

CHILDREN IN OLD BODIES

Age and Ageing in the History of Institutional Psychiatry

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The aim of this paper is to examine meanings of “age” in Swedish psychiatric institutions from 1850 to 1970. The paper focuses on psychiatry’s perspectives on individuals of advanced age and on the way that they were understood in terms of age. The majority of aged patients were described as irresponsible, unable to provide for themselves, and more or less unaware of the consequences of their actions. Such patients were regarded as child-like. The childish person’s development had stopped prematurely, and any improving, i.e. through developmental therapies, were scarcely to be had. For old people, this child-like stage in life might be reached sooner, or later. No matter: all that remained was a more-or-less steep downhill course marked by confinement in bed, lack of activities, and waiting for the inevitable.

My choice of psychiatry as object of investigation is motivated by its place at the very centre of modern society. In psychiatry we find explicit norms of how human beings are meant to behave, how they are supposed to think, and to what moral standards they should conform. This paper analyses and shows the slow change and continuity in the practices of psychiatric care and its everyday perspectives on age.

Keywords: age, ageing, psychiatry, everyday practices, history, institutions, mental hospitals

Senex comes from the Latin “old”. When we speak of senility we generally have in mind some form of mental weakness due to old age. The connection between ageing and this failing capacity is obvious and seems to be far removed from another common stereotype associated with advanced age, that of wisdom accumulated over a lifetime. Ageing, in the sense of advancing senility, hardly generates wisdom but rather a journey away from reason, a journey that is sometimes compared to becoming a child again. To lose one’s mental faculties in this way is generally regarded as the definitive sign of old age.

As individuals, we age differently and we encoun-

ter society differently depending on how the ageing occurs and how the society looks upon and deals with age. Age in this sense is not an absolute concept. There are plenty of historical studies showing how meanings of age and ageing have changed over time (see e.g. Ottaway 2002; Odén 1984, 1985; Thane 2002). An important question for these studies is what influences the view of advanced age and in what way old people have been taken care of by the family, household and society. This article is a contribution to this research on the conditions of ageing.

My aim is to examine what meanings age, and above all advanced age, was given when Swedish psy-

chiatry was defining, categorising and taking care of its patients during the second half of the nineteenth century and the first half of the twentieth. I will focus on psychiatry's perspective on individuals of advanced age but also on how individuals were understood by being described in terms directly or indirectly associated with age. Age in this latter sense, in other words, is to be regarded rather as a perspective on people than as concrete information about biological age. How were people of advanced age regarded and treated within the framework of psychiatry? What was considered to be an advanced or a low age, respectively? In what way did interpreted and perceived age relate to the biological age of the client or patient?

The theoretical framework of this study is basically inspired by the works of Michel Foucault, especially *The Birth of the Clinic* (1994) and *Discipline and Punish* (1979) and the ways in which these studies examine power, knowledge, discipline and the gaze produced by institutions of medicine and other projects of correction. One could argue that the works of Foucault might be difficult to apply to the ethnological concern with everyday practices with their multitude of – and some times contradictory – meanings, but Foucault discusses a number of ideas which can be readily applied in the material presented here.

The choice of my research subject – the institutions of Swedish psychiatry – is motivated by the concentration of norms to be found in those of its activities that have focused on social maladjustment. In this sense this article is not a contribution to what sometimes is called studies of marginalization. Psychiatry and its patients were and are not to be found in the margins of modern society but in its very centre and core. In psychiatry we find an explicit focus on norms and normality: what human beings are supposed to be, how they are meant to behave, to think, and to what moral standards they should conform. This is why the everyday life of psychiatric institutions is so rewarding for cultural analysis. It gives the ethnologist opportunities to make close readings of not only how deviance is treated but also what behaviour is considered deviant.

In this period, the state institutions of psychiatry

had as a principal task the care of and in certain respects treatment of people whose behaviours were perceived as abnormal. This relatively general task, paired with uncertain diagnostics, resulted in the hospitals being populated by people with a number of different needs and variously defined problems. Hence, a discussion as to which patients belonged where, in what kind of establishment, is also part of the history of state psychiatry.¹ One issue had to do with whether so-called mentally deficient patients should live in the same institutions as the mentally ill. To resolve this, separate wards were established and, starting in the 1930s, separate state institutions as well.² A second issue concerned ageing and aged patients, who were divided into two major groups: (1) those who suffered from mental illness and grew old in the hospitals, and (2) those who as a consequence of advanced age were suffering from states of mental illness. In practice, however, in the everyday life of the wards, this division was of less significance. For day-to-day purposes in the hospitals, diagnosis and etiology were of fairly peripheral significance overall. Rather, the hospitals classified and took care of their patients according to symptom: the behaviour they displayed.

My study thus does not take its point of departure or draw its material from activities in which age had an explicit central significance. Geriatric care, for example, might be one such field. Instead, I draw my examples from the archives of state psychiatric hospitals, in which age is one of several parameters used by the staff to understand their patients and clients. The question of what age signifies in these contexts is at the centre of my discussion.

Sources and Methods

I have drawn on the sources from the history of Swedish institutional psychiatry, spanning the years 1850 to 1970, which are composed of patient case-records, annual reports from the hospitals, inspections of the hospitals, textbooks and other psychiatric records on how treatments and other activities were meant to be pursued. When one reads these archival documents it is obvious that they are authored from a certain standpoint: they reflect psychiatry's perspectives on

the inmates and on the workings of the hospitals. Seldom or never is the patient's voice heard. The patient was silent; even in her or his own case-record the patient's speech is largely absent. When something the patient had said was noted down, this was done for the purpose of illustrating pathological behaviour. The patient's speech was interpreted as a symptom and was never regarded in institutional psychiatry as part of a possible therapeutic method.

My analytic interest is in the discourse of psychiatry, particularly with regard to how patients are spoken about. In my review of over 200 case-records, some general patterns can be seen. However, it is the close reading and analysis of individual case-records that is of most interest. What is contained in these case-records – the social biographies of individual patients – and the way they were written, reflects the way psychiatrists and staff related to the inmates and what practical treatments and custodial care were prescribed. An advantage of this approach is that it brings one closer to the concrete activity in the ward, the cell and exercise yard where the patient, the psychiatrist and the hospital staff interacted. In contrast to scientific psychiatric writings and textbooks, the case-records give me the opportunity to come closer to everyday practises and imaginations, that is, phenomena that go beyond explicit therapeutic aims and practices.

Much of the history of psychiatry tends to build on scientific debate and the publications within this discipline of medicine. But if, as a researcher, one turns instead to the everyday practises of the mental institutions, a different picture emerges. Underneath the changing theoretical debates and recommendations for new kinds of treatments that one finds in the scientific literature, there was a rather unchanging world in the hospitals and this is very striking in relation to the dominant group of patients: the elderly and the chronics.

The Institutions

Characteristic of every modern institution, regardless of whether we are talking about schools, prisons, hospitals, community youth homes or other establishments, was – and is – that they aim at cor-

recting and improving the individuals admitted (see Foucault 1979: 104ff). There existed an underlying belief that the stay at the institution, with its regulated days and clear order would influence the inmate in a positive direction, that is to say, in the direction of becoming a socially acceptable citizen – to function according to societal standards of morality, not least to manage one's sexuality in an acceptable manner. A further goal for the institutions was to make the inmates capable of providing for themselves (see e.g. Jönsson 1998; Topp, Moran & Andrews 2007).

It is obvious that in this intention to improve the individual and make him or her capable of providing for herself or himself, the ageing person constituted a particular problem. In the world of the mental hospital, the person who was admitted was expected to acquire the ability to keep to routines, to be able to be in the right place at the right time, and to subordinate himself or herself to the will, regulations and systems of the authorities (Jönsson 1998: 268). In this ideal sense, psychiatry was active in nature and engaged in treatment. But in practice, the care of the mentally ill which was provided in Swedish institutions far from always embraced this ideal. The patients had a tendency to respond badly to the treatment efforts. Although the discharge frequency should not be underestimated, it is obvious that periods of care extending for quite a few years were common. Consequently, one outcome of the poor results of the treatment efforts was that the mental hospitals had a large group of old patients.

Discipline in a Foucauldian sense, characterized by the aim of making the inmates' bodies obedient and therefore productive and efficient (Foucault 1979), belongs more to the ideal outcome of the psychiatric efforts than to actual everyday life within the institutions. The presence of these old patients was naturally unavoidable but hardly desirable. In the hospitals' annual reports, comments about the presence of the ageing patients recur regularly. Advanced age was often connected to chronic conditions. For the aged patient there was no hope. As with other chronic patients, treatment efforts were curbed at the same rate that outcomes and prognoses were judged worse. They spoke of "long liars",

referring primarily to the long periods these patients had been lying in hospital beds.

From several newly opened hospitals it was reported, throughout the entire 1850–1970 period, how the beds had been filled all too quickly by old people whose course of illness seemed impossible to treat. They spoke of sedimented, chronic cases, of “a backlog of old asylum cases”, of old chronics. For Swedish psychiatry the old patients, it appeared, were an eternal problem. In part, the mental difficulties that accompanied advanced age seemed especially difficult to treat; in part, the ageing patients were, in many cases, persons who were regarded as hospitalised chronics, beyond all hope. Here the hospital could furnish only palliative care.

From the hospital in the city of Falköping, newly opened in 1961, complaints came as early as 1964 that “the sedimentation of old people and other patients who do not need treatment and are difficult to place in other, less expensive, institutional care constitutes a serious threat to progressive care of the mentally ill”.³ Similar complaints came from a number of other hospitals, in the nineteenth as well as the twentieth centuries. In 1887 Fredrik Björnström, medical superintendent of Stockholm Asylum (Konradsberg), included in an annual report to the National Board of Health a complaint about the composition of the patients:

The asylum suffers particularly through overpopulation by old chronic incurable cases. A careful inspection of the 270 patients who were present in the asylum the last of December 1887 yielded the result that at most 8 men and 12 women among them could be counted as possibly curable, and therefore that 250 patients were incurable.⁴

The chronics became increasingly numerous and occupied beds in which the psychiatrists would have preferred to see young, acute, treatable cases. Thus the chronics not only had a tendency to remain in the hospitals, they also aged there, which generated further lack of interest from the eager-to-treat doctors. In a psychiatry with ambitions, ageing patients had no place.

The Old

This lack of interest in the old and chronic patients can be read in the patient case-records. Let me give an example. A female patient, Karin Moström,⁵ from a small village in southern Sweden, had been admitted to Lund Asylum at the turn of the twentieth century when she was in her twenties. The diagnosis was dementia hebephrenica.⁶ Only a year or so after her admission, the asylum lost hope in her. She was therefore transferred to the part of the hospital intended for chronic cases. The following case-record notes from 1901 are fairly characteristic of how the hospital saw this patient during the first years:

1/4. No change. Responds seldom, merely chuckles when one talks to her. Is fairly compliant except when she is supposed to get up in the morning, for she would rather linger in bed. At that time it may happen that she strikes out, which also can happen when she is to be looked after. Is a bit more co-operative when she is promised coffee. Can be given insignificant occupations. Is tidy and was moved to calm ward today. (A1). Due to heartburn she has started with bicarbonate since 27/3.

The hospital was not able to note any conclusive changes in Karin Moström’s condition. She was perceived as difficult to communicate with, had her own agenda and did not allow herself to be looked after without being persuaded. The treatment that was offered to her was intended first and foremost for physical complaints. Psychiatry at that time had an obviously limited arsenal of treatment for what were judged to be psychopathological conditions. In the main, the therapies were a matter of sedative preparations on the one hand, and on the other what can be called regimen treatment, i.e. a kind of fosterage. After a couple of years the case-record notes became ever sparser. In the face of the patient who did not demonstrate any change, psychiatry lost interest. The following notes are a selection that extends across three years:

1908. 30.6. During latest period increasingly calm and quiet. Silent and nice. Sleeps well. Idle. CII.

To B1.

31/12. No change BII.

1909. 30.6. Unchanged. BII.

31.12. Violent occasionally and shoves. On such occasions has been given Trional to good effect. Idle. Unchanged BII.

1910.30.6. Unchanged BII.

31.12 Knits but no further work with that; sings often, hits and shoves sometimes. Clean. On the whole unchanged. BIII.

1911.30.8. No change.

In 1941 came the first note that commented on Karin Moström's advancing age:

1941. 1/12. Unchanged. Old and feeble for this reason lies in bed all the time. Never says anything either spontaneously or when spoken to. Able to care for herself partly on her own. During tending often stubborn and intractable. Shoves when she gets a chance.

At this time she was 63 years old. She was now reported mostly as lying in bed, idle. The word "apathetic" recurs on several occasions. It refers not so much to laziness as to passivity and unwillingness or inability to respond when she was spoken to and called. In 1955 she was described as "deeply apathetic, demented and without contact". In 1963 she was moved to a ward for older patients. She was then reported to be up for a while every day. At that time she sat on a chair, "silent and still". "Also able to walk short distances with support from nurse. Still without contact and does not participate in any improvement." One day in April 1965 she had a fever, became somatically worse, and died one month later at an age of about 85 years.

The hospital's view of age appears well synchronised here with the biological. It was only when the patient had passed 60 that she was regarded as old but also feeble. Precisely this, the feebleness, was an attribute of the advanced age. It is as if the author of the case record wanted to strengthen the impression of the now advanced age. The patient was old and for this reason feeble as well. Or was it perhaps

the reverse? She was feeble and therefore old?

Let us examine a further case from the same hospital, Lund Asylum. In 1879 Nils Andersson was admitted to the new, just-opened asylum in Lund. In his personal information he was reported to be "44 years old, pauper, unmarried. adm. 22 July 1879, disch.⁷ as unimproved 27/2 1880. Dementia." At the beginning of the case record he was described as "an old pauper. Admitted as suffering from some chronic mental illness."

The diagnosis "some chronic mental illness" demonstrated some degree of uncertainty and lack of precision but was counterbalanced by a much more definite socioeconomic categorisation: an old pauper. When he came to the hospital Nils Andersson went to bed, as he was reported saying, "from old habit". After a couple of weeks the hospital had its approach settled: "1879. 6/8. No change in condition. The old fellow needs only food and care. – He belongs completely in asylum care."

Nils Andersson was reported to be a quiet, good-natured patient whose diagnosis was consequently uncertain and who, according to the hospital's judgement, needed to be taken care of rather than treated. In other words, he belonged in the chronic section.

In the case-record there are three attributions of age to be found. Nils Andersson was 44 years old. He was an old pauper. He was an old fellow. How do these go together? To have reached a biological age of 44 years hardly meant in 1879 that one was automatically considered old. But here the hospital was reacting to other signals as well. He was an old pauper and behaved like an old pauper, indicated chiefly by his preferring to lie in bed from old habit but also by his not appearing to suffer from any "real" illness. That is, the hospital saw no possibility of relating his symptom to any diagnosis. Nils Andersson did not fit in at the asylum. Nor did he fit into the society outside. Together, all these choices of words and attempts to characterise him point to his not being able to provide for himself.

As mentioned earlier there was a strong connection between the view of advanced age and the ability to provide for one's self. Perhaps this is the clue to why age has had such great significance in psychia-

try, not least in these institutions. The individual was living there because he or she was not seen as able to function and provide for himself or herself in the society outside. The 44-year-old old fellow indicates that the judgement of age was far from revolving only around the years that had actually passed. Being an “old pauper” seems almost to be a tautology. There appears to have existed a silent or invisible equals-sign between these two concepts: “old” and “pauper”. Being old was equal to being a pauper. Being a pauper was equal to being old.

This clear relation between the inability to make a living and the cultural significance of age also took a concrete institutional form. It was not only an exchange of inmates that took place between the poorhouses, or later the old people’s homes, and psychiatric establishments. Between these establishments there was also a discussion about which patients ought to come under which establishment. Not least during the second half of the nineteenth century or the first half of the twentieth century, there were reports about how the poorhouses and the old people’s homes contained inmates who were considered to come under psychiatry.⁸ At the same time, psychiatry fostered a perception that the mental hospitals were filled to far too great an extent by old people, without hope of improvement.

The Child inside Them

Age and ageing do not, however, stand out in any unequivocal way in the psychiatric literature. At the same time that the lack of ability to provide for one’s self had significance for the perception of old age, there was also a view of the patients as child-like. This has to do in part with the fact that the patients were seen as not responsible for their actions and that many of them had been declared legally incompetent to manage their own affairs. Even more important were the authoritarian system of rules and the obvious hierarchy of the hospitals. The doctors, naturally enough, were at the top of the hierarchy and the patients at the bottom of it. Furthest down of all were the most disturbed patients and those whose mental faculties were perceived as least and whose abilities to communicate as most rudimentary.

In this respect all patients were regarded as children, that is, younger than their biological age. In the case-records from both the nineteenth and twentieth centuries, descriptions recur of patients as foolish, difficult, smutty, calm, silent, etc. Behind all these efforts to characterise, to put words to, the patients’ behaviour were observations. The staff watched the patients. Ideally, each individual was always supposed to be under observation. The staff approached the patient when cooperation was required. Perhaps it was a correction, a helping hand or a joint task to be worked out. It is obvious, however, that the notes which were written into the case-record and thereby acquired medical significance were based on a distanced vision (Jönsson 1998: 71ff). The descriptions of the patient’s behaviour therefore stopped, in fact, at apparently unmotivated and inexplicable behaviour. Guided by the case-record descriptions, it is impossible to understand the patient’s motivations for her or his behaviour. It is in the deepest sense incomprehensible, impossible to grasp. There is no rationality in the described behaviour. The inmates appear to be ruled by instinct, with an emotional life inaccessible to their carers. In this sense they were childish.

All patients were regarded more or less explicitly as children. But there were also others who were openly ascribed the qualities of the child. Märten Haglund was admitted to Stockholm Asylum in 1889. He was then 24 years old and had been working in a shoe factory in Södertälje. As cause of illness, religious obsession and masturbation were given. The diagnosis was ‘melancholia’. Märten Haglund was described as dull and confused. At night he had a straitjacket to prevent him from masturbating. After a couple of years he was described as “lucid, slow, hard working”. He worked in the shoemaker’s workshop of the hospital. In the mid-1890s the masturbation resumed.

1/3 1895 Same condition; straitjacket at night for masturbation. Works daily in the shoemaker’s workshop; appears very childish, talks like a child that has not learned to speak clearly; e.g. ‘kin I have thum pennieth for ginnerbread’ (can I have some pennies for gingerbread).



Ill. 1: A small woman is supported by a nurse in S:t Mary's hospital in Helsingborg, southern Sweden. It is a summer's day in the 1920s. The yard is densely populated by women. To the left a young woman sits in the grass with some knitting or needlework. The supported woman seems to be of old age but is taken care of like a child. In the perspective of the hospital she has returned into childhood. Life appears cyclic. (Photo: Private)

Mårten Haglund, then, was a patient who was productive and able to contribute to the hospital's economy but who also showed deviant behaviour that was not acceptable. Masturbation was a sign that he allowed himself to be ruled by his instincts, not master of himself and his body, but his speech also seemed to underscore that he was a child in a grown man's body. The quotation in the case-record is chosen, moreover, as if to give further emphasis to the inmate's relationship of dependence on the hospital. He asks to be given a little money, which he does, naturally enough, because he does not earn or does not have access to any of his own. In other words, he is not in a state to provide for himself. And he does it with a childish mode of expression, as if to further express his dependence.

From then on, Haglund was for the most part isolated in a cell up until 1897, when he was described as calmer and spending more and more time in the day

room, dull, confused and idle. No change was noted up until 12/12 1899, when the hospital board decided that he was to be discharged as unimproved and not in further need of the asylum's care. To what he was discharged does not emerge, but it is not unreasonable to suppose that he would subsequently be found in a poorhouse together with other inmates, not least old people, whose upkeep lay within the responsibility of his local community.

Adult Body, Childish Mind

The view of the patients as children was most developed and most clearly expressed in the care of the mentally deficient, a branch of institutional psychiatry that had the task of taking care of individuals who were considered to suffer from learning disabilities. For such patients, special state institutions were established in the 1930s.⁹ In these hospitals, tests of the newly admitted patients' intelligence were regu-

larly performed, the results of which were expressed partly as a so-called intelligence quotients, partly in terms of mental age.

In 1953 Lisa Maria Jonsson was admitted to Västra Mark Hospital. She had been born in 1924 and was thus 29 years old. In her case-record I find an anamnesis written at the time of her registration and the first conversation that this admitted patient had with the doctor. Here it was noted that she had grown up in her parents' home and "nothing abnormal" had been noticed in her preschool years. In school, however, she had become increasingly "surly and unresponsive, sulky, stubborn and unsociable". Although her schooling was said to have been normal, she was described as increasingly recalcitrant. After her schooling was completed she had a couple of positions as home help, of which she was reported to have tired of after initial enthusiasm. At the age of 23 she started at an agricultural college. After a few weeks she became pregnant. In her misfortune she tried to take her life. After this she was admitted to a state mental hospital in Umeå.

Appeared mentally undeveloped and childish. On 11/8 1947 Ment. Age accord. to Point Scale 10.7 years. No signs of psychosis. She stated that she had never had any serious suicidal intentions. Refused to submit to legal abortion. Discharged improved 'in good equilibrium' 30/8 1947.

Just before Christmas she gave birth to a son. Three months after the birth she was sterilised. She was now living in her parents' home together with her child, "during which her mood and conduct had gradually deteriorated. Lost all desire to work, became gloomy and unresponsive."

She was said sometimes to take her clothes off and go outside despite the fact that it was winter and cold. She was reported to have difficulty accepting a reprimand. Her relationship to her stepmother, as well as to other young people in the region, was described as poor. In 1955 she was admitted to Västra Mark Hospital with the diagnosis of imbecility. Here she stayed until 1958, when she was discharged as "improved" to a smaller regional care institution.

Here the personal file in the hospital archive ends.

Three notations from the case-record demand special attention in this context. She underwent an intelligence test and was given a developmental age of the remarkably precise figure of 10.7 years. She gave birth to a child after having refused an abortion. After this she was sterilised. Under what possibly compelling circumstances this occurred does not emerge, but as with many other fertile women whose mental age was compared to a child's, we can surmise that some form of coercion or pressure had taken place (see Eivergård & Jönsson 2000).

Reason and Age

Many people who were admitted to the mental hospitals came from other welfare institutions, not infrequently from poorhouses or old people's homes. Many were advanced in years, and a large number of the country's accumulated psychiatric patients came under what we would call psychogeriatrics today. For these patients the care was manifestly palliative and custodial. Interest in the mental status of these patients decreased concurrently with increasing age. Instead the physical conditions were focused upon. Altogether, then, psychiatry's interest in these patients was low. It was the young, newly ill cases that generated interest and a more extensive production of knowledge. The older patients with age-related problems generated no extensive documentation. Perhaps the ward psychiatrist made a semi-annual notation: Same as before. Or: Condition unchanged.

On the face of it, the examples from case-record archives that I have given here have to do only in part with age. Upon closer inspection, however, it becomes apparent that psychiatry's perspective on age was both powerful and significant but also in essential respects unspoken. The case records conceal taken-for-granted conceptions of the patients' abilities, conceptions generated from daily life and more or less explicitly tied to the view of age.

In the case-record narratives about the biologically old patients, it is a sedentary, quiet image that emerges. With changes of the patient's mental condition reason was given, as a rule, to move the patient from

one ward to another, or from a large common room to a room meant for only one patient. The Swedish mental hospitals, up to the middle of the twentieth century, were spatially organised by symptom and sex. The standard designations of the wards were disturbed, semi-disturbed, semi-calm and calm. Thus the diagnosis had minor significance for which ward a patient was placed in. The sparse case-record notes for the typical ageing chronic patient were matched by long spatial continuities. The patient whose condition did not change appreciably remained in the ward for a long time. Finding one's self in the same ward for a long time often had its analogue in an uneventful case history, which in turn was matched by a sparsely written patient case record.

Within psychiatry the majority of patients were described as irresponsible and more or less unconscious of their actions. But the case record also described to no small extent the practical life in which the patients participated in the hospital. Many elements like getting dressed, eating, and not least managing one's excrement were interpreted as indicators of the patient's ability, social competence and, of course, mental condition. One can say that to some extent the institution itself supplied the frames for these practical elements. Things were to be done in a particular manner – the institution's manner. And it was along these frames of reference that the patient's ability or inability was described and understood.

Unreflectiveness, irresponsibility and the inability to take care of daily practical tasks were deficiencies generally connected to the incapacities of the small child. In the institutions these deficiencies and incapacities were perceived as signs of the disorder and deviations from the normal. A major portion of the patients were regarded as belonging to a different age than their biological one, either as children or as old people. It is not hard to relate these discrepancies between cultural and biological ages to Erving Goffman's concept of total institutions (Goffman 1961). In these institutions, Goffman says, all aspects of every day life are planned and executed by one single authority and every individual is treated the same way. This itself generates the subordination of the

patients in ways that easily correspond to relations between parents and children.

Furthermore, psychiatric diagnoses during the decades around the turn of the twentieth century coincided in an interesting way with the perspective of the daily practices on age. The most common diagnostic concept then – and possibly now – was dementia, which in Latin means approximately “out of one's mind”. The most well-known Swedish psychiatrist of the early twentieth century, Bror Gadelius (1862–1938), put an equals-sign between dementia and dullness in 1917 (Gadelius 1917: 634).

In my source material, dementia is found paired with a number of other qualifiers, e.g. dementia primaria, dementia hebephrenica, dementia senilis and, not least, dementia præcox. Dementia præcox was the diagnosis that largely corresponds to a condition that later became known as schizophrenia. The term dementia præcox was introduced in 1860 by the French psychiatrist Benedict A. Morel (1809–1973) as the name of an illness in which the mental faculties are dissolved, eventually to an apathetic state of dementia. In 1896 the German psychiatrist Emil Kræpelin (1856–1926) came to use the concept as a collective term for a number of different illnesses, which would later come to be called schizophrenia by Eugen Bleuler. In contrast to the concept of schizophrenia, which refers to the separation into two parts, or splitting, of the personality, dementia præcox refers to the person's age and expected development. Too-early dementia suggests two phenomena: in part the age-related “natural” dementia of the human being, in part the too-early, diseased form of dementia. Dementia præcox could be seen, then, as a way of understanding the illness as too-early ageing.

In the institutions for mental deficiency the idea of development was even more significant, thus manifesting itself not least in the efforts to establish the age of the inmate according to an expected development from child to adult. The diagnoses of intelligence revolved above all around this idea of development and an idea that the mentally deficient person had stopped in her or his development and was to be regarded as a child in an adult body. The



Ill. 2: One summer's day in one of the men's yard of S:t Mary's hospital in Helsingborg. Two patients have turned to the photographer. The other patients continue with what ever they are doing. To the left there is a bed with a tied patient under the sheets. Are these middle-aged men considered children or old men? This photograph shows a piece of everyday life in the mental hospitals, characterized by the absence of treatments and the presence of idle time. (Photo: Museum of the History of Medicine, Helsingborg)

problems that were connected to so-called mentally deficient people were above all of a moral kind. One spoke of their lacking "moral backbone". Men were regarded as criminal, women as immoral. One spoke of asociality, unreliability and inferior heredity. The women especially were problematic in this regard since they were considered to combine a bad hereditary disposition with general depravity and promiscuity. The outcome was feared to be a large number of congenitally inferior offspring that the mother was not capable of taking care of (see Engwall 2000: 50ff).

Individualisation and Development

With the nineteenth century's modern sciences of the human being came an individualisation of the people who were objects of various societal measures.

Foucault sees this as *descending individualization*, which is characterized by surveillance, observation and by comparative measures that have a "norm" as reference rather than genealogies giving ancestors as points of reference (Foucault 1979: 193). The mentally ill, criminals, school children, paupers, the anti-social and maladjusted, along with other social-problem categories, had in common that their place was in various forms of institutions. The old people can also be counted among these groups. Like the groups enumerated here, they could be counted as among the people who were not in a state to be able to provide for themselves and therefore required society's help. They differed from these others, however, by not being objects of ambitions of change. A central aspect of the criminal's, the school child's and the mentally-ill person's stay in the institution was that

they were assumed to be capable of being changed through exposure to various disciplinary measures.

The perspective of change was especially powerful in the treatment of children and youth. School was of course a central institution for the society's creation of productive citizens. Modern reform prison, as it developed in Sweden after 1850, was intended to influence the criminal in a morally correct direction. In the cell, the isolated prisoner was expected to contemplate his crimes and better himself (see Foucault 1979: 128). For psychiatry, the institutions in themselves were the most important instruments of treatment. Through the very stay in the institution and its pre-established order, the disturbed were meant to be influenced in a healing direction.

Nicholas Rose (1995) considers psychology's first contribution to the project of individualisation to be the psychological intelligence test. This test signified a way to make visible the difference that was not possible to observe on the body's surface and that connected behaviour with mental status. The first field of application for intelligence tests developed by the Frenchman Alfred Binet was to cull out so-called mentally deficient children and young people, not least in order to prevent their reproducing themselves and passing on their "inferior" heredity. The intelligence tests were constructed according to performance norms for children of different ages. It was thought, therefore, that the tested person could be compared with a so-called normal curve. A retarded child's mental age could thus be said to correspond to that of a younger normal child (Rose 1995: 183). The idea of development was of course fundamental to this test alongside the normal curve that the average child described. This curve was constructed of average abilities or results in children of certain ages (Rose 1995: 186). In relation to the normal curve, children and young people could be evaluated along a scale between precocious and retarded.

But the intelligence test was also applicable to adult persons, outside as well as inside the hospital establishments. In Rickard Eriksson's (1999) study of psychotechnology's testing and description of individuals, the intertwining between the perspective on the individual and the perspective on the evolu-

tion of humankind is clear. To be not really adult, despite biological age, was regarded as being primitive, which can be associated to more Darwinist perspectives. In this sense, the word primitive describes a person who is regarded as not properly brought up and "without culture". In Eriksson's opinion, this need not be only negative. It can be understood as a way of being more natural, artless and simple in a meagre sort of way. The primitive stands close to the unpolished, which describes a potential that is not adequately put to use or exploited. The infantile approaches the pathological in terms of developmental retardation but may also refer to a more ordinary understanding of being childish, gullible, inexperienced, thoughtless, even perhaps a bit dense (Eriksson 1999: 154).

In the world of the psychiatric institutions a child in a grown person's body was a deviation, like the old person in a younger person's body. For the childish person, as for the ageing person, hope is gone. The childish person's development had stopped prematurely, and any improving, i.e. developmental therapies, were scarcely to be had in all the institutions, national, regional or private, that had the task of taking care of childish people. For the old people in psychiatric institutions, regardless of whether old age accorded to the norm or had befallen the patient prematurely, there remained a more or less steep downhill course marked by confinement in bed, lack of activities, and waiting for the inevitable.

Making a Living

Alongside individualisation and the idea of human development, the individual's ability to make a living was as we have seen a central theme in the relationship of the inmate to the institution in general and psychiatry's view of the patient in particular. Taking responsibility, being an adult, was closely connected to the ability to support one's self. Many anamneses – the previous history of the illness – describe the way the newly admitted inmate had not been able to manage or keep his or her job and had thereby, as it often was written, been put out of a state to be able to provide for him- or herself. Herein was also an extensive part of the societal task of the mental

hospitals: taking care of people who for various reasons did not have the ability to work and earn their own keep, a task that the state institutions had along with district poorhouses/old people's homes and establishments for mental illness.

In modern industrial society the family alongside the institutions were the most important forms of taking care of people. The historian Birgitta Odén (1985, 1994) notes among other things that the guiding principle of peasant society – in Sweden, from the early middle ages to the mid-nineteenth century – was that the younger generations, who were going to inherit, took care of the old (Odén 1985: 8). People who had no property had to rely on Christian charity (Odén 1985: 10, 1994: 15). Concurrently with the population increase of the nineteenth century, the parishes had increasingly greater responsibility for the care of the elderly. As the collective labour of the village community weakened in connection with the nineteenth-century consolidations of farmland, new institutions were given more and more responsibility, not least in the form of public workhouses.

The ability to work and support one's self is an almost trans-historical theme that marks perspectives on ageing and advanced age. It is not only in the world of psychiatry that the definition of advanced age was tied to the ability to work. The historian Susannah Ottaway notes in her book *The Decline of Life: Old Life in Eighteenth-Century England* (2004) that the ability to work, alongside the place of the aged person in the household and society, has governed the definition of advanced age. Tied to this definition were also cultural conceptions of how advanced age "looked" and what could be regarded as typical behaviour for old people (Ottaway 2004: 12). In the world of the mental hospital we have seen examples of how the immobile patient, sitting or lying, was understood as old. Similarly, the inability or unwillingness to work was interpreted as a kind of irresponsibility that in turn was associated with the child. These two ages, in other words, could live in the same body, the irresponsible child and the incapable, worn-out old person. In these respects, and in that institutional world, age was scarcely associated with increasing wisdom but rather with the child's

naive and apparently untroubled, unreflective outlook on life.

My analysis of this long period in Swedish psychiatry shows a remarkable continuity or slow change, bordering on permanence. Of course, verbal expressions and concrete practises change but it seems as the institution in itself – including space and the basic social set of patients, staff and psychiatrists – had a power to conserve, to stop time or at least build long-lasting perspectives and traditions of care and treatment. My argument is that this continuity is much more obvious in the actual practices of mental care than in the world of textbooks and public debate, where new ideas and treatments were developed, but seldom affected everyday institutional practices.

The Staircase, the Cycle and the Ladder

Today we sometimes speak of being parents to our parents, of people becoming children again when they grow old and lose their reason. A circle is closed, and life appears cyclic. We return to where we once were, in childhood. The metaphor of the ascending and descending staircase is powerful as well, i.e. the idea that as far as our forties and fifties we are developing and after that we find ourselves on a downhill course. A third perception of the course of ageing revolves around the notion of our becoming wiser and more knowing the older we get; here, the metaphor is that of a ladder leading upwards to ever-greater wisdom and experience-based competence.

The history of institutional psychiatry teaches us how our view of age and ageing is seldom unalloyed but consists of parallel conceptions of how time affects the living person and how this person's abilities might be related to work and making a living. In the world of institutional psychiatry the view of advanced age was manifestly complex, a bricolage of associations that in part ran in the direction of the person's various ages, and in part were manifestly tied to the ability to provide for one's self. Sometimes these tracks coincided. In childishness there was also irresponsibility and an inability to contribute to one's own maintenance. In this respect, the view of age is clearly connected to conceptions of

what is required of a functioning citizen in society. The child's civil rights are circumscribed, and to regard an adult person as a child contributes to giving legitimacy to limiting this person's rights. Nicholas Rose (1999) has pointed out how liberal, bourgeois ideas of freedom have their equivalence in a series of obligations and expected behaviour. The free citizen is a person who is able and willing to govern him- or herself with reference to given norms and responsible and civilised conduct (Rose 1999: 233).

To define someone as a child is to exercise domination. The use of intelligence tests in the treatment of the mentally retarded may be the most obvious example of how psychiatry, through establishing an individual's age regardless of her biological age, was also given the right to pare down his or her rights. Above all, by retaining the right to make discharge decisions, the hospital had the power to determine whether the individual would be allowed to live in society as a free citizen or not. In regular psychiatry, where mental illness was concerned, rather than retardation, the situation was more complicated. But from the examples I have given above, it is clear that the judgement of biological/chronological and cultural age was important for the way the hospital viewed, took care of and treated the patient. In one and the same body, the child and the elderly met.

Notes

- 1 During the nineteenth century and up until 1967 the state was the responsible authority for the major part of Swedish psychiatry. In 1967, county councils took over this authority.
- 2 Institutions for the care of the mentally retarded most often had county councils and primary districts as responsible authorities. In the 1930s the state institutions of Salberga in Sala, Källshagen in Vänersborg, Vipeholm in Lund and Västra Mark in Örebro were established.
- 3 Annual report of Falköping District Hospital, Archive of Swedish National Board of Health and Welfare.
- 4 Archive of RA Sundhetskolligium, Annual reports E 5 C.
- 5 For reasons of confidentiality, all information about names, dates and places is changed and is fictitious.
- 6 This diagnosis was considered a form of dementia praecox. It referred to a pathological state of mind suffered

- by young patients in their teens and with a prognosis of life-long dullness (dementia).
- 7 Abbreviation for discharged.
- 8 The most well known and most conspicuous of these reports is the book and reportage by Ivar Lo-Johansson and the photographer Sven Järlås in Sweden of the 1940s (Lo-Johansson 1949).
- 9 These institutions were: Salberga in Sala, Källshagen in Vänersborg, Vipeholm in Lund and Västra Mark in Örebro.

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