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Borderlines of psychosis – nosological propositions of Polish psychiatrists of the interwar period

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Summary

This paper examines nosological categories relating to borderlines between psychosis and other clinical categories, introduced by Polish psychiatrists in the interwar period. In the United States, the discussion about the borderline between neuroses and psychoses was urged by the 1938 article by psychoanalyst Adolph Stern. In Poland, nosological categories regarding the borderline between neuroses and psychoses were proposed by Adam Wizel, Maurycy Bornsztajn, Jan Nelken, and Władysław Matecki. Wizel coined the term 'underdeveloped schizophrenia', Bornsztajn introduced 'schizothymia reactiva' and 'hypochondriac (somatopsychic) schizophrenia', Nelken described 'mild schizophrenia', first introduced by Moscow psychiatric school of Rosenstein, and Matecki presented the category of neurosis-like (pseudo-neurotic) schizophrenia. Additionally, Julian Dretler, after studying the borderline between schizophrenia and manic-depressive psychosis, coined the term 'mixed psychosis' and expressed conviction that it is an independent nosological entity. Like in the United States, the majority of Polish pioneers of the nosological studies of borderline cases were influenced by psychoanalysis. As a consequence of World War II and the new regime, which forced dialectical materialism and Pavlovism as an official ideology of psychiatry and condemned psychoanalysis, the categories presented in the article became forgotten and have not impacted Polish psychiatric nosology.

Key words: borderline, history, psychosis

Introduction

The difficulty of classifying some forms of mental illness into the category of neurosis or psychosis was first noticed in 1919 by the American psychoanalyst L. Pierce Clark [1]. In 1921, Thomas Vernon Moore [2] first used the term borderline to describe these problematic states. The problem raised by Clarke and Moore did not attract wider attention at first. The discussion on cases on the border between neuroses and psychoses began in the environment of American psychoanalysts and

psychiatrists only after the 1938 article by Adolph Stern [3]. The interest in the borderline category was established in 1953 by Robert Knight [4]. In the 1960s, the understanding of borderline gradually shifted from the borderline between neurosis and psychosis to character/personality disorders. In 1980, with the release of DSM-III [5], borderline personality disorder became an official diagnostic category, which resulted in its worldwide expansion. Echoes of the borderline concepts from the 1940s and 1950s, understanding borderline psychopathology as closely related to the schizophrenia spectrum, found expression in the construction of criteria for schizotypal personality disorder, also introduced in DSM-III [6]. Today, borderline is one of the most popular diagnostic categories, and at the same time one of the most controversial [6, 7].

Two clinicians of Polish origin contributed to the development of the borderline category: Helena Deustch and Gustaw Bychowski. Deustch's work [8] from 1942, describing the functioning of the personality she called "as if" personality, is mentioned by historians as the first such detailed clinical description of borderline psychopathology [9–11]. Also, Otto Kernberg [12] in his influential work *Borderline Personality Organization* from 1967, pointed to the merits of Deustch's work as one of his theoretical inspirations. Historians [9–11] and Kernberg [12] point also to Gustaw Bychowski's article [13] *The Problem of Latent Psychosis* as an important work for the development of the borderline category. While Helena Deutsch left Poland early and did not write a single article in Polish, Gustaw Bychowski, a psychiatrist and psychoanalyst, did not emigrate to the United States until 1939, having previously worked and published in Poland.

The study of the Polish psychiatric literature of the interwar period shows, however, that it was not Bychowski who was the leading researcher trying to put borderline cases into a nosological framework. Polish psychiatrists were prolific in this field. This article will present the following nosological categories proposed by Polish psychiatrists of the interwar period relating to the problem of borderline psychosis: Adam Wizel's underdeveloped schizophrenia, *schizothymia reactiva* and somatopsychic schizophrenia by Maurycy Bornsztajn, mixed psychosis by Julian Dretler, mild schizophrenia by Jan Nelken, and neurotic-like (pseudo-neurotic) schizophrenia by Władysław Matecki. As for Bychowski, the category of latent psychosis was created only in the United States, so it will not be presented in this article.

Adam Wizel's underdeveloped schizophrenia

Adam Wizel was born in 1865 in Warsaw in an assimilated Jewish family. After graduating from the University of Warsaw in 1889, he went on an eight-month internship in the Salpêtrière Hospital in Paris, where he learned, among others, from Jean-Martin Charcot. In 1898, he became the director of the psychiatric ward of the Jewish Hospital in Warsaw, a position he held until his death in 1928 [14].

In a paper published in 1925, he introduced the category of underdeveloped schizophrenia [15]. He proposed to classify in this way "those cases of schizophrenia in which clinical symptoms do not fully develop and sometimes appear in the nascent form" [16, p. 194]. He was influenced by the criticism of the contemporary concepts of schizoid by Bleuler and Kretschmer, put forward by German psychiatrists Bumke and Berze, who believed that schizoid was rather an undeveloped form of schizophrenia than a type of character [15]. Referring to this idea and the French notion of *formes frustes* of schizophrenia, Wizel created a category of underdeveloped schizophrenia.

The characteristic symptom of underdeveloped schizophrenia was an excessive occurrence of daydreams and phantasies. Wizel understood daydreams as underdeveloped delusions. According to him, daydreams arise "on the basis of affect, on the basis of certain wishes – delusions are born from the same affective source" [16, p. 194]. Delusions, Wizel believed, were daydreams *in extrememis*. Wizel's understanding of the function of dreams and delusions as wish fulfilment was inspired by Freudian psychoanalysis. Patients with underdeveloped schizophrenia tended to withdraw from social activities and pursue their aspirations in the form of fantasies and dreams [15, 16]. Wizel also pointed out that the process of phantasmatic wish fulfilment sometimes occurred in the symbolic form, as in dreams. Even though the development of daydreams and phantasies in underdeveloped schizophrenia was a kind of breaking away from reality, patients with underdeveloped schizophrenia generally were able to critically refer to their symptoms and were characterized by relatively good social adaptation.

Schizotymia reactiva and hypochondriac (somatopsychic) schizophrenia by Maurycy Bornsztajn

Maurycy Bornsztajn was born in 1874 in Warsaw in an assimilated Jewish family. He graduated in medicine from the University of Warsaw in 1899. In the years 1907–1908, he completed an internship at the Munich Psychiatric Clinic run by Emil Kraepelin. After the death of Adam Wizel in 1928, he became the director of the psychiatric ward of the Jewish Hospital in Warsaw [17]. Bornsztajn was one of the most ardent promoters of psychoanalysis in the Polish psychiatric community [18]. He was also inspired by the phenomenology of Karl Jaspers and Eugeniusz Minkowski [17, 18].

Maurycy Bornsztajn introduced the category of *schizothymia reactiva* in 1916 [19]. Both categories, *schizothymia reactiva* and hypochondriac (somatopsychic) schizophrenia in the primary form were included in the classification of schizophrenia presented by Bornstein in 1922 in the textbook *Outline of Clinical Psychiatry*, in which he distinguished six types of schizophrenia: simplex, somatopsychic, schizothymic, hebephrenic, catatonic, and paranoid [20].

For Bornsztajn, the basic symptom of schizophrenia was autism, which he understood as "a human tendency to withdraw from the influence of the external world, to contest the meaning and importance of the external world, and finally to completely

negate reality and create his own world […]" [21, p. 84–85]. He criticized Bleuler for degrading autism to the role of a secondary symptom, being a consequence of the process of disorders of associations, and not its cause. Schizophrenia was explained by Bornsztajn in a psychoanalytic framework, as a regression to the stage of narcissism. Bornsztajn perceived schizophrenic disorders as a spectrum – from normal individuals with a schizoid constitution, through various reactive forms, to full-blown schizophrenia. Autism, in varying degrees, was supposed to be a symptom characteristic of the entire spectrum.

The category of s*chizothymia reactiva* referred to certain cases of reactive schizophrenia characterized, in addition to autism, by regression to primitive, magical thinking, rapid outbreak and severe course. The reason for an outbreak of *schizothymia reactiva* was supposed to be an unbearable experience for a given individual, triggering too strong and flooding affect. The delusions occurring in *schizothymia reactiva* were limited to the experience that caused the outbreak of the disease – often their content concerned the removal and cancellation of the suffering that caused the disease. Another symptom was the overwhelming feeling that something bad was about to happen. Other kinds of delusions and disturbances in associative processes did not occur. *Schizothymia reactiva* usually ended in remission after several months, sometimes after several years [22].

The category of a hypochondriac, or somatopsychic, schizophrenia resembled in some ways *schizothymia reactiva*. It was also a disease of a reactive character, characterized by the presence of autism, a rapid outbreak being a consequence of psychological trauma, usually of a sexual nature, and a severe course. The difference was in the content of the delusions. The clinical picture of a hypochondriac (somatopsychic) schizophrenia was dominated by delusions about the patient's body, taking various forms – from a vague sense of internal change and transformations in the sense of self to grotesque beliefs that the head is made of glass, there are no internal organs, food goes to the bones instead of stomach, etc. [23, 24]. There were no delusions and hallucinations of other content and no disorders of associative processes. Cases of hypochondriac schizophrenia, according to Bornsztajn, usually ended in remission, although some of them remained chronic. Bornsztajn considered hypochondriac schizophrenia as a form of underdeveloped paranoid schizophrenia.

Jan Nelken's mild schizophrenia

Jan Nelken was born in 1876 in the village of Skomroszki near Kyiv. He graduated in medicine in 1902 at the Kazan Imperial University. Known for his socialist activities and psychoanalytic inspirations. In the years 1919–1934, he served in the Polish Army and worked at the Ujazdowski Hospital in Warsaw. In 1930, he became the scientific director of the Sanitary Training Centre of the Psychiatric Ward of the Ujazdowski Hospital. He was murdered in 1940 in Katyn [25].

Jan Nelken is not the author of the category of mild schizophrenia – he took it from Russian psychiatry, specifically the Moscow school of Rosenstein [26]. In his 1935 article *Mild schizophrenia*, Nelken analysed European concepts of the borderline between psychosis and neurosis and, in his opinion, it was Moscow psychiatrists who best described the specificity of this type of psychopathology. Nelken pointed out that the systematic scientific interest of Russian psychiatrists in mild forms of schizophrenia was closely related to the Soviet organization of mental health care. The well-developed mental hygiene movement – "psychiatry going beyond the walls of psychiatric institutions" in the words of Nelken [26, p. 91] – allowed psychiatrists to deal with ambulatory cases of mental disorders that did not require hospitalization. Rosenstein, cited by Nelken, regarded mild schizophrenia as a separate disease entity, not as the initial phase of psychosis. Within the category of mild schizophrenia, according to Nelken [26, p. 91], two groups can be distinguished:

1) a group in which the schizophrenic complex of symptoms is clearly observable;
2) a group with other symptoms that apparently exclude this schizophrenic complex (simple indolence, 'depression', 'hypochondriac experiences', neurasthenic reactions, obsessions, stuttering, 'vegetative neurosis', alcoholism, etc.). Mild forms of schizophrenia are therefore covered with neurosis.

Other characteristic features of mild schizophrenia were the preservation of the personality structure, as well as the ability to socially adapt, relate, and communicate, lack of schizophrenic personality disorganization, and psychomotor, thinking and speech disorders. Individual 'microsymptoms', to use Nelken's term [26, p. 96], could be identified only after a more thorough examination of the patient's overall personality. They had the character of "short-lived isolated episodes, like dots in a complete and preserved personality (e.g., short-lived states of depersonalization)" [26, p. 97]. The premorbid personality of patients with mild schizophrenia usually could be qualified "to this or that type of psychopathy (psychasthenic, schizoid)" [26, p. 97]. Thus, the interaction between personality and the disease process was bidirectional – personality traits determined the clinical picture of mild schizophrenia, and the disease process sometimes led to permanent personality changes. The dynamics of the disease process was characterized by periodicity: "all movement of the pathological process has the character of periodically successive states of compensation and decompensation, often appearing under the influence of external situations, but also without them" [26, p. 96].

In conclusion, Nelken pointed out that the systematic clinical studies of cases of mild schizophrenia were at a very early stage, so this category was far from being considered useful in psychopathology. He pointed to the possibility of blurring the boundaries of the schizophrenia category in the case of including in it all its mild and latent forms. He considered the basic question to be legitimate: can mild schizophrenia be considered schizophrenia at all?

Julian Dretler's mixed psychosis

Julian Dretler, born in 1905, graduated from medical studies at the Jagiellonian University in 1929. He worked in the Psychiatric Facility in Kobierzyn. He died in 1944 [27].

The category of mixed psychosis was presented by Dretler in 1936 in the work *On Mixed Psychoses* [28]. He pointed out the difficulty in clearly separating schizophrenia from manic-depressive psychosis[1]. Thus, the problem he raised was not of the borderline between psychosis and neurosis, but the borderline between the two main groups of psychoses. Dretler [28 p. 103] collected clinical material in the form of 85 cases, which he arranged into six groups:

1) periodic schizophrenia manifested as catatonic excitement with manic features;
2) schizophrenia with remissions without catatonic features, but with manifested periodicity and manic features;
3) schizophrenic states with increasingly marked cyclic elements;
4) manic-depressive psychosis progressing into schizophrenia;
5) manic-depressive psychosis with schizophrenic features;
6) indifferent mixed psychoses.

Reviewing the European psychiatric literature on borderline cases between schizophrenia and manic-depressive psychosis, as well as conducting extensive statistical analyses of the above six groups by age, race, body constitution, and personality, as well as examining heredity, he argued that the form he called mixed psychosis, is a clinical entity independent of schizophrenia and manic-depressive psychosis, separating these two groups [28]. Dretler was led to this conclusion primarily by the results of heredity studies, which indicated that mixed psychosis occurs in families where neither schizophrenia nor manic-depressive psychosis was present, and in families where both schizophrenia and manic-depressive psychosis occurred, no higher incidence of mixed psychosis was noted. Mixed psychosis, as Dretler concluded, could not be merely a symptomatic form that was a mixture of heterogeneous elements of schizophrenia and manic-depressive psychosis. Dretler [28, p. 190] summarized the results of his research as follows:

> *mixed psychosis is much more than an accidental or constantly coupled combination of two psychoses in their 'residual' form. It is the expression of a specific deviation from the norm that recurs with sufficient frequency and can be classified sufficiently clearly. It is something that demarcates quite sharply, despite theoretical transitions to one or another intrinsic psychosis (transitions that can*

[1] Instead of the term 'manic-depressive psychosis', Dretler used the old Polish term *psychoza szałowo-posępnicza*.

be arranged between many individuals or groups of diseases). It is […] a 'true natural hypothesis', what we demand from the concept of 'disease entity'.

As indicated by the six groups, mixed psychosis was a disease with a very diverse clinical picture.

Władysław Matecki's neurosis-like (pseudo-neurotic) schizophrenia

Władysław Matecki was born in 1895 in Tomaszow Lubelski. He graduated from medicine at the University of Warsaw in 1925 and started working at the Jewish Hospital in Czyste as an assistant first to Adam Wizel and then to Maurycy Bornsztajn. He died in 1941 [29].

Neurosis-like, or pseudo-neurotic, schizophrenia was presented by Matecki in the article *Neurosis-like (pseudo-neurotic) forms of schizophrenia as a matter of diagnosis and treatment* published in 1937 [30]. Matecki saw neurosis-like schizophrenia as a specific group of underdeveloped schizophrenia characterized by a significant number of neurotic symptoms in the clinical picture, which, however, constituted a kind of facade for the developing schizophrenic process. The apparent similarity of the symptomatology to the group of neuroses and, on the other hand, the identifiable schizophrenic process, placed neurotic-like schizophrenia on the borderline between neurosis and psychosis. Matecki understood the schizophrenic process in psychoanalytic terms, similarly to Maurycy Bornsztajn, as an autistic mechanism of withdrawing the libido from the objects of the external world towards one's own body – so as a regression to the stage of narcissism. In neurosis-like schizophrenia, there was no complete loss of contact between the self and reality, as a consequence of which the ego remained largely aware of the schizophrenic process of personality disintegration. Pseudo-neurotic schizophrenia was characterized by the ego's reaction to the progressing disease process, causing symptoms in the form of extreme anxiety, a sense of impending death, depersonalization, as well as somatopsychic or paranoid delusions. Matecki saw the causes for such a clinical picture of pseudo-neurotic schizophrenia in the fact that in these forms of schizophrenia, not only libido was subject to narcissistic regression from external objects to one's own body, but also destrudo (death drive). Hence the sense of imminent death and aggressive somatopsychic and paranoid delusions. The reaction to this process of the conscious part of the ego was intensifying anxiety [30].

In 1949, the American psychiatrists Hoch and Polatin [31] proposed the category of *pseudoneurotic schizophrenia*, which, according to historians, was an important voice in the discussion about borderline disorders and contributed to the process of evolution of the *borderline* category in the United States [9–11]. Hoch and Polatin did not refer to Matecki's work in any way, and it is unlikely that they would have known the work

of the Polish psychiatrist. Nevertheless, the fact that Matecki proposed the category of pseudo-neurotic schizophrenia 12 years before American psychiatrists is worth noting.

Conclusions

The discussion on identifying and categorizing border areas between nosological units, usually neuroses and psychoses, which took place in the Polish psychiatric community of the interwar period, was an attempt to respond to the difficulties that European psychiatry was facing at that time. Polish psychiatrists, dissatisfied with Bleuler's concept of latent schizophrenia or the widely discussed concept of schizoid, sought their own nosological solutions. Particularly active in this field was the society of psychiatrists from the Jewish Hospital in Warsaw, which included Władysław Matecki, Adam Wizel and Maurycy Bornsztajn. Categories of underdeveloped schizophrenia, *schizothymia reactiva,* hypochondriac schizophrenia, and neurosis-like schizophrenia, were the original contribution of Polish psychiatry to the nosology of borderline cases. Jan Nelken took the category of mild schizophrenia from Russian psychiatry, presenting it in the context of other European concepts and emphasizing its connection with the Soviet organization of mental health care, which took into account the postulates of the mental hygiene movement. Julian Dretler's category of mixed psychosis was an expression of his belief that there was an independent clinical entity on the borderline between schizophrenia and manic-depressive psychosis, whose symptomatology included a diverse mixture of symptoms of both schizophrenia and manic-depressive psychosis.

It is worth paying attention to the issue of the relationship between researchers of borderline categories and psychoanalysis. Historians of the borderline category [6, 9–11] emphasize the fact that its American pioneers were psychoanalysts. Among the authors of the categories presented in this article, the supporters of psychoanalysis were Bornsztajn, Matecki and Wizel [14, 17, 18, 29]. It can be stated that the majority of Polish authors of borderline categories in the interwar period were associated with psychoanalysis. Jan Nelken was inspired by psychoanalysis, but there he did not refer to it in the article *Mild Schizophrenia*. Julian Dretler's work is also not related to psychoanalysis.

The discussion on the borders of psychosis in Polish psychiatry took place even before the publication of the famous article *Psychoanalytic investigation of and therapy in the border line group of neuroses* by Adolph Stern in 1938, therefore preceded the American discussion that eventually led to the creation of the categories of borderline personality disorder and schizotypal personality disorder. However, World War II and the change of the political system in Poland, which imposed the ideology of dialectical materialism and Pavlovism on Polish psychiatry, and the condemnation of psychoanalysis by the regime [32], led to the oblivion of the original Polish nosological categories from the interwar period. Dretler, Matecki and Nelken died during the war.

In 1948, Maurycy Bornsztajn published the second edition of his psychiatry textbook, in which he consistently included *schizothymia reactiva* and hypochondriac form as types of schizophrenia [33]. After he died in 1952, the categories he developed went into oblivion for the period of the Polish People's Republic.

The post-war development of the borderline category was contributed to by Gustaw Bychowski, who in 1928 described certain forms of schizophrenia bordering on neurosis, which, in his opinion, were available for psychotherapeutic treatment, although he did not give them a name at that time [34]. Working in New York after his emigration in 1939, Bychowski proposed the category of latent psychosis [13, 35] and described the principles of its psychotherapy [35]. Otto Kernberg [12, p. 643] noted that Bychowski studying the symptoms of borderline patients "… described important structural characteristics of these patients, such as the persistence of dissociated primitive ego states and the cleavage of parental images into good and bad objects".

References

1. Clark LP. *Some practical remarks upon the use of modified psychoanalysis in the treatment of borderland neuroses and psychoses*. Psychoanal. Rev. 1919; 6(3): 306–308.
2. Moore TV. *The parataxes: A study and analysis of certain borderline mental states*. Psychoanal. Rev. 1921; 8(3): 252–283.
3. Stern A. *Psychoanalytic investigation of and therapy in the border line group of neuroses*. Psychoanal. Quart. 1938; 7(4): 467–489.
4. Knight RP. *Borderline states*. Bull. Menninger Clin. 1953; 17: 1–12.
5. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders. 3rd ed*. Washington, D.C.: American Psychiatric Association; 1980.
6. Zandersen M, Henriksen MG, Parnas J. *A recurrent question: What is borderline?* J. Pers. Disord. 2019; 33(3): 341–369.
7. Tyrer P, Mulder R, Kim YR, Crawford MJ. *The development of the ICD-11 classification of personality disorders: An amalgam of science, pragmatism, and politics*. Ann. Rev. Clin. Psychol. 2019; 15: 481–502.
8. Deutsch H. *Some forms of emotional disturbance and their relationship to schizophrenia*. Psychoanal. Quart. 1942; 11(3): 301–321.
9. *Essential papers on borderline disorders: One hundred years at the border*. Stone MH, editor. New York, NY: New York University Press; 1986.
10. Stone MH. *Borderline personality disorder: History of the concept*. In: Zanarini MC, editor. *Borderline personality disorder*. New York–London: Taylor & Francis; 2005. P. 1–18.
11. *Current and historical perspectives on the borderline patient*. Fine R, editor. New York, NY: Brunner/Mazel; 1989.
12. Kernberg O. *Borderline personality organization*. J. Am. Psychoanal. Assoc. 1967; 15(3): 641–685.
13. Bychowski G. *The problem of latent psychosis*. J. Am. Psychoanal. Assoc. 1953; 1(3): 484–503.

14. Marcinów M. *Adama Wizla projekt „psychoterapii psychoanalitycznej”*. In: Dybel P, editor. *Przywracanie pamięci. Polscy psychiatrzy XX wieku orientacji psychoanalitycznej*. Krakow: Towarzystwo Autorów i Wydawców Prac Naukowych “Universitas”; 2017. P. 205–254.
15. Wizel A. *O postaciach niedorozwiniętych schizofrenji*. In: *Pamiętnik szpitala dla psychicznie i nerwowo chorych „Kochanówka” (pod Łodzią) ku uczczeniu ś.p. prof. dr. med. Antoniego Mikulskiego*. Lodz; 1925. P. 59–92.
16. Wizel A. *Pamiętnik pacjentki*. Warsaw: F. Hoesick; 1928.
17. Prot-Klinger K. *Maurycy Bornstein (Bornsztajn) – psychoanalityczne rozumienie psychoz* In: Dybel P, editor. *Przywracanie pamięci. Polscy psychiatrzy XX wieku orientacji psychoanalitycznej*. Krakow: Towarzystwo Autorów i Wydawców Prac Naukowych “Universitas”; 2017. P. 255–276.
18. Dybel P. *Psychoanaliza – ziemia obiecana? Dzieje psychoanalizy w Polsce międzywojnia (1918–1939). Część II. Między nadzieją i rozpaczą*. Krakow: Towarzystwo Autorów i Wydawców Prac Naukowych “Universitas”; 2016.
19. Borsztajn M. *O odrębnym typie rozszczepienia psychicznego (Schizothymia reactiva circumscripta)*. Warsaw: Wyd. Kasy Mianowskiego; 1916.
20. Bornsztajn M. *Zarys psychjatrji klinicznej. Dla lekarzy i uczących się*. Krakow–Lviv–Warsaw: Spółka Wydawnicza Lekarska; 1922.
21. Bornsztajn M. *Stanowisko kliniczne schizofrenji i nowa teorja jej patogenezy*. Rocznik Psychjatryczny 1927; 5: 79–92.
22. Bornsztajn M. *Nowy przyczynek do t. zw. schizothymia reactiva*. Rocznik Psychjatryczny 1927; 6: 191–196.
23. Bornsztajn M. *Hipochondryczna (somatopsychiczna) postać schizofrenji*. Rocznik Psychjatryczny 1927; 5: 93–94.
24. Bornsztajn M. *O schizofrenji somatopsychicznej (Studjum klininczo-psychologiczne)*. Rocznik Psychjatryczny 1936; 26–27: 156–166.
25. Dobroczyński B. *Pod Słońcem Tanatosa. Jan Władysław Nelken (1876–1940) – szkic do portretu*. In: Dybel P, editor. *Przywracanie pamięci. Polscy psychiatrzy XX wieku orientacji psychoanalitycznej*. Krakow: Towarzystwo Autorów i Wydawców Prac Naukowych “Universitas”; 2017. P. 297–380.
26. Nelken J. *Łagodna schizofrenja*. Rocznik Psychjatryczny 1935; 24: 87–102.
27. Gliński JB. *Słownik biograficzny lekarzy i farmaceutów ofiar drugiej wojny światowej*. Wroclaw: Wydawnictwo Medyczne Urban & Partner; 1997.
28. Dretler J. *O psychozach mieszanych*. Nowiny Psychjatryczne 1936; 13(1–4): 101–194.
29. Dobroczyński B. *Władysław Matecki (1985–1941)*. In: Dobroczyński B, editor. *Polskie zmory. Psychoanaliza w międzywojniu*. Krakow: Towarzystwo Autorów i Wydawców Prac Naukowych “Universitas”; 2021. P. 423–426.
30. Matecki W. *Nerwicopodobne (rzekomonerwicowe) postacie schizofrenii jako zagadnienie rozpoznawcze i lecznicze*. Nowiny Psychjatryczne 1937; 14(1–4): 113–134.
31. Hoch P, Polatin P. *Pseudoneurotic forms of schizophrenia*. Psychiatr. Q. 1949; 23(2): 248–276.
32. Nasierowski T. *Rys historii psychiatrii w Polsce*. In: Shorter E. *Historia psychiatrii. Od zakładu dla obłąkanych po erę Prozacu*. Warsaw: Wydawnictwa Szkolne i Pedagogiczne; 2005. P. 359–462.

33. Bornsztajn M. *Wstęp do psychiatrii klinicznej dla lekarzy, psychologów i studentów. Wydanie drugie, uzupełnione*. Lodz: Księgarnia Ludowa; 1948.
34. Bychowski G. *W sprawie psychoterapji schiofrenji*. Rocznik Psychjatryczny 1928; 8: 57–69.
35. Bychowski G. *Psychotherapy of Psychosis*. New York, NY: Grune & Stratton; 1952.

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