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Jönsson, Lars-Eric

Published in:
Ethnologia Scandinavica

2013

[Link to publication](#)

Citation for published version (APA):

Jönsson, L.-E. (2013). Writing History : Past and Future in Transforming Swedish Psychiatry, 1970–1990. *Ethnologia Scandinavica*, 113-127.

Total number of authors:

1

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LUND UNIVERSITY

PO Box 117
221 00 Lund
+46 46-222 00 00

Writing History

Past and Future in Transforming Swedish Psychiatry, 1970–1990

By Lars-Eric Jönsson

To write history is to write about change. It deals with how it once was but no longer is, but also about how it could be. We can distance ourselves from the past or long for its return. However we relate, we always write history in relation to our own present time. History in this sense is always to be regarded as a commentary on contemporary life. But it is not just any comment whatsoever, nor should we be fooled into thinking that it is passive in nature. The historiography this article concerns was remarkably active and productive in its own time.

I will focus on the history of psychiatry, especially the kind written in the context of health policy studies and programmes in 1970s and 80s. The text (and images) treated in the article is part of a larger amount of psychiatric production of history in Sweden extending at least 200 years back. A common feature of the texts is that they played an active role in a desire to change. The past was used as part of an argument for a different psychiatry from the existing one. In the 1970s and 1980s, it was about leaving the old mental institutions.

It is unclear whether psychiatric historiography is more comprehensive than other medical specialities. My impression is that it is. Whatever the situation with respect to the matter, we note that psychiatry's self-produced history is extensive. Mark S. Micale and Roy Porter have indicated two possible objects of this production: to generate professional identity and to socialize young doctors (Micale & Porter 1994:4). A third reason could be to strengthen psychiatry's insecure and vulnerable position as one of several medical specialities. Writing history can of course

also be a way to produce legitimacy by claiming a long past, especially if it contains great men with significant scientific achievements. However, in this article I will explore a fourth purpose for writing history. This object can be described as a desire to change.

The Usable Past

A vital part of psychiatry's own history is its evolutionary approach, which has been expressed in at least two ways. One was based on the contrast between the present day and the past, where the present is presented as superior, more efficient, brighter, and not least resting on humanistic values (Jönsson 1998:186). The past in these stories has taken shape as a dark time whose lack of science and humanism resulted in people being treated poorly. The other way to describe the evolution and the present has been to focus on scientific progress, and how every period has added its progressive contribution, a development whose goal has been the present. The present in these stories of progress is always superior to the past. In the former kind of story the shortcomings and imperfections are in focus, in the latter the good progress. No matter which of these two evolutionary perspectives you apply, the future will always appear bright and promising. Writing history in this way has not only aimed at understanding and commenting on the past. It has also been a way to understand the present and point to a possible and desirable future.

This way of looking at history and historical production revolves around the usefulness of the past. Such use is found in a variety of contexts. In psychiatry, we

note a heavy use of history as a way to argue for contemporary changes. When the Swedish modern psychiatry pioneers – Magnus Huss (1807–1890), Carl Ulric Sondén (1802–1875) and C. J. Ekströmer (1793–1860) – wrote about what ought to be done, it was as a reaction to the past treatment of the “insane”.

In the mid-1800s Sondén and Huss made trips on the continent where they saw major differences compared to Swedish conditions. Above all Danvik hospital in Stockholm served as an intimidating example. The future was found in the new European institutions which, according to Huss and Sondén, could show a recovery rate as high as 70 per cent (Jönsson 1998:117). The references to differences in time (Danvik and the past failures) and space (the continent’s exemplary institutions) led to an argument for a new mental health care based on humanity and science. What the proponents wanted to leave was described in terms of darkness, superstition and coercion. Restrained limbs trapped in dark cells or lunatic boxes belonged, or should belong, to the past (ibid.:262).

More than a hundred years later, a new radical reform affected Western psychiatry, including Sweden. This reform established powerful and concrete approaches to the past. In many respects the criticism of the institution system took its fuel from the past. The ideal was found in voluntary and outpatient care. A stance was taken against closed institutional compulsory care. There was vehement criticism stemming from both inside and outside psychiatry. R. D. Laing’s *The Divided Self* (1960), Erving Goffman’s *Asylums* (1961), Michel Foucault’s *Histoire de la*

folie à l’âge classique (1961), Thomas Szasz’s *The Myth of Mental Illness* (1961), and Franco Basaglia’s *L’istituzione negata* (1968) are only some important examples where arguments for a new psychiatry more or less explicitly were to be found.

It is apparent that the criticism included perspectives on the past. Michel Foucault’s *Histoire de la folie à l’âge classique* is of course the most obvious example, but also other critics viewed the traditional institutional psychiatry as part of the past. A striking difference from the early psychiatry in the nineteenth century was, however, that in the 1960s and 1970s history was produced not only by psychiatrists themselves but also by researchers and commentators from outside. Psychiatry’s change, as well as its history, was not only an issue for medics but was given a broader social significance.

In this article I intend to approach a kind of historiography that does not belong to academic knowledge production, nor to the media debate (Ohlsson 2008). Instead, I have chosen to explore historical perspectives in texts formulated at central authorities of the medical sphere and the administrative field. I have chosen a few texts from the National Board of Health and Welfare (Socialstyrelsen), the Healthcare and Social Welfare Planning and Rationalization Institute (SPRI) and Government Official Reports (SOU). The period includes the 1970s and 1980s, that is, when a substantial portion of the institutional psychiatry was criticized, investigated, and closed down.

My investigation has as its primary premise that all desire for change is based

on opinions and perspectives not only on the present but also on the past. This was not only evident when scientific psychiatry had its breakthrough in the decades of the mid nineteenth century. The past was also part of argumentation techniques used when the compulsory institutions were to be left and abandoned. But what history was written? What events were seen as essential? What was left unnoticed? And how could history be related to the proposed changes?

The Texts

When investigating problems, history was essential. In a long series of government reports contemporary relationships were described as a kind of residue from historical conditions. Anachronistic is a word used in several contexts, a word that suggests how something is out of step, belonging to another time and having no place in our own. In this sense the past is still, in an undesired manner, alive and active (Ricoeur 2005:468). The development has not gone unaffected from the past. The present has not overrun the past. The past not only affects but is active in the present.

Obviously, this was not really the case. But by describing the present as colonized by the past it appeared advantageous to argue against what was considered wrong and flawed. In modern society, the past should not be present, except in the museums and other cultural institutions.

The word anachronistic also suggested how the present was given meaning by its historicity. The inadequate or imperfect were history. Making psychiatry contemporary included coming to terms with

history, clearing it away, and replacing it with ... well, what? Was there anything in the descriptions of the history that showed the way to what was desirable? Was there in this sense a direction in history? Could the past be seen as a compass for today?

Psychiatry, Coercion, and Legal Security

In the report *Psychiatry, Coercion and Legal Security* (SOU 1984:64), the National Social Committee proposed new legislation on psychiatric coercion. The committee also presented viewpoints on cooperation between social services and psychiatry, particularly for discharged in-patients (SOU 1984:64:15). The report also delivered some thorough historical depictions. The investigators made comparisons between the perception of the eighteenth-century lunatic and the modern psychiatric patient. The similarities were found in viewing the insane from a distance and the authorities' right to lock him up for his own good (ibid.: 41). The report organized the description of eras with headings: "The Lunatic and God", "The Breakthrough of a New Era", and "Asylums Become Mental Hospitals".

"The Breakthrough of a New Era" began with a depiction of Philippe Pinel as the man who released the insane from their chains in revolutionary Paris. The insane would not be kept in iron but treated gently. For, "Human rights apply also to them" (ibid.:45).

The psychiatrists Carl Ulric Sondén, Magnus Huss, C. J. Ekströmer and Georg Engström took on the role of reformers and humanists. "The first reformers were

carried by a humanistic passion. It was with love and understanding one should encounter the sick” (ibid.:49). Especially Engström’s and Sondén’s influence was considered strong in the nineteenth as well as the twentieth century. “Their criticism of the past was relentless” (ibid.:44). Sondén’s perspective on mental illness was exemplified with his suggestion that the fool was not obsessed but ill. And those who were sick needed help, “primarily from physicians. To become healthy requires treatment. For Sondén this meant isolation” (ibid.:46). The investigators themselves seemed to stand behind Sondén’s demands of therapy. But his notion of isolation as healing, the Committee left to the past.

Implicitly the National Social Committee gives the impression of having a rather hesitant view of the institution. The patient’s isolation from the community was considered negative. It was noted that Sondén’s “idea about the institution was realized. But on a larger scale than he had in mind” (ibid.:58). What did he have in mind? Was the large scale the problem or institutional idea in itself? The National Social Committee gave no definite answer. As a psychiatrist and advocate of a medical perspective on social deviation Sondén was considered a kind of historical hero. At the same time he was misunderstood by institution advocates who would follow him.

No, the National Social Committee was strongly critical of mental hospitals. The Committee compared traditional mental health care with the prison system, where individuals were forced inmates and isolated from society. The love, understanding and humanity ex-

pressed by the early reformers when meeting the sick soon gave way to a scientific approach. Sondén, Engström, Ekströmer, and Huss were thus stripped some of their scientific status in favour of a universal human empathy. Around the turn of the century, when phase three, “Asylums become mental hospitals”, began, psychiatry would be characterized by a scientific approach and an urge to approach physical medicine. The psychiatrists Bror Gadelius and Olof Kinberg were appointed the main representatives of this approach. The National Social Committee argued that a common denominator for these two was their sharp criticism of psychoanalysis and that they contributed strongly to keeping it outside institutional mental care. Kinberg’s approach to crime as a disease was considered to be a major contributing factor to the increasing number of offenders ending up in psychiatric confinement. This widening of the concept of disease was considered together with the deviants’ increasing difficulties to cope in society, the rapid social change and increased life expectancy were considered possible causes of the need for increased mental health care (ibid.:56).

The investigators found the ideological foundations of the laws in a charter from 1858. All care was then tied to mental hospitals and associated with coercion. Until 1959 the doctor decided whether the patient could leave the hospital, irrespective of whether he had gone there voluntarily or not.

The National Social Committee had an obviously ambivalent attitude to the past. It stood behind the early psychiatrists and what was seen as humanitarianism and

philanthropy. It disagreed with their ideas about the closed institution and the compulsory health care. Perhaps this could be considered as a desire to support Huss and Sondén as empathetic individuals but to distance itself from what the committee thought was their scientific, professional side.

Generally, these depictions rested on a history seen through the bright light of the present. In most cases, the approach to the past was based primarily on dissociation. We can also note how the psychiatric approach to physical medicine was placed in the twentieth century, although the late nineteenth century must also be considered in the light of psychiatry's quest to become real medicine. Why this is so is difficult to elucidate. Perhaps the nineteenth century appeared too anachronistic and distant to be able to harbour the origin of the close relationship between psychiatry and physical medicine.

The National Social Committee's own time was described as new and it was considered obvious that biological, social and psychological factors were involved in the onset of mental disorders. The Committee decided to use the term "serious mental disorder" instead of "mental illness" as it was considered to give a different and wider explanation than, as the investigators put it, an individually oriented disease concept (ibid.:64). The National Social Committee's rejection was therefore mainly aimed at the twentieth-century institutionalized psychiatry which had its greatest extent in the 1950s and 1960s, not only in the number of beds and patients, but also in biomedical focus.

Generally speaking, it was problematic to view the 1950s and 1960s with a his-

torical perspective. On the one hand, several claimed that the new drugs had come to form the basis for the new open and activating psychiatry. On the other hand, there were others, not least in the patients' organizations, who argued that drugs were to be considered as one more straitjacket. That was the first thing. The second was that these decades of psychiatry seemed particularly anachronistic. The National Social Committee described interiors from the mid-1970s where patients were still in hospital clothes and had few personal belongings. Training apartments, short-term institutions and transitional apartments were missing. Just under half of the patients had their beds in rooms with four beds or more (ibid.:98).

From Mental Hospitals to Independent Living

In 1982 there were several reports published in Sprö's series called *Psychiatry in Transition*. Report 109/1982 was titled *From Mental Hospitals to Independent Living*. Like *Psychiatry in Progress*, this was a significant title. Mental hospitals were already considered a key symbol of the old. Patients' own apartments, own homes, were presented as a contrast.

The "From ... To" heading also implies a psychiatry "on the move", which was underscored by a couple of chapter titles. Chapter 1 was titled "From Hospitalization to Re-socialization". Here the Sidsjö Hospital from 1943 in Sundsvall functioned as a metaphor for the old. Hospitalization had occurred in the hospital, that is, the environment that in the institution era had been regarded as therapeutic. Its resocializing perspective was not only di-

rected towards the patient him- or herself but also towards the patient in the hospital. The patient would be brought back to the community from the hospital. This process took place at a nearby nursing home, Hamsta nursing home, equipped with training apartments for independent living.

The authors scoffed that Sidsjö had been called the Temple of Humanity. They wrote about long hospital stays, monotonous days, passivized and incapacitated patients. The following description could apply to many other mental hospitals.

The wards were crowded and the majority of patients lived in halls open to the corridor. The toilets stood in a row without walls separating them. It was easy to monitor patients as they sat on the toilet together. Even the washrooms were open and had no walls to the corridor. In many wards, there was only hot water if necessary. In some departments the patients ate from copper vessels, and were only allowed to use spoons. The patients wore hospital clothes and had no possessions of their own.

The open wards, the open toilets and washrooms, the lack of hot water, the plates, cups and spoons, and last but not least, the hospital clothes. These elements of the actual hospital environments recur in a variety of contexts from the 1960s. They were justified. I cannot question that. But it is worth noting the consensus that it was precisely these things that were particularly anachronistic. I mean not only a consensus in the 1960s, 1970s, and 1980s about what was bad in mental hospitals. Toilets, overcrowding, the passivized patient, the lack of hot water and metal plates are found in the sources on psychiatry's past as important reference points when the degree of modernity in

the institutions would be fixed. It is a landscape that certainly changed, but its features seem fairly constant in the institutional era. By screening the wards for these benchmarks, it was possible to assess where in time a ward or a hospital was located. Was it contemporary or anachronistic?

Chapter 3 was titled "A New View on Human Beings" and included a description of the so-called Hamsta model, whose aim was to reproduce the patient's self-esteem and dignity (Psykiatriomvandling. SPRI rapport 109/1982:49). Patients were trained to manage their own finances, cooking, laundry, and cleaning.

The mental hospital set against one's own apartment was not just contrast between two rooms, a large compared to a small one, one outside the regular society compared to one inside. Based on these two rooms, associations ran in directions that seemed to talk about completely different ways to nurse, care for, and treat the patient. An important feature in the small room was its individuality. At home you could be not only *by* yourself but also yourself. You could have your own schedule. At the hospital, the patients in most cases shared rooms with each other. The hospital also had a schedule for each day. Patients got up, ate, worked and went to bed at a given time. The apartment encapsulated individuality as opposed to the institution which, although individualizing its patients, hardly took the individual's own wishes, identity, and needs into account.

The relationship between the apartment and the institution is a key element for understanding the changes that began in the 1970s. The institution appeared not only

as an anachronistic place but also a place for coercion and depersonalization of the prisoner. The apartment was, in contrast, a space of freedom, a space for the patient to live a normal life. Where the past seemed to talk about collective coercive isolation from the surrounding community, the present seemed to strive for individualized housing in the community.

The Images

Perspectives on the past are most often expressed in text but the choice of illustrations also reveals obvious approaches. In the reports, memos and reports that I have examined in this study, the artwork – if there are any pictures – describe two main types: (1) general images of people and places from contemporary psychiatry, often uncommented, (2) images from the past, which explicitly or implicitly represent what the authors want to distance themselves from.

Psychiatry in Progress is not just the title of this article but also the title of a memorandum published by the National Board of Health and Welfare in 1988, i.e. during a time when the closure of mental hospitals was taking place on a massive scale. In this decade, it seems to me, psychiatry changed in several fundamental respects. The talk of reform and the disassembly of the institutions in the 1960s and 1970s now turned into action. The subtitle of the memorandum was *Towards Outpatient Care and Increased Collaboration*. The memorandum was related to two key processes of change that psychiatry was going through: (1) less coercive and institutionalized care and more open and voluntary care outside the institutions; (2) the incorporation

of psychiatry into regular health care and with the municipal social services as a given participant.

It is no news that psychiatry's own history, like much other history of science, was written and meant to show a clear tendency. Where many sciences are characterized by what Mark S. Micale and Roy Porter (1994) call "a Hall of Fame approach" I would argue that psychiatry had a rather ambivalent attitude to its story. That is, the progressive perspective has remained constant but the generator of progress has been the conflict between the old and the new as much as it has been the cumulative constructive perspective.

Psychiatry in Progress exhibited one picture. You find it on the cover and it shows how one of the pavilions at Säter Mental Hospital was blasted in 1983. From a conflict perspective, the picture was well chosen. By blowing up the old we are moving towards the new. Development rests in this sense on destruction, in concrete terms. The picture also shows a metaphorical rejection. Of course it was not necessary to tear down buildings to reform mental health care. But the buildings, the mental hospitals, had been given status as a key symbol of the kind of psychiatry supposed to be left behind. History was blown apart, it seemed, both in practical terms and in a metaphorical sense.

In 1977 another SPRI report was published, entitled *Psychiatry in Transition* (i.e., which later became the title of the above mentioned series of reports from SPRI).¹ The publication argued for what was called sectorized psychiatry, that is, outpatient psychiatry and closed psych-

pLO
s 1732

PM 1988:21

Psykiatri i utveckling

- mot öppnare vårdformer
och ökad samverkan



 Socialstyrelsen

Psychiatry in Progress. PM 1988:21. Cover of the National Board of Health and Welfare's memorandum *Psychiatry in Progress* (1988). The photograph shows the pavilions at Säter Mental Hospital being blown up in 1983. The old institutional buildings were torn down to make way for a new psychiatry in a concrete as well as metaphorical sense. It was of course not necessary to demolish buildings to reform psychiatry. However, the hospital buildings had become a kind of key symbol of what psychiatry wanted to leave behind.

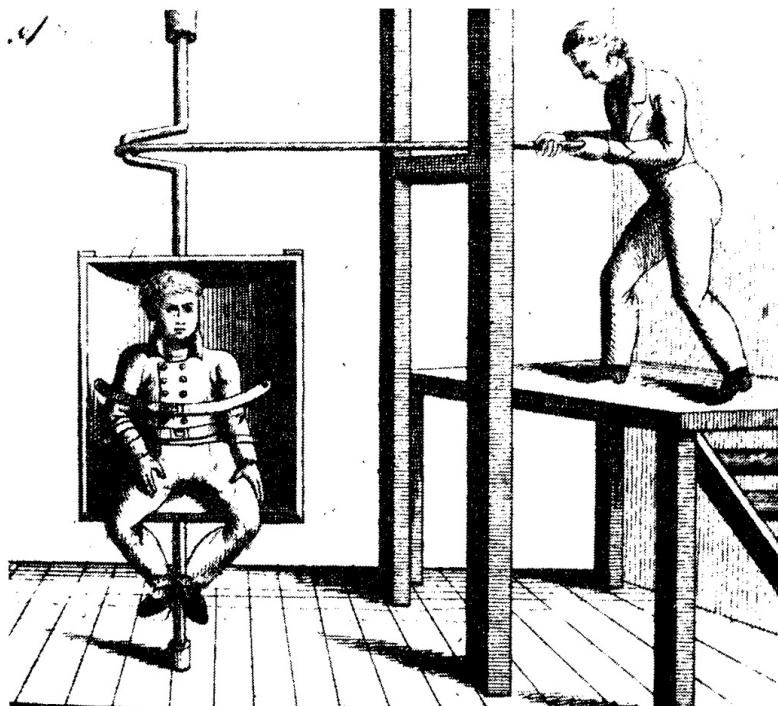
iatry in a well-defined and not too large catchment area. Parallel with a review of “the psychiatric concept of disease” were shown pictures of older psychiatric care and treatment. A German lunatic asylum from 1507 (Tollhaus with guard), a set of graphical images with treatments from the first half of the nineteenth century, a (perhaps) contemporary pillbox, a woodcut by the well-known Swedish painter Carl Larsson (1853–1919) picturing King Gustav III visiting the asylum of Danvik outside Stockholm. A similar arrangement existed in the following chapter 3 (“Some Problems in Today’s Psychiatric Organization”). In a spread, there was an interior picture from “Southern workhouse” (later Rosenlund retirement home) in Stockholm and a picture from an outing for first-class patients in the early twentieth century (Psykiatriomvandling 1977:22–23). There were also two dormitory interiors from Söderby Hospital in Stockholm (1910) and St Lars Hospital in Lund (1950) (ibid. 1977:24). Section 4 (“Trends in Psychiatric Services in General”) was illustrated with two graphic images from the German psychiatrist Ernst Horn’s book (1774–1848), *Das Bild des Kranken* (1818).

A spread (pages 28 and 29) presents pictures which contrast the past and the present. On page 28 we find a graphic image declared to show a swing chair used by the physician Benjamin Rush (1745–1813). Below these are two images said to represent a “Straitjacket, from E. Horn, 1818” taken from his book *Das Bild des Kranken*. The pictures depict people fettered to different objects – a rotating chair, an earflap armchair and a tensioned rope with solid handles on the walls. The per-

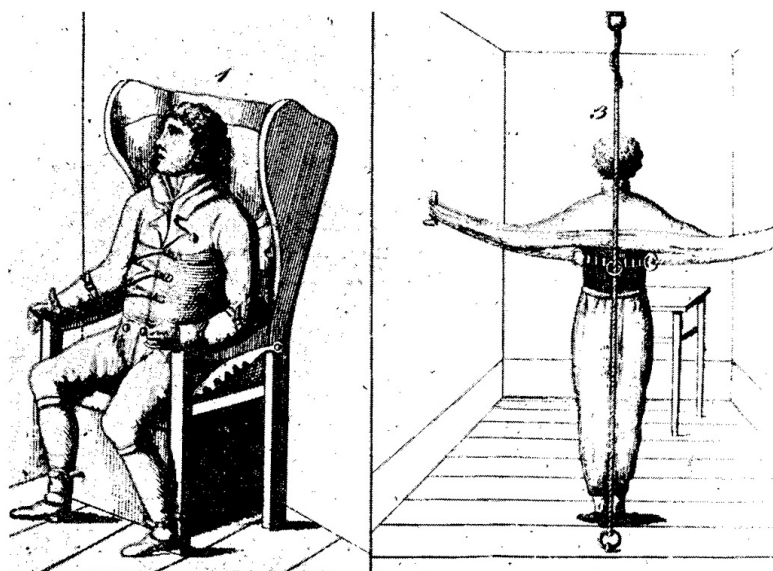
son at the rope is locked into a particular posture, in a clearly defined space with a table in front of him. The man in the earflap chair sits alone, bound hand and foot in his chair with a straitjacket. In the picture of the swinging chair a staff member is visible along with the prisoner. The two have contact only via a rod and a shaft that make up the swing device. There appears to be no personal contact or relationship. All three inmates give the impression of being entirely in the hands of the treating institution.

Page 29 shows a picture of the new, contemporary psychiatry. Actually, it consists of two images – a map of the catchment area of the Nacka Project and outlines of five people in full figure. Thus, there are two perspectives – one directly above the map, one from the viewpoint of the people. Both perspectives suggest a context. The map represents not just a territory, but also all the people – up to 70,000 – that live within it. The outlines of the five people symbolize with even greater emphasis the context patients might come from, and should continue to be in. Is it a family of three generations? Or do they illustrate that psychiatry works with adults, the elderly, and children? But in a familiar context in which the sufferer should not be or become socially isolated?

What role did historical images have in this report arguing for a sectorized psychiatry represented by the Nacka Project? Apart from rudimentary captions of what the images showed, they appear here in an implicit contrast with the report’s own time, that is, 1977. The captions contributed little to make the reader understand the situation from which the historical images



Svängstol använd av B. Rush. Han arbetade ungefär samtidigt och i samma anda som Esquirol. Hans hemland var USA.



Tvångsjacka ur E. Horn, 1818

Spri report *Psychiatry in Transition*. Past and present, old and new, meet on a spread. Page 28 shows a graphical image. It was said to display a swing chair once used by the physician Benjamin Rush. Below we find two pictures from the book *Das Bild des Kranken*. These two images depict patients fettered to different objects. The staff member handling the swing chair does not seem to have any personal relation or contact with the patient.

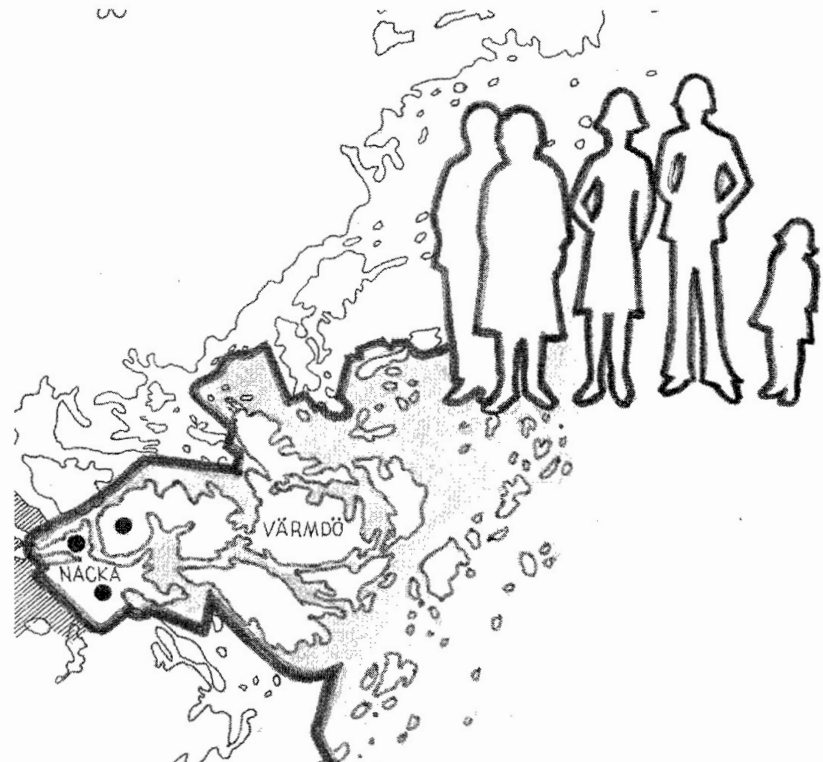
5 Några av de överväganden som utgör underlag för sektoriserad psykiatri

Med begreppet "sektoriserad psykiatri" avses en speciell organisationsform där en organisation har "total"-ansvar för psykiatrisk vård inom ett avgränsat befolkningsområde.

Riktlinjerna för sektoriserad psykiatri grundar sig bl a på erfarenheten att människan insjuknar respektive utvecklar sin sjukdom som en konsekvens av de sociala system av vilka hon har varit och är en del.

Minoritetstillhörighet, ekonomisk status, familjestruktur och andra grupprelationer är av betydelse för de enskilda människornas psykiska sårbarhet respektive motståndskraft, men också för sjukdomsbild, symptomatologi, försvarsmetoder och val av metoder till anpassning. Likaså är benägenheten och förmågan att utnyttja psykiatrisk service samvarierande med etniska, ekonomiska och andra sociala faktorer. För en strukturering av framtida service gäller sålunda att med organisatoriska och andra åtgärder skapa optimala förutsättningar för att samla och applicera kunskaper om de sociala faktorernas roll i såväl det enskilda fallet som hur de verkar inom grupper och befolkningssektorer.

Sektoriserad psykiatri avser att skapa sådana förutsättningar.



Nackaprojektets upptagningsområde med såväl tätorts- som glesbygdsbefolkning — ca 70 000 invånare.

Spri report *Psychiatry in Transition*. Page 29 shows a picture of the new and contemporary psychiatry. The image has two perspectives – one directly above the map, one from the viewpoint of the people. Both perspectives suggest a context. The map represents not just a territory, but also all the people – up to 70,000 – that live within it. The outlines of the five people symbolize with even greater emphasis the context that patients might come from, and should continue to be in. Is it a family of three generations? Or do they illustrate that psychiatry works with adults, the elderly, and children? But in a familiar context in which the sufferer should not be or become socially isolated?



Spri report *Psychiatry in Transition*. Among the images in the report this shows a hut-like building for one of the teams in the Nacka project. The contrast to the old monumental institutions could not be greater. The architecture is strikingly anonymous and gives the impression of not only being prefabricated in large sections but also being temporary. Apart from a few small signs beside the entrance there was nothing to indicate function or content.

derived. They worked rather as a kind of contrast to the new psychiatry. In this sense one can say that the image editing expressed an evolutionary perspective.

The second half of the report was illustrated with contemporary images from the Nacka Project. The present appeared in obvious contrast to the past, which in itself was not given any clear trend. Instead, it seems that both the present and the past formed two homogeneous categories, which was emphasized by how the historical pictures were placed in the report's first half and contemporary images in the second. Exclusively in the spread – pages 28 and 29 – past and present met. Any talk about change, or even progress, was divided into now and then. It is a little surprising that the differences were not linked to the concept of science or lack of science,

but rather to boundaries between the therapist and patient on the one hand and humanity and equal meetings on the other. Three of the contemporary photographs depicted three different kinds of meetings and conversations. One showed a hotline phone conversation. One showed a barrack-like building for one of the teams, and another showed a person entering a psychiatric reception, housed in a modern, anonymous and seemingly neutral functional brick building, architectural light years away from the old mental hospitals' monumental aesthetics.

Individuality–Collectivity, Isolation–Sociality

The use of history is present in a variety of medical contexts. I have pointed to passages in which history is explicit, where

you are writing history in the form of for example backgrounds. I have also given examples of how the past has acted as a more inarticulate and quiet background to the present.

History emerges in these texts as something to reject. The present and future, which investigators and report writers in my examples wanted to dwell on and come into, seemed to appear more clearly when it was contrasted with the past, whether it really belonged to the past or if it appeared to infiltrate our time in the form of anachronism. The past was, in this respect, a tool to clarify current psychiatric programmes. If you could be really explicit about the conditions that should be abandoned, then it was easier to argue your own aims, the model you believed in, and what you wanted to implement.

In this regard, it is not difficult to notice how the authors chose the history that suited their arguments. I have given examples of how the institution was contrasted to the home, a home of one's own. Here collective forms of care stood against individual forms, the big room's powerful psychiatry against the home where the individual was intended to manage by himself. The relationship between the past and present was slightly more blurred, but not less striking in the report *Psychiatry in Transition* (1977). Here it was mainly pictures that created the contrasts between then and now. The images from the past described individuals who gave the impression of being socially isolated, and subjected in the institution to – by our standards – weird and obviously painful treatments and coercion. The pictures from present were

characterized by social interaction and communication.

The individual could in other words, be depicted in two different ways: in terms of the isolated institutionalized inmate who found himself at the mercy of institution arrangements and methods, and the – ideally – free individual who was in his own home, managed by himself and chose freely whether to seek psychiatric treatment. Similarly, the concept of collectivity was depicted. In the past it was an abomination, something to which the individual was subordinated by force and which appeared to wipe out an individual's identity, needs and desires. In the present and the future collectivity was considered positive social interaction, as an aid to the suffering individual. Image-wise, the old-fashioned, poor collectivity was symbolized by the mental hospital with its impersonal, levelling patient uniforms, daily schedules and spatial transparency, none of which was unseen. The general meeting was the most obvious and prominent image of the good contemporary collectivity.

Manifestos and History

The link between historical and contemporary changes and political programmes or manifestos is not limited to the type of texts to which I have dedicated this study. Of course, the relationships between academic historical research and contemporary society exist, although they are rarely as obvious as in the government and practitioner spheres. In this regard, all history is subordinate to the present. I have previously mentioned Foucault's *Histoire de la folie à l'âge classique* as one of the more obvious ex-

amples of how history has been influenced by contemporary conditions, and has returned into the present, affecting it in certain directions.

If we linger for a while in Swedish psychiatric history research, it is not difficult to notice how it can be seen as reflexive comments on the researcher's own societal present. During the 1980s and 1990s, we were several scholars who paid attention to the history of the institutions.² For myself and certainly for other researchers this interest was to a high degree based on an urge to comment on and provide a deeper understanding of what psychiatry had left or was about to leave – and for that matter, the temporal long-lasting components psychiatry had *not* left behind. Since 2000 we have seen a slight change of focus towards a greater interest in psychiatry's activities outside the mental hospitals and the interaction with the (local) community. This adjustment can be understood as a cultural-historical commentary on today's psychiatry where the question of the division of responsibility between the county and municipality is still under discussion (Berge 2007), and the sufferer's position in the local community and its relation to psychiatry (Riving 2008) is an open and difficult question for psychiatric care, whose trust and faith in outpatient care remains strong.

The academic historical research can or should not stand outside contemporary influences. It can and should also influence its own time. This is almost a given fact that sometimes needs to be repeated. That does not mean that research results are always, for better or worse, used as the researchers intended. Control over the re-

sults is obviously released as soon as they are published.

All history has a link and is influenced by its own time, whether it originates in an academic environment or – as I have noticed here – in a health-policy context. The differences between these two contexts are a matter of degree rather than kind. The health policy history is of course dependent on academic research but also affects the definition of the problems and issues of social relevance. My aim has been to explore how history can and has been used in health policy documents. I have given examples of how investigators and politicians used the past to argue for changes in psychiatry. You could say that the possibility of change went through a historicizing process. In this respect, history is the result of contemporary choices, a story that is given legitimacy and meaning through its relationship to the historian's own lifetime. I have argued for the great importance of differences in the history I have examined. These differences were a method to argue for change. Any continuity appeared to be quiet, not only because their usefulness was slight, but also because continuities and slow changes are generally more difficult to detect in the archive than the dramatic changes. The latter is surrounded by speech and texts in the archives and lends itself easily to a political and argumentative history to which one can relate quite critically.

History had at least two features of these current processes of change. To historicize meant to define and conceptualize but also to set something in motion. Everything that has a story is and has been the subject of a construction. Whatever

can be historicized cannot be fixed but must by definition be moving and changing (Hacking 1999). To historicize also means to take distance (Ricoeur 2005). In our view, such a distancing rather represents a desire to distance, that is, a desire to distance itself from something that *ought* be in the past but is not. The historical perspective on the present and the contemporary gaze on the past intertwined in an odd way together in this process of change, a braid that can hardly be reduced to cover mental health care; it is relevant to any history that is activated in processes of change.

Lars-Eric Jönsson

Professor

Div. of Ethnology, Dept. of Arts and Sciences,
Lund University

Biskopsgatan 7

SE-223 62 Lund

e-mail: lars-eric.jonsson@kultur.lu.se

Notes

- 1 The authors of the report were chief physician Bengt Berggren, initiator of the Nacka project, and investigating secretary Börje Strand, Spri.
- 2 For example Qvarsell 1982; Sjöström 1992; Jönsson 1998; Eivergård 2003.

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