sedative, and this seems to be well corroborated by the numerous requests for it from psychiatrists that have remained in the archives. Other substances listed in Minzdrav's report were barbiturates, bromides, scopolamine, hexanol, "Krasnushkin's Mixture," and "many others." A. Portnov (Nach. Otdela psikhonevrologicheskoi pomoshchi MZ SSSR, "Otchet o rabote psikhonevrologicheskogo otdela MZ SSSR za 1950 g.," sometime after 9 December 1950, GARF f. r-8009, op. 33, d. 263, l. 10.

<sup>26</sup> V. E. Galenko, "O novykh variantakh lecheniia snom psikhicheski bol'nykh," *ZhNiP* 53, no. 1 (1953): 58. For total patients who passed through USSR psychiatric hospitals in 1950 ("Postupilo bol'nykh"), see "Otchet Ministerstva zdravookhraneniia Soiuzna SSR o seti, deiatel'nosti i kadrakh meditsinskikh uchrezhdenii SSSR za 1950 g.," RGAE, f. 1562, op. 18, d. 545, l. 3.

at least 60% of those were back in the hospital within a year. Other methods of “active therapy” were considered less dangerous and more effective. Insulin, for instance, produced 50% “good remissions” in fresh cases and had a slightly lower rate of repeat hospitalization.<sup>27</sup> If results had been the only consideration, sleep therapy should have been discarded as an also-ran.

Instead, Soviet psychiatrists expanded their use of sleep. Rather than judging sleep therapy a failure in comparison with other methods, psychiatrists changed the criteria they used to evaluate their results. And when judged by its capacity to bring calm and order to the wards, prolonged sleep therapy was judged a resounding success. In Pavlov psychiatrists had found the ideal authority to help them rationalize their use tranquilizers to subdue problem patients.

Soviet psychiatrists were deeply enmeshed in a discourse of “no-restraint,” the idea that the mad should not be held as if they were prisoners. This idea dated back to 1789, when French psychiatrist Philippe Pinel had famously removed the chains from the patients at his hospital in Paris. This gesture resonated metaphorically with the era of the French revolution. The chains of the old regime were being removed, and now men would be ruled by science and reason.<sup>28</sup> The phrase “no-restraint” itself was popularized in England in the 1790s by Quaker named William Tuke. Like Pinel, Tuke hoped to use kindness to help establish a rapport with his patients. And, like Pinel, he believed that reason could be restored to the mad if they were allowed to “gain confidence” in themselves. He therefore set about designing a “therapeutic environment” in which patients would gradually be restored to their reason. This approach was referred to as

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<sup>27</sup> M. M. Zak, "Katamnez shizofrenikov, lechennykh razlichnymi metodami," *Nevropatologiya i psikiatriya* 19, no. 3 (May-June 1950): 52-56.

<sup>28</sup> Shorter, *A History of Psychiatry*, 11.

“moral therapy,” and by the early nineteenth century it had become “the gold standard of enlightened asylum administration.”<sup>29</sup>

Russian psychiatrists had embraced the rhetoric of no-restraint in the 1880s, and it remained a central part of their self-understanding throughout the Soviet period. Like the French Revolution, the Bolshevik revolution was supposed to liberate people from the arbitrary force used under the old regime. Under the new regime, social conditions would improve, and this would inevitably lead to improvement in the health of both body and mind. Metaphorically, chains, straight jackets, and shackles were antithetical to this ethos of liberation. The mentally ill might have to leave general society for a time, but they should still be treated like human beings. In 1941, for instance, instructions to Red Army nurses explained that, “In soviet medical institutions it is categorically forbidden to use on the mentally ill measures of forced restraint which degrade the human personality (straight jackets, binding the patient, wrapping the patient, etc).”<sup>30</sup> In 1949, following an inspection of psychiatric hospitals in Estonia, a Moscow psychiatrist wrote a concerned letter about the use of restraint that he had seen there. “As far as straightjackets are concerned, they openly recall the mad houses of old.”<sup>31</sup> And so psychiatrists had a problem. Their psychiatric hospitals were desperately overcrowded and violent patients could easily become agitated. How could psychiatrists justify restraining the disruptive patients who upset their overcrowded wards?

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<sup>29</sup> Shorter, *A History of Psychiatry*, 20-21.

<sup>30</sup> A. I. Zhichin (Zam. NKZ RSFSR, Nachal'nik Uprav. Evakogospitalei), “Pravila nabliudeniia i ukhoda za ranenymi i bol'nymi s narusheniiami psikhiki (Dlia srednego med. personala evakogospitalei NKZ RSFSR),” 17 November 1942, GARF f. a-482, op. 47, d. 1393, l. 25ob.

<sup>31</sup> Letter from V.A. Grombakh (Starsh. nauch. sotrunik Instituta Psikhiiatrii MZ SSSR) to the Head Physician of Tallin Psychiatric Hospital, Esonian SSR, 1948, GARF f. 8009, op. 33, d. 4, 46.

Pavlov's theory of "protective inhibition" offered an elegant solution. Even though they were giving their patients tranquilizing drugs, the psychiatrists could argue that they were offering the patient an actual treatment, not just a chemical form of restraint. Pavlov, as psychiatrists frequently noted, believed that tranquilizers like those used in sleep therapy did not simply "depress nervous excitation," they also "regulate[d] it."<sup>32</sup> The drug stopped the patient's disruptive behavior because the underlying brain state that caused the behavior had been eliminated. As one of Pavlov's most often cited protégés wrote, "The beneficial influence of bromide, which reestablishes the disrupted equilibrium in sick animals . . . , is related to the fact that bromide is a restorative [*vosstanovitelem*], a strengthener and a concentrator of inhibition."<sup>33</sup> As sleep therapy and the cognitive justifications associated with Pavlovian thought became more ubiquitous, Soviet psychiatrists increasingly came to see behavior as a signifier of underlying bodily dysfunction.<sup>34</sup>

This Pavlovian correlation between calm patients and healthy bodies was embraced by harried psychiatric hospital directors who saw it as a welcome justification for their ongoing efforts to calm the wards. Psychiatrists at Moscow's Psychiatric Hospital No. 1, for instance, explicitly drew on Pavlovian theory to justify using sleep therapy as a tool in what they referred to as "the fight against agitation." In 1950 they began to use a modified form of sleep therapy on the patients in one of the wards for disturbed women. They put the women to sleep for 12-20

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<sup>32</sup> I. P. Pavlov, quoted in V. E. Galenko, "O novykh variantakh lecheniia snom psikhicheski boln'ykh," *ZhNiP* 53, no. 1 (1953): 58

<sup>33</sup> M. K. Petrova, quoted in *ibid.*, 58

<sup>34</sup> See my discussion of the "fight against agitation" in Chapter One. See also Joel Braslow's discussion of psychiatric hospitals in California, in which he concludes that, "... throughout the first half of this century, and in spite of heaping disdain on physical restraint, doctors ascertained a given remedy's effectiveness by how well it measured up against these simplest methods of bodily control." Joel Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley: University of California Press, 1997), 36.

hours per day, justifying this on the grounds that it helped “to stop or decrease the agitation of disturbed patients, primarily in patients with schizophrenia.” After the sleep treatment, they reported, the majority of the patients ceased to be agitated, and many of them were calm enough for their case to be considered “an intra-hospital improvement, that is, the removal of agitation, the ordering [*uporiadochenie*] of behavior sometimes with the possibility of transfer of the patient to a calm ward.” A few patients were reported to unexpectedly have recovered after sleep therapy, and had been checked out after years of unsuccessful active therapy.<sup>35</sup>

### **The “Protective Therapeutic Regime”**

Sedative drugs were only the most extreme way that Pavlov’s followers thought might help evoke “inhibition” in the brains of their patients. They also advocated a method of organizing the work of psychiatric hospital that they claimed was uniquely founded in Pavlov’s scientific principles. Pavlov had referred to this as a “protective therapeutic regime,” and, like sleep therapy, he intended this technique to be used to promote “protective inhibition” in disordered minds.

As popularized by Ivanov-Smolenskii, the idea of the “protective regime” was based on Pavlov’s belief that the environment had a powerful impact on the nervous system. Stimuli in a patient’s environment produced excitation which might overwhelm an already depleted nervous system. Repeated stimuli might establish conditioned reflexes which could in time become pathological “layers” in their own right. In short, being in the hospital could harm a patient’s mental state. Conversely, a well-organized hospital could have a soothing, healthful effect. Ivanov-Smolenskii suggested organizing psychiatric wards to resemble sanatoriums rather than

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<sup>35</sup> E. N. Kameneva and V. K. Iurasovskaia, "O lechenii psikhicheskikh zabolevanii modifikatsiei preryvistogo sna posredstvom malykh doz snotvornykh," *ZhNiP* 53, no. 4 (1953): 279-282.

asylums, reducing to a minimum “strong stimulations” like screams, cries, and fights, and stressing the need for hospital staff to treat patients gently and kindly so as not to “strike further heavy blows to the weak cells.”<sup>36</sup> The ideal hospital would be organized in a way that helped the patient’s “nervous activity” become well balanced and that promoted the nervous system’s own restorative mechanism, “protective inhibition.” Calm behavior was interpreted by Pavlovian psychiatrists as a sign that a correct balance between inhibition and excitation had been established in the brain.<sup>37</sup> In short, Pavlov had re-articulated the late eighteenth century ideal of “moral therapy.” Psychiatrist Vladimir Grombakh made this connect explicit in an article he wrote in the summer of 1951: “The enormous positive role of the closed psychiatric hospital is expressed in an aphorism: ‘In the hospital the walls heal’ [*v bol’nitse steny lechat*].”<sup>38</sup>

The concept of the Pavlovian “protective regime” was particularly taken up by Efim Smirnov, the USSR Minister of Health. In the summer of 1951, Smirnov talked frequently about Pavlov’s ideas about hospital organization, each time telling the story of how he himself had spent six dreadful days in the Kremlin hospital. The hospital, according to Smirnov, was so noisy that “not once could I fall asleep.” Doors creaked, people yelled, and the nurses were rude. All of this led to excitation in the brain, new conditioned reflexes, and further health problems; what was needed was calm. Smirnov’s ideal hospital was a place where the rooms were quiet, the lights were dim, and nurses did not wake their patients by yelling, “Patient, get up! [*bol’noi,*

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<sup>36</sup> A. G. Ivanov-Smolensky, *Essays on the Patho-Physiology of the Higher Nervous Activity According to I. P. Pavlov and His School*, trans. S. Belsky (Moscow: Foreign Languages Publishing House, 1954), 282.

<sup>37</sup> I. G. Ravkin (Zaved. klinicheskim otdeleniem Gos. NII Psikh. MZ RSFSR) and N. N. Zak (St. Vrach b-tsy im. Gannushkina Mosgorzdravotdela), “Metodicheskoe pis’mo: Priemy bor’by s psikhomotornym vzbuzhdeniem psikhicheskii bol’nykh (proekt),” undated, sometime in 1952, TSMAM, f. 1126, op. 1, d. 76, ll. 1-2, 4.

<sup>38</sup> V. A. Grombakh, “Neprestanno sovershenstvovat’ usloviia lecheniia i sodержaniia psikhicheskii bol’nykh,” *NiP* 20, no. 4 (1951): 42.



stavai!].”<sup>39</sup> Hospital conditions were not just “unimportant nonsense,” Smirnov insisted.

“Believe me, these elementary concepts come out of Pavlov’s theory, and thus we can base them on science.”<sup>40</sup>

In the hospital environment, Smirnov claimed, words could be the most powerful stimuli of all. Pavlov had argued that language constituted a “second signal system” in the human cortex where the stimuli provided by language created conditioned reflexes. The concept of the second signal system, Smirnov argued, should make physicians think seriously about how they spoke to their patients and what they said, even if sometimes meant telling lies:

... we are required by Pavlov’s theory to protect the psyche of the patient [*patsienta*], the psyche of the sick person [*bol’nogo*] by not telling him the truth. In our profession untruth [*nepravda*] is sometimes necessary, even often necessary, to avoid traumatizing the patient [*chtoby ne travmirovat’ bol’nogo*]. A person who does this is not committing any kind of crime . . . If you tell a patient that he has cancer, you understand very well how the patient will take that, even if the person is intelligent [*intelligentnyi*]. Everyone understands that with [cancer] we are frequently powerless to help . . . but if we protect the patient’s psyche that gives him extra months or even a year.<sup>41</sup>

In Smirnov’s understanding, then, this approach to hospital organization was a form of psychological intervention – precisely the original meaning of the phrase “moral treatment.”

What is more, the concept of moral treatment seemed to provide intellectual warrant for psychiatrists to renew the sort of “bio-social” theories that had been forbidden by the Party in

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<sup>39</sup> E. I. Smirnov (Chairman), “Stenogramma Soveshchaniia u Ministra s nachal'nikami upravlenii i glavnymi spetsialistami,” 18 October 1951, GARF f. r-8009, op. 1, d. 896, l. 386; and idem., “Vystuplenie ministra zdavookhraneniia t. Smirnova o dal'neishem razvitii Pavlovskogo ucheniia,” 4 October 1951, GARF f. r-8009, op. 1, d. 984, ll. 7-23. The ideal Pavlovian hospital regime had come close to being realized at a hospital in the provinces, according to Smirnov, and he himself had gone to see what it was like. “There they really, in practice, understand the significance of calm [*pokoi*] in a hospital. There they really, in practice, understand the significance of the word as the strongest, most powerful stimulus. There, in practice, there are serious attempts to use conditioned reflex sleep in place of medicated sleep.” In that hospital rooms were kept quiet, and the staff used phonograph records to create a soothing atmosphere, playing sounds like the falling of rain. In the morning, instead of waking patients by yelling, “Patient, get up!”; instead they put on records of morning sounds. The hospital had apparently been profiled in *medrabortnik* sometime in 1949 or 1950. Smirnov (Chairman), “Stenogramma Soveshchaniia u Ministra,” 18 October 1951, GARF f. r-8009, op. 1, d. 896, l., 386, 388-390.

<sup>40</sup> Ibid., ll. 383-390.

<sup>41</sup> Ibid., ll. 383-390.; Smirnov, “Vystuplenie,” GARF f. r-8009, op. 1, d. 984, 8.

1936 and that psychiatrists like Giliarovskii had sought to revive after World War Two. If the psyche was so easily affected by words spoken and by the organization of the social environment, then should psychiatrists not have a role in helping to create healthful environments outside the hospital as well?

Some psychiatrists did use Pavlov's ideas to support a new approach to mental hygiene.<sup>42</sup> The psychiatrists who worked in the upper levels of Minzdrav, however, saw Pavlov's ideas about the healing nature of the psychiatric hospital environment as an opportunity to push forward an ongoing project to standardize and rationalize psychiatric practice. Introducing laboratory tools like x-ray machines was an important component of this project, in part because they signified "normal" medical practice. The long term goal for psychiatry, as administrators sometimes admitted, was to erase the division between general hospitals and psychiatric hospitals. Another major way in which they sought to modernize psychiatric hospitals, however, was simply by sorting patients into separate wards according to their patterns of behavior. Pavlov's work gave them an irreproachable theoretical justification for their plans.

In one of these attempts to use Pavlov's ideas to theorize hospital management, the researchers found that 17% of patients should be living on wards that were organized to encourage protective inhibition, and should be kept dimly lit and very quiet<sup>43</sup> Another 14% of patients needed the opposite, a "stimulation regime," where they would do labor therapy, calisthenics [*lechebnaia fizkul'tura*], and cultural entertainment, all of which was intended to

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<sup>42</sup> Kutanin, in G. Sukhareva (Chairman), "Stenogramma soveshchaniia UMS Instituta Psikhiatrii RSFSR," 29 May 1954, GARF f. a-482, op. 48, d. 1750, l. 73; O. V. Kerbikov, "S. S. Korsakov i zadachi nauchnykh issledovaniy v oblasti profilaktiki psikhicheskikh zabolevanii," in *Trudy Vsesoiuznoi nauchno-prakticheskoi konferentsii posviashchennoi 100-letiiu so dnia rozhdeniia S.S. Korsakova i aktual'nym voprosam psikhiatrii*, vol., ed. V. M. Bانشchikov, et al. (Moscow: Medgiz, 1955), 3-8.

<sup>43</sup> E. S. Zorina, "K voprosu o profile otdelenii pri proektirovanii i rekonstruktsii psikhonevrologicheskikh bol'nits," *Zhurnal nevropatologii i psikhiatrii im. Korsakova*, no. 5 (1952): 64

help them “break pathological connections” and establish “new dynamic stereotypes.”<sup>44</sup> The other patients, the author concluded, needed to be placed on strict surveillance wards for disturbed patients, placed in wards for somatic treatment, or sent to special nursing homes for chronic patients.<sup>45</sup>

Other psychiatrists began to write about how Pavlovian principles might be incorporated into the construction of new psychiatric hospitals. The new hospitals were to be built in a way that enabled “patients to be kept in comfortable and humane conditions, while at the same time allowing for active treatment to be done, and for the total person to be treated (allow access from all specialties.)<sup>46</sup> The authors imagined a three-story building with the top floor devoted to radiology, pharmacy, and culture; the middle floor devoted to wards for calm patients, and offices for neurologists, dentists, and administration; and the ground floor devoted to wards for acute and disturbed patients, as well as admissions, cooking, and water treatment. In this scheme every patient would be close to laboratories and general medical care. Calm patients in need of a “protective regime” would be isolated from disturbed and agitated patients.<sup>47</sup> Other authors made

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<sup>44</sup> “Dynamic stereotype” was the term that Pavlov used for behaviors that involved more than a single stimulus-response, but which nevertheless became habitual. The term was used by psychiatrists and psychologists who wanted to articulate ideas of individual psychology, mind-set, and outlook, but who needed language that would allow them to do so without resorting to the idiom of functional psychology. For a full-throated defense of the value of the dynamic stereotype concept, see George Windholz, “Pavlov's Conceptualization of the Dynamic Stereotype in the Theory of Higher Nervous Activity,” *American Journal of Psychology* 109, no. 2 (Summer 1996): 287-295.

<sup>45</sup> E. S. Zorina, “K voprosu o profile otdelenii pri proektirovanii i rekonstruktsii psikhonevrologicheskikh bol'nits,” *Zhurnal nevropatologii i psikiatrii im. Korsakova*, no. 5 (1952): 64-65.

<sup>46</sup> A. A. Portnov and A. M. Rapoport, “K voprosu o planirovanii novykh psikhonevrologicheskikh bol'nits,” *Zhurnal nevropatologii i psikiatrii im. Korsakova*, no. 5 (1952): 52-58.

<sup>47</sup> Ibid.

similar suggestions, emphasizing the need to guarantee calm for all patients, make treatment more efficient, and make observation of patients by staff easier.<sup>48</sup>

Their goal was to turn psychiatric hospitals into institutions that were totally unlike the popular image of the asylum. As the head of Minzdrav's psychiatry department wrote, "The implementation of Pavlovian methods is being held up by the inadequate mental hospitals in the USSR," which were either old prison hospitals built by tsarist police, or massive rural hospitals built by the *zemstvo*. Pavlovian psychiatric hospitals would be modern hospitals where the environment was constructed on the basis of Pavlovian theory, hospitals that incorporated modern equipment and techniques. The government's newfound appreciation for Pavlov's doctrine and its commitment to public health gave him hope that it was now possible "to radically eliminate harmful influences, and thus to radically improve the conditions of patients in our hospitals."<sup>49</sup>

A key aspect of the Pavlovian regime, however, was that it not only brought more order to the patients, it also brought more order to the hospital staff. The 1950 Pavlov Session had established Pavlov's principles as a part of the ideological discourse of Late Stalinism. To show their party-mindedness, medical personnel needed to show that they understood Pavlov as well as the classics of Marxism-Leninism. The link between being a good Pavlovian and good Communist was publicly demonstrated at the highest levels. Beginning in July 1950 soon after the Pavlov Session in physiology, the Central Committee of the Party ordered the Ministry of health to "promote" researchers and professors from central research institutes in Moscow to top

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<sup>48</sup> Sokolov rejected the idea of a multi-story hospital, suggesting instead a one-story building in the shape of a Cyrillic letter "П." A. A. Sokolov, "O proektirovanii psikhiatricheskoi bol'nitsy," *Zhurnal nevropatologii i psikhiatrii im. Korsakova*, no. 5 (1952): 59-62.

<sup>49</sup> V. A. Grombakh, "Neprestanno sovershenstvovat' usloviia lecheniia i sodержaniia psikhicheskii bol'nykh," *NiP* 20, no. 4 (1951): 41-44.

posts in medical institutes in the provinces.<sup>50</sup> These senior researchers in the center were to be replaced by “young capable scientific cadres working on the periphery” chosen from “those who are most capable and well prepared in an ideological-scientific sense and in the area of Pavlovian physiology.”<sup>51</sup> As anyone could see, those who were “promoted” to the provinces were overwhelmingly Jewish. It seems clear that the Ministry was using this campaign as an excuse to purge Jewish psychiatrists from the top levels of the profession.<sup>52</sup>

These ideological pressures were applied at the local level as well through the process of “attestation,” or credential vetting. In 1952, all the directors (*glavnie vrachi*) of republic-level psychiatric hospitals were vetted by Minzdrav RSFSR; the remaining psychiatrists in these hospitals underwent attestation in 1952-1953, a process that was done when special Minzdrav commissions visited regional hospitals. These “attestations” included questions about medial work, war service, scientific research, working relationships in the hospital, study of the

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<sup>50</sup> Four major psychiatry departments were identified that were in need of directors: Kuibyshev, Minsk, Riazan', and Molotov. Specialists from other disciplines were also promoted from central institutes to vacant provincial positions. A. Shabanov (i.o. Ministr Zdrav. SSSR), “Prikaz MZ SSSR no. 644: O realizatsii psotanovleniia nauchnoi sessii AN SSSR i AMN SSSR, posviashchennoi problemam fiziologicheskogo ucheniia akademika I. P. Pavlova,” 31 July 1950, GARF f. r-8009, op. 1, d. 905, l. 22.

<sup>51</sup> In particular, among “young capable scientific cadres working on the periphery,” the TsK investigators singled out Oleg Kerbikov, [?] Shevelev, Igor Sumbaev, and [V. A. ?] Glazov. P. V. Kovanov (Zav. sektorom Administrativnogo otdela TsK VKP/b/) and Larionov (Otvetstv. kontroler KPK pri TsK VKP/b/) to P. K. Ponomarenko (Sekretar' TsK) and M. F. Shkiriatov (Zam. pred. KPK pri TsK) (October 11, 1949), RGANI, f. 6, op. 6, d. 1556, ll. 10-11. A partial publication of this document can be found in G. V. Kostyrchenko, *V plenu u krasnogo faraona: Politicheskie presledovaniia evreev v SSSR v poslednee stalinskoe desiatiletie*. (Moscow: Izd. "Mezhdunarodnye otnosheniia", 1994), 295, or in the English translation, pp. 253-254.

<sup>52</sup> At least half a dozen of the top psychiatrists who were removed from central research institutes in Moscow were sent to head psychiatry departments in other parts of the Soviet Union. Vladimir Iosifovich Akkerman had been the head of the psychiatry department at the medical institute in Minsk since 1939. In 1950 he left his position and became head of the psychiatry department at Samarkand Medical Institute; I have not been able to discover who his replacement was, and the reason for his departure is unclear to me, but the timing and nature of the transfer (to Central Asia) suggests that he was probably “exiled” in the same way that higher profile Jewish psychiatrists like Lukomskii (who was sent to Omsk medical institute), Rokhlin (Kazan Institute for Advanced Medical Studies), Shmar'ian (Iaroslavl' medical institute), Chalisov (Azerbiadzhan medical institute), and Lukomskii (Arkhangelskii medical institute). G. V. Kostyrchenko, *V plenu u krasnogo faraona: Politicheskie presledovaniia evreev v SSSR v poslednee stalinskoe desiatiletie. Dokumental'noe issledovanie* (Moscow: Izd. "Mezhdunarodnye otnosheniia", 1994), 295-296.

Nineteenth Party Congress, and Pavlov's theories.<sup>53</sup> Regional health authorities carried out their own attestations of psychiatric workers during roughly the same time period.<sup>54</sup> When local inspectors uncovered overcrowding and barely existing active therapy in Kursk Psychiatric Hospital, they recommended that the staff not only reform their organization on the wards, they also recommended that they "organize a cycle of lectures on Academic I. P. Pavlov's theory, bringing in local physicians and medical institute specialists for this purpose," and that they "develop practical measures to use Pavlov's theory in the therapeutic work of the psychiatric hospital."<sup>55</sup>

Following rules that were grounded in Pavlov's doctrine was not just a matter of following work procedures, therefore, it was also a matter of demonstrating one's political consciousness. Psychiatrists at Minzdrav and psychiatric hospital directors took advantage of this fact to use the campaign for a Pavlovian hospital regime to impose strict new work routines and standards of conduct on psychiatric hospital personnel. The fundamental principle of Pavlov's "protective regime," according to Minzdrav's official instructions, was "the active protection of the patient from all possible negatively influencing factors in the surrounding environment: the creation of conditions that beneficially influence the organism of the patient; the establishment of

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<sup>53</sup> "Reshenie Kollegii MZ SSSR," 24 July 1953, GARF f. a-482, op. 49, d. 6621, l. 189; Egorovskaia, "O rabote apparata Otdela psikhonevrologicheskoi pomoshchi MZ RSFSR," 20 July 1953, GARF f. a-482, op. 49, d. 6628, ll. 140, 142; "Dokladnaia zapiska glavnogo vracha Voronezhskoi psikhonevrologicheskoi bol'nitsy No. 10 o rabote za 1954 g.," GARF f. a-482, op. 49, d. 8721, ll. 120-160.

<sup>54</sup> In Moscow, attestation of psychiatric hospitals was done in February and March 1953. Pridannikov (Zav. Mosgorzdravotdel), "Prikaz No. 117: V tseliakh izucheniia i dal'neishego uluchsheniia sostoianiia rukovodiashchikh kadrov nevro-psikhiatricheskikh dispensarov i psikhonevrologicheskikh otdelenii poliklinik..." 9 February 1953, TsAGM, f. 533, op. 1, d. 3, l. 30; Pridannikov (Zav. Mosgorzdravotdel), "Prikaz No. 248: V tseliakh dal'neishego izucheniia kadrov i pravil'noi ikh rasstanovki v ambulatornykh sudebno-psikhiatricheskikh ekspertnykh komissiiakh..." 14 March 1953, TsAGM, f. 533, op. 1, d. 3, l. 30a.

<sup>55</sup> I. Iarochkin (Zam. Predsedatelia ispolkoma oblsoveta) and N. Solodovnikov (Sekretar' ispolkoma oblsoveta), "Reshenie No. 215 Ispolkoma Kurskogo oblastnogo Soveta o rabote Kurskoi psikhiatricheskoi bol'nitsy MZ RSFSR (kopiia)," 11 January 1951, GARF f. r-8009, op. 1, d. 924, l. 91.

total trust on the part of the patient, and the unity of action of the medical worker and the patient, which helps guarantee effect in treatment.”<sup>56</sup> In practice this was taken to mean that staff should not shout or use loud voices, that they should wear soft shoes and open doors soundlessly. Staff were sternly reminded to give patients sleep therapy, labor therapy, entertainment, and food on a strict and dependable schedule. They were to keep rooms dark during sleeping hours so that patients could get good sleep. Agitated patients were to be strictly separated from calm patients.<sup>57</sup>

Psychiatric hospital directors used this to discipline hospital staff, particularly the nurses and nurses’ aides, many of whom came from rural communities, had little education, and who, by the standards of the psychiatrists, were deeply “uncultured.” With proper training, nurses at Moscow’s Gannushkin hospital were told, “work in this direction can be done with some success even in the existing conditions of overcrowding of the ward.”<sup>58</sup> The nurses were not the only ones who were said to be in need of regimentation. The place to start, according to one senior psychiatrist, was with the reeducation of psychiatrists. Many psychiatrists still held to “the mistaken concept of the confinement [*prizrenie*] of mental patients that developed under conditions of bourgeois barbarity.” These traces had to be “removed from the consciousness” of

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<sup>56</sup> The instruction recommended establishing trust between patient and staff by having “individual conversations with the goal of preparing the patient to the upcoming treatment,” and also recommended explaining to the patient “the role and importance of the protective regime of the hospital from the position of Pavlovian theory.” A. Shabanov (Deputy Minister of Health USSR), “Ob organizatsii raobty bol’nykh na osnove fiziologicheskogo ucheniia akademika I. P. Pavlova,” 24 March 1952, GARF f. r-8009, op. 1, d. 1094, ll. 37-37ob.

<sup>57</sup> I. G. Ravkin (Zaved. klinicheskim otdeleniem Gos. NII Psikh. MZ RSFSR) and N. N. Zak (St. Vrach b-tsy im. Gannushkina Mosgorzdravotdela), “Metodicheskoe pis’mo: Priemy bor’by s psikhomotornym vzbuzhdeniem psikhicheskii bol’nykh (proekt),” undated, sometime in 1952, TSMAM, f. 1126, op. 1, d. 76, ll. 2-3.

<sup>58</sup> “*Okhranitel’nyi rezhim* [protective regime]” was the subject of the meeting of the senior nurses and head of wards. “Protokol no 5 proizvodstvennykh soveshchaniy zaveduiushchikh otdeleniiami i starshikh sester otdelenii pri glavnom vrache bol’nitsy im. Gannushkina,” [day illegible] April 1952, TsAGM, f. 533, op. 1, d. 6, ll. 47-48.

psychiatrists and public health administrators so that the problems of psychiatric hospitals could finally be overcome.<sup>59</sup>

So far as most psychiatric hospital directors were concerned, the concept of the protective regime was most useful as a way to squeeze long-overdue funding out of Minzdrav. As I discuss in chapter one, psychiatrists had been trying to change the way that their psychiatric hospitals were organized since at least the 1930s. After 1950, they began to stress that by not giving them the resources they needed, Minzdrav itself was undermining the implementation of Pavlov's theories. They would of course like to use Pavlovian methods like sleep therapy, psychiatrists reported to Minzdrav, but that they could not because they did not have enough drugs, staff, or space.<sup>60</sup> They would like to expand their hospital laboratories, but the Ministry's decrees did not provide for laboratory staff. Indeed, without more staff, they were unable to introduce a Pavlovian protective regime. "The requirements of personnel norms at the present time," one psychiatrist said at a conference early in 1951, "should be based on active therapy in general, the restructuring of medical work of psychiatric hospitals on new Pavlovian foundations, and the need for treating 'chronics.'"<sup>61</sup> Sometimes such exchanges became heated, as exasperated psychiatrists vented their frustration. In a 1950 meeting at Minzdrav RSFSR, for instance, one psychiatrist exclaimed to the Minister that, "A single physician cares for 100 calm patients – surely that isn't enough!" The Minister responded that this was old news: "We have already

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<sup>59</sup> V. A. Grombakh, "Neprestanno sovershenstvovat' usloviia lecheniia i sodержaniia psikhicheski bol'nykh," *NiP* 20, no. 4 (1951): 41-44.

<sup>60</sup> Burkovskaia (i.o. zav. Psikh kliniki) to T. I. Eroshevskii (Director Kuibyshev State Medical Institute), GARF f. r-8009, op. 33, d. 353, ll. 20-20ob.

<sup>61</sup> N. N. Zak (St. Vrach b-tsy im. Gannushkina Mosgorzdravotdela) in A. A. Portnov (Chairman), "Protokol soveshchaniia glavnykh vrachei psikhonevrologicheskikh bol'nits i dispanserov g. Moskvy," 15 February 1951, GARF f. r-8009, op. 33, d. 397, l. 3.



heard this. We understand this,” to which the psychiatrist shot back, “If you understand, then you need to do something!”<sup>62</sup>

### **Conclusion: Pavlovian Psychiatry and Clinical Nosology**

The campaign to promote Pavlovian psychiatry changed the way that Soviet psychiatrists talked about their work. It also accelerated the process of regimenting psychiatric hospital wards in ways that were suited to new forms of psychiatric treatment like sleep therapy and shock therapy. Older ways of organizing the psychiatric hospitals were superseded, and psychiatric hospital directors were given new tools to ask for funds, discipline their staff, and justify using drugs and other methods to subdue agitated patients. None of this was new, of course. Examples of virtually all these techniques can be found in the pre-Pavlovian psychiatric hospital. The campaign for Pavlovian psychiatry turned these existing tendencies toward more medical testing and more stringent standards of behavior and mixed them with the politically charged ideology of Late Stalinism.

These changes in psychiatric hospital practice had significant effects that outlasted the campaign for Pavlovian psychiatry itself. By 1954, psychiatrists had changed the way they organized their hospitals, and these changes helped them collect more information about their patients. Not only did the staff have new laboratory tests to use, they also had new training on how to use them to see in new and different ways. In a Foucaultian sense, then, these new disciplinary practices enabled new forms of knowledge to be produced. It was this new capacity to produce clinical knowledge that had the most lasting impact on Soviet psychiatry.

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<sup>62</sup> Novikov and Beletskii, in G. N. Beletskii (Ministr Zdrav. RSFSR), “Protokol No. 58 zasedanii kollegii MZ RSFSR,” 16 November 1950, GARF f. a-482, op. 49, d. 1519, l. 34.

The case of schizophrenia is useful to help illustrate the significance of this newly enhanced power of the psychiatric hospital to produce knowledge. Many hypotheses about the causes of schizophrenia have been proposed, but even now the disease remains poorly understood. As I discuss above, Pavlov hypothesized that schizophrenia was caused by pathological inhibition in the cortex of the brain, inhibition that was brought on in response to some sort of metabolic disorder that slowly destroyed cells in the brain. In the short run, the cells could be saved by protective inhibition. In the long run, cells would begin to die, and the damage would become irreversible. Pavlov's theory was empirically testable. For psychiatrists who wanted to demonstrate the power of the Pavlovian laboratory, this test was to be an important demonstration. To their chagrin, the demonstration failed.

Anatolii Ivanov-Smolenskii had sought to make the study of the "second signal system" the new foundation that would guide psychiatric knowledge. He proposed an ambitious agenda to use conditioned reflexes in humans to study the dynamics of higher nervous activity. This research, if proven effective, would lead to insights into the mechanisms that lay at the heart of psychoses like schizophrenia, as well as other forms of mental illness.<sup>63</sup> In the five years that followed, however, this research failed to produce any of the promised breakthroughs. Some researchers were still hopeful that the second signal system would prove amenable to experimental research,<sup>64</sup> but others were beginning to question the whole undertaking.

Stalin's death in 1953 brought a sudden end to the campaign against cosmopolitanism, and this seems to have diminished the political potency of Pavlovian science, emboldening some

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<sup>63</sup> I. G. Ivanov-Smolenskii, *Ocherki patofiziologii vysshei nervnoi deiatel'nosti (Po dannym I. P. Pavlova i ego shkoly)*, 2nd ed. (1952), 136-143.

<sup>64</sup> "Stenogramma soveshchaniia direktorov institutov psikiatrii v Institute psikiatrii MZ SSSR," 25 July 1957, GARF f. r-9592, op. 1, d. 23, l. 3.

psychiatrists to criticize Ivanov-Smolenskii and other zealous Pavlovians. By December 1953 some psychiatrists were accusing Ivanov-Smolenskii of having tried to establish a “scientific monopoly.” For his part, Ivanov-Smolenskii declined to participate in meetings of the editorial board of *Neuropathology and Psychiatry* (of which he was theoretically an important member).<sup>65</sup> Having taken psychiatry by storm in 1950-1951, Ivanov-Smolenskii seems to have been content to limit his efforts to his own small domain. By 1956, the editors of *Neuropathology and Psychiatry* had stopped publishing articles that were written using the language of higher nervous activity.<sup>66</sup>

One would think, then, that the editors of the journal in particular, and Soviet psychiatrists more generally, might have dropped all pretense of being “Pavlovian.” They did not. Instead they continued to describe themselves as Pavlovian, and stress the need for Pavlovian methods to be used on fundamental questions like the laws of psychology and the nature of schizophrenia. Instead of claiming that Pavlovian science was already a reality, psychiatrists began to speak of it as a future inevitability. Eventually they would understand the physical causes of mental illness and be able to diagnose and treat with perfect confidence. Until then, however, they would have to make do with the knowledge that they could generate using currently existing techniques. Along with his colleagues at *Neuropathology and Psychiatry*, Andrei Snezhnevskii, became one of the primary spokesmen for this pragmatic approach, which he described as “clinical realism.”

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<sup>65</sup> K. N. Tret'iakov, “Otchet komissii po obsledovaniiu zh. ‘Nev i psikh im. Korsakova,’” 15 December 1953, GARF f. r-8009, op. 2, d. 1925, l. 54.

<sup>66</sup> I. F. Sluchevskii in V. A. Giliarovskii (Chairman), “Plenum pravleniia vsesoiuznogo obshchestva nevroptologov i psikhiatrov,” 6 February 1956, GARF f. r-9592, op. 1, d. 39, l. 33.

Snezhnevskii had articulated an early version of this idea in 1951, even before the Pavlov Session in psychiatry. Writing in *Neuropathology and Psychiatry*, he wrote that, “Only on the basis of the most irreproachable clinical qualification of the expression of mental disorder is it possible to identify [*raspoznavat*] disease, the examination of its pathological essence, the pathogenesis, and the correct treatment.” He criticized psychiatrists like Shmar’ian and Gurevich for trying to create theories of disease that were too simplistic. Reality, Snezhnevskii suggested, was much more complex. Appealing to the traditions of pre-Revolutionary founding fathers like Korsakov, he wrote that, strength of “our national psychiatry” was precisely its “clinical realism.”<sup>67</sup>

Snezhnevskii, like his friends Sergei Kurashov and Dmitrii Fedotov, had spent many years working as a psychiatric hospital director before moving into research. Though all three had spent some time training in Moscow psychiatric institutes, the bulk of their training had been on the job in the psychiatric hospital during the difficult 1930s and 1940s. For psychiatrists of this generation psychiatrists, finding the underlying anatomical or functional causes responsible for mental illness seemed like just one of many important problems. Proper diagnosis of mental illness, on the other hand, was something very close to their hearts. By drawing on the irreproachable greats of Russian psychiatry, they were able to defend traditional clinical psychiatry as an important part of “Russian tradition.” Snezhnevskii’s attack on Shmar’ian and Gurevich was overdrawn and very much in the ugly spirit of summer 1951, but it also had an element of truth. Like Ivanov-Smolenskii, Shmar’ian had hoped to use the laboratory to discover the true causes of mental illness. While Ivanov-Smolenskii was studying reflexes, Shmar’ian was studying brain tissue, but the two shared a belief that true knowledge was produced in the

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<sup>67</sup> "Ot redaktsii," *Nevropatologiia i psikiatriia* 20, no. 4 (1951): 8.

laboratory and that the causes of mental illness could be reduced to the essential causes of discrete disease entities.

“Clinical realism” was a vague concept, but it served as a justification for an expansion of clinical research. The psychiatric knowledge produced by analyzing data from psychiatric hospitals might not be perfect, and it might someday be superseded, but for psychiatrists it was necessary to use such information in order to develop more accurate knowledge of the types and subtypes of mental illness. By 1953, of course, psychiatric hospitals in the USSR were capable of producing a great deal more information about their patients than they had been able to produce in the past, a capability that was in large part to the rapid growth in the number of new tools and techniques like x-ray machines that had been set up during the campaign for Pavlovian physiology. This information was potentially of great value for psychiatrists who wanted to figure out how to make diagnoses that would be useful for deciding on a method of treatment.

This new capacity to produce clinical knowledge was probably the most lasting legacy of the campaign for Pavlovian psychiatry. After all, by 1955 and 1956 psychiatrists were no longer using Pavlovian terms when they described their patient’s behavior, and other Pavlovian methods were dropped one by one. Researchers no longer were interested in doing new studies of prolonged sleep therapy after the new anti-psychotic drug chlorpromazine was imported from the West in 1954.<sup>68</sup> Nor did researchers continue to pursue Ivanov-Smolenskii’s methods of analyzing the second signal system.<sup>69</sup> What remained was the legacy of the Pavlov campaign not as a specific scientific dogma, but as an effective example of mobilizing people to systematize

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<sup>68</sup> A. V. Snezhnevskii, “Dokald glavnogo redaktora zhurnala,” 6 February 1956, GARF f. r-9592, op. 1, d. 39, ll. 3-6; D. D. Fedotov (Chairman), “Stenogramma zasedaniia Uchenogo Soveta Instituta Psikhiatrii MZ SSSR, 2 November 1955, GARF f. r-9592, op. 1, d. 20, l. 7.

<sup>69</sup> V. N. Miasishchev in D. D. Fedotov (Chairman), “Stenogramma soveshchaniia direktorov institutov psikhiatriia,” 25 July 1957, GARF, f. r-9592, op. 1, d. 23, l. 3.

the practices of their social institutions according to a particular understanding of modern efficiency and rationality.

Andrei Snezhnevskii was a man who understood how to use the knowledge produced by this milieu. He clearly articulated this at the first major psychiatric conference that was held after Stalin's death. Some scientists at the conference were still talking about their laboratory studies of higher nervous activity. Not Snezhnevskii. He presented a paper that was based in the assumptions of the clinic. Studying the way that disease symptoms developed and changed over time, he contended, could give psychiatrists fundamental insight into the essence of the "general pathophysiological laws" of the disease.<sup>70</sup> In the decade that followed Snezhnevskii built on this approach. He explicitly positioned himself as someone who was critically developing the legacy of Kraepelin. Under his stewardship, a generation of Soviet psychiatrists was trained to understand "scientific psychiatry" to mean the knowledge generated in the clinic.<sup>71</sup>

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<sup>70</sup> A. V. Snezhnevskii, "O formakh techeniia shizofrenii," in *Trudy Vsesoiuznoi nauchno-prakticheskoi konferentsii posviashchennoi 100-letiiu so dnia rozhdeniia S.S. Korsakova i aktual'nyim voprosam psikhiiatrii*, ed. V. M. Banskchikov, V. A. Giliarovskii, O. V. Kerbikov, E. A. Popov and D. D. Fedotov (Moscow: Medgiz, 1955), 148.

<sup>71</sup> A. V. Snezhnevskii, "O nozologicheskoi spetsifichnosti psikhopatologicheskikh sindromov," *ZhNiP* 60, no. 1 (1960): 91-107; Joravsky, *Russian Psychology*, 91-107.

## CONCLUSION

In this dissertation I have attempted to show how Soviet psychiatry developed in a complex social, intellectual, and disciplinary milieu. Soviet psychiatrists were severely constrained by the political system in which they lived, but even so they continued to debate the nature of mental illness and contest fundamental questions of epistemology and ethics. Their understanding of the nature of mental illness was shaped by social process, not dictated by political leaders or derived from self-evident laws of nature.

The politics of the profession were driven in part by a struggle for institutional power. Soviet medical science was part of a highly centralized institutional system. It was also a system that was starved for resources. For psychiatrists who wanted to have an impact on their field, then, power meant being able to get other members of their profession to develop a specific set of ideas about how psychiatry should be practiced or what types of research should be done. Simply publishing research for others to read required both access to resources, including precious paper, and access to people who could help get things done. In this sense, the social world of Soviet psychiatry was given coherence by both state and non-state solidarities. Research institutes, psychiatric hospitals, and other organizations were part of the Soviet state system and played very important roles in structuring the choices and possibilities available to the professionals who worked in them. As in other parts of Soviet society, however, informal

networks of people also served important social functions. For psychiatrists, this often meant networks of former students, advisors, and colleagues – the extended groups that could loosely be referred to as “schools” of psychiatry. The tension between social solidarities rooted in state institutions and social solidarities rooted in kinship networks was one of the sources of potential conflict with Party and state authorities during the late 1940s and early 1950s campaigns against cosmopolitanism and “nepotism.”

Within this internal world of structured social relations, psychiatrists struggled to develop effective approaches to the treatment and understanding of mental illness. For professionals who were educated to see themselves as enlightened healers, the conditions in Soviet psychiatric hospitals were particularly demoralizing. Overcrowded, dilapidated, ineffective – these institutions did not fit the self-image of the scientifically trained modern psychiatrist. The period under consideration in this dissertation, roughly 1939 to 1953, was a particularly significant period in the history of world psychiatry because it was in this period that psychiatrists began on a large scale to introduce radical new methods of shock therapy, sleep therapy, and psychosurgery into their clinical practice. These methods were attractive in large part because they gave psychiatrists a feeling of agency. Furthermore, in order to use these methods properly, the psychiatric hospitals themselves had to be modernized with the space being used more systematically, patients being monitored more carefully, and staff comporting themselves in a way that was suggestive of laboratory or surgery ward. Part of the attraction of the so-called “active therapies,” in other words, was that they made psychiatric hospitals fit people’s expectations of what modern psychiatric hospital should look like.

The introduction of these more regimented, more “medicalized” regimes was more than just aesthetic, however. By taking more quantitative measurements of patients bodies,



psychiatrists were able to generate new ways of seeing the psychiatric bodies that they had not previously had access to. At this level, I see power operating along lines sketched out by Foucault. Rather than psychiatrists asserting their will over patients, we see both patients and psychiatrists caught up in new ways of structuring their activities in the hospital. These activities were certainly constraining in some ways, which is one reason that they were valued by psychiatric hospital directors. But they were also productive of clinical knowledge.

In the later portion of the dissertation I argue that the disciplinary practices necessary for effective “active therapy” were brought to many psychiatric hospitals as part of the Communist Party-sponsored campaign for Pavlovian psychiatry. The ideal of Pavlovian psychiatry was an ideal of complete knowledge of the physical laws that went into making the mind work and in generating mental disorder. If mental processes are accessible to objective study, the Pavlovian logic went, then surely this grand project can be realized. Ironically, the campaign for Pavlovian psychiatry’s greatest success was in enhancing the ability of psychiatrists to produce useful clinical knowledge. Instead of giving rise to a new era of laboratory governed knowledge, Soviet psychiatric hospitals reengaged with the continental European tradition of psychiatric nosology. For the next three decades, Soviet psychiatrists developed ever more complex bodies of clinical facts which they sought to turn into useful scientific knowledge.

Soviet psychiatry’s professional politics, theoretical arguments, and evolving disciplinary practices took place within a broader system of soviet institutions and within a cultural and ideological framework that was fraught with the elaborate rituals of High Stalinism. Soviet psychiatrists, particularly those in positions of power within their profession, were also adept at navigating this broader Soviet system. They sought to gain control over institutional resources and types of work by appealing to audiences within the Communist Party leadership,

the Ministries of Health, and other committees and commissions that could be of use to them. To convince these audiences of their superiority over rivals, they used re-cast their psychiatric knowledge claims using the ever-changing language and rhetoric of Stalinist ideology. Bolshevik discourse and European psychiatric discourse were to some extent both rooted in common intellectual heritage and philosophical assumptions. The large claims that psychiatrists made about the nature of disease easily blended with claims made by the party about the nature of social relations. Thus psychiatrists could adapt political and ideological labels like “idealism,” “mechanicism,” and “Pavlovian” to explain to powerful Party members just why these particular ideas were worth supporting and why their opponents’ ideas were tantamount to counterrevolution.

In the tense years before Stalin’s death, these rhetorical strategies became more and more high risk. While psychiatrists tried to work out their ideas about active therapy, the roles of the laboratory and the clinic, and the nature of disease, they also had to work out how these ideas could become Party-minded ideas, ideas that could be deployed to further the ideological goals of the Communist Party and the Soviet state. Of course, deciding which psychiatric theories would further the goals of the Soviet state was precisely what the psychiatrists were struggling to do. They did not act alone or autonomously, but their actions did ultimately affect what psychiatric policy and theory would be.

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