



Trends in Soviet and Post-Soviet Psychiatry

Lawrence M. Probes, M.D.,* Vladimir Kouznetsov, M.D., Ph.D.,† Vladimir Verbitski, M.D., Ph.D.,‡ Vadim Molodyi, M.D.§

Soviet psychiatry can now be observed from the vantage point of the post-Soviet era, a period of transition, uncertainty, and new opportunities. With the atmosphere of open discussion that has been permitted since the latter years of glasnost, it is now possible to gather information about Soviet psychiatry and critique it with unprecedented thoroughness. Although improvements in political systems and economic conditions will in the long run lead to better conditions for psychiatry in countries that were part of the U.S.S.R., there is a tremendous short-term need for international assistance to introduce psychiatrists in the former Soviet republics to current trends and developments in Western psychiatry. Exchange programs are needed to offer these psychiatrists training and clinical experience in other countries. [PSRQ 1992;2:67-76]

Before the Bolshevik revolution, Russian psychiatry had been developing in tandem with European, and especially German, psychiatry [1,2], incorporating new trends and even pioneering a few

original developments, such as the 1832 "no restraint" policy taken by St. Petersburg mental hospitals, seven years before John Conolly's no restraint approach in 1839, and Ivan Sechenov's concept of

0051-2438/1992/0202-0067\$03.00/0

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*LMP was Assistant Clinical Professor of Psychiatry, Michigan State University, College of Human Medicine, Department of Psychiatry, and Medical Director, Kent Oaks Psychiatric Unit, Grand Rapids, Michigan, at the time this article was written. He is currently Medical Coordinator, Moscow Delegation, International Federation of Red Cross and Red Crescent Societies. Address correspondence and reprint requests to Lawrence M. Probes, M.D., 2960 Gulliford, Lowell, MI 49331-9514.

†VK is Director, Acute Women's Unit, Riga Neuropsychiatric Hospital, Riga, Latvia; Visiting Professor of Psychiatry (1991), Michigan State Uni-

versity, College of Human Medicine, Department of Psychiatry; Kent Oaks Psychiatric Unit, Grand Rapids, Michigan. Much of the research leading to the publication of this paper was based on an 11-month visiting professorship for Dr. Kouznetsov sponsored by the Department of Psychiatry at Michigan State University and financed by an educational grant from the Kent County Community Mental Health Board of Grand Rapids, Michigan.

‡VV is Lecturer, Department of Medical History and Culture, Moscow Medical Academy; Head of Editorial Department, Publishing and Research Center, Meditsinskaya Entsiklopediya, Moscow, Russia.

§VM is a psychiatrist, formerly from Moscow, U.S.S.R., now residing in Chicago, Illinois.

"biologism" in the 1860s, which emphasized physiological brain dysfunction as the cause of psychiatric disease. After a brief period of exploration during the early 1920s, however, Soviet psychiatry and psychology slipped into nationalistic isolation, although the profession did not stagnate. For example, it developed a major new approach to the classification of schizophrenia. Unfortunately, Soviet psychiatry in the last two decades became more and more compromised as state interference led to psychiatric abuse. Since glasnost and perestroika, and now the dissolution of the Soviet Union as a political entity, psychiatry in the former Soviet republics faces major challenges as it struggles to free itself from past abuses and to recover from grave problems of economic privation, lack of medications, shortages of psychiatrists and other medical workers, lack of books and educational materials, and facilities that are overcrowded, outdated, in poor repair, and unsanitary.

GENERAL FEATURES OF CLINICAL PRACTICE

In 1989, there were 37,337 psychiatrists and 347,000 psychiatric beds in the Soviet Union [3]. Almost all psychiatrists worked in hospitals and dispensaries (outpatient medication clinics), although, since glasnost, private practice has emerged and grown. Psychiatrists in the U.S.S.R. were better paid and received longer vacations than their colleagues in other medical specialties. Psychiatrists dominated the mental health field. There were comparatively few psychologists in the U.S.S.R., about 5,000, and they played only a minor role in clinical psychiatry. The field of sociology was not related to psychiatry, and there were no training programs in clinical social work. The roles typically performed by hospital-based social workers in the U.S. (contacts with employers, filling out forms for disability benefits, assistance in finding an apartment, etc.) were performed by psychiatrists and nurses. Psychiatric nurses worked closely with psychiatrists in both the hospital setting and the dispensaries, which were basically outpatient medication clinics.

PSYCHOTHERAPY

Psychotherapy has been a constant feature of Soviet psychiatry, consisting primarily of hypnosis, biofeedback, autosuggestion, and group therapy (not a psychodynamic group, but more a class in

which the "therapist" instructs or educates about some topic). Another widely used method of psychotherapy has been "rational therapy," developed by the Swiss neuropathologist, Paul Dubois, in the early 1900s [4-6]. Psychodynamic and interpersonal psychotherapies based on psychoanalytic theory and its variants have been absent. Behavior treatment based on the work of B.F. Skinner, as well as other forms of cognitive-behavioral therapy, which are widely applied in the U.S., have not been generally utilized in the U.S.S.R. Principles of conditioning, reinforcement, extinction, flooding, and desensitization have not been systematically applied in the clinical setting.

THE DOCTOR-PATIENT RELATIONSHIP

There has been a tendency for the Soviet medical education system to reinforce an authoritarian and paternalistic approach to the doctor-patient relationship in which the doctor knows what is best for the patient and considers it unnecessary to educate the patient about treatment. Discussions with patients generally consist of advice, instructions on how to take medications, and exhortations to follow such advice and instructions. It has been a long tradition of Soviet and Russian medicine not to explain to the patient details about his or her illness, and the contemporary U.S. concept of informed consent to treatment has never been recognized. An exception is made when the patient is a physician [7].

SOCIAL AND MILIEU THERAPIES

Hospital patients are generally referred for "occupational therapy" (*trudovaya terapiya*, alternately translated as labor therapy or work therapy), which typically involves games, physical exercise, various forms of entertainment, and the assembly of small items such as crafts or spare parts [8]. Resources are limited, and, although this intervention may be of reasonable quality in a few institutions, it is often dull and monotonous. In some cases of involuntary commitment, this intervention amounts to a form of forced labor. Attempts have been made to implement procedures of milieu therapy at the Bekhterev Institute in Leningrad (now St. Petersburg) and other major psychiatric centers, but the concepts of U.S. authors such as A.H. Stanton, M.S. Schwartz, and M. Jones are not widely applied. Most patients remain passive recipients of medications, meals, and

visits by the doctor or family members. The first author (L.M.P.) visited psychiatric hospitals in Riga, Moscow, and Irkutsk between 1988 and 1991. He observed that patients inside the hospitals wore pajamas or hospital gowns, nurses wore white uniforms, and psychiatrists wore white coats, which was the usual custom in the U.S. until the 1960s. These practices were eventually discontinued in the U.S. on the realization that they reinforced a number of negative characteristics, including a patient's sense of being "sick."

Some hospitals, such as the Riga Neuropsychiatric Hospital, maintain special unlocked units for "borderline" patients where ordinary street clothes are allowed. These units are also used at times for certain "elite" or "VIP" patients, even those with psychotic decompensations. At such units, a greater variety of psychotropic medications may be available, and length of stay can be more flexible.

HOSPITAL FACILITIES

With some exceptions, Soviet psychiatric hospitals have been and remain overcrowded, understaffed, and in poor repair. Sanitary conditions are often deplorable [9]. One author describes a provincial psychiatric unit: "There was no sewerage system or indoor plumbing, and gerontological patients of both sexes lay pell-mell on the floor in a fecal stench" (personal written communication, Vadim Molodyi, M.D., observations in 1975 at Kolomenski Psychiatric Hospital No. 10, about 70 km from Moscow). However, it is important to consider this in light of the overall housing situation in the former Soviet Union, in which there are severe shortages and in which multiple families, including divorced couples, must sometimes share a single kitchenette or bathroom. There are almost no private or semiprivate rooms in Soviet and post-Soviet psychiatric hospitals. Patient beds are located in chambers or wards of 10 or more beds in one room, to which a nurse is assigned for the purpose of monitoring.

Psychiatric hospitals are of either the "ordinary" type or the "special" type, the latter constructed and staffed more like a penal facility than a hospital and intended for the treatment of mentally ill criminals. The number of these special psychiatric hospitals grew from 11 in 1977 to 16 in 1988 [10]. Political dissidents who were given psychiatric diagnoses and hospitalized involuntarily were usually referred to

the "special" psychiatric hospitals (SPHs). Even ordinary psychiatric hospitals are surrounded by walls with a guard station and checkpoint at the main entrance. This contributes to the atmosphere in most psychiatric hospitals of high security and control, similar to special forensic psychiatric facilities or older state hospitals in the U.S. "Special" psychiatric hospitals were operated by the Ministry of Internal Affairs (MVD) until January 1988, when they were transferred to the Ministry of Public Health. The MVD performed many police, military, intelligence gathering, and internal security functions, and its methods and aims were often harsh and repressive, similar to those of the KGB. The transfer of jurisdiction of SPHs to the Ministry of Public Health was a positive step, but it did not necessarily lead to a rapid, major improvement in the conditions at SPHs [11,12]. Many such hospitals still have no warm running water, and the conditions inside these institutions are often grossly unsanitary and dehumanizing.

FREUDIANISM AND PSYCHOANALYSIS

The Russian Psychoanalytical Society was established in 1910, but, although many of S. Freud's works were translated into Russian after 1912, there was professional resistance to his ideas. A series entitled "Psychological and Psychoanalytical Library" was issued until the late 1920s by Professor Ivan Ermakov. Criticism of Freud in the 1920s occurred in the context of general debates going on at that time in the Soviet Union about how to create a genuinely Marxist psychology. During the early 1920s, academic opposition to Freud criticized his emphasis on sexuality, but even his most strident critics in the academic realm accepted his basic concept: the primacy of the unconscious. In the second half of the 1920s, however, Freud's teachings were exposed to systematic criticism from all quarters, especially philosophy. His concepts of unconscious psychic archaisms (such as the Oedipus complex), the priority of the unconscious in mental processes, and the sexual nature of all psychic phenomena were determined to be inconsistent with dialectical materialism [13].

Freud was only one of many victims of Communist Party politics as well as the politicization of sciences in general and social sciences in particular. His works were eventually banned, and they were

available only to researchers with special permission. Psychoanalysis and the various schools of thought that emerged from it remained almost unknown and virtually unexplored until the late 1980s, when glasnost and perestroika made it possible to revive the writings of Freud. There is now a great deal of interest in Western theories and practice of psychotherapy, especially Freudian psychoanalysis [14,15].

SOVIET APPROACH TO PSYCHIATRIC ILLNESS

A major determinant of the current Soviet approach to psychiatric illness dates back to the notorious "Pavlovskaja" session of 1950, as well as a joint meeting of the Academy of Medical Sciences and Academy of Sciences of the U.S.S.R. held in October 1951 in Moscow. The "Pavlovskaja" session was a reactionary political show, inspired by Stalin, in which several outstanding neurophysiologists (L.A. Orbeli, I.S. Beritashvili, among others) were ostracized. A vulgarized interpretation of I. Pavlov's doctrines was declared to be the scientific basis of Soviet medicine, while Western psychological theories were denounced as imperialist propaganda [16].

At the joint meeting of the Academies in 1951, the main topic was the "Bolshevik psychiatry" of Pavlov (psychopathology primarily based on neurophysiological reflex dynamics involving the cerebral cortex) versus the "bourgeois, nonscientific, enemy psychiatry" of A.S. Shmarjan, M.O. Gurvich, M.Y. Sereisky, and V.A. Giliarovsky (who espoused a broader biological approach involving brain pathology). Following this meeting, top academic positions were taken over by a new generation of psychiatrists, including Professor A. Snezhnevsky (see below). These sessions proved to be an obstacle for the further development of Soviet psychiatry. Nevertheless, certain branches of psychiatry managed to progress even at that time, despite heavy ideological pressures. For example, the works of Russian psychiatrist and psychotherapist Konstantin I. Platonov led to hypnosuggestive therapy as a popular modality in the treatment of psychosomatic abnormalities (i.e., peptic ulcers), as well as alcoholism and "hysteria" [17].

Soviet psychiatry has concerned itself primarily with "big psychiatry" (*bol'shaia psikhiatritia*), which refers to major psychotic disorders (schizophrenia, manic-depressive psychoses, reactive psychoses),

severe organic brain disorders (dementia, delirium, traumatic brain injury, endocrinopathy), epilepsy, and mental retardation ("oligophrenia") [18]. Although of major theoretical importance, "small psychiatry" (*malaja psikhiatritia*) has received less therapeutic attention, since treatment modalities were not so clearly available or effective. Small psychiatry encompasses nonpsychotic conditions such as personality disorders (referred to as psychopathies), neuroses, nonpsychotic adjustment reactions, alcoholism and other substance abuse disorders, mild depressions, and sexual perversions. It also includes "boundary conditions" (*pogranichnyye sostoiianiia*), or "soft," borderline, subclinical, and transitional forms of mental illness [19]. Patients suffering from these conditions have been quite reluctant to turn to psychiatry for help, preferring instead to consult a neurologist. Even patients with nonpsychotic disorders were placed on the psychiatric registry and faced various forms of social discrimination such as the inability to obtain a driver's license. "Socially dangerous" patients on the psychiatric registry were also subject to being rounded up for short-term "preventative" hospitalizations surrounding important holidays, such as the commemoration of the October revolution. Hospital and clinical medical directors were expected to assist the militia, police, and emergency medical teams in locating them and facilitating hospitalization.

Soviet psychologists have played almost no role in clinical psychiatry or psychotherapy until very recently, and their work has focused on those areas not addressed by the mainstream of Soviet psychiatry: personality styles, milder neuroses, nonpsychotic reactive conditions, group dynamics, developmental psychology, normal psychology, and psychological aspects of sociology [20]. Some psychologists have begun to practice what they claim to be psychoanalysis, transactional analysis, and other Western forms of psychotherapy, but many questions remain as to their training and credentials, and the psychiatric establishment is reluctant to recognize them as legitimate clinicians. Furthermore, their free-market, fee-for-service approach to the provision of care is considered abusive by some:

"In recent times there has appeared a huge army of 'doctors,' [the Russian word is *lekar*, an obsolete and pejorative word for a doctor who attended a medical institute but who did not defend a doctoral thesis]

who are dealing with the mentally ill. Psychologists-psychoanalysts have appeared. There exists the opinion, right, that psychologists can deal with mental correction, but this notion is also eroded. So what are we to do with these 'doctors,' these parapsychologists? License them to work miracles? And just who has authorized and credentialed them? O.K. That reminds me of the cash register. The sums which these sorts of 'doctors' take from patients reach incredible figures. A visit by a patient to a psychoanalyst costs about 25 rubles for an hour of work! Why, isn't this a violation of human rights? Perhaps the Ministry of Public Health should appoint a commission to look into this issue. . . ." [21].

SCHIZOPHRENIA, "SLUGGISH" SCHIZOPHRENIA, AND PSYCHIATRIC ABUSE

In recent years, the West has focused a great deal of attention on psychiatric abuse in the U.S.S.R., especially the diagnosis of sluggish schizophrenia. Although this is a serious problem that requires continued investigation and monitoring, there is a demonstrable need for research into other aspects of Soviet psychiatry. ("Few, if any, Americans can speak with expertise on the Soviet approach to the diagnosis of schizophrenia and related conditions" [22]) To understand the relationship between psychiatric abuse and sluggish schizophrenia, it is useful to review the Soviet approach to the classification of schizophrenia.

A key figure in Soviet psychiatry in the 1930s was P. B. Gannushkin, who had been a student of S.S. Korsakov and who made important contributions in the area of "small" (*malaia*) or "boundary" (*pogranichnaia*) psychiatry, which encompasses the concept of sluggish schizophrenia [23]. Gannushkin's book, "*Klinika psikhopatii, ikh statika, dinamika, sistematika*" (Clinical aspects of psychopathies; their statics, dynamics, and systematics), first published posthumously by the publisher Sever in Moscow in 1933, is considered a classic of the literature by Soviet psychiatrists, and its influence can be compared to the writings of E. Kretschmer or K. Schneider. Another leading figure was G.E. Sukhareva, a child psychiatrist, who made a major theoretical contribution to Soviet psychiatry. In 1937 she published a study that rejected the Kraepelinian classification system for schizophrenia based on symptoms, which was in use at the time [24]. According to Sukhareva, a more accurate approach to classification could be obtained by emphasizing the clinical

course of the illness. Her observations on the course of schizophrenia in children later became the basis for the concept of slow progradient¹ schizophrenia or "sluggish" schizophrenia in adults [25]. L. Rozenstein was one of the most prominent authors and advocates of the concept of "soft" (*miakhkaia*) schizophrenia in the 1930s. A. Snezhnevsky originally opposed the concept of "soft" schizophrenia in the early 1950s, but he later promoted the idea under a different title: "slow-flowing," or "sluggish" (*vialo-tekushchaia*) schizophrenia, a term that became widespread only in the 1960s.

Soviet psychiatry has classified schizophrenia on the basis of two disease parameters:

- 1) phenomenological form (cross-sectional symptomatology) and
- 2) course (pattern and rate of progression over time)

The phenomenological subtypes of schizophrenia in the U.S.S.R. have been [26]:

- 1) simple (*prostaiia*) (cf. the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition, revised [DSM-III-R]: schizoid and schizotypal personality disorders);
- 2) hebephrenic (*gebefrenicheskaia*) (cf. DSM-III-R: schizophrenia, disorganized type);
- 3) catatonic (*katatonicheskaia*) (cf. DSM-III-R: schizophrenia, catatonic type);
- 4) paranoid (*paranoidnaia*) (cf. DSM-III-R: schizophrenia, paranoid type); and
- 5) circular (*tsirkuliarnaia*) (cf. DSM-III-R: schizoaffective disorder and bipolar disorder with psychotic features).

The basic types of clinical course and their subtypes have been [26]:

- 1) continuous-progradient (*nepreryvno-progredientnyi, nepreryvno-postupatel'nyi*):
 - a. sluggish (*medlenno tekushchaia, vialo tekushchaia*),
 - b. progradient paranoid (*progredientnaia paranoidnaia*), and
 - c. malignant (*zlokachestvenno tekushchaia*);

¹ "Progradient" cannot be found in any Russian dictionary and is psychiatric jargon in the former Soviet Union. It is related to the Latin roots "pro" (forward) and "gradus" (moving, movement). Thus, modifiers such as *medlenno* (slow), *malo* (sluggish), and *malo* (little) all refer to a condition that moves forward or progresses very slowly.

- 2) periodic (*rekurrentnyi, pristupoobraznyi*); and
- 3) shift-like (*pristupoobraznyi-progredientnyi, shu-boobraznyi*).

The Soviet phenomenological subtypes are similar to comparable DSM-III-R categories (note: DSM-III-R recognizes an "undifferentiated" subtype; Soviet classification, like DSM-III-R, includes a "residual" form that may be the ultimate result of several subtypes). By contrast, the Soviet approach to clinical course has distinguished itself sufficiently from the DSM-III-R model that further elaboration is necessary.

DSM-III-R formally incorporates clinical course into its framework, recognizing the following types of course: combined duration of prodromal, active, and postdromal phases less than six months (schizophreniform disorder); greater than six months and less than two years (subchronic); greater than two years (chronic); acute exacerbation (recurrence of active psychosis during postdromal or residual phase of subchronic or chronic subtypes) and remission (all signs and symptoms of schizophrenia have abated) [27].

An analysis of DSM-III-R clinical course subtypes reveals an emphasis on either *duration of time or cross-sectional symptomatology*. What is not addressed so much in DSM-III-R, and what is the essence of the Soviet perspective on clinical course subtypes, is the *slope of the line of progression (rate) and its characteristics (i.e., degree of decompensation) over time*. These two ways of thinking about clinical course help to explain the difficulties that arise when attempts are made to compare DSM-III-R with Soviet nosology.

One reason why the Soviet classification of schizophrenia has emphasized clinical course is that the classification system reflects a prevailing theory of etiology, unlike DSM-III-R, which, with the exception of organic mental disorders, generally does not presuppose a particular etiology or theoretical model. Soviet psychiatrists have consistently held to the Kraepelinian concept of schizophrenia as an endogenous-process, biological disorder, typically exhibiting a chronic, deteriorating course. They consider it only natural to differentiate schizophrenias, just as other endogenous-process, biological diseases (hypertension, arthritis, and diabetes), according to how slowly ("sluggish") or how rapidly ("malignant") they progress over time. Furthermore, patterns of progression (continuous-progradient, periodic, shift-

like) have been deemed as applicable to schizophrenia as to lupus erythematosus, inflammatory bowel disease, and asthma.

American psychiatry eventually came under the influence of Eugen Bleuler, who believed that the basic pathognomonic feature of schizophrenia was not a deteriorating course (as suggested by E. Kraepelin), but a disharmony of functions, which are primarily expressed by cross-sectional signs and symptoms (particularly the four "fundamental symptoms" often referred to as Bleuler's four "As" [disturbance of Association, Autism, Ambivalence, and disturbance of Affect], and "accessory" symptoms, including hallucinations, delusions, and catatonia) [28]. Evaluation of signs and symptoms, together with their duration, continues to form the basis of the approach of U.S. psychiatrists as expressed in DSM-III-R.

While Soviet and post-Soviet psychiatrists have paid close attention to cross-sectional symptomatology and have described it in detail, they consider it less reliable for establishing long-term diagnoses and prognoses, and they believe that a diagnosis based on clinical course is more stable over time. They accept the practice of updating psychiatric diagnoses on the basis of new information or a change in the patient's condition, and they recognize that one form of clinical course may transform itself into another, although this is a subject of ongoing debate. For example, some believe that it is not uncommon for shift-like schizophrenia to develop into the continuous progradient type.

Sluggish schizophrenia, also referred to as slow progradient schizophrenia, is a heterogeneous category that encompasses a variety of milder forms of mental illness and a wide range of potential symptoms over time. What all these forms have in common is a slow, gradual progression over many years. Andrei V. Snezhnevsky, the main architect of the contemporary Soviet concept of sluggish schizophrenia, defined it as follows:

Sluggish schizophrenia distinguishes itself on the basis of a very slow course and the gradual development of personality changes, which never lead to deep emotional devastation. The disease more often arises during adolescence. The initial symptoms—sharpening of the mental patterns of puberty with an increase in emotional unsteadiness, irritability, oppositional attitudes toward close friends and family members, and reflection. Along with this appear autistic isolation, asthenization, especially in the area of intellec-

tual activity, and an inclination toward abstract philosophizing with a general lowering of range of interests. The ability to exhibit subtle modulation of affective responses is lost. Upon this background appear neurosis-like disturbances: annoying thoughts, astheno-hypochondriacal and depersonalized symptoms, hysterical-like manifestations, and overvalued ideas. The intensity of these disturbances varies over the course of many years, and they gradually come to dominate the clinical picture and the full-blown (manifest) stage of the disease. A single neurosis-like disorder predominates in some patients, but many patients exhibit various combinations of symptoms. Further differentiation of the forms is defined (with the exception of the paranoid form) on the basis of neurosis-like symptoms [18].

Smulevich, in his definitive work on this topic, defined slow progradient schizophrenia as

an independent and freestanding form of the endogenous process. . . its debut is seen during the latent period with manifestations of positive symptoms and a period of stabilization. Above all, slow progradient schizophrenia characteristically exhibits slow development of all the stages of the illness over many years, from a lengthy subclinical course in the latent period, to a gradual reduction of positive symptoms in the period of stabilization, ending with the formation of residual states. . . . As the years go by, patients become more and more bland, withdraw into themselves, and they lose their friends. Emotional coldness and egocentrism are often combined with increased sensitivity. Attitude toward the external environment is determined, as a rule, by rational thinking. There is an increase in inadequacy and eccentric behavior with deep disturbances of the higher spheres of self-awareness, higher emotions, as well as instincts and drives. . . . In a number of cases the onset of illness is heralded by the formation of changes, which have been defined by Emil Kraepelin (1911) and Karl Birnbaum (1916) as *Verschrobenheit* [The term *Verschrobenheit* in German psychiatry (strangeness, peculiarity, eccentricity) is used in Soviet psychiatry as the definition of a type of defect.] They pay special attention to the disruption of the harmony of bodily movement and facial expressions, multiple inexplicable facial expressions, carelessness, and sometimes sloppy dressing and bizarre behavior, which are interpreted by E. Minkowski (1927) as autistic behavior in which the activity of the patients is, as it were, deprived of its integration with personality, so that it appears as an isolated act of the will. In speech, as well as in an abundance of stereotypical expressions, a tendency is revealed toward the use of rare and unusual words, and in addition, long-winded responses, which are combined with viscosity and preoccupation with insignificant details. Symptoms of the *verschrobene* type are most pronounced in

schizophrenia with poverty of symptoms. The first aspect of the clinical picture of negative changes is the contrast between preserved psychic activity (at times with continued ability to function at work) and bizarreness, with a peculiar external appearance and unusual ways of going about life [29].

Soviet psychiatrists generally have considered sluggish schizophrenia to be a further development of Bleuler's concepts of "latent schizophrenia" and "basic deficiency." Sluggish schizophrenia encompasses a heterogeneous group of patients who meet the criteria for a variety of DSM-III-R categories, including cluster A personality disorders (schizoid, schizotypal, paranoid), cluster B personality disorders (histrionic, antisocial, some cases of borderline personality disorder),² hypochondriasis, depersonalization disorder, obsessive compulsive personality disorder, adjustment reactions, paranoid state, schizophrenia, and possibly affective disorders.

To further integrate U.S. terminology, patients with sluggish schizophrenia exhibit a lengthy period during adolescence of subclinical or latent symptoms (or certain "negative" symptoms: social withdrawal, decreased range of interests, laconic speech, emotional coldness), which gradually crescendo into a comparatively brief period of active, although not necessarily psychotic-level, symptoms (or "positive" symptoms: odd body movements and gestures, hypersensitivity, viscosity of speech, overinclusive speech, preoccupation with overly abstract ideas, use of rare or unusual words; infrequently thought derailment, paranoia delusions, and other overt psychotic symptoms), followed by a period of gradual stabilization and reduction of "positive" symptoms, and the eventual development of a residual phase with chronic "negative" symptoms.

How has it happened that sluggish schizophrenia has become almost synonymous in the West with psychiatric abuse? One reason is probably that this diagnosis often was assigned to political and religious dissidents who the state wished to silence. Before the latter years of glasnost and perestroika, certain political and religious expressions were considered crimes against the state, since they "defamed the Soviet state and social system" [30] or represented "social dangerousness" [31,32]. The behaviors in question included activities such as publishing

² The Soviet use of the term "borderline conditions" (*pogranichnyye sostoyaniya*) differs substantially from that in DSM-III-R; hence the Russian term (*pogranichnyye sostoyaniya*) might best be translated "boundary conditions."

and distributing political or religious materials without official permission or open criticism of state policy or public officials [33].

Sluggish schizophrenia was initially unpopular with the state, since it was a medical diagnosis that exempted otherwise young, able-bodied men from compulsory military service. Also, this label was sometimes given to genuine criminals who bribed psychiatrists to diagnose a psychiatric illness as a means of avoiding prosecution and harsh sentences [34]. Psychiatrists sometimes intentionally misdiagnosed dissidents out of decent and humane motivations to spare them from concentration camps, which meant almost certain death. In these cases, no medications were administered, and the "patients" were relatively free inside the psychiatric facility [35].

The state eventually adopted psychiatric commitment as the preferred mechanism for disposing of troublesome dissidents [36]. A standard criminal trial required witnesses and evidence, which were not always easy or simple to obtain. It was far easier to have the person found insane. In such cases, the subject could be "tried" in a closed courtroom without witnesses and without the presence of the "patient." Furthermore, the state could even appear to be magnanimous by excusing a person for his or her "dangerous" acts and offering "treatment."

Psychiatrists were drawn into these forensic proceedings, and many sincerely established one or another psychiatric diagnoses [37], often sluggish schizophrenia. Thus, "mental illness," combined with "social dangerousness," satisfied the requirements for involuntary psychiatric hospitalization and treatment, a formula similar to the commitment process in the U.S. It is important to note that the diagnosis of sluggish schizophrenia did not bear negative connotations among Soviet psychiatrists until recently.

The diagnostic criteria for slow progradient schizophrenia have been sufficiently elastic in the minds of compromising and dishonest practitioners that it was often possible to stretch the criteria ordinarily reserved for truly mentally ill persons to fit the behaviors of a dissident. One former Soviet psychiatrist pointed out, "Even by Snezhnevsky's own criteria of sluggish schizophrenia, those political prisoners didn't fit" [38]. Thus, a dissident's focus on a particular political issue was considered an "overvalued idea," "unitary activity," or "delusions

of reformism," and it reflected a "heightened sense of self-esteem." A religious believer who worshipped in private (or in secret) with those of like mind exhibited "social isolation," "religiosity," or "abstract philosophizing." Any mild personality trait could be construed as a "soft" sign of a "latent" psychiatric disorder. A sign of sluggish schizophrenia cited in one case was "failure to adapt to society," which was used to describe a patient with "inability to live in society without being subjected to arrest for his behavior" [39].

Some psychiatrists quietly resisted this abusive process, hospitalizing the person only under pressure, which often came in the form of telephone calls from public officials, law enforcement officers, the medical director of the hospital, or the KGB [32,40].

A few psychiatrists compromised themselves in a blatantly dishonest and criminal fashion. Some accepted bribes from the KGB to establish a psychiatric diagnosis, and the concept of sluggish schizophrenia could usually be stretched far enough to admit a person who the KGB wished to silence or remove from the public eye. Furthermore, the diagnosis of a type of schizophrenia gave dishonest psychiatrists the license to force neuroleptic medications, often in high doses, for months or years. Sulfozine³ "treatments," which produced a high body temperature and a very painful condition, were justified. Dissidents were usually referred to a "special psychiatric hospital," a euphemism for a high-security facility, staffed and operated like a prison, where orderlies were at times sadistic misfits required to work there as a form of punishment.

It is not difficult to see how sluggish schizophrenia came to be associated with psychiatric abuse, but the relationship remains one of *association*, not inevitable causality. Slow progradient schizophrenia is a legitimate nosological construct, part of an alternative systematic approach to the classification of schizophrenia but lately the victim of abuse and guilt by association. Although the relatively broad diagnostic criteria for sluggish schizophrenia may have made it susceptible to abuse by incompetent, compromising, or criminal psychiatrists, this alone

³ Sulfozine is not used in American psychiatry, and its use in psychiatry has now been officially discontinued in the former U.S.S.R. It was used as "pyrogenic therapy" for detoxification in alcoholism, severe agitation, and explosive behavior, as well as in combination with antibiotics for treatment of progressive paralysis.

should not result in outright rejection or condemnation of the overall concept. Sluggish schizophrenia has commonly been diagnosed in cases of psychiatric abuse, but one can find other diagnostic categories as well [41]. According to Aleksandr P. Podrabinek:

"Psychiatric abuse is the result of bad politics, not bad psychiatry. To stop abuse we have to change the politics. If the diagnosis of 'sluggish schizophrenia' was eliminated, this might be taken as a sign of some change—but a very unreliable one—and they're committing healthy people using other diagnoses as well" [42].

Broad criteria for a disorder do not, *per se*, inevitably lead to abuse. Before DSM-III, the U.S. concept of schizophrenia was rather broad in comparison with that of Great Britain and a number of other European nations, and, while this led to a tendency in the U.S. to diagnose affective psychoses as schizophrenia, it did not lead to allegations of wide-scale, systematic abuse of patients based on political motivations or a defective nomenclature.


CONCLUSION

Psychiatric abuse is a moral, ethical, and legal issue that must be dealt with on these levels. Psychiatrists who accept bribes to impose false psychiatric diagnoses with the aim of perverting justice or simply enriching themselves are guilty of immoral, unethical, and criminal acts. Their unprofessional behavior probably would have occurred with or without the concept of sluggish schizophrenia.

To address properly the issue of sluggish schizophrenia, it is necessary to consider it apart from the problem of psychiatric abuse. A thorough academic study of slow progradient schizophrenia is greatly needed in the scientific community. The discussion should focus on the concept itself, with less emphasis on the way in which it has been subverted. This does not mean that the social consequences of a diagnostic category are irrelevant, but the rhetoric associated with psychiatric abuse is highly charged, so that objective consideration is more difficult.

To address properly the question of psychiatric abuse, it is likewise necessary to disengage it from the scientific discussion of sluggish schizophrenia. Defective concepts of classification are unavoidable, since classification reflects only the current state of knowledge, which is constantly changing and ex-

panding, rendering some previous approaches obsolete. The moral, ethical, and legal questions raised by psychiatric abuse in the Soviet Union, however, transcend a particular diagnostic entity, and any attempt to diminish the significance of immoral and criminal behavior on the basis of some defect in psychiatric nomenclature would itself be another form of psychiatric abuse.

Because of the general material privation Soviet psychiatry shares with other medical specialties, the relative absence of a variety of psychotherapeutic and psychosocial treatment methods, the special distortions that were imposed upon psychiatry as a discipline closely related to political ideology, and the particular problems of abuse of psychiatry by the government for political purposes, Soviet psychiatry, perhaps more than any other branch of medicine, needs assistance from and professional collaboration with colleagues from other nations. It would be helpful if programs could be arranged to bring psychiatrists from the former U.S.S.R. to the U.S. and other countries for periods of study and training. Such programs would provide these psychiatrists with additional skills needed to improve their own systems, and it would strengthen their morale and create new vision. 

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