

Solitary Persons?

The Conceptualisation of Autism as a Contact Disorder

by Frankl, Asperger, and Kanner

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Introduction

“I am looking into three early theories of autism. Today, most people define autism spectrum disorder as a cognitive disorder, as a disorder of conditioned learning, or as a form of neurodiversity. In contrast, these three early theories defined autism as a *contact disorder*.

“A contact disorder, really? Luckily, we have come a good way since.”

“Why do you say that?”

“Well, for me autism is not all about contact. I am also quite sensitive to sound and I am easily overwhelmed, for example. If we must talk about contact, I am no island. I do want to be close to other people. I have good friends too, you know. That I am different, does not mean that I have a disorder. My autism has positive sides too. I wouldn’t change it, even if I could. These psychologists of you got it all wrong. I sometimes wonder whether they have even met a person with autism, like me.

“Actually, all three proponents of the idea that autism is a contact disorder were medical doctors, specializing in mental problems. They did not base their theories on laboratory research, but on their experience with diagnosing and treating autism. It is true, though, that they all worked with children, not adults.”

This short dialogue, with a university educated autistic adult, which took place when I was halfway through my research, nicely illustrates three contemporary biases that people have (and I used to be one of them) towards the historical idea that autism is a contact disorder.

The first bias is that the idea of a *contact* disorder entailed that the person is not interested in being in contact with other people at all. The research presented here will show that this is indeed a bias. Although the idea of contact disorders did include the possibility that the child would *almost* make no contact at all, even in such extreme cases, this was not usually seen as a *total* absence of contact. The proponents of the idea that autism is a contact disorder were well aware that children with autism do have contact with other people;

their point was that they do so in *a different way*. That is, they described the difference as qualitative, not quantitative.

The second bias has it that the idea of a contact *disorder* entailed that autism only involves problems and difficulties, to be overcome through treatment, not talents and skills that must be accepted or even celebrated. On this view, the choice of the term ‘disorder’ reflects the exercise (or even abuse) of power by psychiatrists who think that they know best and impose the way of life they consider to be ‘normal’ on children seen as ‘different’ and ‘mentally ill’. This idea will also be exposed as a bias. The idea of ‘contact disorders’ was actually introduced to protect autistic children against mistaken interpretations of their behaviour that prevailed at that time: their teachers, parents and therapists believed that their behaviour stemmed from intellectual disability, deafness, or disobedience. Moreover, the idea of an autistic contact disorder was introduced not in the first place to treat or ‘improve’ autistic children but rather to get to know them and to really understand them.

The third bias is that early theories described autism as *only* a contact disorder. My research refutes this bias too. We will see that autism was not reduced to a contact disorder but was considered to affect the whole personality of a child. Differences in the desire and aptitude for contact were considered the most visible manifestation of a different personality, but certainly not the only one. I have learned that ‘autism’ is a bit of a misnomer, in the sense that it is derived from ‘being only a self’ (*autos*), that is, a disorder of contact, but came to stand for much more. Ultimately, the proponents of the idea that autism is a contact disorder described autism in terms of *integration*. On this view, autism is the opposite of a smooth integration of different forms of speech, different inner and outer functions, or different factors of the personality.

These biases belong to the misunderstanding of the idea that autism is a contact disorder by its critics. They criticized an idea that wasn’t actually defended by anyone, a so-called strawman fallacy. My aim is to overcome such a misunderstanding. I will do so by detailing how the idea was presented and defended *by its proponents*.

Three authors have presented and defended the idea that autism is a contact disorder: Georg(e) Frankl (1897-1975), Hans Asperger (1906-1980) and

Leo Kanner (1894-1981). This dissertation focuses on the period from 1935, when Georg Frankl introduced the concept of contact disorders, until 1977, when Hans Asperger delivered his last lecture on autism. Many other scholars published on autism in children in these decades. My best estimate is that in this period about a thousand titles were published on childhood autism.¹ Some scholars applied the term autism to children before Frankl, Asperger and Kanner and among them certainly were women.² Then again, these three men are the scholars who introduced and developed the idea that there is an autistic disorder that has as a core feature *a qualitatively different form of contact*. From this feature it derives its name.

Kanner, Asperger and Frankl were practicing physicians who, in their daily clinical work, encountered children, predominantly boys, who did not play with other children, did not look their parents and teachers in the eye, and did not engage in pretend play with toys. They did share information with others, but in a repetitive, and unusual way. Because these children had a different kind of contact with their environment than other children, Frankl, Asperger and Kanner called them 'autistic', a term coined by Eugen Bleuler and derived from the Greek word *autos* (self).

Frankl, Asperger and Kanner were also scholars, who wrote articles and gave lectures on child psychopathology. As part of their academic work, but based on their clinical experiences, they formulated theories of autism. Frankl introduced the idea that some children may have no intention to communicate with the people around them. He compared them to *solitary persons*, that is, persons without human company, because they acted as if there were no people around. Frankl introduced the concept of *contact disorder* to clarify that an inability to make contact with other people need not be a symptom of another

¹ Covering a somewhat larger period, Kehrer listed 1.958 academic publications in 9 languages, but he included publications on psychosis and schizophrenia in childhood, which we would no longer file under the heading of autism. Kehrer, *Bibliographie über den kindlichen Autismus: Von 1934 bis 1981* (1982). Three years later, an English-only bibliography, more restricted to autism, listed 1.164 academic publications. Andor J. Tari, Janet L. Clewes and Shirley J. Semple, *Annotated bibliography of autism 1943-1983* (1985).

² Annemieke Van Drenth, "Rethinking the origins of autism: Ida Frye and the unraveling of children's inner world in the Netherlands in the late 1930s" (2018); Annio Posar and Paola Visconti, "Tribute to Grunya Efimovna Sukhareva, the woman who first described infantile autism" (2017). I should also mention Anni Weiss, Frankl's wife. See Samantha Druzak, "Les pionniers oubliés de l'autisme: la vie et l'œuvre d'Anni Weiss et de Georg Frankl" (2021).

disorder but can be a disorder itself. Asperger and Kanner took up Frankl's idea but extended it, proposing that such contact difficulties are one aspect of a wider autistic disorder that affects the whole personality. Influenced in turn by the ideas of Asperger and Kanner, Frankl later also developed a theory of autism. The autism theories of Frankl, Asperger and Kanner had in common that they focussed on *diagnosing* rather than treating children with autism. Although treatment was certainly part of their medical practice, they did not address it in their theories of autism.

It is significant that Frankl, Asperger and Kanner were medical doctors. They worked in hospitals and used medical terms such as 'disorder' and 'syndrome'. In this dissertation I will not avoid this terminology, even though the medical model of autism to which it belongs is now criticized³ or combined with the social model.⁴ Frankl, Asperger and Kanner sometimes use terms for disorders we would not use today, such as 'autistic psychopathy' and 'intellectual inadequacy'. When I use these terms, this should not be understood as an endorsement of them, but as a historical description of the parlance of the past. As a conceptual historian, my aim is not to heed to present-day sensibilities, but rather to foster the understanding of both the insensitivities and the sensitivities of the past. Moreover, this dissertation is about the conceptual history of *psychiatry*, a field where clinical terms are still the standard. I will, then, write about autism as a disorder with symptoms.

In this dissertation, I will use both identity-first language ('autistic children') and people-first language ('children with autism'). I do not believe that a choice has to be made; there are valid arguments for both. This should not be taken as endorsement of an underlying model of autism.

In the remainder of this introduction, I will present the experiential basis of my research, my research problem and research question, my research strategy and my conceptual framework. I will end with an overview of the chapters that will follow.

³ Katherine Runswick-Cole et. al., *Re-thinking autism: Diagnosis, identity and equality* (2016).

⁴ Steven K.Kapp, et al. "Deficit, difference, or both? Autism and neurodiversity." *Developmental psychology* 49.1 (2013), p. 59.

My experience

I was diagnosed with autism when I was 34, by an interdisciplinary team specializing in autism spectrum disorders. The formal DSM-5 diagnosis was autism spectrum disorder (ASD), but I was told: “you have Asperger’s syndrome, even though we no longer officially call it that”.

As a child, my autism never caused any problems and remained unnoticed by my parents and teachers. It was not until puberty that I first encountered difficulties, though not enough to need professional help. I first experienced serious psychiatric problems when I was 28.

My diagnosis came after six years of disabling psychiatric problems. From the start of this period, I had been diagnosed with generalized anxiety and disorganized thinking, and these diagnoses were helpful for getting the right professional help and for personally understanding my problems. Through a combination of therapy, self-education and practical support, I developed an understanding of what was happening to me. Even so, I pressed for an additional diagnosis, as I felt that these two diagnoses did not explain the very root of my problems. Because I led a highly structured life, on a strict schedule, my psychiatrist expected that I was autistic and the autism team confirmed his suspicions. I became what I already was: autistic.

The autism team did help me recognize my symptoms. I was hypersensitive to sound, but inattentive to bodily feedback. As a student, it was a challenge to deal with my ‘special interests’ (a hyper focus on certain topics), but they were also my strength. I found social interaction exhausting. I had difficulties with informal and unstructured social interaction, such as making small talk. I was (unexpectedly) good in ‘reading’ other people and had little difficulty with social contact in formal settings (e.g. chairing meetings). I was able to organize myself practically, but had very little interest in it. I rather had a propensity for theory and abstraction. Most of all, I was simply interested in other things than other people: I was entirely focussed on my own interests, which were in academics, neglecting other developmental tasks: making friends, taking care of my body, relaxing my mind, getting a job, finding a boyfriend.

I had a list of symptoms and a term (‘autism’), but to my surprise no one seemed to know how they fit together. I experienced wonder at this lack of a

clear *concept* of autism. The psychologists and psychiatrists who worked with me seemed to lack an understanding of nature of the disorder *as a whole* and did not seem to know how all these different symptoms can be signs of a single disorder.

The conceptual tools that my psychologists did have were the three dominant cognitive theories of autism. In my case at least, these three theories did not afford any understanding. First, I had no problems with imputing mental states to other individuals or more generally with ‘second order representation’, as is proposed by the theory of mind hypothesis.⁵ Second, even though at the time I had ‘executive dysfunctions’, especially rigidity of thinking, I had not always had them (nor do I have them now), and they were better explained as disorganized thinking.⁶ Third, I did not generally have a weak central coherence or a “detail-focussed cognitive style”⁷, but was actually very good at seeing the big picture. I was, and still am, not so good with details. As a student, my thinking style was very abstract, and that I had chosen philosophy as my field did not help in this regard. It was only until recently, both through therapy and through my turn to historical research, that I learned to consider concrete details and the context in which ideas function.

To sum up, although I think that autism is at the basis of my mental problems, the diagnosis ‘ASD’ was not as helpful as the other two diagnoses were. The diagnosis of my problem as a form of autism was unhelpful because it remained only that: the identification of the relevant disorder – not an understanding of it. I now had a list of symptoms, but I was surprised to find no coherent conceptualisation to cement these symptoms together.

My autism diagnosis turned out to be helpful in a different way: it helped me find other people with similar experiences. Three years after my diagnosis, I founded an autistic-led organisation (Autism Digital), which in different ways offers information about autism in adulthood. I now work with over 30 autistic

⁵ Simon Baron-Cohen, Alan M. Leslie, and Uta Frith, "Does the autistic child have a "theory of mind"?" (1985); Alan M. Leslie, "Pretense and representation: The origins of 'theory of mind'" (1987).

⁶ James Russell (Ed.), *Autism as an executive disorder* (1997); Sally Ozonoff, Bruce F. Pennington, and Sally J. Rogers, "Executive function deficits in high-functioning autistic individuals: relationship to theory of mind" (1991).

⁷ Uta Frith, *Autism: Explaining the enigma* (2003); Francesca Happé and Uta Frith. "The weak coherence account: detail-focussed cognitive style in autism spectrum disorders" (2006).

adults on a daily basis, which has been a joy of recognition. For example, my colleagues and me like clear and direct communication, explicit written rules of conduct, and meetings that last no longer than an hour.

Soon after my diagnosis I started the research that led to this dissertation. Two years into my (part-time) research, after exploring many angles (all special interests), I came to believe that the autism theories of Asperger and Kanner still offered what seems to have been lost in later theories: a pervasive conceptualisation of autism that ties together all of its symptoms. My mission became to recover this historical conceptualisation of autism.

My research problem and questions

What helped me to formulate a scientific problem on the basis of this experience was a twin pair of metahistorical concepts proffered by G.E. Berrios, a conceptual historian focussing on psychiatry. In a research note in the journal *History of Psychiatry*, Berrios claims that “mental [...] disorders are constructed by the convergence in the work of a writer of a name, a concept and behaviours”.⁸ Moreover, Berrios suggests that many such convergences “are no more”: their elements have become part of other convergences but the convergences themselves have dissolved. He suggests that of the three elements of a convergence, concepts are special: whereas the “word and behaviours are absorbed into later convergences”, concepts “have less chance of survival because their meaning is dependent upon medical theory”.⁹ This idea, that mental disorders are convergences of elements that may later diverge again, suggested to me that the word ‘autism’ and the symptoms of autism might have belonged together with an integrative conceptualisation at some point in history, but ceased to do so at a certain time.

Berrios’ pair of concepts offered me the tools to describe in scientific terms the aim of my research. I was looking for a convergence “that is no more”: a convergence between the term autism, a conceptualisation of autism and the symptoms of autism that has been discarded. My assumption was that this convergence occurred in the work of Hans Asperger and Leo Kanner, who not only

⁸ Germán Elías Berrios, "Convergences that are no more" (2011), p. 133

⁹ *Ibid.*

were among the first authors to write about an autistic disorder in childhood, but more importantly, shared a singular concept: the idea that autism is a contact disorder. I soon discovered that this concept was introduced by a third, lesser known, child psychiatrist: Georg(e) Frankl.

As a philosopher, it was a strange realisation for me that the theories of these authors have never been fully documented. This is understandable for the work of George Frankl, which was only rediscovered in 2015. However, that Hans Asperger and Leo Kanner have been important to the early history of autism has been known, at least in Europe, since the 1950's. In spite of this, I seem to be the first to historically research their entire work in comparison. In doing so, I have made several discoveries that shed new light on their ideas and on their relationships.

My historical problem, then, was simply that there is still a lot that is unknown about contact theories of autism and that much of what we do think to know comes from critics, not from Frankl, Asperger and Kanner themselves. Thus, the general aim of my research was to fill this gap in our historical knowledge and to problematize some of the assumptions about the early stages of what is now called *autism studies*. The more specific aim was to investigate whether there was indeed a convergence of the term 'autism', a concept of autism and the symptoms of autism in the work of these three medical doctors.

My assumption in doing so was that the idea of contact was central to their theories. It seemed to me at the time that autism was originally defined as a 'contact disorder' and that this concept was the missing link between the term 'autism' and autistic symptoms. This gave rise to the question in the title of this dissertation: are autistic children solitary persons?

I had two formal research questions:

1. *How did Georg(e) Frankl, Hans Asperger and Leo Kanner as proponents of the idea of contact disorders describe it?*
2. *Did Frankl, Asperger, and Kanner use the idea of contact disorder to conceptualize all symptoms of what are now called autism spectrum disorders?*

My experience as autistic person and my experience with other autistic adults may have helped me while answering these questions. However, Frankl,

Asperger and Kanner focussed on autistic children, not adults. Moreover, my main focus was on understanding these three men and their conceptualisation. The main challenge for me was to understand their experiences, problems, concepts and theories without any medical or psychiatric training. In so doing, I relied on a conceptual model, as we will see next.

My conceptual model

The limitation of Berrios's approach is that he merely describes the outcome of the historical process, the convergences and reconvergences, without, however, specifying how authors bring these about. To complement his idea, I was looking for an approach that could help me see how Frankl, Asperger and Kanner connected the name and symptoms of autism to the concept of autism. To this end, I turned to the historiographical approach proposed by historical psychologist Pieter van Strien. He has developed it for the history of psychology, but I have adapted it to psychiatry.

Van Strien suggests that the task of a historian is to show that a scientific theory is "a historical practice of coping with the world".¹⁰ To be precise, it is a form of problem solving, in which a situated individual creatively uses the available resources to respond to the world as he or she experiences it. On this basis, my assumption was that the convergence between the term autism, its conceptualisation as a contact disorder, and the symptoms of autism is best understood as a response to specific problems by particular child psychiatrists. They used the best tools available to them to solve these problems and did so within a network of relations. Hence, understanding this original convergence, requires understanding the problems, tools and relations of each author.

Van Strien's approach makes understanding scientific theories concrete by specifying two steps. First, he calls for a *reconstruction* of the historical context in which scientific problem solving takes place. This reconstruction involves the analysis of the context into components. Second, Van Strien calls for a *recontextualization* of scientific problem solving by showing how it was informed by each of these components.

¹⁰ Pieter J. van Strien, "The Historical Practice of Theory Construction" (1993), p. 149. I also draw on "Recontextualization as a contribution of history to theoretical psychology" (1990).

Figure 1: the adapted model

