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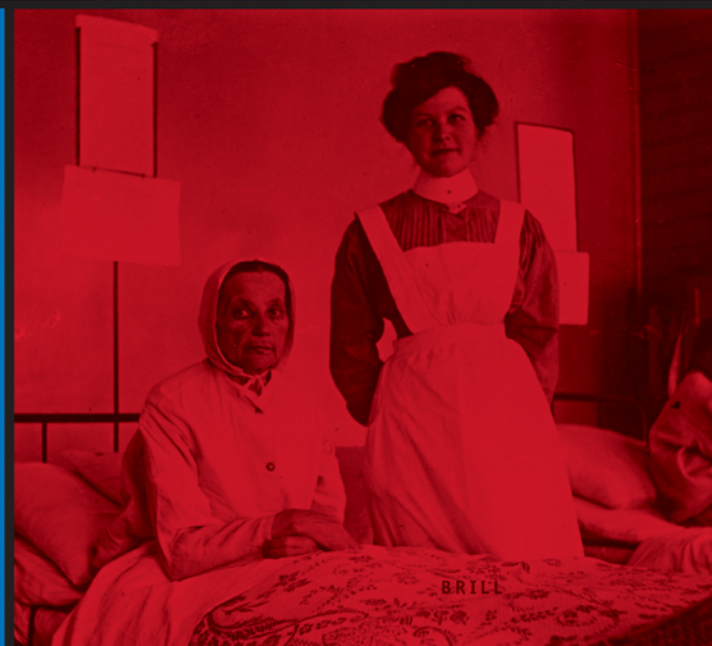
Neurosis and Modernity

The Age of Nervousness in Sweden

PETTERI PIETIKAINEN



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VOLUME 2

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The Age of Nervousness in Sweden

By
Petteri Pietikainen

BRILL

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Cover illustration: student nurse with patients at the Helsinki University Internal Diseases Hospital in the 1920s. Courtesy of the Helsinki University Museum Arppeanum.

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In the proximity of madness.—The sum of sensations, items of knowledge, experiences, the whole burden of culture, that is to say, has become so great that an over-excitation of the nervous and thinking powers is now a universal danger; indeed, the cultivated classes of Europe have in fact become altogether neurotic, and almost every one of its great families has come close to lunacy in any rate one of its branches. It is true that health is nowadays sought by all available means; but what is chiefly needed is an abatement of that tension of feeling, that crushing cultural burden which, even if it has to be purchased at a heavy cost, nonetheless gives ground for high hopes of a *new Renaissance*.

(Nietzsche, *Human All Too Human*, 1878)

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present my own ideas on 'Swedish nervousness' to an expert audience. With the support of the Ax:son Johnson Foundation, I could also invite Karin Johannisson, Frans Luttenberger, Mark S. Micale and the late Paul Roazen as guests to the Foundation's premises at the Old Town in Stockholm. They have all deepened my understanding of medical and psychological history.

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LIST OF ABBREVIATIONS

ACTA	=	*Acta Psychiatrica et Neurologica*
ASLT	=	*Allmänna Svenska Läkartidningen* ('Journal of the Swedish Association of Medicine', 1904–1919)
DN	=	*Dagens Nyheter*
Förhandlingar	=	Förhandlingar vid Svenska Läkaresällskapets Sammankomster ('Minutes of the Meetings of the Swedish Association of Medicine')
Handlingar	=	*Svenska Läkaresällskapets Handlingar* ('Publications of the Swedish Association of Medicine')
HP	=	*History of Psychiatry*
HV	=	*Hälsovännen*
JHBS	=	*Journal of the History of the Behavioral Sciences*
LT	=	*Läkartidningen* ('Journal of the Swedish Association of Medicine', 1965–)
MFT	=	*Medicinska Föreningens Tidskrift*
NM	=	*Nordisk Medicin*
NMT	=	*Nordisk Medicinsk Tidskrift*
PTSU	=	*Populär Tidskrift för Sexuell Upplysning*
SLT	=	*Svenska Läkartidningen* ('Journal of the Swedish Association of Medicine', 1920–1964)
SMT	=	*Social-Medicinsk Tidskrift*
SOU	=	*Statens Offentliga Utredningar* ('Public Inquiries of the State')

INTRODUCTION

THE AGE OF NERVOUSNESS

When August Strindberg visited Paris in the 1890s, he was overwhelmed by his sense impressions. The enfant terrible of Swedish intellectual culture asked himself,

> what is happening to me? Are my nerves undergoing an evolution towards over-sensitivity and are my senses becoming much too delicate? Am I shedding my skin? Am I becoming a modern man?[1]

Upon entering Paris, Strindberg, a native of the still rather rural Sweden, was entering a new age, the Age of Nervousness, which made him and many other Europeans "lose breath and get nervous".[2] Paris of the 1890s, like other urban metropolises in Europe, was a veritable hotbed of nervous illnesses, the most fashionable of which was neurasthenia, 'nervous exhaustion'. When Strindberg articulated his feelings and thoughts in the new language of nerves, he was indeed becoming a 'modern man'.

Strindberg was one of the first Swedes to enter the Age of Nervousness and exhibit nervous symptoms that increased people's distress without making them serious invalids. Or, rather, Strindberg was one of the first nervous *intellectuals* in Sweden: while he walked the streets of Paris and wondered what was going on in his nervous system, his working-class compatriots were consulting doctors at the newly-opened Neurological Outpatient Clinic at the Serafimer Hospital in Stockholm. These workers, farmers, artisans, petty officials and their wives were nervous, depressed, overstrained; their sleep was disturbed; they were plagued by diffuse pains, dizzy spells and headache; and their symptoms could not be explained by reference to any organic illness or lesion.

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[1] August Strindberg, "Förvirrade sinnesintryck" (1919–20), in *Samlade Skrifter* Vol. 27: *Prosabitar från 1890-talet* (Stockholm: Bonniers, 1987), 540. All translations from Swedish to English are mine unless otherwise indicated.

[2] Ibid., 540. Strindberg's essay was first published in the French newspaper *Le Figaro* in the autumn of 1894.

A considerable number of these patients, some of whom were aware of the new epidemic of 'nervousness' or 'weakness of nerves', were diagnosed as suffering from hysteria or neurasthenia, two grand neuroses of the late nineteenth century. As a cultural metaphor, the Age of Nervousness had been inspired by the violent historical events of the time, since both an American president (James A. Garfield) and a Russian czar (Alexander II) had been assassinated in 1881, and there had been violent terrorist acts in London in 1883. For a growing number of late nineteenth-century Europeans and North-Americans, the world had become more unpredictable, unstable and nervous.

The Triumph of the Therapeutic

This book examines the history of neuroses in Swedish medicine and culture from 1880 to 1950. These turbulent years comprise a major part of what I would call the 'Nervous Century' (1880–1980), since it was a period in western culture during which so-called weak nerves, together with a myriad of diffuse somatic symptoms, haunted countless people whose ailments were diagnosed as hysteria, neurasthenia, traumatic neurosis, psychoneurosis, psychasthenia, depression, or just plain neurosis. In twentieth-century psychiatry, neurosis and psychosis constituted the two major illness categories: 'psychosis' was a generic term for such severe mental illnesses as schizophrenia and manic-depression (the bipolar disorder), while 'neurosis' was a generic term for milder mental afflictions, such as neurasthenia, psychogenic depression and psychoneurosis.[3] To simplify: if your medicalised symptoms of distress were not so severe that they seriously impaired your mental functioning and social interaction, and you had insight into your own state of mind, then during the period under research you were likely to be diagnosed as suffering from neurosis. What today are called depression, anxiety, phobias, panic attacks, post-traumatic stress disorder, anorexia nervosa and obsessive-compulsive disorder were once labeled as neuroses.

[3] For a historical study of these two dichotomies, see Dominic M. Beer, "The Dichotomies: Psychosis/Neurosis and Functional/Organic: A Historical Perspective," *HP* 7 (1996): 231–55.

I begin with the year 1880 for a number of reasons.[4] First of all, in 1880 an American nerve doctor, George Beard, published an enormously influential book on neurasthenia;[5] second, in the early 1880s the renowned French clinical neurologist Jean-Martin Charcot began to give lectures on hysteria at the Salpêtrière Hospital in Paris; third, the German neurologist Hermann Oppenheim's 1889 monograph on 'traumatic neurosis' introduced a predominantly male nervous illness which, through becoming a compensatable illness in Bismarck's Germany, also became a condition of the 'masses';[6] fourth, the German-Austrian nerve doctor Richard von Krafft-Ebing's 'highly eclectic encyclopedia of sexual aberrations',[7] *Psychopathia sexualis* (1st ed. 1886), played a key role in the reconceptualisation of sexual pathology as a form of nervous illness; fifth, the rise of hypnotism, studied and legitimated as a clinical method by Charcot, signified the beginnings of the modern psychotherapy of neuroses in the early 1880s; sixth, the first references to and discussions of modern neuroses in Swedish medical journals began to appear in the early 1880s; and, seventh, the establishment of the Neurological Clinic at the Serafimer Hospital in Stockholm in 1887 heralded a new era in the study of nervous illnesses in Sweden. The 1880s witnessed the rise of neuroses in Sweden, and by the end of the century, physicians routinely conjured up the idea of 'our nervous age' to describe the hazards 'the modern life' posed to the health of nations. The Age of Nervousness had become fully established in the Nordic kingdom—so much so that nervousness attained the status of a national malady or 'folk disease' (*folksjukdom, Volkskrankheit*) alongside such diseases as tuberculosis, syphilis and alcoholism.

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[4] Interestingly, historians of medicine Roger Cooter and John Pickstone date the beginning of a new era of medical science to 1880 and the rise of bacteriology. They see the mid-1970s as the end of this era and a beginning of a new one (with the 'new challenges' of genetics, new reproductive technologies and informatics). Roger Cooter and John Pickstone, Introduction to *Medicine in the Twentieth Century*, ed. Roger Cooter and John Pickstone (Amsterdam: Harwood Academic Publishers, 2000), xvi.

[5] George M. Beard, *A Practical Treatise on Nervous Exhaustion (Neurasthenia), Its Symptoms, Nature, Sequences, Treatment* (New York: W. Wood & Company, 1880).

[6] Andreas Killen, *Berlin Electropolis. Shock, Nerves, and German Modernity* (Berkeley: University of California Press, 2006); and Mark S. Micale and Paul Lerner (eds), *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870–1930* (Cambridge: Cambrigde University Press, 2001).

[7] Harry Oosterhuis, *Stepchildren of Nature: Krafft-Ebing, Psychiatry, and the Making of Sexual Identity* (Chicago: The University of Chicago Press, 2000).

In early twentieth-century Sweden, physicians coupled the decline of the nation's health (*folkhälsa*) with what they saw as widespread nervousness. The medical authorities became concerned enough to take measures against this new folk disease when the newly-founded Royal Board of Pensions (*Pensionsstyrelse*) began in the early 1920s to establish its own clinics for the care of the nervously ill (and rheumatics). The epidemic of nervous illnesses called for medical, psychiatric, psychological, theological, philosophical, sociological and political interpretations, as a result of which variants of the language of nerves filtered into the common vocabulary, mentality and worldview. Teachers, clerks, factory workers, farmers, household servants, housewives, businessmen, civil servants, academics and artists of all kinds, among others, all adopted this new language to some degree. They began to suffer from nervous exhaustion, inferiority complex, psychoneurosis, organ neurosis, trauma, anxiety, over-sensitivity and 'weak nerves', and they consulted experts in the clinic, hospital, consultation room and the Church, or, at the very least, they read popular books and articles on nervous illnesses, tiredness, headache and the overall 'nervousness' of modern life.

In the first decades of the twentieth century, and especially after World War I with its phenomenon of shell-shock, a distinctly psychological approach to neuroses became more accepted and legitimate in the western medical community. In Sweden, an 'environmentalist' interpretation of neuroses attracted pedagogues and psychologists, but also the younger generation of Lutheran theologians and pastors, for whom neurosis was typically a manifestation of spiritual malaise that could be healed by the religious 'curing of the soul' (*Seelsorge*). In a Lutheran society where feelings of guilt and inadequacy were increasingly regarded as psychological symptoms of inferiority complex rather than expressions of contrition, neurosis was not just a popular diagnosis, but also a major symbol of discontent and rhetorical device that was applied to designate problems both in the life of the individual and in social arrangements. As a concept, twentieth-century neurosis consisted of various medical and socio-cultural components, and came to signify psychological and psychosomatic malaise ideally suited to various psychotherapies.

What was by far the most important result of the rise of neurosis was that it became a standard signifier of the grey zone or middle ground between a state of full health and severe mental illness. And as this middle ground is extraordinarily diffusive and vulnerable to diagnostic infections, it is small wonder that an exceedingly 'omnivorous'

psychopathologisation of human behaviour has characterised much of modern mental medicine. As the popular private practitioner Henrik Berg pointed out in his medical manual of 1903, "nervousness is an intermediate illness, a transitional stage between health and illness."[8] His view was shared by many of his peers, who did not want to identify neurosis with a full-blown disease, but who acknowledged that people whom they diagnosed as nervously ill often required medical care (and not only advice or persuasion).

Then, in 1980, one hundred years after the appearance of Beard's paradigmatic book on neurasthenia, a new edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, DSM-III, was published. DSM-III, which soon attained the status of the 'Psychiatric Bible', was quite different from the earlier edition that had appeared in 1968 (DSM-II). In contrast to its psychoanalytically-oriented (and much less extensive) predecessor, DSM-III "eliminated the entire construct of neurosis",[9] splitting and relabelling many neuroses as specific types of anxiety disorder. One major neurosis that was dropped from DSM-III was neurasthenia. Despite a fierce resistance from American psychoanalytic psychiatrists, neurosis lost its status in 1980 as a psychiatric disorder and a general category for milder mental afflictions. The decades-old distinction between psychoses and neuroses was by and large abandoned as a fundamental organising principle in psychiatry, mainly because neurosis had become an over-inclusive diagnostic category 'contaminated' by psychoanalytic and psychosomatic theories, which were in decline in the final quarter of the century.

Neurosis as a term did not disappear altogether with the publication of DSM-III, and it retained its recognised status in the other major manual of mental disorders, the World Health Organisation's *International Classification of Diseases* (ICD). Yet, psychiatrists around the world began to consult DSM-III (and its follower, DSM-IV) for its practical value, and the manual's scant references to neurosis meant that this disorder disappeared from the official medical limelight. By coincidence, the Serafimer Hospital, where the first neurological clinic in Sweden had been founded in 1887, was closed down in 1980, the year DSM III was published. Although the Serafimer's neurological

[8] Henrik Berg, *Läkareboken 1* (Stockholm: Kommanditbolaget Chelius & Co, 1903), 678.

[9] Herb Kutchins and Stuart A Kirk, *Making Us Crazy: DSM: The Psychiatric Bible and the Creation of Mental Disorders* (London: Constable, 1999), 25.

and psychiatric clinics had been removed to the Karolinska Hospital some decades earlier, the closing down of a hospital that had played the leading role in establishing neurosis in Swedish medicine had symbolic significance; the end of the Serafimer coincided with the end of the Nervous Century.

Neurosis as a Contagious Diagnosis

I shall argue throughout this book that neurosis was a contagious diagnosis. I would suggest that the term 'contagious diagnosis' denotes a medical diagnosis that becomes relatively popular in the medical community within a fairly short period of time (ca. ten years), and which is also accepted or even embraced by (certain segments of) the general population. All psychiatric diagnoses are contagious diagnoses in so far as their birth and life cycle depends heavily on the conceptual creation of the illness, and on the general agreement of medical professionals in denoting a particular set of symptoms or syndromes with a specific diagnosis, such as 'schizophrenia' (formerly known as 'dementia praecox') or 'borderline personality disorder'.[10] And neurosis was a contagious diagnosis, because it was a remarkably elastic category which could encompass a stunning array of symptoms and causes, and which was extremely responsive to outside influences, such as prevailing theories of mental health and human behaviour, dominant values, social and cultural processes, and popular but often unarticulated assumptions about human life and human nature. It was extremely malleable to socio-cultural developments and medical innovations and fashions, and it spread over the decades from middle-class women to *all* segments of the population, including working-class women and men, children, the organically ill and, in the end, virtually everyone.

Neurosis would never have become a contagious diagnosis had it not become a useful illness for the professionals who represented the growing fields of mental medicine and the human sciences. At first, neurosis belonged almost exclusively to the domain of neurology, but over the years it was gradually annexed by psychiatrists, psychoanalysts, clinical

[10] On this issue, see Håkan Eriksson, "The Creation of Psychiatric Ill-Health," in *Modernity and Its Discontents: Sceptical Essays on the Psychomedical Management of Malaise*, ed. Petteri Pietikainen (Stockholm: Ax:son Johnson Foundation, 2005), 49–68.

psychologists, therapists of all kinds and, to a lesser extent, theologians and pastors, social workers and sociologists (and, most recently, by historians…). Neurosis was an essential part of the claims-making of these professions and occupations.[11] I shall examine how neurosis as a contagious diagnosis was passed on in medicine and culture, and my focus is on the ideas and activities of the professional groups chiefly responsible for spreading the diagnosis, namely neurologists, psychiatrists and psychodynamic psychotherapists or 'nerve doctors'. At one level of analysis, I examine how representatives of these groups were actively involved in the spread of neuroses, either directly as physicians or therapists, or indirectly as commentators and critics of the Nervous Culture. And at another level of analysis, I show how science-based social groups legitimised their expertise in the expanding field of 'transitory mental illnesses', as the philosopher Ian Hacking calls them.[12]

In brief, my aim is to demonstrate that neurosis was a contagious diagnosis that became a folk disease in Sweden; that neurosis was an essential component of the 'nervous culture' as well as of the nascent psychoculture; and that in the professional debates between neurologists, psychiatrists and psychodynamic psychotherapists, one's alleged expertise in nervous illnesses was used rhetorically to highlight the socio-medical significance of one's discipline and the demarcation of disciplinary boundaries. My basic assumption is that psychomedicalisation of specific aspects of the human condition needs to be analyzed historically. But we must also take into account the more implicit and intricate socio-cultural effects of modernisation on the understanding of the human condition. Through its preoccupation with a contagious diagnosis, this book aims to provide substantial evidence in support of the general thesis that a historical analysis of a single important diagnosis or diagnostic category can fundamentally increase our understanding not only of medical history but also social and cultural history of modernity.

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[11] There are numerous studies on professions and professionalisation that illustrate mechanisms at play in the professionalisation of medical disciplines. See, for example, Elliott Freidson, *The Profession of Medicine* (New York: Dodd & Mead, 1970); *Professionalism—The Third Logic* (Cambridge: Polity Press, 2001); Magali Sarfatti Larson, *The Rise of Professionalism* (Berkeley: University of California Press, 1977); and F. W. Hafferty and J. B. McKinley (eds), *The Changing Medical Profession: An International Perspective* (Oxford: Oxford University Press, 1993).

[12] Ian Hacking, *Mad Travelers: Reflections on the Reality of Transient Mental Illnesses* (Cambridge, MA: Harvard University Press, 1998).

As the late Roy Porter, a champion of disease-centred medical history, stated in his article on hysteria:

> A central aim of medical history must surely be to chart the history of disease, for without that, we will never fully gain a sense of people's health, sufferings, morbidity profiles, life expectations, and expectations out of life.[13]

To Porter's 'manifesto' I would only like to add that a historical analysis of a single disease can also provide an important insight into mechanisms behind our changing conceptions of morality, personhood and human life as a whole. A historian can clarify not only why it was considered good and beneficial to talk to a doctor or a behaviour expert about one's suffering, but also why some aspects of the human condition became sources of suffering in the first place.

Throughout this book, I use the term 'illness' rather than 'disease' when I discuss neuroses. 'Illness' is commonly used to refer to the subjective perception of the disease, to the *experience* of health or disease. Thus defined, 'illness' is 'heavily influenced by the prevailing values and norms of a given society',[14] and, as values and norms are to a large extent produced and shaped by socio-cultural forces, our subjective perceptions of sickness and suffering are subject to change. This is very much the case with regard to neurosis, which as an illness is more or less in the eye of the beholder. Neurosis is an almost archetypal example of a 'cultural illness', the very existence of which is dependent on what is considered 'normal' and 'abnormal', acceptable and unacceptable, healthy and pathological, ordinary and deviant, in a given society.

In the nineteenth-century United States, medical textbooks included diseases of the mind that

> seemed to afflict only black men and women in astounding numbers. One of the most important disorders was a condition labelled 'drapetomania', a horrible plague that denoted an obsessive desire on the part of a slave to run away from his or her owner.[15]

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[13] Roy Porter, "The Body and the Mind, the Doctor and the Patient: Negotiating Hysteria," in Sander L. Gilman et al., *Hysteria beyond Freud* (Berkeley, University of California Press, 1993), 225.

[14] Arthur L. Caplan, "The Concepts of Health, Illness, and Disease," in *Companion Encyclopedia of the History of Medicine*, ed. W. F. Bynum and Roy Porter (London: Routledge, 1993), Vol. 1, 240.

[15] Ibid., 244.

As an illness, neurosis was of course more 'real' than drapetomania, a shameful medical justification for oppressive policy, but it was not as real as diabetes or Parkinson's disease. It was in fact quite common among early twentieth-century physicians to regard neurosis as a kind of psychopathological equivalent to drapetomania: in their view, the nervously ill were not slaves running away from their owners, but they were undisciplined (or, untrustworthy, degenerate, lazy, irresponsible, etc.) weaklings running away from their responsibilities and duties as citizens. Their neurotic symptoms were perceived as a manifestation of a sometimes cowardly 'flight into illness', some doctors claiming that patients used their 'ill health' to avoid work and responsibility. There were strong normative components in the discourse on neurosis, which makes it a potentially rewarding topic for historians.

The Specifically Swedish Experience of Neurosis

This book is a historical analysis of the ways in which neurosis became a national health problem in Sweden, inciting interpretations that tell us about the intentions and beliefs of the people who made these interpretations, and about the increasingly visible role of psychological medicine in Swedish society. In some essential ways, the Swedish experience of neurosis differed from that of most western nations, which were devastated materially and mentally by the two world wars. Sweden remained neutral during both wars, and, after World War I, social democracy as a powerful political force aiming to unite the nation rather than seeking radical solutions to 'class conflicts' contributed to the peaceful and prosperous development of Swedish society in the twentieth century. The already existing socio-cultural climate emphasising national unity helped create a type of welfare capitalism that became the foundation for social-democratic social engineering. Accordingly, the large group of the nervously ill were regarded by the authorities as a people who for hereditary ('neuropathic constitution', etc.) or environmental reasons were unable to function properly, and the authorities saw it as their duty to help these people to regain their health by providing institutional care for them. Beyond the medical interest in issues related to national health, there were ideological, demographic and national-economic aspects in the discourse on health that sustained the norm that it was a social obligation to remain in good health.

There were tensions and conflicting tendencies in the modernisation of Swedish society, which had implications for the development of health care, including the care of neuroses. Consequently, the history of neurosis in Sweden is different from that of other western countries, and I show in this book that an analysis of these differences tells a uniquely Swedish story that complements the existing scholarship and historical knowledge on the culture of nerves in such countries as Britain, France, Germany and the United States. At the same time, modernisation in Sweden included basic elements found in other western countries, and in the inclination of the state to put its trust in the ability of experts to solve problems in the different fields of social activity, Sweden shared many resemblances with Britain, France and especially Germany, where the issues of national health, economic productivity and the moral and physical strength of the people were constantly debated by the medical establishment. The rise of psychomedical disciplines and currents in Sweden during the first half of the twentieth century (first psychiatry, then psychology, psychoanalysis and psychodynamically-oriented social work and pedagogy) invites comparisons with other countries where psychomedical thought patterns have been applied not only to the more immediate therapeutic needs, but also to the seemingly non-authoritarian 'management of people' (or, 'government of the soul', as the sociologist Nikolas Rose puts it).[16]

The psychomedicalisation of neuroses was one element in the process whereby the more 'scientific', socially-oriented therapeutic ideology began to replace the normative emphasis on the social obligations of citizens and on the medicalised or racialist interpretations of deviancies. During the first half of the twentieth century, Swedish health ideology was shaped by international psychological and mental hygienic ideas and practices that put a premium on preventive measures, eugenics, enlightenment, information and psychological interpretations of malaise and maladjustment. In the formation of psychomedical language, neuroses began to be conceived of as resulting from psychic conflicts or traumas rather than, as used to be the case in late nineteenth-century medicine, from overtaxing of the nervous system or the constitutional weakness of nerves.

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[16] Nikolas Rose, *Governing the Soul: The Shaping of the Private Self*. 1st ed. 1989 (London: Free Association Books, 1999); *Inventing Our Selves* (Cambridge: Cambridge University Press, 1996).

A comparative perspective should highlight not only cultural differences, but also similarities. Even if there was something called the Swedish 'special path' (*Sonderweg*) to modernity, there was also much that connected Sweden with other western nations. As we shall see, this was true of the Swedish Age of Nervousness as well.

Ideas of Madness: On the Intellectual History of Psychiatry

This book is the work of an intellectual historian who examines scientific, medical, moral and political ideas, intentions and beliefs in their socio-cultural settings. I study ideas in action, which in the present context means that my focus is on medical professionals, behaviour experts and academics who discussed, debated and developed theories of neuroses, or who treated the nervously ill in clinics, hospitals and private consultation rooms. But I shall also discuss the illness behaviour of 'nervous patients', especially in Part III. I have searched for connections between intentions and the often unarticulated 'mental habits' and beliefs of psychiatrists and other experts on the one hand, and the nervously ill patients on the other. It is instructive to study, for example, how nervous patients in early twentieth-century Sweden articulated their suffering; how they related their experiences and beliefs to the medical and psychological language of their time; and how they 'used' particular ideas for particular purposes (e.g. to receive compensation or to be able to spend time in a sanatorium, spa or health resort). In my work, I have been inspired by what may be called the 'behavioural science of ideas', the study of the 'behaviour' of ideas and beliefs in specific situations.

Of those who have developed this 'behavioural science of ideas' I would like to single out R. G. Collingwood and Quentin Skinner, two major historical thinkers of the twentieth century. Collingwood, a philosopher of history, viewed history as the history of thinking, as the mind's self-knowledge of itself.[17] And to understand how people think, said Collingwood, one has to conceive of thinking as a set of answers to questions that preoccupy people. In order to find out what people

[17] R. G. Collingwood, *An Autobiography*. 1st ed. 1939 (Oxford: Clarendon Press, 2002); *The Idea of History*. Rev. ed. J. van der Dussen (Oxford, Oxford University Press, 1994); *An Essay on Metaphysics*. Rev. ed. Rex Martin (Oxford: Oxford University Press, 1998).

mean when they say something, we have to know the questions they are trying to answer. Collingwood taught us that an essential aspect of historical scholarship is posing the right questions. This, as he knew very well, is quite difficult, because the questions that occupied people's minds in the past are not necessarily the same as those of today. Besides, authors did not usually explicate the question to which they gave answers in their texts, because they mostly wrote to their contemporaries who were interested in the same question and who understood the specific context without the author having to spell it out explicitly. And what questions are asked is determined by tacit assumptions or presuppositions (a term used by Collingwood) that remain more or less hidden in the text. When presuppositions are different, so too are the questions that occupy people's minds. To understand the process of question and answer is to 'reenact', which in Collingwood's view is the goal of historical scholarship.[18]

For Quentin Skinner, a historian of political ideas (inspired by Collingwood) texts are acts, in the philosopher J. L. Austin's meaning of the term they are 'speech acts'.[19] Skinner has studied the complicated question of the relationship between the intentions of historical agents and meanings in their texts. This relationship is complicated, because texts may have meanings that the author did not intend to convey. Thus Skinner urges historians to

> focus not just on the text to be interpreted but on the prevailing conventions governing the treatment of the issues or themes with which the text is concerned.[20]

An interpretation of a particular text requires not only the identification of intentions, but also of beliefs, and as these beliefs are something that authors typically take for granted and do not articulate—they may not be aware of all of their beliefs—these beliefs can be seen as presuppositions in Collingwood's sense. An intellectual historian, who tries to identify and describe particular beliefs, interprets them in a wider 'network of beliefs' or mentality, which refers to beliefs that were commonplace and typical at a given time. And what is called

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[18] "The history of thought, and therefore all history, is the re-enactment of past thought in the historian's own mind." Collingwood, *The Idea of History*, 215.

[19] Quentin Skinner, *Visions of Politics*, Vol. 1: *Regarding Method* (Cambridge: Cambridge University Press, 2002); James Tully (ed.), *Meaning and Context: Quentin Skinner and His Critics* (Cambridge: Cambridge University Press, 1988).

[20] Skinner, *Visions of Politics*, 101–2.

'contextualisation' is a search for *connections* between intentions and (often) unarticulated beliefs. This search requires that, to use Skinner's terms, a historian tries to recapture the prevailing beliefs that 'govern the treatment' of a particular issue in a particular time and place. The foremost task of an intellectual historian is to identify and describe beliefs (Skinner) or presuppositions (Collingwood), and the starting point of this inquiry is to find out what the historical agents *themselves* have possibly said about their beliefs.

In addition to intellectual history, historians of psychiatry should take into account the relationship between social practices and the language which is embedded in these practices. The authors of the volume *Hysteria beyond Freud* are certainly right in emphasising that "the social history of language cannot be overlooked when tracing the rise and fall of medical conditions."[21] In recent decades, the social and intellectual history of concepts (*Begriffsgeschichte*) has been developed especially by German historians, Reinhart Koselleck and Rolf Reichardt leading the way.[22] Koselleck, for example, has contributed to both intellectual history and social history with his study of the conceptual history of marriage and the family. He has also studied the conceptual history of 'history'. History of concepts and history of mentality are closely related, especially when the latter is understood as a study of the unreflected everyday meanings of concepts. As a dimension of intellectual history, the history of concepts is obviously relevant to the history of psychiatry, which is concerned with changing concepts, changing meanings of concepts (e.g. of melancholy, hysteria and moral insanity), and the mechanisms behind these changes. Although historical reality and concepts are not reducible to each other, they are interconnected, and the history of concepts teaches historians to be extremely sensitive to concepts and their changes. Such sensitivity is exactly what historians of psychiatry should possess.

In the end, a historian of psychiatry can never be sure whether his or her story is a story of 'how it really was' (*wie es eigentlich gewesen*). I agree with Isaiah Berlin in his claim that in historical scholarship

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[21] Sander L Gilman et al., Introduction to *Hysteria beyond Freud*, viii.

[22] Reinhart Koselleck, *Futures Past: On the Semantics of Historical Time*. Trans. Keith Tribe (Cambridge, MA: The MIT Press, 1985); Rolf Reichardt, Eberhard Schmitt and Brigitte Schieben-Lange (eds), *Handbuch politisch-sozialer Grundbegriffe in Frankreich 1680–1820*, Vols. I–II (Oldenbourg: München, 1985).

> there is an element of improvisation, of playing by ear, of being able to size up the situation, of knowing when to leap and when to remain still, for which no formulae, no nostrums, no general recipes, no skill in identifying specific situations as instances of general laws can substitute.[23]

Collingwood has pointed out in turn the significance of historical imagination for constructing a picture of the past and seeing things the way people in the past saw them.[24] Berlin's emphasis on improvisation, as well as Collingwood's emphasis on historical imagination, is especially valid in the history of medicine and psychiatry, because historians in that field mainly rely on textual material, which can present certain methodological problems. Medical practices do not result from a merely textual-based training, since psychiatrists are medical specialists who learn the skills of their 'craft' first by observing experienced clinicians at work and then later by sharing in the diagnostic and therapeutic work under supervision.[25] The importance of the clinical dimension in psychiatry means that historians should be aware of the limitations of the available source material and, when drawing conclusions, make it clear to their readers that what they are offering is a construction of a view of the past based on the often rather ambiguous or controversial evidence that admits several interpretations. Historians of psychiatry, like all historians, have to exercise the art of historical imagining à la Collingwood and, while pursuing the historical truth, tolerate the fact that they truly represent what the intellectual historian Bruce Mazlish has called the 'uncertain sciences'.[26]

On the Study of Neurosis

It was the patient who displayed symptoms interpreted as being indicative of neurosis, but it was the expert who gave neurosis its publicity by writing, lecturing, debating, teaching, training and supervising students and younger colleagues. Thus the principal source material in this book consists of professional journals and minutes of the meetings of the Swedish Society of Medicine; I have systematically gone through all

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[23] Isaiah Berlin, *The Sense of Reality: Studies in Ideas and Their History* (New York: Farrar, Straus and Giroux, 1998), 33.

[24] Collingwood, *The Idea of History*, 231–49.

[25] William Watson, "Psychiatry as Craft," *HP* 9 (1998): 355–81.

[26] Bruce Mazlish, *The Uncertain Sciences* (New Haven, Yale University Press, 1998).

major Swedish and inter-Nordic medical, psychiatric and psychological journals, as well as the minutes of the Society of Medicine, including presentations given at the Society's meetings. With regard to nervous patients, invaluable source material is provided by the case records of Dr Lennmalm's private practice and of the Serafimer Hospital's Neurological Polyclinic. Valuable material is also provided by medical manuals, textbooks, popular books on neuroses and nerve illnesses, conference programmes, and the annual reports of the Serafimer Hospital in Stockholm. An extensive secondary literature, both Swedish and international, on the various aspects covered in this book has also been immensely helpful to me.

In the light of its popularity as a medical diagnosis and a cultural symbol of discontent and distress in twentieth-century western societies, it is quite surprising that historical studies on neurosis are few and far between. The only 'genre' in neurosis studies that has really flourished is hysteria studies. This is quite understandable for a number of reasons. First of all, "hysteria is arguably the oldest and most important category of neurosis in recorded medical history."[27] Second, hysteria is an appropriate subject of *historical* studies, because it does not exist any more as a separate disease entity—as a historical phenomenon, hysteria has its beginning and its end, which makes it easier to analyse it historically. Third, hysteria has appealed to representatives of women's studies, cultural studies and feminism. Hysteria was long considered a women's disease, and as such it has cried out for gender-specific interpretations. By contrast, its younger siblings in the family of neurosis (neurasthenia, psychoneurosis, depression, etc.) do not have such a long conceptual history, and neurosis has not been totally extinguished as a nervous disorder even today. Most importantly, neurosis was not a gender-specific diagnosis, although, roughly speaking, about two-thirds of the nervously ill in Sweden were women during the early period of the Nervous Century (1880–1980). However, by the mid-twentieth century, at least at the Serafimer Hospital, the percentage of male neurotics had come very close to the percentage of female neurotics. Moreover, in contrast to hysteria, neurosis has *not* become a popular subject of cultural studies and women's studies, and it has not been interpreted and re-interpreted by scholars in a way reminiscent of

[27] Mark S. Micale, *Approaching Hysteria: Disease and Its Interpretations* (Princeton: Princeton University Press, 1995), 3.

hysteria. Of course, modern hysteria itself was considered a nervous illness, and although it lost in importance as a diagnostic category in Sweden during the first decades of the twentieth century, I include hysteria in the list of neuroses that I examine in this book, the other main neuroses being neurasthenia, psychoneurosis, traumatic neurosis and 'plain' neurosis.

Aside from Janet Oppenheim's excellent study of 'shattered nerves' in Victorian England, and Joachim Radkau's medico-social study of neuroses in Germany between the years 1870 and 1933, there are no historical studies of neurosis that might delineate its rise (and fall) in a specific national setting.[28] The British clinician and historian German Berrios, for example, has produced an impressive number of conceptual histories of psychopathologies, including nervous illnesses, but his approach is more sensitive to changing clinical practices in professional psychiatry than my approach, which lends more weight to intellectual, social and cultural factors.[29] In the course of my study, I have greatly benefited from those few historical works on neuroses that have appeared to date,[30] as well as from the studies of Swedish scholars working in the field of the history of medicine, psychiatry, psychology and psychoanalysis.[31] Without their invaluable studies, this book would not be nearly so informative and factually based as I hope it is now. The fact that the author is not a Swede but a Finn (who speaks Swedish) may

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[28] Janet Oppenheim, *'Shattered Nerves': Doctors, Patients, and Depression in Victorian England* (Oxford: Oxford University Press, 1991); Joachim Radkau, *Das Zeitalter der Nervosität: Deutschland zwischen Bismarck und Hitler* (München: Carl Hanser, 1998).

[29] See especially G. E. Berrios, *The History of Mental Symptoms: Descriptive Psychopathology Since the Nineteenth Century* (Cambridge: Cambridge University Press, 1996); and G. E. Berrios and Roy Porter (eds), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London: Athlone, 1995).

[30] J. López Piñero, *Historical Origins of the Concept of Neurosis* (Cambridge: Cambridge University Press, 1983); Georg F. Drinka, *The Birth of Neurosis* (New York: Simon and Schuster, 1984); Oppenheim, *'Shattered Nerves'*; Michael Gossop, *Theories of Neurosis* (Berlin: Springer-Verlag, 1981); Edward Shorter, *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era* (New York: The Free Press, 1992); Radkau, *Das Zeitalter der Nervosität*; Ben Shephard, A *War of Nerves: Soldiers and Psychiatrists 1914–1994* (London: Pimlico, 2002); Paul Lerner, *Hysterical Men: War, Psychiatry, and the Politics of Trauma in Germany, 1890–1930* (Cornell, Cornell University Press, 2003); and Killen, *Berlin Electropolis*. In Finland, Minna Uimonen has studied the early history of the age of nervousness in Finland; see Minna Uimonen, *Hermostumisen aikakausi: Neuroosit 1800-ja 1900-lukujen vaihteen suomalaisessa lääketieteessä* (Helsinki: Suomen Historiallinen Seura, 1999), English summary.

[31] In particular, I would like to mention the following Swedish scholars whose contributions have been helpful to me: Karin Johannisson, Franz Luttenberger, Roger Qvarsell and Eva Marie Rigné (see Bibliography for further details).

help him to see the peculiarities of Sweden and the 'Swedish mentality' more acutely than would be the case if he were a native Swede.

The Structure of the Book

This book is divided into three parts, and in each part I have a distinct yet interrelated goal. In Part One, I examine the development of the medical care of nervous disorders in the context of modernity and health ideology in Sweden. Chapter 1 is a short introduction to the 'Swedish path to modernity', and in the next chapter I introduce the major neuroses of the period under survey before I focus on the early history of neurosis in Sweden in general and on the Serafimer Hospital's Neurological Clinic in particular. Chapter 3 illustrates aspects of health ideology which are relevant for understanding the medical and socio-cultural interpretations of 'nervousness' in Sweden. In Chapter 4, I examine how neurologists and psychiatrists studied, treated, discussed and debated neuroses.

In Part Two, the overarching theme is the historical development from 'nervous culture' with its physicalistic language of nerves and the nervous system to the psychodynamically-inspired language of 'psychoculture' revolving around the psyche, psychic conflict and emotional trauma. In Chapter 5, I discuss the interpretations and medical diagnoses of women's and children's nervousness, as well as sexuality as the major locus of nervousness. I give special attention in this chapter to the activities of the Swedish Association for Sexual Education. Chapter 6 examines various therapies and methods of healing that were in vogue between 1880 and 1950. I start with hypnotherapy and end with psychodynamic therapy and the religious cure of the soul (*Seelsorge*). Chapter 7 deals most explicitly with the socio-cultural transition of the Age of Nervousness to the Era of Psychoculture, by which I refer to the process of psychomedicalisation that changed the ways in which people interpreted their mental states and especially the alleged connections between their mental states and their every-day problems. In this chapter, I am also interested in the process whereby the Lutheran idea of spiritual conflict (the guilty conscience) changed into the psychomedical idea of psychic conflict (the complex-ridden psyche).

In Part Three, the emphasis is on the nervous patients and the clinical encounters between doctor and patient. In Chapters 8 and 9, the patient records of Dr Lennmalm's private practice and of

the Neurological Polyclinic at the Serafimer Hospital are examined and discussed to illustrate how nervous diagnoses were employed by physicians, and how patients articulated their suffering and related it to different contexts (domestic problems, difficulties at work, fear of insanity or syphilis, etc.). These two chapters analyse the relationship between a) the patients' symptoms and their account of the sources of these symptoms; b) different diagnoses; and c) the language used in the doctor-patient relationship. In Chapter 10, the issues related to Swedish health ideology (discussed in Chapter 1) are raised again through an examination of the Royal Board of Pensions' attempt to 'rehabilitate' nervously ill workers in their clinics in order to make them productive citizens. The concluding chapter discusses the idea of a 'contagious diagnosis' and examines the process whereby a growing number of people in the western world became 'neurotic' during the 'Neurotic Century' (1880–1980). I end my story with some reflections on the nature of present-day contagious diagnoses.

This book aims to show that our psychologised language of discontent and malaise has a history that goes back to the birth of modern neuroses in the 1880s. The subtitle of this book—*The Age of Nervousness*—emphasises the extent to which the language and rhetoric of nerves suffused western societies from the 1880s to the 1980s (and beyond). My ambition has been not only to contribute to the historical scholarship on psychiatry and medicine, but also to illustrate and analyse general aspects of social and cultural history in Sweden, and to raise broad comparative questions concerning paths to modernity in the western world. The essential point I have tried to bring out in this book is that a story of neurosis is simultaneously a story of the human condition.

PART I

MEDICALISED MODERNITY

CHAPTER ONE

ON THE SWEDISH PATH TO MODERNITY

> The intellect of the Swede is alert in nearly every sphere of life. He is blessed by Nature with great intelligence. He can easily understand and absorb new ideas and even initiate new lines of thought. He is both receptive and productive, perhaps at the latter, he is stronger than any one else.[1]

This is how the Reverend Georg Bergfors, a Swede, described the Swedish national-character in 1921. As his observations of the mentality of the Swedes may not have been thoroughly objective, it may be useful to turn to the observations of someone who is not Swedish. In her book, *Sweden: The Land and the People* (1934), the American travel writer Agnes Rothery describes the life of the Swedes and gives a very favourable picture of the Nordic kingdom. She also illustrates the character of its inhabitants:

> The stranger in Sweden is impressed by two things: the superb physical fitness of the people and their quiet manners. Merely to sit in a restaurant filled with holiday makers is to be conscious of an almost tangible emanation of health from glowing bodies, shining hair, and clear eyes, from athletic muscles and strong frames. The sun-browned skins do not cover nervous emaciated figures, but are the proper accompaniment of sturdiness and agility.[2]

"Tangible emanation of health"? It seems as if these sturdy, robust Swedes would be the last people on earth to be affected by nervous complaints. Agnes Rothery may not have been as keen an observer as Charles Darwin, but she did notice that

> while the Swedish temperament is susceptible to gusts of elation, it seems incapable of sustained cheerfulness… Some quirk of temperament, some deficiency in emotional training, produce the rather depressing phenomenon

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[1] Georg Bergfors, "The Swedish National-Character," in *The Swedish Nation in Word and Picture*, ed. H. Lundborg and J. Runnström (Stockholm: Hasse W. Tullberg, 1921), 34–8.

[2] Agnes Rothery, *Sweden: The Land and the People* (New York: The Viking Press, 1934), 179–80.

> of a people working persistently, intelligently, effectively, to better their lot and develop their country and yet being incapable of enjoying or even realizing their success.[3]

In other words, even though the Swedes were living in a Utopia—that's the word Rothery herself used—they seemed to be remarkably unimpressed by their own achievements.

When Rothery's travel book was published, Sweden had become a modern, increasingly affluent industrial nation that had taken its first steps towards the kind of social-democratic welfare state that it would epitomise during the latter half of the century. The year 1934 being in the middle of the Neurotic Century (1880–1980), I shall dig a little deeper into the past and give a short account of Swedish health ideology in the early decades of the twentieth century.

Sweden Around 1900

In 1887, when the first Neurological Clinic was established in Sweden, the country was undergoing rapid structural change. Industrialisation had gained momentum, and in effect it transformed Sweden from an agricultural and manufactural nation to a modern industrial power within a few decades.[4] Together with forests, ore mills had become of particular importance to Swedish industry, and iron ore was the principal product for export together with forest products. In addition to these more traditional industries, new technological advances were quickly adopted as a basis for new industries, such as electricity, telecommunication and explosives (Alfred Nobel's work was crucial to this form of industry). A tell-tale sign of modernisation was the introduction of the car industry in Sweden: the Scania Company started the mass-production of automobiles in the town of Malmö in 1903 (but in 1905 there were only 115 motor vehicles in the whole of Sweden).[5]

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[3] Ibid., 235.

[4] On industrialisation and its different cultural and social contexts in Sweden, see Peter Elmlund and Kay Glans (eds), *Den välsignade tillväxten* (Stockholm: Natur och Kultur, 1998).

[5] I have mainly used the following text books in the history of Sweden as my source material here: Hans Albin Larsson (ed.), *Boken om Sveriges historia* (Stockholm: Forum, 2001); and Hans Dahlberg, *Hundra år i Sverige* (Stockholm: Albert Bonniers Förlag, 1999).

Industrialisation brought with it urbanisation, when factories, workshops, and the burgeoning service industry attracted mainly low-income people, especially landless labourers, living in the countryside. These twin processes of industrialisation and urbanisation created a new social class, workers, whose political consciousness was raised by socialism and the budding social democratic movement in the 1880s. At the same time, emigration to North America for economic reasons was intense, reaching its culmination in the 1880s. Between the years 1850 and 1914, about one million people emigrated from Sweden, and although every fifth emigrant eventually returned to the homeland, emigration meant an enormous loss of people in a country that only had 3,5 million inhabitants in 1850. At the turn of the twentieth century, when the population had increased to five million, emigration was a burning social issue, and both the authorities and social commentators agreed that reforms were needed in order to put an end to the mass emigration.

Emigration was a concrete manifestation of the prevailing social problems, the most acute of which was poverty. Between the years 1890 and 1900, five per cent of the population received public assistance because of poverty, and more than 35,000 Swedes lived in poorhouses. During the first two decades of the twentieth century, the number of the relief-dependant went down a little, only to increase again in the 1920s. During the economic depression between the years 1930 and 1935, more than half a million Swedes received public assistance (8,5 % of the population).[6] Poverty and economic crises notwithstanding, for the period 1871–1970, the Swedish economic growth rate, at about 2,1 percent annually on a per capita basis, was second only to that of Japan.[7] In a few decades, Sweden changed from a relatively poor rural country to that of an affluent industrial nation.

The standard of living increased in the latter half of the nineteenth century, but, as emigration to North America also testified, poverty and social misery were still major problems in the country. Since there were more and more people working as waged labourers, unemployment became a constant social problem and increased the political pressure to introduce reforms that would take the heat off the radical socialist

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[6] *Historisk statistik för Sverige*, Statistiska översiktstabeller (Stockholm: Statistiska Centralbyrån, 1960), 164.

[7] Asser Lindbeck, *Swedish Economic Policy* (Berkeley: University of California Press, 1974), 1.

demands. Reforms did not come about solely through political debates at Parliament (the *Riksdag*); there were also demonstrations and strikes, and sometimes outbursts of social protest culminated in a direct confrontation between the police (or military) and angry citizens. Trade unions, the most important of which was LO, the umbrella organisation of workers' unions that was founded in 1898, gradually became a powerful opponent of employers' institutions, and a political force in itself.

In addition to political, economic and social developments, Sweden was also changing culturally and 'mentally'. Little by little, the Lutheran Church of Sweden lost its power as a state authority and the principal institutional setting through which the sense of community was propagated.[8] In 1860, it became possible to become a member of any church and, in 1862, municipalities became self-governing, which meant that their direct connection to the Church disappeared. The pastor, who personified the state-church interconnection, was no longer both a spiritual and worldly authority in the reformed communities. The Church of Sweden began its transformation from a disciplinary and authoritative institution into an inclusive 'folk church' and a therapeutic institution. Rather than monitoring citizens and passing moral judgements, pastors began to listen and offer spiritual-therapeutic support to the flock. Yet, despite its attempts at modernisation and 'updating' of its core message, older religious mental habits were decisively on the decline, and the Church lost the administrative and normative grip it once had on the people. The Lutheran pastors, who formerly had a powerful influence on education and social care on the municipal level, came to have a more restricted and less important social role in the twentieth century, and the number of practising Christians decreased dramatically. Yet, full religious freedom was guaranteed by law only in 1951, which signalled the final break with the religious unity of traditional society.

Whereas the Lutheran Church started to lose in importance in the latter half of the nineteenth century, secular forms of education developed rapidly. In particular, the establishment of the nation-wide compulsory primary education (*folkskolan*) in 1842 meant that all parishes were forced to organise basic education for all children regardless of their parents' income or willingness to provide education to their

[8] Henrik Stenius, "The Good Life Is a Life of Conformity: The Impact of Lutheran Tradition on Nordic Political Culture," in *The Cultural Construction of Norden*, ed. Øystein Sørensen and Bo Stråth (Oslo: Scandinavian University Press, 1997), 162.

offspring. As historian Pia Lundquist Wanneberg has pointed out, "mass education helped to integrate all the citizens into the state and offered an opportunity to eliminate the differences and conflicts that belonged to the old society."[9] There were also changes at the secondary level: the traditional dominance of Latin and theology was criticised, and there was a demand for the incorporation of natural sciences and modern languages into the curriculum. Reforms in the early twentieth century updated curricula in secondary schools, and there were now a modern non-classical school (*Realskola*) and a gymnasium, which was divided into modern and traditional (with Latin) curricula. During the twentieth century, the influence of the Church on education was gradually minimised. Institutes of higher learning were also developing, albeit at a slower pace. The old university towns of Lund and Uppsala retained their positions as centres of intellectual culture, but new colleges (*högskolor*) were founded in Stockholm (1878) and Gothenburg (1891). In 1870, women gained the right to matriculate and study in a university (all in all, about one thousand young men and women matriculated annually around the turn of the century).

"A Bigger State Is a Better State".[10] *A Note on the* Folkhem

The ruling classes in early twentieth-century Sweden strived to efface class distinctions not only through carefully executed social reforms but also through a kind of 'embourgeoisement' of society. The elites entertained the hope that if one could instil bourgeois values in working-class people, this would create a sense of comradeship across social boundaries and minimise social friction: a worker and a manager would respect each other's feelings and talk out their differences. Indeed, the consensus-based ideology of the *Folkhem* that the social-democratic government started to promote in the 1930s seems to flow effortlessly from the by then traditional anti-antagonistic ethos of Swedish political culture. In a now legendary speech, leader of the Social-Democrats and the future prime minister Per Albin Hansson announced in 1928 that

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[9] Pia Lundquist Wanneberg, *Kroppens medborgarfostran* (Stockholm: Stockholms universitet, 2004), 223.

[10] Yvonne Hirdman, "Crisis: The Road to Happiness?," in *Culture and Crisis: The Case of Germany and Sweden*, ed. Nina Witoszek and Lars Trägårdh (New York: Berghahn Books, 2002), 161.

> the basis of home is togetherness and a sense of belonging. A good home doesn't make a difference between privilege, backwardness, between darlings and stepchildren… In a good home equality, thoughtfulness and cooperation rule.[11]

As Donald Sassoon, historian of socialism, has pointed out, the Swedish social democrats developed a standard model for the post-World War II European conception of social democracy. The political framework of such a model was made of the "compromise between labour and capital, with a welfare state and full employment".[12] The Social Democratic Party had been in government repeatedly after World War I, and, in the parliamentary elections in 1932, socialist parties received almost forty-two per cent of the votes. This marked the beginning of a triumphant era of social-democratic rule in Sweden, boosted by landslide victories in the elections of 1936 and 1940; in the latter elections, the socialists gained more than half of the votes (53,8 %). The Social-Democratic party remained in power continuously from 1933 until 1976, and has largely dominated the political scene throughout the past quarter of a century.

The secret of social-democratic success was that the party took a reformist and consensus-seeking rather than revolutionary and confrontational course when it came to power in 1932. Social-democrats were willing to make compromises with the owners of capital, which convinced the major industrialists that Swedish socialists were not intent on socialising the means of production. Indeed, the social-democrats made it clear that they wanted to manage capitalism through a corporate structure, the essential element of which was the policy of "permanent negotiations between employers, trade unions and government on labour market and social policies". The keystone of the 'reformed capitalism' of social democracy became "the 'class compromise' between labour and capital".[13] The social democrats managed to become the party of the state as well the voice of the people's movements, representing themselves as the party that best expressed national unity.[14] In social-

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[11] Quoted in Nina Witoszek, "Moral Community and the Crisis of Enlightenment," in *Culture and Crisis*, ed. Witoszek and Trägårdh, 58. On the concept of *folkhem*, see also Lars Trägårdh, "Crisis and the Politics of National Community," in *Culture and Crisis*, ed. Witoszek and Trägårdh, 75–109.

[12] Donald Sassoon, *One Hundred Years of Socialism: The West European Left in the Twentieth Century* (London: I. B. Tauris, 1996), 42.

[13] Ibid., 44.

[14] Lars Trägårdh, "Statist Individualism: On the Culturality of the Nordic Welfare

democratic ideology and rhetoric, the goal of history was Swedish social democracy.

As a result, Sweden became the leading welfare state in the world after World War II, a nation with a strong emphasis on the equilibrium between the core values of liberty and equality, a consensus-based democracy, full employment and an expansive, export-oriented economy, which accepted and even endorsed private industry. A political factor which played into the hands of the social democrats was that both bourgeois and extreme left-wing opposition to the hegemonic social democracy was ineffective, fragmented and exceedingly cautious. The economic downside of the social-democratic hegemony was the increasing rate of income tax and high public sector employment, which, because of the high level of public expenditure, had become a burden to the Swedish model. From the early 1990s onwards, the public sector has been systematically downsized, which, together with an open emigration policy, has changed the social structures, even if Sweden can still be called the leading welfare state in the world.

In Sweden, the 'triumph' of socialism meant the triumph of the social-democratic welfare capitalism that came to represent 'harmony in contrariety', a dynamic compromise between the opposites of the state and capital, and between *Gemeinschaft* and *Gesellschaft*. As historian Erik Ringmar has observed, "the Swedish nation was a creation of institutions completely controlled by the state—the Church, the universities, and the primary school system."[15] Throughout the period covered in this book, it was the state rather than civil society or an enterprising individual that was most responsible for the major changes in Swedish society. Swedish democracy could be called the 'people's democracy' (*folkdemokrati*)—it was founded on organicist, monistic thinking about a society which strives to avoid factionalism and tends to see conflicts and confrontations in terms of sickness, infection and defects in the body politic.[16]

State," in *The Cultural Construction of Norden*, ed. Sørensen and Stråth, 259; Henrik Berggren, "Den framåtvända ängeln—Nationalism och modernitet i Sverige under 1900-talet," in *Den svenska framgångssagan*, ed. Kurt Almqvist and Kay Glans (Stockholm: Fischer & Co., 2001), 80.

[15] Erik Ringmar, "The Institutionalization of Modernity: Shocks and Crises in Germany and Sweden," in *Culture and Crisis*, ed. Witoszek and Trägårdh, 39.

[16] On Swedish democracy as 'people's democracy', see Maciej Zaremba, *De rena och de andra* (Stockholm: Bokförlaget DN, 1999), 292–320. Zaremba refers to the following statement given in 1938 by the prime minister Per Albin Hansson, one of the main

From the liberal, pluralist perspective, there are elements in the Swedish welfare state that can be interpreted as having more sinister implications, such as restrictive paternalism; only a minor emphasis on the ideal of individual rights; pressure to conform; inordinate levelling tendencies and a cultivation of a mentality that puts a premium on averageness ('thou shall not stand out!');[17] political willingness to intrude in the private sphere of individuals and monitor the behaviour of citizens in different social contexts; and state-sponsored moralism, which fans a peculiar 'welfare nationalistic' spirit, encouraging the Swedes to regard their country as the best society in the world and as a moral superpower that sets the standards for other, morally and politically inferior nations (including all European countries south of Denmark).[18] Still, modern Sweden has hardly been an authoritarian state where Big Brother watches over the life of the citizens. With some modifications, the image of the free and independent peasant may be applied to the modern Swede, whom the welfare state has not made a passive and pampered citizen unable or unwilling to take responsibility for his or her behaviour and deeds. The self-image that the Swedes like to cultivate is that of a rational, pragmatic and forward-looking individual—even if this image may be partly illusory and self-congratulatory, there is no doubt that Sweden represents a type of modernity that is grounded in the Enlightenment ideals of reason and progress, and developing along the parameters provided by the democratic state. Sweden appears to have attained an uneasy equilibrium between the core values of liberty and equality.

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architects of *Folkhemmet* ideology: "Democracy does not in fact mean that individuals have a right to take action which is harmful to the general welfare." Quoted in Ibid., 316. Hansson referred here to the spontaneous 'antifascist' opinions in the country…

[17] On the 'culture of envy' that represses and minimises acts of individual brilliance (so-called Jante-lagen), see Bernd Henningsen, "Jante eller den skandinaviska medelmåttans lag. Om ett inslag i välfärdsstatsidentiteten," in *Den svenska framgångssagan?*, ed. Kurt Almqvist and Kay Glans, 181–96. It is worth noting that such a culture of envy has characterised the mentality of people in other Nordic countries as well. Thus it is not a uniquely Swedish phenomenon, although it has perhaps been more perspicuous in Sweden than anywhere else.

[18] Bo Stråth, *Folkhemmet mot Europa* (Stockholm: Tiden, 1993).

No Place for Übermensch

A reflection of the anti-antagonistic mentality of the modern Swedes is the fact that extreme ideologies and movements have had a hard time establishing themselves in Sweden. Neither communism nor fascism gathered momentum in Sweden, not even in the 1930s when fascist parties and groups gained political power in many European countries. When Hitler and the National-Socialists rose to the power in Germany, Sweden was developing into a modern social-democratic welfare state where violent, antagonistic attitudes and the elitist ideal of the Nietzschean *Übermensch* had no chance of survival. Still, many educated Swedes had close ties with Germany, and it was not uncommon to think that there existed both a racial and cultural bond between the two 'Aryan' nations of Sweden and Germany. Thus the middle classes in Sweden did not necessarily judge the Nazi Germany only in negative terms. Social groups that felt strong affinity with Germany included pastors,[19] teachers and physicians, who had a high regard for the spiritual, intellectual, and cultural achievement of the nation which had produced Luther, Goethe, Beethoven, and Robert Koch. Indeed, the Swedish medical profession was "rather disproportionately susceptible to some anti-democratic elitist ideologies".[20] One famous Swede who was surrounded by Germanophiles in his childhood and youth was the movie (and theatre) director Ingmar Bergman, one of the great cinematic geniuses. His father, a minister, supported the Nazis, and his brother was one of the founders of a (tiny) National-Socialist party in Sweden. This is how Bergman describes his upper-middle-class upbringing in Stockholm and Uppsala:

> Most of our upbringing was based on such concepts as sin, confession, punishment, forgiveness and grace, concrete factors in relationships between children and parents and God. There was an innate logic in all this which we accepted and thought we understood. This fact may well have contributed to our astonishing acceptance of Nazism. We had never heard of freedom and knew even less what it tasted like . . . Many of the

[19] For a study of Swedish churchmen who adopted the Nazi ideology, see Birgitta Brodd, *Var Sveriges sak också kyrkans? Svenska kyrkans utrikespolitiska aktivitet* (Skellefteå: Norma, 2004), Chapter 6.

[20] Arnold J. Heidenheimer, "Conflict and Compromises between Professional and Bureaucratic Health Interests 1947–72," in *The Shaping of the Swedish Health System*, ed. A. J. Heidenheimer and Nils Elvander (London: Croom Helm, 1980), 122.

> teachers were National Socialists, Nazi-adherents, some from foolishness or bitterness over their failure to gain academic advancement, others from idealism and veneration of the old Germany, 'a nation of poets and thinkers'… Our history teacher worshipped 'the old Germany', our gymnastics teacher went to officers' meetings in Bavaria every summer; some of the pastors in the parish were crypto-Nazis and the family's closest friends expressed strong sympathies for the 'new Germany'.[21]

In her study of the development of the Swedish medical profession, historian Motzi Eklöf has examined the ideas of some extreme right-wing physicians and the overall Germanophile attitudes of the medical community in Sweden.[22] Although there were only very few active supporters of National Socialism among Swedish doctors, there seemed to be a rather widespread sympathy for developments in the Third Reich in the 1930s. Furthermore, anti-Semitic attitudes were rather common in the medical community, and, in general, "anti-Jewish ideas were deeply rooted in all social classes".[23] Even if there was not anything like a systematic oppression of Jews in Sweden, Eastern Jews (mostly from Poland or Russia) were a specific group of immigrants who were discriminated against when they applied for Swedish citizenship.[24]

Israel Holmgren, professor at the Karolinska Institute medical school, wrote in his memoirs that the whole of Swedish society, including the Society of Medicine, was infected by Nazism. This was an exaggerated statement, for there were also fierce opponents of Nazism in the Swedish medical profession, and Swedish society was quite resistant to the more virulent forms of Nazi ideology. Still, there is no doubt that many Swedish doctors had affinities with the 'new Germany'. The Swedish-German friendship association (*Riksföreningen Sverige-Tyskland*), which was founded in 1937 to contribute to the 'just evaluation of the new Germany', had 199 doctors enlisted as members. Israel Holmgren was not one of them: he was in fact actively involved in anti-Nazi activities. During the war, he was sentenced to four months in jail for

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[21] Ingmar Bergman, *The Magic Lantern*, trans. Joan Tate (Harmondsworth: Penguin, 1988), 8, 113, 123.

[22] Motzi Eklöf, *Läkarens ethos. Studier i den svenska läkarkårens identiteter, intressen och ideal 1890–1960* (Linköping: Linköpings universitet, 2000), 65–70.

[23] Carl Henrik Carlsson, *Medborgarskap och diskriminering. Östjudar och andra invandrare i Sverige 1860–1920*, Studia Historica Upsaliensia 215 (Uppsala: Uppsala universitet, 2004), 316 (English summary).

[24] Ibid., 318 (English summary). On the history of antisemitism in Sweden during the years 1880–1930, see also Mattias Tydén, *Svensk antisemitism 1880–1930* (Uppsala: Centre for Multiethnic Research, 1986).

his anti-German booklet on 'Nazi Hell' (*Nazisthelvetet*, 1942) which was confiscated by the authorities. For the new edition of the booklet, he changed the title to 'Nazi Paradise' (*Nazistparadiset*, 1943), but it did not make any difference to the authorities. He never went to jail, however, for, to his dismay, he was pardoned when a number of renowned public intellectuals pleaded for him. After the war, he was honoured as a fierce opponent of Nazism.[25]

Health of a Nation

What was the state of health of Swedes around 1900? First of all, the average life expectancy was fifty-seven years for women and fifty-five years for men. Second, nutrition was often one-sided and inadequate, consisting of salted Baltic herring, pork fat and potatoes. Third, in Stockholm, which was by far the largest town in Sweden with its 300,000 inhabitants, it was not that uncommon for a working-class family with four-five children to live in a one-room apartment. Fourth, houses were populated by vermin and rats. Fifth, the level of hygiene was poor and infant mortality was twenty per cent. Sixth, in urban centres, infectious diseases spread easily and every eighth person in Sweden died of tuberculosis—about two thirds of the adult population had consumption at some point in their lives. Seventh, public hospitals were mostly populated by the poor, who were unable to make a living due to sickness or disability; those who could afford it had family doctors, consulted private practitioners, or went to private sanatoria, nursing homes and clinics.

The most common fatal diseases were respiratory diseases, especially pneumonia, bronchitis and tuberculosis, the deadliest of all diseases. Infants died of such diseases as mumps, measles and scarlet fever, which are relatively harmless today. Polio and rickets were the two other diseases that haunted children. As there were only about 300 district medical officers scattered around the country, which was bigger than France, and as medical knowledge and technology were still inadequate and unable to conquer many infectious diseases, the sick did not often

[25] Israel Holmgren, *Mitt liv* (Stockholm: Natur och Kultur, 1959); Eklöf, *Läkarens ethos*, 69; and Nanna Svartz, "Holmgren, Israel," in *Svenskt Biografiskt Lexicon* (Stockholm: Norstedts, 1973), Vol. 19, 264–8.

receive any medical treatment at all. People in the countryside were often dependable on quacks, and even if the sick consulted a physician, they often could not afford to pay for the prescribed medicine. On top of this, the consumption of alcohol was high: in Stockholm, an average annual consumption of cheap liquor was 16,6 litres per capita. Alcoholism was one of the 'national diseases' and there was an active temperance movement in Sweden, which aimed at the total prohibition of alcohol (the term 'alcoholism' was coined by the Swedish physician Magnus Huss in his famous mid-nineteenth century study of this 'illness'). As medical historian George Drinka writes, "the morose Swedes were notorious in the nineteenth century for their rampant alcoholism, just as the indolent Chinese were for their consumption of opium".[26]

Swedes drank a lot, but otherwise they were healthier than most Europeans. As Henrik Berg, physician and author of popular medical manuals, observed in 1903, the mortality rate was lower (1,6 %) in Sweden than in any other European country, and between the ages of fifteen and seventy-five the mortality rate in all age groups was about twenty-five per cent lower in Sweden than in western European countries in general; infant mortality was also lower in Sweden than in any other country. In an elevated mood, Berg announced that the nineteenth century witnessed a revolution in practically all areas of human life, including health. Challenging therapeutic nihilism that saw diseases as comprising a natural part of life, he gave a list of great medical achievements and noted that never before had medicine made such advances as it did in the nineteenth century.[27] As a result of medical advances and the professionalisation of physicians in the nineteenth century, medicine claimed to be more a rational science than an inexact art.

One peculiarity of the Swedish health care system has been (and still is) that the system is run by municipalities and administrative authorities in the county assemblies (*Landstinget*). The Swedish health care system has traditionally been publicly funded, but not state-governed. Another Swedish peculiarity is that, in contrast to the Anglo-American understanding of medicine as a free profession, Swedish medicine has been dominated by academic physicians who have simultaneously been representatives of the state. This collective self-understanding of the

[26] Drinka, *The Birth of Neurosis*, 50.
[27] Berg, *Läkareboken I*, 8.

medical profession as the Platonic physician-guardians of the health of the nation was an essential ideological component in the twentieth century Swedish health policy.

Mental Health of a Nation

What about the state of *mental* health care in Sweden? The first modern hospital for the mentally ill was founded in the little town of Vadstena in 1826. Somewhat later, another central hospital, Danviken, was opened near Stockholm.[28] The physician employed at Vadstena, surgeon Georg Engström, was the first Swedish doctor who can be called a psychiatrist. Until the 1820s, there had been a large number of smaller lunatic wards in Sweden, and doctors had had to compete with pastors, who had traditionally represented authority in the field of mental illnesses by, for example, exorcising 'evil spirits' from the possessed.[29] Now Parliament wanted to close these wards and reform mental health care so that it would be more in line with the development of medicalised health care in general.[30] At that time, the state was also concerned with compulsory primary school education and prison reform, and the trend towards the centralised mental asylum may be seen as the 'birth of the social' in the mid-nineteenth century Sweden. The authorities had an ambition to reform and educate criminals, workers and the poor by changing their behaviour patterns and modes of thinking.[31] The ideals of individual self-control, social stability and moral order were at the centre of these governmental policies, which were "influenced by the

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[28] For the history of Swedish mental health care in the nineteenth century, see Roger Qvarsell, *Ordning och behandling: Psykiatri och sinnessjukvård i Sverige under 1800-talets första hälft* (Umeå: Umeå Universitet, 1982); and "Locked Up or Put to Bed: Psychiatry and the Treatment of the Mentally Ill in Sweden 1800 to 1920," in *The Anatomy of Madness: Essays in the History of Psychiatry*, Vol. II, ed. W. F. Bynum and Roy Porter (London: Tavistock Publications, 1985), 86–97. For an account of daily practices in the mental asylum in Danviken, see Eva Eggeby, "'…Tills med honom bättre warder…'—Vård och vardag på Danvikens dårhus under 1800–talet," in *Hur skall själen läkas?*, ed. Bengt Erik Eriksson and Roger Qvarsell (Stockholm: Natur och Kultur, 1997), 47–75.

[29] Bengt Erik Eriksson, *Vägen till centralhospitalet* (Göteborg: Daidalos, 1989); and "Före psykiatrin—Praktiska omständigheter och kunskapsmässiga sammanhang," in *Hur skall själen läkas?*, ed. Eriksson and Qvarsell, 27–46.

[30] For a study of the history of mental health care in Sweden from the Middle Ages to the mid-nineteenth century, see Eriksson, *Vägen till centralhospitalet*.

[31] Frans Lundgren, *Den isolerade medborgaren: Liberalt styre och uppkomsten av det sociala vid 1800-talets mitt* (Hedemora: Gidlunds Förlag, 2003).

social and moral ideals of the expanding intellectual middle class".[32] This reformistic optimism, together with the increase of rationalised and centralised state control over citizens in general and the lower classes in particular, characterises the development of mental health system in the nineteenth century Sweden.

The first law concerning the mental asylum system came into force in 1858, more than thirty years after the establishment of the first mental hospital in Vadstena. The law emphasised that the therapeutic goal of the hospital was to cure the mentally ill and send them back home again. Easier said than done…A few years later, in 1859, psychiatry was established as a medical specialty, when the first clinical lectures to medical students were given by the asylum doctor Gustav Kjellberg at the University of Uppsala. Two years later, a two-month course in psychiatry became compulsory for medical students in Uppsala. Karolinska Institute, the medical school in Stockholm, appointed the first professor of psychiatry in 1861, three years before the first chair in psychiatry in Germany was created for Wilhelm Griesinger in Berlin, and nine years before Austria-Hungary appointed its first chair in psychiatry.[33] In 1863, Kjellberg, who became professor of psychiatry in Uppsala, published the first textbook of psychiatry in the Swedish language. In it, he divided mental illnesses into eight distinct disease entities, and his classification was adopted as the basis for the official diagnostic categories of mental illness, which began to be used in all hospitals.[34] As historian of medicine Roger Qvarsell has observed, the fact that psychiatry in Sweden became a scientific discipline decades *after* the centralised organisation of mental health care was established, suggests that the large asylums were a precondition for the rise of psychiatry as a medical science. Patients in these asylums provided physicians with the necessary 'clinical material' on which to develop diagnoses, classifications, theories and methods of treatment.[35]

The first two or three generations of Swedish psychiatrists were influenced mainly by French and German medicine, and, in accordance with the dominant German neuropsychiatric approach of the latter half of

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[32] Qvarsell, "Locked Up or Put to Bed", 96.

[33] Albrecht Hirschmüller, "The Development of Psychiatry and Neurology in the Nineteenth Century," *HP* 10 (1999): 400.

[34] Frans Luttenberger, *Freud i Sverige. Psykoanalysens mottagande i svensk medicin och idédebatt 1900–1924* (Stockholm: Carlssons, 1989), 102.

[35] Roger Qvarsell, *Vårdens idéhistoria* (Stockholm: Carlssons, 1991).

the nineteenth century, they usually presented mental illnesses as being similar to somatic disorders and diseases. In this somatic view, the insane suffered from lesions in or damages to the central nervous system. The somatic view of mental illnesses was also reflected in the way mental hospitals began to be organised in the late nineteenth century. Patients in mental hospitals were treated as if they had somatic illnesses, and, just like patients in general hospitals, they were put to bed. Another important principle that was implemented in mental hospitals was the constant supervision of the sick.[36]

In 1900, a large minority (41,3 %) of mental patients were peasants, and the great majority (87 %) lived in the countryside.[37] Another large group of patients consisted of artisans and small entrepreneurs. Among those who were admitted to asylums in 1900 there was one academic, one 'capitalist' and three artists.[38] Of the patients who had been admitted between the years 1890 and 1900, a little more than thirty-three per cent had regained their health (43,5 per cent of those whose illness had lasted for less than two years before admission).[39]

Gradually, the therapeutic optimism of the early period of the Age of Asylum gave way to a more pessimistic mood among psychiatrists and the medical authorities, not only in Sweden but in all developed western societies. The problem was not only that modern hospitals did not manage to cure the majority of the insane; there was also another, even more alarming problem: the number of the mentally ill was growing all the time. In Sweden, the official number of the mentally ill rose from 7,542 in 1870 to 16,312 in 1900, while the number of hospital beds for the mentally ill grew from 1,322 to 5,056 during these three decades—in one generation, the number of the insane more than doubled, and the number of beds almost quadrupled.[40] At the turn of the century, there were fourteen hospitals for the mentally ill and only twenty-eight doctors working in these asylums. In 1900, a new asylum with no less than 800 beds in Uppsala was opened, and in the next half a century more and more asylums were established. In proportion to the

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[36] Qvarsell, "Locked Up or Put to Bed", 94.

[37] *Bidrag till Sveriges officiella statistik för år 1900, Helso- och sjukvården I* (Stockholm: P.A. Norstedt & söner, 1900), 3, 22.

[38] Ibid., 13.

[39] Ibid., 15.

[40] *Historisk statistik för Sverige*, *Statistiska översiktstabeller*, 157; Karin Johannisson, "Folkhälsa: Det svenska projektet från 1900 till 2:a världskriget," *Lychnos* (1990): 149.

population, there were probably more institutionalised mental patients in Sweden by the early 1970s than anywhere else in the world.[41]

The status of psychiatry as a medical science was undermined by these alarming developments, and some newspaper reports about cases in which healthy persons were declared legally incompetent fuelled an anti-psychiatric mood both among laymen and other medical professionals. As a consequence, the professional status of psychiatrists was rather low at the turn of the twentieth century. At the same time, there was no doubt that psychiatry was becoming more and more important and socially visible as a medical discipline: new hospitals were built, the number of patients was increasing rapidly, and more patients representing the middle and upper classes consulted psychiatrists. The question of the mental health of the nation had become a matter of considerable concern to the medical authorities.

[41] Frans Luttenberger, "Striden mellan David och Goliat—Psykoanalytiska och psykodynamiska synsätt i svensk medicin," in *Psykiatrins marginaler*, ed. Roger Qvarsell and Bengt Erik Eriksson (Linköping: Linköpings universitet, 1997), 39.

CHAPTER TWO

HOW SWEDES BECAME NERVOUS

In the nineteenth century, the grand dame of the neuroses was hysteria, which had been around as a female illness since antiquity. It made a diagnostic come-back in the 1880s, by which time the medical discussion of hysteria had become more scattered and confused.[1] Discovery of the process of ovulation, the doctrine of animal magnetism and the notion of the 'hysterical constitution' that laid stress not on the physical symptom profile but on negative character traits, such as eccentricity, impulsiveness and hypersexuality, all had their impact on the medical representation of hysteria. That these negative traits of the hysterical constitution were usually attributed to women contributed to the revival of the ancient notion that hysteria was a female malady. It was the British physician Thomas Sydenham who, apart from the psychologisation of hysteria, had set the stage for a conceptualisation of the feminine 'constitution' as 'weak' and 'nervous' in the eighteenth century. This prejudice about the inferior feminine constitution became one of the medical cornerstones of late nineteenth-century misogynistic language (see Chapter 5). Hysteria was by its very nature a protean illness, functioning as a diagnostic *tabula rasa*, the content of which was determined by socio-cultural factors.[2]

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[1] As Mark Micale observes, the "sheer accumulation of meanings of hysteria a hundred years ago is extraordinary. In France during the late nineteenth century, hysteria was employed as a metaphor for: artistic experimentation, collective political violence, radical social reformism, and foreign nationalism. It became shorthand for the irrational, the will-less, the uncontrollable, the convulsive, the erratic, the erotic, the ecstatic, the female, the criminal, and a host of collective 'Others'. It was a synonym for everything that seemed excessive, or extreme, or incomprehensible about the age." Mark S. Micale, "Discourses of Hysteria in Fin-de-Siècle France," in *The Mind of Modernism: Medicine, Psychology, and the Cultural Arts in Europe and America 1880–1940*, ed. Mark S. Micale (Stanford: Stanford University Press, 2004), 84.

[2] Micale, *Approaching Hysteria*; Gilman et al., *Hysteria beyond Freud*.

The Introduction of 'Neurosis'

Together with hysteria, 'neurosis' became cultural illness *par excellence*. In 1769, the Scottish physician William Cullen used the term 'neurosis' in his *Synopsis Nosologiae Methodicae* to refer to the then established concept of 'nervous disease'. Cullen referred to the two famous British physicians, Francis Willis and Thomas Sydenham, and stated that "since the time of Willis, British physicians have grouped some diseases under the category of nervous".[3] By the late eighteenth century, an understanding of the mechanism of the nervous system had become more advanced, and this signified in part a clean break with traditional Galenic medicine. For Cullen and his neurologist successors, the nervous system was believed to be the unitary principle regulating all organic functions. Cullen, who invoked the idea of the hysterical womb that his eminent predecessors, Willis and Sydenham, had rejected, called 'neuroses' those 'nervous diseases' which were thought to result from dysfunction in the unitary regulator. The two most common such diseases at that time were hysteria and hypochondriasis, the latter signifying a dysfunction afflicting males. Cullen differentiated between general and local diseases, the first group comprising three classes, 'neuroses' among them. He then subdivided neuroses into four orders, arguing that neuroses resulted from "general alterations of the nervous system".[4] In his *more botanico* taxonomy, he was following in the footsteps of Carl Linné, the famous Swedish botanist who did groundbreaking work in creating a basic classificatory system in botany.

Cullen's ideas were widely disseminated through foreign translations of his works (in Germany, neurosis was translated as *Nervenkrankheit*), and his reputation as an outstanding medical scientist helped immortalise the concept of neurosis. In the nineteenth century, Cullen's broad, vitalist concept of neurosis was challenged by the new generation of neurologists, whose anatomo-clinical model saw all diseases as reducible to an anatomical lesion. Cullen's vitalist notions of the 'principle of life' and his broad taxonomic system of neuroses were discredited by nerve pathologists, but he remains an important figure in the history of neuroses, for it was he who coined the term, deliberated widely on the nature of nerve diseases, and influenced a number of physicians

[3] Cullen, quoted in López Piñero, *Historical Origins*, 1.
[4] Cullen, quoted in ibid., 15.

concerned with mental illnesses. Cullen regarded neuroses as physical diseases—diseases of the nerves and the muscles—, and this 'organic' formulation of neurosis was to stand in stark contrast to the 'functional' and 'psychological' approaches to neuroses that came to the fore during the final decades of the nineteenth century.

In western Europe, the idea of the importance of the central nervous system made 'nervousness' something of a buzz-word among doctors and patients alike by the early nineteenth century. It did not require too much clinical acumen to diagnose the ailment of a patient as deriving from 'nerves', and nervous disorders became stock-in-trade in the medical profession. The patients, especially the affluent ones, learnt to articulate their complaints in the language of nerves, and it was relatively easy for doctors to link these nervous complaints to all kinds of diseases, especially mental illnesses. Characteristically, the full emergence of nervous disorders went hand in hand with the rise of the notion that 'irritation of the mind' could explain pathological states and phenomena, such as drunkenness and 'sexual deviancies' (e.g. masturbation).

During the first half of the nineteenth century, the anatomo-clinical approach became dominant in European medicine, and this trend was especially developed in German psychiatry in the latter part of the century. Neuropsychiatrists in German-speaking Europe (Hitzig, Meynert, Westphal, Wernicke, etc.) were research-oriented champions of the physiological study of mental and nervous illnesses, and they proposed that these illnesses were caused by undetected lesions of the nervous system or the brain. Their organic approach to mental disorders held sway until the turn of the twentieth century, by which time it had become apparent to the medical community that the somatic approach had failed to shed light on the mysteries of insanity. Yet, the failure of biological psychiatry did not mean that physicians kept on groping around in total darkness. During the latter part of the century, a number of ailments then classified as neuroses proved to have an organic basis, or to be merely symptoms and not diseases at all. The two major neuroses, hysteria and hypochondriasis, were reformulated between 1850 and 1880 so that hysteria came to represent solely the category 'major neuroses', while hypochondriasis was broken down and its elements subsumed under different psychiatric diagnoses.[5] As

[5] On the history of hypochondria, see Esther Fischer-Homberger, *Hypochondrie:*

for the 'minor neuroses' such as the neuralgias, they were no longer considered neuroses at all, but were classified as a separate group of nervous diseases.

What was of crucial importance to the emergence of neuroses was that a new understanding of health and illness had emerged in mental medicine during the latter half of the nineteenth century. The binary opposition between insanity and mental health began to be replaced by the view that there exists an intermediate zone or a grey area between insanity and health; the *demi-fous*, or half-mad. As historian Jan Goldstein has noted,

> this conceptual move eventually led to the articulation of two categories fundamental to the enterprise of twentieth-century psychiatry: the 'psychotic', whose contact with reality is severely ruptured, and the 'neurotic', whose minimal maladaptations do not preclude getting on in ordinary society.[6]

Regarding development within this category, instead of placing neuroses in two major categories of hysteria and hypochondriasis, physicians started to 'find' intermediate and 'specific' neuroses, such as 'spinal irritation' and 'reflex neuroses', which were placed between hysteria and the now obsolete 'minor neuroses'.[7] Hence, neurosis became not only a generic term for functional nerve illnesses; it was also to become a major psychiatric category for more than a hundred years.

Charcot's Clinic at the Salpêtrière

In the final quarter of the nineteenth century, the work of the French clinical neurologist Jean-Martin Charcot (1825–1893), *prince de la science*, completely dominated medical discussion of hysteria.[8] His great contribution to the study of neuroses was his formulation of a neurological

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Melancholie bis Neurose (Bern: Hans Huber, 1970): Susan Baur, *Hypochondria: Woeful Imaginings* (Berkeley: University of California Press, 1988). On hypochondria in Swedish medicine, see Karin Johannisson, *Kroppens tunna skal: Sex essäer om kropp, historia och kultur* (Stockholm: Norstedts, 1997), 103–34.

[6] Jan Goldstein, "Psychiatry," in *Companion Encyclopedia of the History of Medicine*, ed. Bynum and Porter, 1364.

[7] See Shorter, *From Paralysis to Fatigue* for a historical account of these 'specific neuroses'.

[8] On Charcot's life and work, see Christopher Goetz, Michel Bonduelle and Toby Gelfand, *Charcot: Constructing Neurology* (Oxford: Oxford University Press, 1995).

model of hysteria. Following Paul Briquet's pioneering work on hysteria, Charcot conceptualised hysteria as a physical dysfunction of the central nervous system, which made the illness comparable to other neurological diseases, such as epilepsy, paralysis agitans (Parkinson's disease) and general paresis of the insane. Although he was unable to locate a lesion in the nervous system of the hysterics, he was adamant in his conviction that the clinicians applying the methods of pathological anatomy would eventually discover a lesion causing hysterical neuropathy in the nervous system. He saw hysteria as constitutional and degenerative, a pathological result of both inheritance and environmental factors, such as physical or emotional shock. He maintained that an alleviation of symptoms was all that a doctor could do to help the hysterical patient, but while he did not pay much attention to cure and potential therapies, he was

> famed for the miraculous cures in which the power of his commandment alone repeatedly enabled paralytic individuals (no doubt largely hysterics) to throw off their crutches and walk.[9]

Charcot's reputation spread far and wide partly because he was master showman. He had an extensive population of hysterical women in the well-stocked wards at the Salpêtrière, an enormous hospital for women, most of whom were near to or at the bottom of the social hierarchy. Charcot took full advantage of these mostly working-class women in the lectures he presented to large audiences and in his more informal bedside demonstrations to his pupils. His fame rested not on any ingenious theoretical treatises on hysteria, but on his case studies: he published over 120 richly-illustrated case histories that fully revealed the drama that was hysteria, *Grande Hystérie* in particular. His female hysterics (and 'epileptics') were immortalised in visual representations, especially in the etchings of Paul Richer and the photographs published in the periodical *Iconographie photographique de la Salpêtrière* (1876–79) and its successor, *Nouvelle iconographie de la Salpêtrière*, which were impressive visualisations of hysteria.[10] There was a 'photographic department' attached to Charcot's clinic, showing how important the concrete bodily representation of hysteria was for Charcot and his colleagues.

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[9] Frank J. Sulloway, *Freud, Biologist of the Mind*. 1st ed. 1979 (Cambridge, MA: Harvard University Press, 1992), 28.

[10] On the visualisation of hysteria at Charcot's clinic, see Georges Didi-Huberman and Maud M. Lavin, *Invention of Hysteria: Charcot and the Iconographie Photographique de la Salpêtrière* (Cambridge, MA: The MIT Press, 2004).

One of Charcot's basic contentions with regard to hysteria was that it was directly linked to hypnosis. In the 1870s, Charcot took up the study of hypnotism, which had fallen into disrepute, and, in February 1882, delivered a famous paper on hypnotism at the Academie des Sciences. In his paper, he gave explicit support to the phenomenon of hypnotism, describing in detail the three sequential stages of the hypnotic trance: lethargy, catalepsy and somnambulism. His paper created a stir amongst the French academic community, and, with the help of his considerable scientific authority, he managed to make the study of hypnosis a respectable scientific and medico-clinical activity.

A chair in nervous diseases was created in 1882 especially for Charcot; it was the first chair in neurology in the world—and, interestingly, the next European country to establish a chair in neurology was Sweden (in 1887). Also of paradigmatic importance for the future development of the care of neuroses was the opening of the first out-patient clinic at the Salpêtrière in 1879. The majority of patients in the neurological and psychiatric polyclinics, which started to be established across Europe at the turn of the century, suffered from milder mental afflictions, which made neurosis a very visible illness to the physicians. If asylums were swelling with the more severely mentally ill, psychiatric and neurological polyclinics were usually attended by people who were neither insane nor in full health; their symptoms were more diffuse and less severe, and, unlike the mentally ill, they could safely remain in the outside world. At Charcot's clinic, there were not only female hysterics, since there was a large ward for epileptics, a thirty-bed ward for children and a fifty-bed ward for men. Patients in the men's ward provided Charcot with clinical material which proved how hysteria was not exclusively a female malady (he fixed the ratio of male to female hysteria at roughly 1:20). Indeed, he published sixty-one case studies of male hysterics, and left notes on many more.

During the last years of his life, Charcot developed an explanation for hysteria that put forward an idea of the *psychogenic* nature of hysteria. At this point, his association between hypnosis and hysteria, and his bold conjectures about the hitherto hidden mechanism of hysterical phenomena, made Charcot's reputation more controversial. His demonstrations of the way he could artificially induce hypnotic fits among his female patients (some of whom became minor celebrities among the public) was spectacular, but not necessarily convincing to other physicians. The results of his hypnotic experiments with the 'hysterically prone' patients were categorically denied by Hippolyte Bernheim, professor of

internal medicine at the University of Nancy. Bernheim and his like-minded colleagues (who comprised the so-called Nancy school) regarded hysteria as an abnormal psychological reaction that was not 'triggered' by hypnosis. They maintained that, in specific situations, almost *anyone* could become hysterical, and that the mechanism of hysteria could be accounted for by heightened suggestibility, not by an innate neuropathic disposition or Charcot's auto-suggestion. The Nancy School's direct challenge to Charcotian doctrine made Charcot's explanation of hysteria look implausible and suspicious.[11] When Charcot died in 1893, his reputation as a theorist of hysteria was in decline, and by the turn of the twentieth century, Charcotian approach to hysteria was largely discredited in academic and medical circles, only to make a comeback in France during World War I, when the phenomenon of shell-shock made the Charcotian understanding of trauma topical again.[12] At the same time, Bernheim and his colleagues at Nancy were instrumental in launching a new, distinctly *psychological* approach to neuroses and their treatment. With regard to neuroses, this transition from a neurological-physiological model to a psychological one was also advanced by some of Charcot's former pupils, such as Pierre Janet, who, like Bernheim, suggested that hysteria was a mental malady.

Traumatic Neurosis

During the second half of his career, Charcot made an intensive study of 'trauma', variously dubbing this new diagnostic entity as 'traumatic neurosis' (*les névroses traumatiques*), 'traumatic hysteria' or 'hystero-traumatism'.[13] In contrast to hysteria, most of his writings about trauma deal with (the working-class) male patients, who exhibited curious syndromes following a minor bodily injury: motoric and sensory disturbances, fatigue, headache, dizziness and fainting spells occurred frequently, but emotional troubles could also be part of the symptom profile. One

[11] According to Axel Munthe, "To speak of the Nancy School at the Salpêtrière was in those days considered almost as an act of lèse-majesté. Charcot himself flew into a rage at the very mentioning of Professor Bernheim's name." Axel Munthe, *The Story of San Michele* (London: John Murray, 1975), 219.

[12] Mark S. Micale, "Jean-Martin Charcot and les névroses traumatiques: From Medicine to Culture in French Trauma Theory of the Late Nineteenth Century," in *Traumatic Pasts*, ed. Micale and Lerner, 131.

[13] Ibid., 116.

conspicuous feature of these symptoms was that they appeared weeks or months after the physical or emotional injury, and that by using hypnosis Charcot was able to artificially reproduce paralyses that had originally appeared in the patient in conjunction with the physical trauma. This was quite a medical achievement indeed, but it seems that Charcot's clinical material in fact contradicted rather than supported his theory concerning post-traumatic amnesia.

Earlier in the century, there had been some medical interest, especially in Britain, in the neurological and psychiatric symptoms seen to be connected with head and spinal injuries. This line of clinical work continued in the 1860s, when John Erichsen, a professor of surgery in London, published *On Railway and Other Injuries of the Nervous System* (1866), a series of lectures where he described the impact of rail travel in general and train accidents in particular. The idea of 'railway spine' was introduced in his book, and it was the first time so-called 'post-traumatic' symptoms were studied systematically. Erichsen's book inspired other British physicians, such as Herbert W. Page, and in the new conceptualisation of the 'neuroses of the railway' more attention was paid to the mind than to the brain and the spine. During the last quarter of the century, railways were often judged responsible for mental shocks.[14]

Besides Charcot, the main theorist behind traumatic neurosis was the German neurologist Hermann Oppenheim, whose 1889 monograph introduced the idea that there is a direct link between an accident and the injury to a "pathologically altered psyche with abnormal reactions".[15] According to Oppenheim, traumatic neurosis was made up of both somatic and psychogenic components, because it was a pathological mental condition deriving from a minor physical injury or traumatic experience. In his monograph on traumatic neuroses, he presented forty-one case histories, sixteen of which seemed to be linked to railway accidents. Only two of his patients were women; nearly all were male workers or railway employees. Both in France and Germany, therefore, traumatic neurosis was characteristically a *male* neurosis. In contrast to

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[14] Ralph Harrington, "The Railway Journey and the Neuroses of Modernity," in *Pathologies of Travel*, ed. Richard Wrigley and George Revill (Amsterdam: Rodopi, 2000), 229–60.

[15] Oppenheim, quoted in Wolfgang Schäffner, "Event, Series, Trauma: The Probabilistic Revolution of the Mind in the Late Nineteenth Century and Early Twentieth Centuries," in *Traumatic Pasts*, ed. Micale and Lerner, 83.

Charcot, however, Oppenheim wanted to keep hysteria and traumatic neurosis diagnostically separate, and he laid stress on the primary pathogenic effects of traumatic experiences rather than on the secondary mental processes with which Charcot was preoccupied.

In its linking of physical trauma (such as a blow to the head or arm) resulting from an accident with pathological mental symptoms, Oppenheim's medical theory became part of concrete social policy in 1884, when Bismarck's accident insurance law came into force in the recently unified Germany.[16] Traumatic neurosis became an element in the nascent welfare state, and there was hot debate in medical circles and among members of insurance boards about the genuine existence of such a mental malady. In the early twentieth century, the German medical authorities adopted the view that it was the insurance itself, and not the accidents, that produced traumatic neurosis, because it prompted individuals to abuse the social insurance system by simulating symptoms of trauma.[17]

This change in the perception of traumatic neurosis signalled the deathblow to Oppenheim's original theory. Traumatic neurosis became a 'pension neurosis' (*Rentenneuros*), which conveyed the notion that it was in fact insurance that triggered psychic traumas. Although, as historian Paul Lerner points out, "the actual numbers of psychological cases never exceeded one to two percent of all accident insurance claims",[18] fear of malingering and detrimental social consequences of 'pension neurosis' was wide-spread in Germany. After World War I, there was pressure to change the insurance legislation, and, in the mid-1920s, the *Reichstag* overturned the 1889 legislative act, which meant that employees suffering from mental trauma could no longer expect to have any compensation from the insurance agencies. As a result, traumatic neurosis was legislated out of existence in Germany.[19] In Sweden, traumatic neurosis remained a minor neurosis, and its link with the insurance legislation was much weaker than in Germany, simply because the compulsory national insurance pension, which afforded an annual sum based on

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[16] Paul Lerner, "From Traumatic Neurosis to Male Hysteria: The Decline and Fall of Hermann Oppenheim, 1889–1919," in *Traumatic Pasts*, ed. Micale and Lerner, 149–50.

[17] Lerner, "From Traumatic Neurosis to Male Hysteria"; and Paul Lerner, *Hysterical Men*.

[18] Lerner, "From Traumatic Neurosis to Male Hysteria," 150.

[19] Lerner, "From Traumatic Neurosis to Male Hysteria;" Lerner, *Hysterical Men*, 223–48.

income at the age of retirement, came into force only in 1913, at a time when traumatic neurosis was becoming an even more marginal diagnosis in Swedish medicine.

As it affected only a comparatively small minority of workers, traumatic neurosis, unlike hysteria, never attained the status of a 'grand neurosis'. It required a new, cross-class and more gender-blind neurosis to really introduce the Age of Nervousness. These basic requirements were aptly filled by a diagnosis revolving around 'nervous asthenia' or 'nervous exhaustion': neurasthenia.

The Breakthrough of Neurasthenia

In 1880, when Charcot was busy studying hysterics at the Salpêtrière, an American physician, George Beard, published a book on a new type of nervous illness that he called 'neurasthenia'; literally 'weakness of the nerves'.[20] His book hit the jackpot, as it were, and, among nerve illnesses, catapulted neurasthenia to international stardom. In the late 1860s, Beard had reconceptualised 'spinal' neuroses by expanding the domain of 'spinal irritation' from the spinal cord to the cerebrum. In 1869, he had published his first paper on neurasthenia—the term 'neurasthenia' was not his invention, for it had been in use at the beginning of the nineteenth century in German Romantic medicine.[21]

Evidently, Beard was in the right place at the right time when he suggested that neurasthenia was the common origin of a staggering variety of symptoms that signalled profound physical and mental exhaustion. A nerve doctor and specialist in electrotherapy, Beard practised in New York, where his specialty was the 'functional nervous disorders'. Such disorders differed from organic disorders in that there was no organic or anatomic lesion to be found in the nervous system of the patient. Physicians did not believe that 'functional' meant 'non-organic'—much as they would have liked to, they just could not detect any anatomic lesion or alteration in the nervous system. Thanks to the germ theory of

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[20] Beard, *A Practical Treatise on Nervous Exhaustion (Neurasthenia)*; see also George M. Beard, *American Nervousness, Its Causes and Consequences* (New York: Putnam's Sons, 1881); George M. Beard, *Sexual Neurasthenia (Nervous Exhaustion)*, ed. A. D. Rockwell (New York: E. B. Treat, 1884).

[21] On the history of neurasthenia in different national contexts, see Marike Gijswijt-Hofstra and Roy Porter (eds), *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam: Rodopi, 2001).

disease, developed by Pasteur in France and Robert Koch in Germany, late nineteenth-century physicians began to be able to determine the underlying *aetiology* behind symptoms. The discovery of micro-organisms responsible for major diseases (such as general paralysis) also confirmed the belief that 'functional' denoted "conditions which had no gross anatomical changes, but were nevertheless thought to have molecular disturbances".[22]

Physicians who could not determine any anatomical lesions or physiological abnormalities in the organisms of their patients had to rely on their own interpretative abilities and determine the nature of illness on the basis of the patient's verbal testimony. For Beard, neurasthenia was a functional disease of the brain, and, like many other physicians, he claimed that functional disturbances were *caused* by organic factors. This suggestion concerning the causal link between a functional disorder and an organic lesion was most evident in the concept of traumatic neuroses, but Beard's neurasthenia had a similar aetiological logic to it.

Compared to the other major neurosis, hysteria, neurasthenia was a more 'heroic' illness, because it initially afflicted the intellectual classes who worked hard and overtaxed their brain day in and day out. Neurasthenics were both paragons and victims of modern life; they represented the vanguard of cultural progress, but they were also victims of a modern, increasingly hectic and nerve-racking urban lifestyle. It was no coincidence that the creator of neurasthenia, Beard, had his office in Manhattan.

Neurasthenia became a popular illness for almost half a century in many European countries and in North America. It has been shown that its history in different countries has different characteristics so that, for example, neurasthenia in the United States was not the same as neurasthenia in Germany, or the Netherlands, or Sweden.[23] A recent study of neurasthenia in various national settings suggests that it was a more popular diagnosis in Germany and France than in Britain or the Netherlands. Sweden was not included in this study, but my own research shows that, partly due to close scientific and cultural links between Germany and Sweden, neurasthenia was a widely-used diagnosis in Swedish medicine, and that it also launched 'the nervous age'

[22] Beer, "The Dichotomies", 241.
[23] See Gijswijt-Hofstra and Porter (eds), *Cultures of Neurasthenia*.

in Sweden.[24] Thus it seems that Sweden was closer to Germany than to Britain in this regard.

Neurasthenia was *the* functional nervous disorder from the 1880s to World War I and beyond, shifting from a predominantly somatic to a predominantly psychic diagnosis. During and after the Great War, a more psychologically and psychodynamically tinged neurosis, variously dubbed as 'psychasthenia' (by Pierre Janet), 'neurosis' or 'psychoneurosis', became the most common nervous illness and the dominant 'functional mental disorder'. But for several decades in the late nineteenth and early twentieth centuries, it was neurasthenia, even more than hysteria, that represented the most wide-spread and talked-about neurosis—also in Sweden, as we shall see.

Translations of 'Nerve Books'

From the 1880s onwards, Swedish translations of books on neuroses written by foreign authors began to appear on the book market. The Swedish reading public first learnt about neuroses through the translated works of such foreign doctors as Beard, Krafft-Ebing, Paolo Mantegazza and Willy Hellpach, and through such popular medical journals as *Hälsovännen*. The first popular book on neuroses written by a Swedish author was probably Jakob Billström's slim 1913 volume on mental exhaustion (*överansträngning*), followed by Poul Bjerre's 'Studies on the Art of Mental Healing' (*Studier i själsläkekonst*) in 1914.[25]

As far as I have been able to determine, the first book on neuroses published in Sweden and addressed to educated laymen, as well as doctors, was Richard Krafft-Ebing's 'On healthy and sick nerves' (*Om friska och sjuka nerver*; orig. *Über gesunde und kranke Nerven*, 1885) that appeared in 1885, the same year the original German edition was published. Not surprisingly, the title of the first chapter of the book is 'Our nervous age'.[26] Krafft-Ebing, like many authors after him, locates the matrix of

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[24] The German edition of Beard's *A Practical Treatise on Nervous Exhaustion (Neurasthenia)* was favourably reviewed in the medical journal *Eira* in 1883. See Seved Ribbing, Review of *Die Nervenschwäche (Neurastenia)*…, by G. M. Beard, *Eira* 7 (1883): 727–8.

[25] Jakob Billström, *Hvad kan göras för vår tids öfveransträngda?* (Stockholm: C. G. Carlssons Boktr, 1913); Poul Bjerre, *Studier i själsläkekonst* (Stockholm: P.A. Norstedt & Söners Förlag, 1914).

[26] Richard von Krafft-Ebing, *Om friska och sjuka nerver* (Stockholm: Jos. Seligmann & C:is förlag, 1885).

nervousness in big cities, which represent modern civilisation as nothing else. In Krafft-Ebing's portrayal of city life, the nerves of urban people are taxed by the fear of political tumult, catastrophes on the stock market, war, socialism, and "many other horrible things".[27] The motto of modern civilisation is the 'struggle for survival', which in Krafft-Ebing's interpretation of Spencer's and Darwin's evolutionary theories is an unnatural phenomenon in human societies. Modern society is heading for moral and physical destruction, which can only be prevented if cultural evolution is allowed to follow a more tranquil path towards the future. Following Beard, Krafft-Ebing sees neurasthenia as a "real modern cultural illness", which is caused most often by mental exhaustion.[28]

In a short but positive review in the Swedish medical journal *Eira*, Krafft-Ebing's book was recommended not only for the nervously ill but also for parents, educators and teachers—"in our nervous age", concludes the anonymous reviewer, "it can be really beneficial to pay heed to the wise words of the author".[29] Krafft-Ebing's book was also reviewed in *Hälsovännen*, in which an anonymous reviewer wrote that while the book can be recommended to the educated urban readers, "it is not proper reading for the common people or the working class".[30] The reviewer did not elaborate his patronising statement, but he might have thought that the book was simply too difficult for the common man to comprehend. Like the reviewer in *Eira*, he subscribed to the view that "our time is the time of nervous weakness"—for the upper classes. A few years later, the medical officer Hjalmar Selldén relied heavily on Krafft-Ebing—"one of the most prominent nerve doctors of our time"—when he examined the "weakness of the nerves in our time" in *Hälsovännen*.[31] He presented heredity, upbringing and social conditions (modernisation) as aetiological factors in nervousness, approvingly quoting Krafft-Ebing's ideas on the significance of these factors for nervous health.

Following Krafft-Ebing's book on nerves, a Swedish translation of Paolo Mantegazza's book on 'Our Nervous Century' (*Vårt nervösa århundrade*)

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[27] Ibid., 3.
[28] Ibid., 90.
[29] Anon., Review of *Om friska och sjuka nerver*, by Richard Krafft-Ebing, *Eira* 9 (1885): 678–9.
[30] Anon., Review of *Om friska och sjuka nerver*, by Richard Krafft-Ebing, *HV* 1 (1886): 15.
[31] Hjalmar Selldén, "Om vår tids nervsvaghet," *HV* 6 (1891): 21–6.

came out in 1888.[32] The author of the book was a physician, professor of anthropology and a member of the Italian parliament. He was a renowned scholar whose three-volume study of the physiology of love, the hygiene of love and the anthropology of love was one of the standard sources for the nature of human sexuality, and Freud and Havelock Ellis were among those who read his works.[33] Compared with Krafft-Ebing, Mantegazza's approach to neuroses is much more socially and culturally oriented. His main point is that neuroses represent a necessary but transitory stage in the mental evolution of humanity; this transitory stage is equivalent to a childbed fever connected with birth pangs, and he predicted that neuroses would not pass on into the twentieth century.[34] In his opinion, the birth of modern nervousness can be traced back to the French revolution and its aftermath, which produced the main carrier of cultural evolution, the middle-class. Middle-class members of society are the ones who are most plagued by neuroses, and the reason they are nervous on a grand scale is that they work hard and, what is worse, in a way that strains only one part of their mental faculties while leaving other parts in a state of inertia. If among the rich one can find a "paralysis of the will", then among members of the middle-class one can find a "St. Vitus dance of the will", a will that is running amok due to badly organised, nerve-racking work. The very existence of the middle-class citizen is characterised by his painful awareness of his precarious position between "the hungry" proletariat and "the bored" rich, and it is this awareness that taxes his nervous system.

Notwithstanding his apparently reformistic zeal in the field of education, Mantegazza was not exactly a paragon of liberal virtues. He was no friend of universal education (it destroys the minds of many good people who are not qualified to strain their brain) or women's emancipation, which in his opinion was causally linked with increased nervousness. And newspapers of good quality had a damaging effect on the higher classes, because they forced people to think and reason.[35] For Mantegazza, ignorance seemed to be a public virtue, at least if it

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[32] Paolo Mantegazza, *Vårt nervösa århundrade* (Stockholm: Hugo Gebers förlag, 1888).

[33] On Mantegazza's influence on his contemporaries, see Sander Gilman, "The Image of the Hysteric," in *Hysteria beyond Freud*, 427–28.

[34] Mantegazza, *Vårt nervösa århundrade*, 31.

[35] Ibid., 78–88.

was coupled with a warm heart (as used to be the case with women before they got the crazy idea of educating themselves). What was new in his otherwise conservative approach to neuroses was that he openly acknowledged that he himself was nervous; that he was a son of a nervous mother and a descendant of a nervous family who for three years had suffered from the most severe form of hypochondriasis. It seems that his point in making this confession about his own nervousness was to give credibility to his opinions, especially in comparison with the foremost authority in the field, George Beard, who was also a "nervous author".[36] This was probably one of first examples of a medical authority admitting in print that he himself was neurotic.

We shall now return to Germany. The German nerve doctor Willy Heinpach's book, paradigmatically entitled 'Nervousness and Culture' (*Nervositet och kultur*, orig. *Nervosität und Kultur*, 1902) appeared in Sweden in 1904, at a time when neurosis had already been established in Swedish medicine and was now making itself known among the educated classes in general. Hellpach's book was published two decades after the emergence of modern 'discourse' on neurosis, and the author is well aware of the paramount importance of the period around 1880. He does not fail to mention Beard's 'discovery' of neurasthenia in 1880, and, like Beard, he sees neurasthenia as a great cultural illness, a pathological expression of an epoch that has gone off the rails, as it were. He is especially interested in socio-economic developments and their links with increased nervousness. He conjectures that, between the years 1850 and 1880, capitalism created social conditions that drove the industrial proletariat to join the socialist movement, in which workers were then susceptible to suggestive influences—the proletariat became "the led"—while among the members of the bourgeois classes one could see the first traces of an altogether new kind of psychic disposition, excitability. In their suggestibility, the proletariat embodied hysteria, while the middle-classes started to suffer from nervousness, which Beard coined neurasthenia in 1880.[37]

Although Hellpach labelled the working-class movement quite unflatteringly as hysterical, his political convictions were much more to the left of Krafft-Ebing's or Mantegazza's, because he was convinced

[36] Ibid., 11, 51.
[37] Willy Hellpach, *Nervositet och kultur* (Stockholm: Hugo Gebers förlag, 1904), 1–19.

that it was the capitalist economy that had prepared the ground for nervousness, and that the "on-going" process of socialisation had had curative effects on the nerves of all those involved in the industrial production, including employers and employees.[38] For Hellpach, then, it was a question of the birth of nervousness from out of the spirit of capitalism. He also criticised racialist doctrines and the excesses of degenerationism.[39] Like a Swedish *folkhem*-socialist three decades later, his outlook was forward-looking and optimistic: he portrayed his own time as a period of recovery and of gathering of healthy forces, and discerned an unmistakable "will to health" in the modern world (this was ten years before the outbreak of World War I).

Swedish Medical Community and the Modern Neuroses

The Swedish medical community was first introduced to Charcot's hysteria and Beard's neurasthenia through reports written by Swedish physicians when they made study trips to the Salpêtrière. Probably the first Swedish physician who wrote about Charcot and his hysteria studies in Swedish medical journals was Axel Lamm (1819–1889). He was a general practitioner in Stockholm who was denied a chair at the Karolinska Institute (medical school) in 1849 because of his Jewish background—the fact that he was Jewish made him "incompetent" to become professor of medicine.[40] From the late 1840s onwards, he had made numerous study trips to and attended many conferences in Europe, and was actively engaged in debates and discussions at meetings of the Swedish Society of Medicine (*Svenska Läkaresällskapet*).

In Sweden, the year 1882 was the turning point with regard to modern neuroses. In that year, the Swedish medical journal *Eira* published Charcot's short paper on 'nervous states', hypnotism and hysteria, while another medical journal, *Hygiea*, published Axel Lamm's translation of an abstract of a research project conducted by two of Charcot's pupils (Dumontpallier and Magnan).[41] Lamm, who had visited Charcot's clinic

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[38] Ibid., 190, 201.
[39] Ibid., 155–67.
[40] *Förhandlingar* [Obituary of Axel Lamm], 1889, 210.
[41] J. M. Charcot, "Olika nervösa tillstånd föranledda af hypnotism hos hysteriska," *Eira* 6 (1882): 355–57; Axel Lamm, [A translation and an introduction of *Étude expérimentale sur la métalloscopie, l'hypnotisme et l'action de divers agents physiques dans l'hystérie* by Dumontpallier and Magnan], *Hygiea* 44 (1882): 613–17. (Dumontpallier's and Magnan's paper was originally published in *Comptes rendus de l'Académie des Sciences*, No. 2, 1882).

in 1878, was in Paris again in 1882, and his translation provides probably the first overview of the Charcotian ideas of hysteria published in Sweden. In the short introduction to this text, Lamm observes that there is a growing interest even in Sweden in the "symptomatology of neuroses", and that it would be useful for readers of *Hygiea* to learn about Dumontpallier's and Magnan's experimental studies about the way hypnosis and the use of metals affect hysterics.

Later in the same year, Lamm, who was on a visit to Paris, wrote a positive review of Paul Richer's (Charcot's pupil) book *Etudes cliniques sur l'hystéro-épilepsie ou grande hystérie*. In his review (dated in October 1882), he wonders why it is so easy for Charcot and his assistants to trigger hysterical fits in their patients, and he thinks there must be something "very strange" about the way the symptoms of the hysterical patients seem to run a very regular course. "One thing is certain", writes Lamm at the end of his review, "and it is that during the past five years the pathology of hysteria has entered a new phase."[42] It is quite remarkable that he published these texts in the same year (1882) as Charcot delivered his famous paper on hypnotism at the Academie des Sciences in Paris. Thanks to Lamm, who was on the spot, the Swedish medical community was given the latest news about recent developments in hysteria studies at Charcot's clinic.

After Lamm had returned to Sweden, it took several years before modern neuroses were again discussed in Swedish medical journals. In 1887, Fredrik Björnström, professor of psychiatry at the Karolinska Institute, wrote an extensive overview of the first four issues of a new international journal, *Revue de l'Hypnotisme experimentale et thérapeutique*.[43] The next paper on modern neuroses to appear in *Hygiea* was the inaugural address of the first professor of neurology, P. J. Wising, given at the Karolinska Institute in May 1887. Later that year, when the Neurological Clinic at the Serafimer Hospital was opened, Wising became the clinic's chief physician.[44] The opening of clinic was of crucial importance not only to Swedish neurology but also to the development of the medical approach to neuroses in Sweden.

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[42] Axel Lamm, Review of *Etudes cliniques sur l'hystéro-épilepsie ou grande hystérie*, af dr Paul Richer, *Hygiea* 45 (1883): 64.

[43] Fredrik Björnström, Review of *Revue de l'Hypnotisme*, *Hygiea* 49 (1887): 273–78.

[44] Wising had studied medicine in Uppsala and had first been appointed at Serafimer as a junior physician in 1869. Ten years later, he became professor of medicine at Karolinska. For biographical details, see his long obituary: Seved Ribbing, "Per Johan Wising," *Hygiea* 75 (1913): 113–24.

Opening of the Neurological Clinic

The history of neurology in Sweden is closely linked to the Serafimer Hospital and the Karolinska Institute, the now famous Medical School in Stockholm. The Karolinska collaborated with hospitals in Stockholm, the oldest and largest of which was the Serafimer Hospital.[45] Founded in 1752, the Serafimer was "a symbol of Swedish medicine, the main seat of classical medicine" for the ill as well as for many generations of doctors and nurses.[46]

In 1885, an anonymous person (later identified as Dr Karl Adam Malmsten) donated 100,000 crowns to the Karolinska Institute as basic funding for the establishment of a chair (*ordinarie professur*) in one of the specialist branches of practical medicine. The collegium at the Karolinska decided to use the donation to establish a chair in a medical specialty that from the mid-1850s had gained stature as a subfield of internal medicine: neurology. The chair of neurology was established by royal decree on the 1st of April 1887. It was the first such chair in Europe after the establishment of a chair in neuropathology for Charcot in France in 1882.[47] The physician who was appointed as the first holder of this chair was professor of medicine, P. J. Wising, who simultaneously became the first head of the Neurological Clinic (henceforth, *Nervklinik*). The clinic opened its doors in September 1887 with twenty beds. Wising, together with an appointed docent ('assistant professor') in neurology and an intern who worked at the clinic half a year at a time, constituted the staff of the clinic.

When the *Nervklinik* was established, neurology was only beginning to be an independent medical specialty. Until then, it had been a special discipline in internal medicine, and clinical neurology remained anything but a unified medical discipline for decades to come. As the medical historian Albrecht Hirschmüller has observed,

> already in the nineteenth century, the term ['neurological medicine'] included a collection of very different tendencies and points of view, and lay at the intersection of psychiatry, internal medicine, anatomy, physiology and pathology of the nervous system. The changing and many-sided significance of this term has survived until this day.[48]

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[45] For a historical overview of Swedish hospitals, see Wolfram Kock, *Kungliga Serafimerlasarettet 1752–1952* (Jönköping: H. Halls Boktr. AB, 1952), Ch. 1.

[46] Ibid., 11.

[47] Henry Marcus, "Frithiof Lennmalm," *Hygiea* 86 (1924): 571.

[48] Hirschmüller, "The Development of Psychiatry and Neurology," 411–12.

Right from the start, the *Nervklinik*'s twenty beds were insufficient for the hospital's needs, but Wising's and his successor's attempts to acquire room for more patients did not materialise until 1918, when the number of beds was increased to twenty-eight. The clinic managed to expand its activities by starting to co-operate with Stockholm's Public Assistance Agency (*Försörjningsinrättning*), which ran its own hospital, housing mainly elderly, poor people with chronic illnesses. This 'hospital for the poor and the aged' provided 'clinical material' for neuropathological research, and was seen by Swedish physicians as a kind of mini-Salpêtrière.[49] Wising had worked at the hospital in the 1870s, and he knew very well that many patients there suffered from neurological and psychiatric problems. An agreement was made between the *Nervklinik* and the Agency which made it possible to transfer the Agency's patients suffering from more extraordinary nerve diseases to the *Nervklinik* for investigation and treatment on a regular basis. In this way, physicians and students at the clinic were able to learn more about all kinds of nerve diseases, and this co-operation, together with the establishment of the Neurological Polyclinic in 1888, expanded the very limited patient population that the twenty beds at the clinic provided. Medical students who were doing their internships at the Serafimer Hospital's Medical Clinic were required to spend two months at the *Nervklinik*, and this arrangement meant that all students at the Karolinska learned about nerve diseases in a clinical setting.

The majority of the patients at the Serafimer Hospital belonged to the 'lower classes': they were labourers, artisans, low-ranking civil servants (railway officials, policemen, etc.), and their family members. That these individuals were diagnosed as 'neurasthenics' refutes the claim that neurasthenia was a typical nervous illness solely or even predominantly of the middle classes. More affluent persons who suffered from milder nervous illnesses did not usually go the public hospitals, such as the Serafimer. Rather, they consulted their family doctors or other private practitioners, and, after the initial consultation, travelled to private health resorts, sanatoria, nursing homes or spas, either to Central Europe (Marienbad, Spa, Vichy, etc.) or, more often, to some of the numerous local water cure clinics. Hydrotherapy was all the rage in the nineteenth century, and water cure clinics had a large clientele of nervously ill patients. For example, in 1847, at the Ronneby Water

[49] Franz Luttenberger, "Hypnotisörernas tid: Hypnotismen i svensk medicin 1880–1900," *Lychnos* (1983): 92–3.

Cure Asylum, 39 persons out of 170 (23%), all representing the gentry, suffered from nervous ailments, including hysteria, hypochondriasis and 'spinal irritation'.[50] Nervously ill patients at the Serafimer, by contrast, rarely had the opportunity to spend weeks or months in a spa, and Serafimer's doctors usually prescribed drugs and gave straight-forward advice to their mainly working-class patients (see Chapter 9).

In 1888, one year after the establishment of the Neurological Clinic, an outpatient clinic (polyclinic) was opened at the Serafimer. This was not a minor medical event, for special outpatient clinics had quickly become centres for neurological research in Germany (e.g. in Heidelberg, Berlin and Leipzig), and the Serafimer's Neurological Polyclinic (henceforth, *Nervpoliklinik*) was of uppermost importance, mainly to Swedish neurology, but also to psychiatry, simply because there were no psychiatric clinics in Sweden until 1929. The Serafimer's *Nervpoliklinik* was the only neurological outpatient clinic in Sweden until the early 1950s, when another neurological clinic, affiliated to the Medical Faculty at the University of Gothenburg, was opened.[51] Many young doctors who later became leading neurologists and psychiatrists in Sweden did their internships at the *Nervpoliklinik*, while their clinical work with the neurotic patients acquainted them with nervous disorders.

Historians of medicine are on a very slippery slope when they try to determine the constantly changing links between illnesses, symptoms and diagnoses. What is safe to say is that there were not that many 'purely' neurotic patients at the *Nervklinik*, which housed mainly chronic patients who predominantly suffered from somatic and organic nerve diseases, such as multiple sclerosis, syphilitic infections and brain tumour. The picture is completely different when we look at the *Nervpoliklinik*, where neurotic patients were in the majority, or at least constituted a large minority.[52] They were usually less serious cases, displaying milder psy-

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[50] A. F. Hellman, "Anteckningar om Ronneby Helsobrunn och Gyttjebad," *Hygiea* 10 (1848): 75–85.

[51] This is also noted by Wolfram Kock in his history of the Serafimer Hospital. See Kock, *Kungliga Serafimerlasarettet*, 177.

[52] Unfortunately, the Serafimer's annual reports start listing the patients treated at the polyclinic only in 1922. Even worse, the polyclinic's patient records between the years 1888 and 1914 have disappeared, and there is virtually no 'hard data' available about the early history of the polyclinic. One has to extrapolate from the first extant patient records from 1915 backwards, and rely on the information and interpretations provided by physicians who worked at the Serafimer and published articles in medical journals in the late nineteenth and early twentieth centuries.

chological and physical symptoms, as we shall see in Chapter 9. Between 1894 and 1903, the number of visits to the *Nervpoliklinik* increased from 274 to 485, and in 1918 there were 894 visits to the polyclinic.

The Serafimer's Annual Reports

In the annual report of the Serafimer's Medical Clinic for 1840, lung diseases (such as bronchitis, pneumonia and tuberculosis) and diseases of the digestive organs dominate the sickness statistics.[53] In the category 'Diseases of the Nervous System', ague (*febris intermittens*) was by far the most common diagnosis (251 cases out of 329). There were also more than ten cases of acute meningitis, cerebral haemorrhage, spinal diseases and hysteria (19 cases). There were also eight cases of hypochondriasis. Decades before the dawn of the Age of Nervousness, there were 'hysterics' and 'hypochondriacs' among the patients at the Serafimer. Unfortunately, the 1840 report does not differentiate between the sexes so it is impossible to know if all hysterics were female and all hypochondriacs male.

A few decades later, in 1878, the most common diseases catalogued in the annual report were pneumonia (158 cases out of 1429), rheumatic diseases, catarrhal diseases and typhoid fever. There were also forty cases of alcoholism and delirium tremens, twenty-five cases of general paralysis, sixteen cases of hysteria (all female), eight cases of hypochondriasis (of which seven were male), and one case each of melancholia (the one and only entry in the category of 'morbus psychici') and 'neurasthenia spinalis'. Seventeen years later, in 1895, the annual reports of the Medical Clinic and the Neurological Clinic list a 'functional' nerve illness that plagued men more than women: neurasthenia (forty-two cases, of which twenty-five were men). There were now even thirteen male hysterics on the list as compared to fifty-eight female hysterics.

[53] Kock, *Kungliga Serafimerlasarette*, 167–8. The mortality rate at Serafimer was 11,7%. In absolute numbers, tuberculosis, entero-colitis and nephritis (kidney disease) were the three most fatal diseases.

Table 1. *The number of the cases of 'functional nervous illnesses' at the Serafimer's Medical Clinic*

NR: Neurasthenia
HC: Hypochondriasis
ON: Organ neuroses
TN: Traumatic neurosis

Year*	Hysteria	HC/ON/TN	NR	Total	% of all cases
1840	19	8 (HC)	—	27	1,7%
1869	7	—	—	7	0,5%
1878	16	8 (HC)	1	25	1,7%
1894	21	1 (TN)	72	94	7,6%
1898	45	2 (HC +TN)	74	121	5,6%
1900	47	2 (TN)	56	105	4,9%
1905	24	37 (TN +ON)	37	98	5,9%

Sources: *Hygiea* and Serafimer Hospital's Annual Reports
* Not all annual reports are extant; there are many omissions until 1894.

One can see that there were no significant statistical changes between the years 1840 and 1878, whereas the change between the years 1878 and 1894 is striking. These figures support the thesis that modern neuroses emerged in Sweden during the last two decades of the nineteenth century, and that the Age of Nervousness was launched in the 1880s: there were not only more hysterics among the patients, but there was also a new category of functional neurosis in which men outnumbered women: neurasthenia. Moreover, there were more cases of neurasthenia than hysteria at the Medical Clinic, and more than half of them were men. Hypochondriasis, the earlier 'male neurosis' that had never become a major illness in Sweden, all but disappeared as a disease entity between the years 1878 and 1895. Hence hysteria and neurasthenia were the two major functional neuroses at the turn of the twentieth century.

In addition to these two major neuroses, there were a few cases of traumatic neurosis from the mid-1890s onwards, and, in the early twentieth century, the number slightly increased. In addition, at the turn of the century, so-called 'organ neuroses', related to 'functional' disturbances in the heart, stomach and sexual organs, began to appear in the annual reports. But hysteria and neurasthenia reigned supreme until 1920, when, at the expense of both hysteria and neurasthenia, 'neurosis' made its first public appearance in the annual report of the

Medical Clinic ('psychoneurosis' appeared only in the first published report of the Neurological Polyclinic in 1922).

After its opening in 1887, many nervous patients were admitted to the *Nervklinik* rather than to the (by now) two Medical Clinics. The following table indicates the number of nervously ill patients at the *Nervklinik*.

Table 2. *The number of cases of 'functional nervous illnesses' at the Serafimer's Neurological Clinic*

Year	Hysteria	Traumatic Neurosis	Neurasthenia	Total	% of all cases
1895	23	—	5	28	18%
1898	17	—	7	24	13%
1900	22	—	—	22	14,8%
1903	7	—	1	8	9,8%
1905	15	2	2	19	16,8%

Source: Serafimer Hospital's Annual Reports

In the early history of the *Nervklinik*, neuroses and especially hysteria constituted a 'medium-sized' diagnostic category. Neurosis was a visible, but not dominant illness at the clinic. Thus, the majority of the patients at the clinic were not 'nervous cases', unlike the patients at the *Nervpoliklinik*. Apparently, the *Nervklinik* had no mentally ill patients in 1895 (although there were seven cases of general paresis), which indicates that there was a division of labour between psychiatrists and neurologists already in the early history of Swedish neurology. In contrast to the *Nervklinik*, there were eleven cases of mental illness at the Medical Clinic in 1895. These 'pre-Kraepelinian' illnesses were divided into acute mania, paranoia, general paresis of the insane ('dementia paralytica'), melancholia and idiotia.

It is impossible to determine the extent to which there existed a continuity in the symptoms of neuroses from the mid- to late nineteenth century, when 'neurasthenia' had fully emerged. What is clear is that modern neuroses did not appear out of the blue, but were in some ways descendants of older neuroses, especially of the 'pre-Charcotian' hysteria and hypochondriasis. But what is also clear is that the number of the nervously ill was on the rise during the last quarter of the nineteenth century, and that, until the last quarter of the *twentieth* century, neurosis was the 'king' of nervous disorders and a major category in 'milder'

mental disturbances. By the mid-1890s, neurosis had become a more egalitarian disorder as it affected both men and women, though not in equal numbers, for women were constantly overrepresented in the statistics indicating the number of the nervously ill in hospitals. In the whole of Sweden, the number of hospitalised women whose ailments were diagnosed as neurasthenia grew from 211 in 1891 to 1,683 in 1920; the number of neurasthenic men was about thirty per cent lower. The revival of an ancient malady—hysteria—together with the emergence of a new, more emphatically 'egalitarian' neurosis—neurasthenia—signified the beginning of the Age of Nervousness in Sweden in the 1880s.

Neurology and Neuroses at the Serafimer

In his inaugural speech in May 1887, Per Johan Wising (1842–1912), the newly-appointed professor of neurology, surveyed the development of 'nerve pathology' in the preceding two decades.[54] He observed, first of all, that the past twenty years had been a time of great discoveries in the study of nervous illnesses, and he gave credit to Charcot and to Pasteur for their contributions in the field. Beginning in 1872, Wising had made study trips to Charcot's clinic in Paris, and he was clearly influenced by the "great nerve pathologist", to whom he admiringly referred a number of times in his talk: Charcot was "perhaps the most outstanding clinical teacher of our time" and the "Great Master at the Salpêtrière". In the second half of his talk, he referred to "psychological research" that had been successfully integrated into physiological and clinical research, especially in the study of the nervous system. He mentioned epilepsy as an example of a disorder which through the localisation of motorical centres in the brain was much less clouded in mystery than it was two decades earlier.

After referring to the renowned Swedish physician Magnus Huss and his pioneering studies on alcoholism, Wising turned his attention to neuroses, referring to specific "illnesses in the nervous system" in which one cannot detect any long-standing pathological changes. In an optimistic tone he stated:

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[54] P. J. Wising, "Om nervpatologiens utveckling under de sista tvänne årtiondena," *Hygiea* 49 (1887): 415–35. It was probably not a coincidence that Wising had been P. H. Malmsten's (whose donation made possible the establishment of the new clinic at Serafimer) pupil at the Serafimer's Medical Clinic in the early 1870s.

> There is no doubt whatsoever that the more scientific technology has developed, the more it has restricted the large domain of neuroses. Our generation, which rightly or wrongly thinks of itself as being more disposed towards these nervous illnesses than any previous generation, has by all accounts fundamentally contributed to the understanding of these illnesses. This is especially true of epilepsy and hysteria.[55]

Indeed, as the nineteenth century drew to a close, the development of technology and knowledge about epidemiology limited the scope of neuroses: not only epilepsy, but such 'neuroses' as chorea (St. Vitus' dance) would also be reclassified as organic diseases or disorders. Wising was right when he predicted that new scientific discoveries would shed light on the "obscure world of neuroses", but what he could not foresee was that although the list of 'traditional' neuroses would shrink in response to a more advanced medical understanding of infectious diseases and the role of bacteria and viruses, a very elaborate list of 'psychogenic neuroses' would emerge over the decades. He witnessed the emergence of modern neurology, but he could not anticipate the reframing of neurosis as a predominantly psychological disorder in the twentieth century.

Wising did not write any scientific articles about neuroses during his short tenure; all that I have found is his statement about hysteria to the Society of Medicine in June 1889: he talked about the phenomenon of hysteria among different nations and referred to the claim that the "Latin races" are more taxed by it than other races. He found this assertion difficult to prove, and went on to point out that hysteria is anything but a rare illness in Sweden, and that there are no hysterical symptoms that have not been observed by Swedish doctors.[56]

Because of his ailing health, Wising took leave of absence already in 1889, and resigned from his professorship the following year, only three years after his appointment (he later became the chief editor of *Hygiea*).[57] In his inaugural speech, he had expressed hopes that during his professorship neurology would become materially so well-established that the following generation could become engaged in substantial work in this new scientific branch. It was left to Wising's follower in the chair, Frithiof Lennmalm, to fully establish neurology as a clinical specialty in Sweden. Wising himself became a highly-respected private practitioner

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[55] Wising "Om nervpatologiens utveckling", 430.

[56] P. J. Wising, [Commentary on hysteria]. *Förhandlingar*, June 4, 1889, 168.

[57] He predicted in his inaugural address that he would probably hold the chair only a short period of time. Wising, "Om nervpatologiens utveckling," 434.

in Stockholm, and his early retirement from academia was apparently not a great loss to Swedish science: "As a man of science, Wising was mainly a non-entity", wrote Nils Antoni, who became professor of neurology at the Karolinska in 1931.[58]

Lennmalm as Head of the Nervklinik

Wising's successor, Frithiof Lennmalm (1858–1924), occupied the chair in neurology from 1890 to 1923, and it was during his long reign that neurology fully emerged as an independent field not only in Sweden but internationally.[59] Lennmalm studied in Uppsala under the famous neuropathologist Salomon Henschen and worked at various hospitals before becoming first docent at the University of Uppsala and then professor of medicine at the University of Lund. He stayed in Lund for only a year (1889–90) before he was appointed professor of neurology, which simultaneously made him the head of the *Nervklinik*. He also had a private practice on the side as a nerve specialist (see Chapter 8). Later in his career, he became chairman of the Society of Medicine (1914–19) and rector of the Karolinska Institute (1917–23). He was also a member of the Nobel Prize Committee for Physiology and Medicine, a member of the Board of Health's (*Medicinalstyrelse*) scientific committee, chief physician at the life insurance company *Thule*, and, just before his death in 1924, Chief Editor of The Journal of Swedish Medical Association (*Svenska Läkartidningen*). On top of that, he wrote 'A History of the Swedish Society of Medicine' (1908) and 'A History of the Karolinska Medico-Surgical Institute' (1910). By all accounts, he was an extremely energetic character and an influential medical authority, who gathered around him a group of talented pupils, one of whom wrote in his obituary of Lennmalm that the revered professor was "an outstanding teacher for many generations of doctors in Sweden".[60]

Lennmalm was one of the most renowned physicians in turn-of-the century Sweden, but he lacked the ambition to establish an international scientific reputation: he wrote only in Swedish and did not attend many international conferences. His most substantial studies were published

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[58] Nils Antoni, "Att bli neurolog," *MFT* Nr. 6–7 (1962): 245.

[59] For a short biography of Lennmalm, see Ingemar Nilsson, "Lennmalm, Frithiof," in *Svenskt Biografiskt Lexicon* (Stockholm: Norstedts, 1979), Vol. 22, 561–3.

[60] Ernst Sahlgren, "Frithiof Lennmalm," *SLT* 21 (1924): 594.

when he was not yet a professor: his well-received dissertation on the cerebral localisation of aphasia (1886), as well as his studies on cerebral hypertrophy (1888), scarlet fever (1889) and a specific form of sclerotic disease (1886) gave him a solid medical reputation, on the strength of which he was called to the chair of neurology in late 1890, after his revered teacher at the University of Uppsala and one of the founding fathers of Swedish neuroscience, Salomon Henschen, had declined the offer.[61]

During his thirty-three-year-long professorship, Lennmalm was not much engaged in medical research, and his professional identity was more that of a practical clinician than that of a research scientist, although he collected a large amount of clinical material for his planned study on the syphilitic nerve diseases, which remained unfinished. His younger colleague at the Karolinska, Israel Holmgren, who later became the director of the Serafimer Hospital, wrote in his published diary in 1916:

> I have great respect for Lennmalm. There are many who say wicked things about him. It is said that his scientific achievements are nil, and that his other achievements do not amount to anything either. But that's a lie. He works diligently and with good results as a physician; and only in the past few years he has written a history of the Karolinska Institute and [a history] of the Swedish Society of Medicine, both of them major works. Moreover, and this is much more important, he's a man of unexceptional objectivity and fairness. I will always be a friend of a man who possesses these qualities.[62]

What makes Lennmalm so relevant to the study of neurosis is that he was more interested in 'functional nervous illnesses' than most of his colleagues or successors, and that his two major articles on neuroses published in the 1890s were paradigmatic in the sense that the Swedish medical community derived much of its knowledge of and many of its assumptions about neuroses from Lennmalm.[63] At the meetings of the Society of Medicine, he liked to give clinical demonstrations of

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[61] Henschen mentions this invitation to the chair in neurology in his 1897 Letter to the King and in his 1925 autobiography, and there is no reason to doubt his statement: Henschen was the most renowned and brilliant neurologist in the late nineteenth century Sweden. Salomon Henschen, "Professuren i medicin vid Karolinska Institutet," *Eira* 21 (1897): 692; *Selbstbiographie von S. E. Henschen. Die Medizin der Gegenwart in Selbstdarstellungen* (Leipzig: Verlag von Felix Meiner, 1925), 18.

[62] Holmgren, *Mitt liv*, 261.

[63] Marcus, "Frithiof Lennmalm," 572.

the different forms of neuroses on the one hand and of syphilitic nerve diseases on the other.[64] Most importantly, during Lennmalm's professorship, the *Nervklinik* gained in stature as more and more nervously ill patients consulted him and his assistants. In his 1910 overview of the activities at the clinic, Lennmalm listed the diseases he regarded as both practically and scientifically most important: arteriosclerosis, syphilitic diseases, toxicant diseases, occupational diseases and—above all—functional neuroses, which in his view were inadequately presented in textbooks and yet were present to a great extent in medical practice.[65]

At the Medical Clinic, neuroses were placed in the category of 'diseases of the nervous system', but Lennmalm, as head of the *Nervklinik*, was obviously unwilling to categorise hysteria and neurasthenia (and epilepsy) as 'diseases of the nervous system' and preferred to list neuroses in the category of 'diseases with indeterminate localisation', thus differentiating between functional neuroses and organic diseases of the nervous system. A few years later, Lennmalm abandoned the rather vague category of 'diseases with indeterminate localisation', and, like his colleagues at the Medical Clinic, began to classify neuroses as 'diseases of the nervous system'.

Lennmalm on Neuroses

'Functional nervous illnesses' played a prominent role in the daily work of physicians at the *Nervklinik*. Small wonder, then, that in his inaugural speech in February 1891, Lennmalm, the newly-appointed professor of neurology, devoted a great deal of time to neuroses. First he speculated about the role of heredity in the aetiology of neuroses, and then he tackled the question as to whether 'nervousness' is causally linked with 'civilisation'. Following Beard's thoughts about neurasthenia, he saw a growing number of people who made their living by using their brains, rather than their hands, as a causal factor in the rise of neuroses. Educated people who strive to better their lot are the ones most likely to suffer from nervous exhaustion, or neurasthenia, "the

[64] Ibid.
[65] Frithiof Lennmalm, "Neurologiska kliniken," in *Karolinska Mediko-Kirurgiska Institutets historia*, (Stockholm: Isaac Marcus' Boktryckeri-Aktiebolag, 1910), Vol. 3, 5.

illness of our century", the symptoms of which are "protean-like".[66] Lennmalm considered excessive intellectual work to be an essential aetiological factor in some nervous illnesses, but he also believed that even manual workers can suffer from symptoms of neurasthenia, albeit in lower numbers. He singled out employees on mail trains (who often worked night shifts) as an occupational group that was particularly vulnerable to nervous disorders. Only at the very end of his talk did he refer to the *treatment* of nervous illnesses, noting that there is not much to be said about therapy. He was then just about to begin his work at the clinic, and in his later writings he was to say much more about therapy than in his inaugural speech.

In the 1890s, Lennmalm wrote two large articles that represent one of the very first detailed accounts of neuroses published in Sweden. But the first medical article in Sweden that dealt with modern neuroses empirically was not written by Lennmalm, but by S. A. Pfannenstill, a junior physician at Serafimer's Medical Clinic (his paper was published in 1891).[67] Using the recently developed gastroscopy, Pfannenstill had examined the gastric acid of neurasthenic patients in order to illustrate the connection between neurasthenia and nervous dyspepsia (which in the twentieth century was to be regarded as a psychosomatic ailment). Through a chemical analysis of gastric acid, he tried to determine whether neurasthenia was characterised by increased acidity ('hyper-acidity') or not, and he focused on one particular acid, hydrochloric. He was consistent in analysing only one physiological aspect of neurasthenia and not making statements about its psychological aspects. He only observed that, contrary to the accepted wisdom, his clinical studies at the Serafimer clearly showed that neurasthenia can also be found among the 'lower classes'.

Now to Lennmalm's two large articles, which are the first publications written by a Swedish physician and published in a Swedish medical journal in which neuroses are examined at length.[68] The topic of the

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[66] Frithiof Lennmalm, "Om de viktigaste orsakerna till nervsystemets sjukdomar," *Hygiea* 53 (1891): 261–80.

[67] S. A. Pfannenstill, "Nevrasteni och hyperaciditet. Ett bidrag till nevrasteniens symptomatologi," *Nordiskt Medicinskt Arkiv* 32:17 (1891): 1–42.

[68] In addition to Lennmalm's articles, Carl C:son Froste, assistant at the clinic, wrote a paper on tics—the first published reference to this nerve illness in Sweden. In his paper, Froste gives a clinical description of a male patient at the clinic, and refers to such authorities in the field as Charcot, Oppenheim and Gilles de la Tourette. Carl C:son Froste, "Maladie des tics convulsifs," *Hygiea* 56 (1894): 201–14.

first of these papers, published in 1893, is traumatic neuroses. It is the first treatise in the Swedish language in which not only traumatic neurosis but all modern neuroses are introduced and discussed. In his article, he devotes many pages to the illustration of Charcot's traumatic hysteria, and, for the first time, he uses the Serafimer's patient population and clients in his private practice as case studies. He refers to no less than fifteen cases for illustration and points out that traumatic neurosis is a very egalitarian illness: it is "perhaps" more common for men than for women to become victims of this illness, because men are more involved in work-related accidents. He also notes that it is sheer ignorance to claim that hysteria is the "privilege of women", for one could easily find it among men.[69]

In addition to the established authorities in the field, Lennmalm also refers to future authorities, Pierre Janet and Sigmund Freud: he writes that "Charcot's views have been developed further by Pierre Janet", and, a few pages later, he discusses Breuer's and Freud's now-famous 1893 paper on hysteria ("On the Psychical Mechanism of Hysterical Phenomena: Preliminary Communication").[70] He concludes his article by deliberating on the relationship between traumatic neurosis, the accident insurance system and the criminal law. He was of the opinion that just as insurance policies exclude the deaf, paralytics and epileptics, they should exclude those who suffer from full-blown hysteria and neurasthenia, or, at the very least, hysterics and neurasthenics should be placed in a specific insurance category with specific conditions.

In his other major article, published in 1896, Lennmalm examines "illnesses which are dependent on mental representations and which can be cured through mental representations" (*föreställningssjukdomar*, *maladies par représentations, Krankheiten durch Vorstellungen*). By such 'representation-dependent' illnesses he means specific types of neuroses; and by 'cure through mental presentation' he refers to the French tradition of hypnosis, suggestion and psychotherapy. He had probably picked up the idea of *Krankheiten durch Vorstellungen* from the German nerve doctor Paul Möbius, who defined hysteria as a result of "morbid changes in the body that are caused by representations" in an article published in 1888.[71] As Lennmalm's article in general and the theory of the medical

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[69] Frithiof Lennmalm, "Om de s.k. traumatiska neuroserna," *Hygiea* 55 (1893): 246–7.

[70] Ibid. He refers to Janet's 1892 book *Etat mental des hystériques*.

[71] Henri F. Ellenberger, *The Discovery of the Unconscious*. 1st ed. 1970 (London: Fontana

role of 'representations' in particular were extremely influential in the Swedish medical community for decades to come, I shall refer to this theory in later discussion as 'The Möbius-Lennmalm theory'—it was Möbius who formulated the idea, but it was Lennmalm who made this idea popular in Sweden (Lennmalm does not refer to Möbius when he introduced this idea in his article; in the preceding paragraph he has approvingly talked about "Charcot's groundbreaking investigations",[72] so it is possible that he—as well as Möbius—picked up the idea from the Master himself. Towards the end of his article, he refers however to a newly-founded German gynaecological journal, and mentions in passing that the first issue of this journal includes Möbius' paper on the nature of hysteria).[73]

Lennmalm writes that his own clinical experiences with a female patient, whose neuralgia (diffuse pains) he cured by giving her a placebo (because the medicine he had given her before had run out), prompted him to see some forms of neuroses as illnesses that are dependent on 'morbid representations'. He mentions both Charcot and Janet's "exhaustive psychological research, especially on the nature of hysterical symptoms"[74] in the context of his discussion of hysteria and hypnosis. He does not see 'representation-dependent illnesses' as identical to 'functional neuroses', because the latter term is much wider in its scope than the former term.

There are a number of points in Lennmalm's articles that are worth highlighting. First, his ideas about neuroses are not very original, but he was clearly well-read in this subject, and his work as head of the *Nervklinik* and as a private 'nerve doctor' gave him ample clinical material, which made him competent in evaluating ideas of European physicians who were working in the same field. Second, he differentiates between organic, functional and 'simulated' or fake illnesses. He admits that physicians are prone to make mistakes when they try to determine whether the illness in question is organic or functional, and he notes that, in the more questionable cases, doctors tend to make an 'organic'

Press, 1994), 758. See also P. J. Möbius, "Über den Begriff der Hysterie," *Centralblatt für Nervenheilkunde* XI (1888): 66–71.

[72] Frithiof Lennmalm, "Om sjukdomar, som bero på föreställningar och som botas genom föreställningar," *Hygiea* 58 (1896): 70–1.

[73] Ibid., 133. On the life and work of Paul Möbius, see Francis Schiller, *The Möbius Strip: Fin-de-siècle Neuropsychiatry and Paul Möbius* (Berkeley: University of California Press, 1982).

[74] Lennmalm "Om sjukdomar, som bero på föreställningar," 77–8.

diagnosis if the symptoms are severe. Conversely, if the symptoms are mild, the patient is diagnosed as suffering from a 'functional disturbance'. As for simulated illnesses, the temptation to fake symptoms is especially strong in the case of traumatic neurosis, due to its link with accident insurance. The tendency towards malingering is evident especially in cases of (hysterical) auto-suggestion, but the more physicians learn about the psychological mechanisms of functional ailments, the less frequent are attempts at malingering: in front of a knowledgeable doctor it is exceedingly difficult for a patient to simulate symptoms. In fact, says Lennmalm, nowadays it is not so much the doctor as the patient's next of kin who claims that the patient simulates or at least exaggerates his or her symptoms, and such a pitiless attitude by relatives towards the 'imaginary ill' can do real harm to the "poor patients".[75]

Third, Lennmalm does not regard functional neuroses as imaginary illnesses in the sense that the patients symptoms are illusory, or that they could get rid of their symptoms merely through exercising their will power. Rather, these illnesses are 'imaginary' in the sense that symptoms are dependable on representations (*Vorstellungen*) that are rooted in the patient's psyche and hold fast there. But, writes Lennmalm, it could be positively harmful to the patients to proclaim that their subjective symptoms are not real but arise from 'mere nervousness'. There are, for instance, severe organic nerve diseases, such as tabes dorsalis, general paresis of the insane and brain tumour, which in their early phase resemble functional neuroses in their symptoms. In order to avoid diagnostic mistakes, the physician has to be very careful in his early judgement of the nature of the disease, and if he hesitates, it is a clear indication that the patient should be treated *as if* he or she were more severely ill than what the symptoms reveal. This is of special importance in the case of syphilis, because physicians often hesitate when they try to determine whether the symptoms are indicative of a functional neurosis or a syphilitic disease. Simultaneously, the physician has to incorporate suggestive (i.e. psychological) elements in his treatment in case the illness is, after all, functional.[76]

Fourth, Lennmalm takes into account the psychological aspects of neuroses. He is inclined to see hysteria as a psychological illness, as a

[75] Ibid., 138.
[76] Ibid., 137.

"some kind of disturbance of the higher cerebral functions",[77] which is caused by the pathological representations of the hysterics, or 'auto-suggestion'. He sees *amnesi* (loss of memory) and *abouli* (weakening of the will) as characteristic psychic symptoms of neurosis. At the same time, he observes that, in the case of traumatic neurosis, there might be some kind of molecular lesion in the nervous system, or a metabolic disturbance in the organism, which gives rise to the symptoms. Therefore, among neuroses, hysteria is an emphatically psychological illness, while traumatic neurosis and neurasthenia are more 'organic' illnesses, although their actual pathological anatomy is still shrouded in mystery. He has a positive view of the significance of 'scientific psychological knowledge' to medicine, and he believes that psychological treatment is the most important form of therapy in functional neuroses: "Illnesses that are dependent on representations can only be cured through representations"—that is, through such forms of "psychotherapy" as suggestion, auto-suggestion and hypnotism. He was probably the first Swedish physician who used the word 'psychotherapy' in print.[78]

Fifth, following the German neurologist Adolf von Strümpell, Lennmalm refers to the 'neuropathic constitution' that predisposes individuals to nervous illnesses. The three principal forms of the neuropathic constitution are nervousness, neurasthenia and hysteria. The first category, nervousness, is a chronic condition of mild psychic irritability with a tendency to states of anxiety and hypochondriac ideas, which find expression in a number of subjective, abnormal sensations. Lennmalm emphasises that these forms of the neuropathic constitution overlap, and that there are additional forms that cannot be subsumed under any of these three categories, such as neuralgias and various 'organ neuroses' (related to the heart, stomach and sexual organs), hybrid forms of neurasthenia and hysteria, and specific forms of psychoses (especially obsessions). In the light of his later endorsement of racial hygiene ideology, it was quite appropriate that he incorporated the notion of 'constitution' or 'innate predisposition' into his conceptualisation of functional neuroses.

Sixth, Lennmalm introduces Sigmund Freud and Pierre Janet to the Swedish medical community. He refers to Breuer's and Freud's argument

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[77] Lennmalm, "Om de s.k. traumatiska neuroserna," 242.

[78] Lennmalm, "Om sjukdomar, som bero på föreställningar," 105. On the origins of the term 'psychotherapy', see Sonu Shamdasani, "'Psychotherapy': The Invention of a Word," *History of the Human Sciences* 18:1 (2005): 1–22.

that different hysterical symptoms are always caused by a psychic shock, which is comparable to a shock that results from a physical trauma. Janet in turn has offered insights into the psychological mechanisms behind hysterical symptoms. Lennmalm obviously sees the psychological work of Breuer, Freud and Janet as relevant to the study of neuroses, and it is probable that the ideas of these authors inspired him to pay more attention to the psychological dimension of neuroses.

Seventh, Lennmalm is of the opinion that nervous illnesses in general and traumatic neurosis in particular are on the rise in 'our nervous epoch'. Although he does not elaborate on this notion, he implies that neuroses constitute not only a medical but also a social problem with a direct bearing on the insurance system, forensic system and working life. Of all the major aspects in Lennmalm's articles discussed here, this is the least developed and rudimentary, but it is an interesting manifestation of a rather commonplace opinion by a late nineteenth-century nerve doctor. The basic 'cultural message' in such statements is that, since cultural evolution makes exceedingly hard demands on our nerves, we are living in the Age of Nervousness, and it is to be expected that in time nervous illnesses will become more and more common. This of course implies that doctors who confront neuroses on a daily basis are engaged in a hugely important and demanding work, which is of great significance to the society as a whole.

Lennmalm was instrumental in launching clinical neurology and the study of neuroses in Sweden. For a reason that is not altogether clear, he did not write anything about neuroses between his 1896 article and his last published article, which was originally delivered as his farewell speech in 1923 when he resigned from his chair. He retained his positions as head of the *Nervklinik* and professor of neurology all these years, and he published some papers on organic nerve diseases (sclerosis, arsenic poisoning and general paresis of the insane), but over the years he seemed to become more interested in the history of Swedish medicine than in doing empirical clinical research.

In his valedictory address at the Karolinska in September 1923, Lennmalm returned to the question that had intrigued him thirty years earlier. In his address, entitled "The position of functional nervous illnesses in relation to the so-called organic illnesses", he mainly reiterated the ideas he had put forward in his two articles in the 1890s. After thirty years of clinical work, Lennmalm was not able to add anything essentially new to his earlier (1896) formulation of neuroses. He concludes his article (his last literary production) by stressing that

functional neuroses do not form a sharply differentiated disease category, but instead constitute a middle ground between a state of full health and a somatic illness.[79] This conclusion represents the 'centrist' view on neuroses which was first articulated by the French psychiatrists and neurologists in the latter half of the nineteenth century, and which became the standard view in twentieth-century mental medicine.

All in all, it almost seems as if Lennmalm had been in a state of somnambulism since 1896: his whole approach to neurosis in 1923 emanates the late nineteenth-century understanding of hysteria and neurasthenia. He does not mention either Janet or Freud or any other psychologically-oriented 'modern' authorities in the field, and, with the exception of the British neurologist Henry Head and the eminent Russian physiologist Ivan Pavlov, neither does he refer to any contemporary researchers. He may have been so preoccupied with his other duties, including the rectorship of the Karolinska from 1917 to 1923, that he was unable to follow recent developments in his field. He represented the old school of clinical neurologists inspired mainly by the work of Charcot and his school. He was of course aware of Freud's and Janet's work (as I mentioned above, he had referred to both of them in his articles in the 1890s), and he sometimes used the diagnosis 'psychasthenia', which Janet had coined in 1903, in his private practice. But he never discussed, for example, the more recent development of psychodynamic theories about neuroses in his writings.

Lennmalm lived only nine more months after giving his valedictory address. When he died in the summer of 1924, he left behind an unfinished manuscript on syphilitic nerve diseases which he had planned to publish as a large monograph.[80] In his exceptionally long obituary (27 pages!) published in *Hygiea*, his pupil and successor, Henry Marcus, described him as "our society's [the Society of Medicine] foremost adornment and pride…We shall never again meet such a man. May he rest in peace."[81]

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[79] Frithiof Lennmalm, "De funktionella nervsjukdomarnas ställning i förhållande till s.k. organiska sjukdomar," *Nordisk Tidskrift* 46 (1923): 461.

[80] Lennmalm's unfinished manuscript (or, a part of it) was published as an article in 'The Journal of Swedish Medical Association' in the autumn of 1924. See Frithiof Lennmalm, "Om lues' betydelse för uppkomsten av kroniska sjukdomar i blodkärlsystemet och nervsystemet," *SLT* 21 (1924): 857–74.

[81] Marcus, "Frithiof Lennmalm," 586.

How Swedes Became Nervous: Some Reflections

There had been hysterics and hypochondriacs among the Serafimer's patients all through the nineteenth century, but it was only in the 1880s that the number of nervously ill patients started to grow. Evidently, some of the nervous patients had brain tumours, neurophysiological disorders (such as paralysis agitans, later re-named Parkinson 's disease) and various infectious diseases which were damaging to both physical and mental health. Physical pain and discomfort caused nervousness on a large scale in 1891, as it did also in 1791 or 1991. Thus, a patient who was nervously ill might very well have been physically ill as well, and observation of the close interrelationship between 'psyche' and 'soma' in such illnesses as neurasthenia makes it readily understandable why neurologists differentiated neuroses from mental disorders.

The establishment of the *Nervklinik* created for the first time a distinct nervously ill patient population in Sweden. Compared with most European countries, neurology in Sweden became an independent medical specialty quite early, only five years after the establishment of the first neurological chair in the world, in France (for Charcot) in 1882, and earlier than the first chairs in neurology in the German-speaking countries. Still, the early history of neuroses in Sweden does not differ that much from in other European countries, for Swedish physicians were heavily influenced by medical trends in Continental Europe, especially in France and Germany. Doctors who first introduced modern neuroses to the Swedish medical community had visited France and watched Charcot or Bernheim (or Liebèault) in action, and the Salpêtrière School in particular had a major impact on the early medical discourse on neuroses in Sweden. Somewhat later, the more psychological views of the Nancy school were also introduced into Swedish medical community. As I have showed in this chapter, the Serafimer's *Nervklinik* and its' chief physician, Lennmalm, were most responsible for introducing modern neuroses to the Swedish doctors.

But, as the later chapters will demonstrate, there was another, more practical and unofficial channel through which neuroses spread among the Swedes. In fact, it was the emergence of two different clinical settings which rendered possible the rise of functional neuroses in Swedish medicine in the last two decades of the nineteenth century. First, the Serafimer's *Nervklinik* gave neuroses an official home base in Sweden, as it were, because physicians at the clinic were predisposed to accept the reality of 'functional nervous illnesses', and to disseminate medical

knowledge about these illnesses through their writings and public discussions. The academic physicians at the Serafimer's clinics were the professional group most instrumental in establishing neurosis as a major malady in Sweden. Second, neurosis was pushed to the foreground of medical attention by hypnotism, partly because of the huge influence of Charcot's coupling of hysteria and hypnotism on the medical explanation on neuroses, and partly because nervous illnesses were thought of as the main clinical targets of hypnotherapy. (I shall examine the short golden age of hypnotism in Sweden in Chapter 6.)

The years between 1880 and 1900 comprise the period during which the Age of Nervousness was inaugurated in Sweden. This does not mean that neurosis suddenly became an endemic or fashionable illness which was the talk of the town in the relatively small middle-class circles in Swedish towns. But the intellectual elite and, increasingly, ordinary people, were not only aware of the existence of the new language of nerves, they were also employing such language themselves: In the Questions and Answers section of the popular medical journal *Hälsovännen* ('A Friend of Health'), many readers in the 1890s inquired about available remedies for nervousness and weak nerves. Like August Strindberg, who 'nervously' walked the streets of Paris in 1894, more and more Swedes were articulating their emotional and mental states in a language of nerves.

CHAPTER THREE

WEAK NERVES, DEGENERATION AND RACIAL HYGIENE: HEALTH IDEOLOGY IN THE AGE OF NERVOUSNESS

As part of the modernisation of the nation-state, the Swedish government became more active in different areas of social life, including health care, at the turn of the twentieth century. New measures of population policy were adopted as a governmental tool that would help make Swedes healthier and stronger as a nation. Social hygienic principles—developed in Germany by Alfred Grotjahn and others—were adopted to enlighten and educate the population, and to make people live correctly. This public health ideology was based on the fundamental assumption that the medical authorities had a right to intervene in the life of the individual for the good of the society, and to create a new kind of citizen who would conduct his or her life according to the rational principles and healthy values provided by men of medicine. Despite the strong egalitarian tradition in Sweden, the mostly upper-middle-class physicians (as well as academic intellectuals and civil servants) had a distinctly paternalistic attitude towards 'the people', who had to be educated into healthy and morally upright living.

Small wonder, then, that the mental hygiene movement, which originated in the United States, found a favourable climate in Sweden.[1] While the 'short-term' or the more practical goal of the mental hygiene ideology was the prevention of mental illnesses through such measures as sterilisation and advice on the proper way to raise and educate children and youth, the ultimate goal was to make the Swedes a healthy, moderate and wholesome people. It became a social obligation to remain in good health,[2] and implicit in this new health ideology was the normative notion that the ill are often responsible for their diseases and disabilities.

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[1] On health ideology in early twentieth-century Sweden, see Roger Qvarsell "Socialmedicinen och den sociala ingenjörskonsten," *Nordisk Medicinhistorisk Årsbok* 1995, 125–48; Qvarsell, *Vårdens idéhistoria*; Karin Johannisson, *Medicinens öga* (Stockholm: Norstedts, 1990); and Johannisson, "Folkhälsa."

[2] On the social role of medicine in early twentieth century Sweden, see Eva Palmblad, *Medicinen som samhällslära* (Göteborg: Daidalos, 1990).

In the Swedish state-governed health ideology, physicians were destined to become the new priesthood of modern society. As professor of practical medicine, Seved Ribbing, wrote in 1915, physicians have to replace pastors and take precautions against social evils that threaten the community. Physicians have to become specialists in medical ethics, and they should not only cure the people, but also help them in troubled times and teach them how to maintain health and strength through prophylactic procedures of planning and discipline.[3] In an earlier article (1900), he had lamented that medical research had not yet penetrated general education and social life.[4] This was, by and large, a correct evaluation of the situation: people increasingly began to see doctors only in the 1910s and the 1920s. Until then, quackery or folk medicine flourished especially in the countryside, and there were 'wise' men or women in virtually every parish.[5] A fight against folk medicine and homeopathy preoccupied physicians in the early twentieth century, and the new medical legislation in 1915 included a law against quackery (the law was revised in 1960).[6] Official medicine did not fully succeed in eliminating quackery, and 'alternative medicine' as well as 'holistic medicine' (which laid stress on the healing powers of nature) have played their role in the modern history of Swedish medicine.[7]

Starting from the 1880s, the public health policy became an essential component in the Swedish social project that aspired to create a new, distinctly 'modern' nation. Doctors, who craved official authorisation and aspired to become scientific policymakers for the new age, began to formulate medical explanations of and solutions to a whole gamut of pathology, ranging from physical and mental illnesses to such 'social illnesses' as criminality, alcoholism, prostitution, vagrancy and 'sexual aberrations'. Alcoholism and venereal diseases (especially syphilitic diseases) were regarded as particularly serious threats to the health of the

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[3] Seved Ribbing, *Den sexuella hygienen och några av dess etiska konsekvenser* (Stockholm: Albert Bonniers Förlag, 1915), 7.

[4] Seved Ribbing, "Läkarevetenskapens och läkareståndets ställning till det moderna samfundet," *Eira* 24 (1900): 39.

[5] Ole Berg, "The Modernisation of Medical Care in Sweden and Norway," in *The Shaping of the Swedish Health System*, ed. A. J. Heidenheimer and Nils Elvander, 26–9.

[6] Motzi Eklöf, "Obehörig psykiatri—Om kvacksalverilagstiftningen och utdefinierandets svåra konst," in *Psykiatrins marginaler*, ed. Qvarsell and Eriksson, 97–130.

[7] Eklöf *Läkarens ethos*. On the relationship between licensed and unlicensed medical practitioners ('quacks') in Sweden in the eighteenth and nineteenth centuries, see Sofia Ling, *Kärringmedicin och vetenskap*. Studia Historica Upsaliensia 212 (Uppsala: Uppsala University, 2004) (English summary).

nation.[8] The conservatives, the liberals and, later, the social-democrats felt equally at home with this moral-hygienic discourse, which was based on the anti-liberal idea that, as professor in neurology, Frithiof Lennmalm put it in his commentary on prostitution, "if society is to remain, we have to hold on to the notion that society is more important than the individual".[9]

'Our Nervous Age'

In the writings on neuroses, nervousness and 'weakness of the nerves' published between the 1880s and World War I, it was customary to refer not only to nervous individuals but also to the nervousness of the whole epoch—'our nervous age'. In his inaugural speech in May 1887, the first professor of neurology in Sweden, P. J. Wising, observed that "rightly or wrongly, our generation considers itself to be more disposed towards these nervous illnesses than any previous generation".[10] In its advertisement for Paul Berger's book on neurasthenia, the publishing house Beijers announced in 1890 that "nervousness is undoubtedly the most wide-spread illness in our time—at least in big cities."[11] Wising's successor Lennmalm remarked in his own inaugural speech in February 1891 that "it is customary to call our age the nervous century".[12] A few years later, Bror Gadelius noted in his dissertation on 'obsessions' that it was only in "our nervous age" that Edgar Allan Poe had gained respect.[13] Nervousness turned out to be an extraordinarily persistent cultural ailment, for half a century later there were no signs of abatement of this problem. "Everywhere one turns one hears that people are nervous,"[14] Torsten Ramer noted in 1936, and he was far from alone in making such an observation. In his 1944 manual on 'nerve illnesses', homeopathic therapist Erik Hultén supported Coué's style

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[8] Palmblad, *Medicinen som samhällslära*, 52–65.

[9] Frithiof Lennmalm, [Commentary on the regulation of prostitution], *Förhandlingar*, April 9, 1912, 352.

[10] Wising, "Om nervpatologiens utveckling," 430.

[11] Paul Berger, *Nervsvaghet (Neurastheni)* (Stockholm: F. & G. Beijer's förlag, 1890).

[12] Lennmalm, "Om de viktigaste orsakerna till nervsystemets sjukdomar," 270. See also Lennmalm, "Om de s.k. traumatiska neuroserna," 252, where he refers to the "increasing number of nervous complaints in our 'nervous' age."

[13] Bror Gadelius, *Om tvångstankar och dermed beslägtade fenomen* (Lund: Lunds Universitet, 1896), 231.

[14] Torsten Ramer, "Nervositet och uppfostran," *PTSU* No. 4 (1936): 171.

of self-suggestion as a means of reducing the widespread nervousness: "Repeat aloud at regular intervals every day: I am not sick! Emphasise the word 'not'. Or [say aloud]: I don't have any complexes!"[15]

It is easy to find numerous similar statements, often expressed in psychological and psychodynamic jargon, in twentieth-century Swedish medicine and psychiatry. To give a few more illustrations, Emanuel af Geijerstam noted in 1920 that the suppression of a "spontaneous, naive lust for life" during cultural evolution was at the root of neurosis;[16] Birger Norrbin announced in 1937 that it was civilisation itself which tended to create preconditions for the increase in mental illnesses;[17] John Agerberg referred in 1943 to "modern machine culture" which had created a previously unheard-of condition, mental stress (*jäktet*);[18] Iwan Bratt estimated in 1946 that seventy-five per cent of people who consulted doctors were damaged by the "spirit of society" (*samhällsanda*);[19] and Pierce Butler observed in 1956 that the modern society's "stress", "relativism" and "secularisation" had a tendency to destroy traditional normative codes.[20] In short, all that was solid melted into the thin air, as a result of which the whole epoch was infused with nervousness.

The fundamental assumption of the Age of Nervousness was that there were elements in modern life that were potentially hazardous to nervous health. These dangerous elements contributed to the cultural 'crisis' that many, if not most, Swedish physicians saw as a characteristic feature of their age. The German historian Reinhart Koselleck—one of the main developers of the history of concepts or *Begriffsgeschichte*—observes that far from designating a state of emergency, the term 'crisis' is an aspect of everyday life, and has been so for much of the nineteenth and twentieth centuries. He refers to the definition of crisis in an 1840 French dictionary: "The concept indicates uncertainty, suffering, an ordeal, and suggests an unknown future whose suppositions will not permit sufficient clarification."[21] He goes on to note that

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[15] Erik Hultén, *Nervsjukdomar och deras behandling* (Göteborg: Rammes förlag, 1944), 7.

[16] Emanuel af Geijerstam, "Några ord om den anagoga psykoanalysen," *SLT* 17 (1920): 645.

[17] Birger Norrbin, "Sinnessjukdom och sinnessjukvård," *SMT* 14 (1937), 30.

[18] John Agerberg, "Livsåskadning och själshälsa," in John Agerberg et al., *Själens läkarbok* (Stockholm: Natur och Kultur, 1943), 451.

[19] Iwan Bratt, *Ett är nödvändigt* (Stockholm: Natur och Kultur, 1946), 175.

[20] Pierce Butler and Erik Arbin, "Sjukdom och andlig hälsa," *SMT* 33 (1956): 71–5.

[21] Reinhart Koselleck, "Some Questions Concerning the Conceptual History of 'Crisis'," in *Culture and Crisis*: *The Case of Germany and Sweden*, ed. Witoszek and Trägårdh, 12.

> if the multiple usages of the word were a sufficient index of actual crisis, we would be living in a crisis of all-encompassing proportions. However, this illustrates a widespread manner of speech rather than [contributes] to the diagnosis of our plight.[22]

Koselleck examines the conceptual history of 'crisis', focusing on the linguistic usage of the term in various social contexts. He has discovered that it was the medical use of the term in the Hippocratic School that provided the blueprint for its future usages. And as medical language also contributed to the metaphorical use of the concept of the nation-state in the nineteenth century, there began to appear political 'diagnoses' of the state's sickness or health, life or death.

Koselleck's historical analysis of the concept of 'crisis' clarifies the reason why so many physicians of the past 150 years or so have been so eager to make diagnoses of the state of society and culture, and why the medical term denoting cultural crisis, 'the nervous age', was such a popular metaphor at the time when modern neuroses appeared on the scene. Furthermore, since the time 'crisis' was adopted by philosophers of history, "it has always been one's own point in time that is experienced as critical".[23] And what Roy Porter has called the 'darkening of the vision' in late nineteenth-century cultural atmosphere affected by degenerationism, social Darwinism and the emergence of revolutionary Marxism, fuelled the pessimistic feeling that "civilization itself was diseased, indeed a disease".[24] This explains why there appeared to be a continual state of crisis in Sweden and Europe between 1880 and 1950 (and beyond). The atmosphere of socio-cultural decay and doom was partly created by a popular doctrine that fanned the spirit of therapeutic nihilism and prompted doctors to explain the apparent proliferation of nervous illnesses in terms of degeneration.

Degenerationism and the Neuropathic Constitution

Starting in France, the idea of the role of heredity in spreading sickness became firmly anchored in medical consciousness in the latter half of

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[22] Ibid.
[23] Ibid., 15.
[24] Roy Porter, "Diseases of Civilization," *Companion Encyclopedia of the History of Medicine*, ed. Bynum and Porter, 592–3.

the nineteenth century.[25] The suggestion that hereditary factors made people constitutionally disposed to specific diseases gave rise to such doctrines as degenerationism, according to which hereditary transmission of bad germ plasm would have a cumulative deleterious effect on the family, culminating in mental insanity and idiocy.[26] Psychiatrists of the founding generation in the eighteenth and early nineteenth centuries, such as Pinel and Esquirol, had already emphasised heredity, and the psychiatry of the latter half of the nineteenth century was emphatically somatic in orientation. Originally created in the late 1850s by two French psychiatrists, Benedictine Auguste Morel and Jacques Joseph Moreau,[27] the theory of degeneration centred on the Lamarckian idea that physical and mental disorders accumulated as a result of the interplay between innate characteristics and pathogenic environments. According to this theory, the Lamarckian mechanism of the inheritance of acquired pathological characteristics contributed to racial decline, the end result of which would be the disintegration of society through internal psychophysiological decay. Thus mental illness and idiocy were interpreted as the last links in the psychogenic chain of degenerate heredity.

During the final quarter of the century, the theory of degeneration became a standard mode of explanation in psychiatry, even though the German biologist August Weismann, on the basis of his research on 'germ plasm', could explain in 1885 why the environment could not cause adaptive changes in the hereditary material. Weismann gave Lamarckism its deathblow, but it took a considerable amount of

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[25] One of the first physicians to pay attention to hereditary factors in mental illness was Jules Baillarger, who published a paper on statistical research in the heredity of madness in 1844. From the early 1850s onwards, the newly-established *Société Médico-psychologique* in Paris was instrumental in establishing the theory of morbid heredity. See Ian Dowbiggin, "Degeneration and Hereditarianism in French Mental Medicine 1840–90: Psychiatric Theory as Ideological Adaptation," in *The Anatomy of Madness*., ed. W. F. Bynum and Roy Porter (London: Tavistock Publications, 1985), Vol. I, 190–1. On the relationship between heredity and madness in French neurology and psychiatry, see also Ian Dowbiggin, *Inheriting Madness: Professionalization and Psychiatric Knowledge in Nineteenth-Century France* (Berkeley: University of California Press, 1991).

[26] Daniel Pick, *Faces of Degeneration: A European Disorder, c. 1848–c. 1918* (Cambridge: Cambridge University Press, 1989). On the doctrine of degeneration in the French medicine, politics, and culture, see Robert Nye, *Crime, Madness and Politics in Modern France* (Princeton: Princeton University Press, 1984).

[27] B. A. Morel, *Traite des dégénérescences physiques, intellectuelles, et morales de l'espèce humaine* (Paris: Baillière, 1857); J. J. Moreau (de Tours), *La Psychologie morbide dans ses rapports avec la philosophie de l'histoire: ou de l'influence des névropathies sur le dynamisme intellectuel* (Paris: Masson, 1859).

time before his rejection of 'soft inheritance' was universally accepted. Although the mechanism of heredity remained basically a mystery to scientists until the discovery of Mendel's theory in the early twentieth century, it did not prevent physicians from making bold conjectures about the hereditary transmission of diseases. Degeneration theory was useful for psychiatrists who very much wanted to be scientists and healers, but whose achievements paled into insignificance when compared, for example, to Pasteur's and Koch's work in bacteriology. Historian Mark Micale has pointed out that degenerationism "provided a comprehensive explanatory system for psychopathology, and it rationalized therapeutic impotence among asylum doctors".[28]

For a few decades, psychiatrists in Continental Europe and Britain searched for 'stigmata' of degeneracy in the symptoms and physical signs of patients. As Henri Ellenberger, a historian of dynamic psychiatry, has observed, at that time "almost all diagnostic certificates in French mental hospitals began with the words *dégénérescence mentale avec*…".[29] As an atavistic doctrine of genetic fate, degeneration theory became increasingly implausible in the early twentieth century, when the developing genetical understanding of the mechanism of heredity made the scientific basis of the theory untenable. But the notion of degeneration was picked up by racial hygienists or eugenicists, who combined the notion of degeneracy with more up-to-date conceptions of heredity and social doctrines.[30]

Connected with degenerationism, the idea that nervous disorders resulted from the 'neuropathological constitution' inspired physicians looking for a solution to the riddle of mental illness. The French psychiatrist Jacques Joseph Moreau introduced the idea of 'nervous heredity' in his 1859 work on 'morbid psychology', where he promoted the view that there were forms of insanity that constitute a 'neuropathic family', and that these forms were rooted in the predisposing cause

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[28] Mark S. Micale, "The Psychiatric Body," in *Medicine in the Twentieth Century*, ed. Cooter and Pickstone, 327.

[29] Ellenberger, *The Discovery of the Unconscious*, 281.

[30] Daniel Kevles, *In the Name of Eugenics* (New York: Kopf, 1985); Sheila F. Weiss, *Race Hygiene and National Efficiency: The Eugenics of Wilhelm Schallmayer* (Berkeley: University of California Press, 1987); Sheila Weiss, "The Race Hygiene Movement in Germany," *Osiris*, Second Series, 3; Peter Weingart, Jürgen Kroll and Kurt Bayertz, *Rasse, Blut und Gene. Geschichte der Eugenik und Rassenhygiene in Deutschland* (Frankfurt am Main: Suhrkamp, 1988); and Ian Dowbiggin, *Keeping America Sane: Eugenics and Psychiatry in the United States and Canada, 1880–1940* (Ithaca: Cornell University Press, 1997).

of heredity.[31] Among such hereditary forms of insanity he and other hereditarians (such as Charles Féré and Morel's pupil Magnan) included epilepsy (which was commonly regarded as a neurosis in nineteenth-century medicine), chorea, hysteria, 'suicidal mania' and alcoholism. Of particular importance was Féré's theory (1884), which divided the 'neuropathic family' into 'neuropathological' and 'psychopathological' branches, the latter branch including hysteria and epilepsy.

One of the legacies of the French preoccupation with *folie héréditaire* ('hereditary insanity') was that neuroses such as hysteria and—later—neurasthenia were seen to be caused typically by the 'neuropathic constitution' or triggered by a 'hereditary disposition'. Physicians readily identified 'neuropathic constitution' with degenerationism, not only in France but also in Sweden: psychiatrist Frey Svenson, for example, suggested in 1909 that 'degeneration' could be disposed of and replaced by the term 'constitutional nervousness'.[32] Although degenerationism became outdated as a scientific theory after World War I, it constituted an essential component of racial hygiene ideology and sterilisation policy that became part and parcel of health care in many western countries, including in Sweden. It also shaped the language of nerves.

Nervousness and Culture in a Popular Medical Journal

In the Swedish popular medical journal *Hälsovännen* ('Friend of Health'), nervousness, neurasthenia and 'weakness of the nerves' were routinely coupled with the idea of the nervous age. Doctors who conjured up socio-cultural explanations of nervousness typically saw the 'struggle for survival', sexual 'excesses', the weakness of will, 'unnatural way of living' and other illness-inducing factors in modern civilisation as either leading to 'honourable' overstrain or exposing the hereditary inferiority of some segments of the population. "In the old days," noted psychiatrist Fredrik Björnström, "people had to strain their muscles; now they have to strain their nerves."[33] Wilhelm Wretlind, the editor and the *primus motor* of *Hälsovännen*, claimed that the nervous system of modern people is of lesser quality than that of past peoples, and he gave a list

[31] Moreau, *La Psychologie morbide*.
[32] Frey Svenson, *Själslivets hygien* (Stockholm: Aktiebolaget Ljus, 1909), 112, 115.
[33] Fredrik Björnström, "Hvilka äro orsakerna till vår tids sinnessjukdomar?," *HV* 3 (1888): 6.

of factors that he held responsible for this unfavourable development: the emergence of new forms of nervous illnesses; a growing number of mentally disturbed (*sinnesrubbade*); and the growing number of suicides.[34] He asserted that the weakness of will has probably become a more common illness in the nineteenth century, while his colleague Seved Ribbing ascribed to neurasthenia great social significance because of the large number of "mental invalids" this illness can produce.[35] Another doctor called neurasthenia the "social plague".[36]

Socio-cultural and psychological factors that were seen to be causative factors in nervousness included women's education, emotional outbursts, overstrain in schools and materialism with its alleged spiritual impoverishment and its 'worship of reason' and money.[37] Doctors who were especially worried about the impact of modern 'over-refined' civilisation on the 'constitutionally' inferior groups of people were prone to interpret nervousness as a sign of degeneration, the indications of which were an insufficient exercise of will power in the 'struggle for life', animosity against the social order, mental illnesses, suicides, and an ambition to go beyond that which is 'natural'.[38] District medical officer Hjalmar Selldén, for example, suggested that the nervously ill people should not start a family and breed offspring, because heredity or the 'neuropathic constitution' was one of the main causes of the weakness of nerves.[39] One's nervousness was therefore a warning sign indicating mental and moral decline. Selldén observed in 1895 that

> [The word] 'nervous' is at least as dangerous as cholera vibrio, or rather, it is much more dangerous, because we have succeeded in keeping cholera out of Sweden, but the whole nation is vulnerable to nervousness, which threatens to lead the whole population to perdition.[40]

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[34] E. W. Wretlind, "Självmorden—ett bevis på vår tids nervsvaghet," *HV* 12 (1897): 343.

[35] E. W. Wretlind, "Om andlig öfveransträngning, specielt genom studiearbete," *HV* 2 (1887): 317–22; E. W. Wretlind, "Vår skolungdom och nervositeten," *HV* 20 (1905): 173–7; Seved Ribbing, [Commentary on Dr Wretlind's presentation], *HV* 2 (1887): 321.

[36] E. P. L. "Om den rådande nervsvagheten hos nuvarande civiliserade människor," *HV* 3 (1888): 222.

[37] E. P. L. "Om den rådande nervsvagheten;" "Om nervsvaghetens förebyggande hos vårt folk," *HV* 7 (1892): 110.

[38] E. M.-U., "Något om den mänskliga urartningen i våra civiliserade samhällen," *HV* 8 (1893): 157.

[39] Hjalmar Selldén, "Några ord om våra nervsvaga," *HV* 9 (1894): 19.

[40] Hjalmar Selldén, "Om vår tids predikant-sjuka," *HV* 10 (1895): 210.

In a later article he proclaimed that "a good part of the people of Sweden is degenerated".[41] One anonymous writer, who signed his articles with the initials E. P. L., saw the nervously and the mentally ill as contagious creatures spreading nervous and moral pests in their environment through their deleterious impact on their fellow humans' brain activity, and he referred to an ecstatic religious phenomenon (*predikosjukan*) in the mid-century Sweden as one illustration of such a nervous epidemic.[42]

'E. P. L.', who was one of the most fervent 'diagnosticians' of nervousness, proclaimed that the weakness of nerves was a folk disease (*folksjukdom*) of the most dangerous kind, and that the "survival of nations could be dependent on our ability to get the upper hand over the fundamental causes [of nervousness]."[43] His opinions reflected the unofficial Swedish 'Jante-law' (also known as the 'Royal Swedish Envy'), according to which 'thou shall not stand out': in addition to singling out gluttony, drinking and fornication as factors that shorten the human life, he referred to an unsound desire to become a Great Man, which only brings with it crushed illusions and shattered nerves.[44] Sound religiosity, humility, modesty and god-fearing, wholesome way of life were typically presented as a counter-force to the weakness of nerves. In such a moral reading of nervousness, it was only natural that doctors laid stress on the moral treatment of the nervously ill, asserting that what needs to be done to overcome nation-wide nervousness is to build up character and strengthen the will of those people who, unfortunately, learned the phrase 'I'm so nervous' before they learned to read or write.[45] As a more practical cure to nervousness (especially among women), physical work was recommended by some physicians, while others saw rest as a way to health, at least if the nervous invalid was a busy businessman.[46] In a way, these doctors regarded nervousness as a *nemesis* (punishment) resulting from a *hubris* of self-assertion and 'selfishness'.

The basic message sounding through in the writings on nervousness published in *Hälsovännen* was that there was a reciprocal link between

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[41] Hjalmar Selldén, "Är vårt folk hopplöst degenereradt?," *HV* 18 (1903): 107–11.
[42] E. P. L., "Nervösa och moraliska smittor," *HV* 4 (1889): 134–9, 149–51.
[43] E. P. L., "Om nervsvaghetens förebyggande hos vårt folk," 107.
[44] Ibid., 111.
[45] Selldén, "Om vår tids predikant-sjuka," 210; Selldén, "Några ord om våra nervsvaga," 21–3; Selldén, "Är vårt folk hopplöst degenereradt?," 193.
[46] Dr Lorentzen, "Huru blifva vår tids affärsman nervösa?" [Originally published in *Dansk Sundhedstidende*], *HV* 4 (1899): 256–60.

socio-cultural changes and nervousness: these changes and reforms were by and large evaluated as harmful to Sweden's national health. In modern Sweden, nervousness, alcoholism, mental illnesses, syphilis and acts of suicide were seen to be rampant, and these pathological phenomena 'demonstrated' that the changing society itself had become pathological. Thus conservative physicians employed a form of rhetoric that was directed against progressive policies of the turn-of-the-century Sweden.

Economist Albert Hirschman has examined formal types of conservative rhetoric in his book, *The Rhetoric of Reaction* (1991), where he illustrates the ways in which conservative critics have argued against progressive policies in the nineteenth and twentieth centuries. Hirschman has found three major reactive-reactionary theses, which he calls the perversity thesis, the futility thesis and the jeopardy thesis. He characterises this 'triad' as follows:

> According to the *perversity thesis*, any purposive action to improve some feature of the political, social, or economic order only serves to exacerbate the condition one wishes to remedy. The *futility thesis* holds that attempts at social transformation will be unavailing, that they will simply fail to 'make a dent'. Finally, the *jeopardy thesis* argues that the cost of the proposed change or reform is too high as it endangers some previous, precious accomplishment.[47]

Hirschman gives an insightful analysis of the formal properties of conservative arguments against the French revolution, political reforms (universal suffrage, rise of democracy) and the development of the welfare state, but he also stresses that these arguments "can be invoked by any group that opposes or criticises new policy proposals or newly enacted policies".[48]

Of the three reactive-reactionary theses that Hirschman analyses in his book, two can be easily found in the rhetoric of Swedish doctors, namely the perversity thesis and the jeopardy thesis. Doctors emphasised the undesirable medical and moral consequences of reforms and changes by conjuring up a picture of a nation that was corrupting medically and morally (the perversity thesis), and, even if they acknowledged that reforms appeared to be 'materially' beneficial to

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[47] Albert Hirschman, *The Rhetoric of Reaction* (Cambridge, MA: The Belknap Press of Harvard University Press, 1991), 7.

[48] Ibid.

large segments of society, they were also quick to proclaim that changes or reforms constituted a threat to the nervous health of the population (the jeopardy thesis). Doctors readily associated women's emancipation, secularisation and social mobility with what they presented as an increasing mental and nervous ill-health, and they employed medical language to express, on the one hand, their discontent with cultural developments and new social arrangements, and, on the other hand, their habit of translating social and political categories into moralistic judgements: it was the individual who was responsible for his or her misery (e.g. poverty or mental illness). And, like in Finland at that time,[49] doctors were prone to associate the 'nervousness' of common people with socio-cultural changes, or with the inferior characteristics of individuals and families, rather than with adverse social conditions, class-based prejudices or political ideologies that legitimated the status quo in society. In short, in the rhetoric of doctors who contributed to *Hälsovännen*, socio-cultural changes and reforms supposedly created 'mental invalids' and undermined both the physical and mental health of the nation. It was these conservative and nationalistic 'mental habits' that prepared the ground for the successful institution of racial hygiene in early twentieth-century Sweden.

The alarmist medical rhetoric of *Hälsovännen* was probably rather favourable received by many medical officers who worked in the countryside, and who had first-hand experiences of the living conditions and diseases of country people. When district medical officer M. Haerén took up the issue of prophylactics against neurasthenia and hysteria at the Fifth General Meeting of the Swedish Society of Medicine in 1891, he presented these nervous illnesses as "a link in the chain of degenerative phenomena that manifest a regressive metamorphosis in overcultivated humanity".[50] This was probably the first time the doctrine of degeneration was applied to nervous illnesses in a published medical discussion in Sweden. Dr Haerén also represented the emerging eugenic or racial hygienic ideology, suggesting that

> the weak elements of the living nation have to be eliminated for the purpose of protecting families from degeneration [...] Consequently [...] the only possible way to take safeguards against neurasthenias and

[49] Uimonen, *Hermostumisen aikakausi*, 102–35.

[50] M. Haerén, "Hvilka åtgärder kunna vidtagas att förebygga den bland vårt folk rådande neurastenien och hysterien? [Autoreferat]," *Hygiea* 53 (1891): 337–9.

> hysterias is something that would be equivalent to infusing new, healthier forms and elements into the hypercivilised society.[51]

It would be interesting to know how Dr Haerén's colleagues responded to his racialist exhortations. A different kind of racial idea came to the fore in Dr Köster's presentation of a case of hysteria at the Society of Medicine in December 1897. When Köster gave a case history of a young Jewish woman of Polish origin who suffered from hysterical paralysis, he mentioned that "the patient belongs to a notoriously nervous race".[52] It was indeed a commonplace prejudice at the turn of the century that Jews were especially prone to hysteria.[53]

Summary of Neuroticising Factors

To sum up, here is a list of the socio-cultural factors that Swedish physicians believed to be responsible for increasing nervousness between the 1880s and World War I:

1. *City life*. It was a commonplace assumption that the immediate source of nervous problems was the tendency of modern urban life to overtax the intellectual and emotional forces of town-dwellers. It was quite fitting that the 'father' of neurasthenia, George Beard, had his office in New York City.
2. *External physical circumstances*. These included bad hygiene, bad or polluted air in factories and offices; too much time spent indoors; exposure to dangerous substances (such as lead and mercury); and so forth. A lack of physical exercise was commonly regarded as detrimental to nervous health. In France, Baron Pierre de Coubertin founded the Olympic movement in order to "halt the universal neurosis of modern life". Coubertin thought of sport as "an incomparable psychic instrument", and "a dynamic to which one can profitably appeal in the treatment of many psychoneuroses".[54]
3. *Bad or insufficient nutrition*. Meat and animal fat were often considered nutritious, and a one-sided diet was to be avoided.

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[51] Ibid., 338.
[52] Dr Köster, "Höggradig hysterisk förlamning," *Hygiea* 60 (1898): 199–200.
[53] See Sander Gilman's studies on this subject.
[54] Quoted in Robert Nye, "Degeneration, Neurasthenia and the Culture of Sport," *Journal of Contemporary History* 17:1 (1982): 62.

4. *Excessive consumption of alcohol, narcotics, tobacco, coffee and tea*. Excessive drinking was perceived as widespread and especially detrimental to the nerves. The misuse of opium, morphine, and chloral-hydrate was less common, but it was seen to pose a serious threat to the nervous system.
5. *Physical exhaustion*. The exhaustion of a particular organ was believed to lead to damage in the nervous system. Thus, for example, watchmakers, painters and draughtsmen have to strain their eyes, which can debilitate their nervous system. Professions and occupations (such as that of doctor, nurse, or railway worker) requiring night-work often disturb sleep patterns which in turn has adverse effects on the nerves. Tedious and monotonous, mechanical work was seen to have a damaging effect on nerves.
6. *Deficiencies in child-rearing, upbringing and the educational system*. Modern parents did not have time to be fully occupied with bringing up their offspring; there was too much emphasis on the material well-being of children and too little emphasis on their moral well-being. A typical medical attitude was that of concern for the mental strain to which children were exposed in modern school, especially at the secondary level (*gymnasium*). This was seen to be partly a result of educational reforms requiring all parents regardless of their social background and mental qualifications, to let their children enter school. Another factor that allegedly increased nervousness at an early age was an excessive amount of intellectual work, especially in the *gymnasium*. Anaemia, weakness of nerves and the increased number of suicides among school children indicated that mental exhaustion in school had serious consequences.
7. *Mental exhaustion in working life*. A common medical perception was that too many people worked too hard, and that those who were occupied with brain-work were particularly vulnerable to exhaustion, which manifested itself in mental lethargy, headache, disturbed sleep, lack of appetite and depression.
8. *The changing role of women*. Neglect in instilling feminine virtues in young girls was seen to be responsible for creating women who were ill-equipped to take on their maternal responsibilities. Full access to education made too many women forget that their calling in life was marriage. It was claimed that female teachers, for example, often suffered a total exhaustion of their nervous energy and ended up as nervous wrecks. The emancipation of women brought with it increased nervousness, because women lacked the mental capacities to compete with men in tasks that required continuous intellectual activity.

9. *Sexual libertinism*. An increased interest in sensual pleasures was manifested in the increase in the number of prostitutes and of venereal diseases, syphilis in particular. A typical medical opinion was that there was a tendency in modern cultural life to provoke an interest in sexuality at too early an age. A natural but excessive and immoderate gratification of sexual instincts—e.g. in the form of masturbation—would soften the brain and damage the functions of the spinal cord.
10. *Mental shocks and emotional disturbances*. These shocks and disturbances were related to diseases, accidents and deaths of loved ones; economic worries; troubles in a marriage; experiences of humiliation or shame; and other distressing events and circumstances. Particularly exposed to emotional disturbances or shocks were individuals who had demanding work with a high degree of responsibility, or whose livelihood was constantly threatened by external circumstances (fluctuations in the financial market, industry, etc.). Military personnel, artists and civil servants were particularly susceptible to nervous illnesses.

I shall next examine the more sinister aspects of public health policy and medical ideology, which were manifested in the racial hygiene movement and sterilisation legislation.

"The Swede of Pure Nordic Type Is Tall and Strong"[55]

The expansion of hygienism became institutionally secured in Sweden in 1878, when the first chair of general hygiene was established at the Karolinska Institute. In 1907, the Medical Society founded a section that was devoted to questions of hygiene. Among other things, the ideological emphasis on the slogan 'a healthy mind in a healthy body' boosted the significance of organised sports, fuelled by the Olympic Games that were held in Stockholm in 1912. A more specific *racial*-hygienic ideology was institutionalised when the Swedish Society for Racial Hygiene and the Swedish Institute for Race Biology were established in 1909

[55] Herman Lundborg, "The More Important Racial Elements that Form a Part of the Present Swedish Nation," in *The Swedish Nation in Word and Picture*, ed. H. Lundborg and J. Runnström (Stockholm: Hasse W. Tullberg Co. Ltd., 1921), 27.

and 1922, respectively. The latter institute was supported by influential politicians and men of science (such as neurologist Frithiof Lennmalm, who became a member of the board of the institute), and its activities seemed to reflect the ambition to apply the latest scientific knowledge for the improvement of the hereditary qualities of the Swedes. As in some other European countries (especially France and Germany), the Swedish doctors were deeply concerned about the physical and moral condition of their national stock, and socially-oriented physicians had an ambition to influence public policy and give an expert's judgements on the 'hygienic' aspect of social issues. Psychiatrist Frey Svenson, a prominent advocate of mental hygiene, asked rhetorically in 1909: "What would they say if we demanded that one member of the government should be a physician?"[56]

The point Svenson and many other leading physicians were making was that medical expertise should be applied to all areas of social life, from hygiene, family life and education to the management of deviancies, including criminality, prostitution, feeble-mindedness, homosexuality, vagabondism and work-shyness. What is more, physicians could also help improve the hereditary qualities of the Swedish stock. The Swedish Institute of Genetics was founded in 1917–18 in connection with an establishment of a chair in genetics at the University of Lund, but it was the founding of The Swedish Institute for Race Biology in 1922 that institutionalised the state-financed study of the race-biological qualities of the nation.

In two articles published in The Journal of Swedish Medical Association in 1920 and 1921, the director-to-be of the Race Institute, geneticist and race biologist Hermann Lundborg, laid out the principles of Swedish racial ideology. In the first article, Lundborg warned against the damaging effects of industrial civilisation on race and public health and propagated the view that traditional rural living was the best prophylactics of social pathology.[57] After announcing that the Swedes were superior to other European nations both physically and intellectually, he tackled the core problems of public health as he saw them:

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[56] Svenson, *Själslivets hygien*, 78.

[57] Herman Lundborg, "Industriens försyndelser mot rasen och folkhälsan," *SLT* 17 (1920): 1102–9.

1. The socially inferior classes ('the proletariat') breed too many children.
2. The socially superior classes ('free peasants, educated middle class') breed too few children.
3. Because of these distorted demographic tendencies, there will be more and more 'inferior' people in Sweden unless the state takes precautions against these alarming tendencies.
4. Women should not enter labour market, being especially unsuited to industrial work.
5. Industry creates a proletariat which is overrepresented in poor houses, hospitals, prisons and workhouses.
6. Industrialisation equals proletarisation equals degeneration, which as a process might culminate in an anarchistic or Bolshevist revolution.

Lundborg admits that the nation cannot do without some sort of industry, but he proposes that it should be kept to its 'proper limits' lest it advance racial degeneration. He underlines his message that it would be too high a price to pay to sacrifice the last national reserve—national strength and racial excellence—in order to offer a temporal material relief to social misery. Judging by the message and the tone of his article, Lundborg was a fervent preacher and an authoritarian conservative, who romanticised peasant life and detested socialism, women in working life, and new modes of production that in his view created the proletariat, the main agent of degeneration. Apparently, Lundborg based his worries on the basic assumption of degenerationism, namely that "the degenerate, driven by perverted sexual appetites and lacking self-control, would breed disproportionately," and that this interbreeding of misfits and profligates "would lead, over the generations, to the swamping of the healthy by the residuum."[58] Moreover, Lundborg was clearly a late representative of a mode of medical thinking which presented urban life as breeding disease (due to population density, poor hygiene, sewers, infected air, lack of morals, etc.). This belief in urban corruption had been considerably weakened by the early twentieth century, when it became evident that town-dwellers did not enjoy poorer life chances than folks in the countryside anymore, quite the contrary.[59] But in Sweden, urbanisation and industrialisation were

[58] Porter, "Diseases of Civilization," 503.
[59] Ibid.

still relatively new phenomena when Lundborg wrote his article, and the poor living conditions in the working-class districts of bigger towns such as Stockholm might have added fuel to Lundborg's flames. His suspicion of the 'socially inferior classes' represented the prevailing conservative attitude which emphasised the need for surveillance of the 'unruly' proletariat that is governed by irrational and potentially violent instincts.[60]

In his second article, Lundborg gives an overview of the planned Race Institute, with a budget proposal and a description of the institute's main policy. He raises the issue of racial degeneration and contends that "the time will soon be passed when the only or the principal duty of medical men was to 'cure' sick individuals." Today, says Lundborg, medical scientists have to expand their scope of activities and duties and become

> advisers and helpers of the family and the nation…Racial biology is not only a medico-biological discipline, but also a socio-medical discipline—it can even be characterised as a branch of sociology.[61]

Lundborg does not fail to mention that two leading physicians at the Karolinska, Frithiof Lennmalm, professor of neurology and his old teacher, and psychiatrist Bror Gadelius, have supported the plan to establish an independent institute (and not just an academic chair) for the study of racial-hygienic issues. He also refers to the leading German racial hygienist, Erwin Baur, who was invited to Sweden to give lectures, and who had publicly supported the planned institute.

Lundborg's article was partly a polemic directed at a group of professors at the Karolinska who, unlike Lennmalm and Gadelius, were not convinced of the necessity of establishing a separate, independently-run institute for racial-hygienic studies. He ends his article in a pompous note by declaring that what is at stake here is "nothing less than an attempt to protect our folk [*stam*] from dangerous internal enemies. To accomplish this, no sacrifice is too big."[62] No mild rhetoric from the foremost advocate of 'racial sociology' for whom the 'pure' family and the 'pure race' are not just objects of study but also objects of boundless

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[60] Nina Witoszek, "Moral Community and the Crisis of Enlightenment," in *Culture and Crisis*, ed. Witoszek and Trägårdh, 51–2.

[61] Herman Lundborg, "Ett svenskt rasbiologiskt institut," *SLT* 18 (1921): 186.

[62] Ibid., 192.

veneration and patronising protection.[63] As a staunch believer in the importance of keeping Sweden racially as pure as possible, he was worried about the influx of foreign racial elements in Swedish soil.[64]

The ultimate goal of Lundborg's work, The Swedish Institute for Race Biology (*Statens Institut för Rasbiologi*), was established in 1922 in Uppsala, and it was supported by the scientific community, as well as by the broad political majority, from social-democrats to conservatives. More than anything else, the institute was Lundborg's creation, an institutionalisation of his burning vision. It was the first of its kind in the world and a model for the Kaiser Wilhelm Institute for Anthropology, Human Genetics and Eugenics that was founded in Germany in 1927. The institute continued its work independently until 1958, when it was assimilated into Uppsala University and renamed the 'Institute for Human Genetics' (*Humangenetiska Institutet*). Obviously, in the post-war cultural atmosphere, 'racial biology' had an ominous ring to it.

Reactionary Modernism, Medicine and the Folkhem

In Lundborg's racial-hygienic views, one can clearly see a conservative, paternalistic and nationalistic attitude combined with a scientific ethos. In his worldview, 'the good' (law-abiding, racially pure Swedes), 'the bad' (criminals, sexual perverts and other degenerate misfits) and 'the ugly' (people of mixed or foreign, inferior racial origins, such as the Finns) were easy to identify and classify, while his more modernist approach to social issues is evident in his conviction that with the help of biological sciences and anthropology, the roots of social evil could be eradicated. He could be called an exponent of 'reactionary modernism', a term used by historian Jeffrey Herf to denote a specific type of German conservative thought which "incorporated modern technology into the cultural system of modern German nationalism".[65] Not surprisingly, Lundborg

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[63] A religious attitude towards the family and the race shines through Lundborg's main work in the field of racial hygiene. See Hermann Lundborg, *Rasbiologi och Rashygien* (Stockholm: Norstedt, 1922).

[64] Lundborg, "Ett svenskt rasbiologiskt institut," 33. See also J. Wilhelm Hutcrantz and Emanuel Bergman, "The Struggle for Race-Improvement in Sweden," in *The Swedish Nation in Word and Picture*, ed. Lundborg and Runnström, 74.

[65] Jeffrey Herf, *Reactionary Modernism* (Cambridge: Cambridge University Press, 1984).

had close contacts with German racial hygienists and, like them, he believed that Germans and Swedes were racially close relatives. In 1921, he refused to attend The Second International Congress of Eugenics in New York because no Germans had been invited there.[66] Like his German counterparts, albeit to a lesser degree, Lundborg rejected the 'soulless materialism' of the Enlightenment while embracing scientific technology and pragmatic rationality.

In Germany, 'reactionary modernism' was a tradition of the political right, and there is no doubt that Lundborg and those who supported his endeavour, such as Lennmalm and Gadelius, were politically conservative and nationalistic to some degree. However, compared to Germany, 'reactionary modernism' in Sweden was less irrationalistic and more concerned with the reconciliation between scientific modernity and traditional national values, often embodied by the free and proud peasantry. In the early decades of the twentieth century, Sweden was still a rather rural country, and many representatives of the educated middle class had their roots in the countryside. It seems that the new members of the *Bildungsbürgertum* in Sweden were proud of their rural heritage, and that this pride in the old, traditional ways of life constituted an essential element in their political views. Lundborg's world view can be seen as an extreme example of a characteristically Swedish type of reactionary modernism.

Lundborg's successor, Gunnar Dahlberg, had a less authoritarian and more egalitarian attitude towards public health and 'racial hygiene'. Dahlberg became head of the Race Institute in 1936, at a time when the era of social-democratic hegemony in Sweden had begun. During the early period of the (predominantly) social-democratic rule that began in 1932, the authorities were keenly interested in public health in general and in practical medical solutions to social problems in particular. In fact, in 1935, the political decision to establish the State Institute of Social Hygiene and the coming into force of the sterilisation law were the final milestones in the early history of Swedish public health ideology. Far from being a relic from the conservative-authoritarian past, sterilisation policy was a major component in social-democratic health ideology that put a premium on the usefulness and productivity of citizens.

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[66] Herman Lundborg, [A written announcement to the Medical Society], *Förhandlingar*, August 2, 1921, 247.

The medical and political discussion of sterilisation legislation had begun after World War I, and the eugenic and non-eugenic policy of sterilisation was carried out between the years 1935–1975.[67] During these four decades, about 63,000 Swedes were sterilised on eugenic, medical and social ('unfit to raise children') grounds, and ninety-three per cent of sterilisations were performed on women, most of whom represented the 'dregs' of society. A substantial historical study of Swedish sterilisation laws shows that the use of sterilisation was frequent in hospitals and institutions for the mentally disabled in the 1940s, and that "Swedish sterilisation policy in the 1930s and 1940s developed into a harsh system of control and coercion with little respect for individual rights."[68]

In spite of the openly authoritarian medical policy, such pro-eugenic physicians as the radical left-winger Gunnar Inghe seemed to be genuinely surprised at the common people's rather negative attitude towards sterilisation. "Among the general public there prevails a widespread suspicion [towards sterilisation and abortion]," writes Inghe in 1945. He continues: "Therefore, it is often difficult to persuade the client to accept sterilisation."[69] Inghe appears to be vexed at the people's apparent inability to concur with the rational standpoints of experts who want to sterilise the 'feebleminded' and other 'defective' individuals for the sake of future generations. Obviously, the relative value monism of the Swedish *Bildungsbürgertum* did not always harmonise too well with the pluralism of the people's will.

The influence of eugenically-oriented medical professionals on the sterilisation policy was crucial, and their role may be seen as a logical outcome of the early twentieth century medicalisation process in which social issues were increasingly treated as medical problems, and in which those segments of the population who did not fulfil the criteria for health, utility, cleanliness and rationality were seen as human

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[67] Mattias Tydén, *Från politik till praktik: De svenska steriliseringslagarna 1935–1975* (Stockholm: Acta Universitatis Stockholmiensis, 2002); Maija Runcis, *Steriliseringar i folkhemmet* (Stockholm: Ordfront, 1998); Zaremba, *De rena och de andra*. Gunnar Broberg and Mattias Tydén, "Eugenics in Sweden: Efficient care," in *Eugenics and the Welfare State*, ed. Gunnar Broberg and Nils Roll-Hansen (East Lansing: Michigan State University Press, 1996).

[68] Tydén, *Från politik till praktik*, 589.

[69] Gunnar Inghe, "Sociala synpunkter på den psykiska hälsovårdens organisation," *Social Årsbok* 1945, 79.

ballast burdening the national economy and contributing to the racial decline of the nation. According to this racial-hygienic ideology, the sole legitimate criterion of a person's value was his or her efficiency in the social machine, and those who were perceived as inefficient were relegated to the category of inferior elements in society.[70]

A medical representative of a rather fanatical kind of racial hygiene was Hugo Toll, a shrill advocate of racial purity and an authoritarian 'law and order' discipline, who accused 'modern culture' of diminishing the 'vital forces' of people, and of taming their 'healthy instincts'. For Toll, the comforts of modern life posed a serious threat to the racial quality of the Swedes, who seemed to have replaced the ancient and honourable principle of the 'struggle for survival' by the soft humanitarian ideal of the 'right to live'—in other words, the Swedes had begun to believe that the weak and the 'inferior' (the mentally handicapped, the demented, the insane, criminals and so forth) have a right to expect support and help from the state. Toll could not have disagreed more with this humanitarian view:

> Our general understanding needs to be changed so that we would understand that, if not always, then at least in most cases, it is a shame, indeed a great shame, to be ill and weak.[71]

It is the alleged discrepancy between the democratic and egalitarian ethos in Sweden and the flagrant suppression of individual rights that makes racial hygiene ideology and policy in Sweden—and other Nordic countries[72]—so puzzling a phenomenon. One explanation for the ardent interest in racial hygiene in the interwar years is that, during this period, the political and medical authorities in Sweden seemed to be inspired by a utopian dream of an 'improved edition of humans', the establishment of a New Man that would embody the rationally-ordered principles of the state and contribute to a building of a new

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[70] See Piero Colla, "Race, Nation and Folk," in *Culture and Crisis*, ed. Witoszek and Trägårdh, 131–54.

[71] Hugo Toll, *Den personliga hälsovårdens principer* (Stockholm: Albert Bonniers förlag, 1919), 21.

[72] For a historical study of eugenics in Finland until the promulgation of the Sterilisation Law of 1935, see Markku Mattila, *Kansamme parhaaksi. Rotuhygienia Suomessa vuoden 1935 sterilointilakiin asti* [English summary] (Helsinki: Suomen Historiallinen Seura, 1999). Between 1935 and 1970, 54,128 people were sterililised in Finland, 10,903 of them for eugenic or social reason (and 43,063 for medical reason). The sterilisation laws of 1935 and 1950 allowed operations without consent.

society. Conversely, those who were seen to represent disorder, impurity, asociality and irrationality (the mentally disabled, the insane, poor epileptics, criminals and prostitutes) constituted an impediment to social progress. Health was propagated as an indication of social progress both at the social and individual level; soundness, wholesomeness and rigour of body and mind were values the adoption of which would promote individual success irrespective of one's position in the social hierarchy. And although the links between hereditarianism and social problems remained strong in the interwar years, it was the development of the mechanisms of *social* selection that politicians and medical authorities were increasingly concerned with. Swedish social policy, which allowed the sterilisation of women whose behaviour was 'asocial', was grounded on social rather than genetic hereditarianism.

Another, related explanation for racial hygiene is the ideal of a productive society that was an essential component in Swedish social-democracy: a person's social worth was directly linked with his or her productive capacity. In an exclusionary concept of social welfare that was developed not only in Sweden but also in England (by Fabian socialists), a society has a duty to marginalise those individuals who were defined as non-productive. As Alberto Spektorowski and Elisabet Mizrachi have observed in their article on eugenics in Sweden, Swedish social democracy "advanced eugenic policies on the basis of technocratic, pragmatic and utilitarian ideas, rather than racist or romantic lines of reasoning".[73] As we shall see, it was this partly social-democratic, partly conservative ideal—derived from the traditional value system of free farmers—of the individual as a productive, efficient citizen that governed the discussion about the proper care of the nervously ill in Sweden, especially in the 1930s.

In the updated, social-democratic version of public health ideology, which gained prominence in the 1930s, health was incorporated into the reformist social vision based on scientific rationality on the one hand and a strong egalitarian ethos on the other. Every citizen had *both* a right to enjoy the benefits of a public health care *and* a duty to uphold a healthy lifestyle. As a manifesto of the working-class movement in the mid-1940s put it,

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[73] Alberto Spektorowski and Elisabet Mizrachi, "Eugenics and the Welfare State in Sweden: The Politics of Social Margins and the Idea of a Productive Society," *Journal of Contemporary History* 39:3 (2004): 339.

> many diseases are a conscious crime against society, an obstacle to the achievement of better living conditions. A socially-oriented citizen does not have a right to be ill in so far as he is himself responsible for his illness.[74]

This manifesto exemplifies the degree to which the workers' movement in Sweden had become accommodating and amenable to the doctrines of official health policy, in which health was part of the rational organisation of everyday life and the core value in the ideology of social engineering.[75] According to this ideology, the principles of a rationally-governed society would be implemented by experts in charge of developing the social and political organisation of society.

As historian Reinhart Koselleck has demonstrated, the concept of 'cultural crisis' has been employed time and time again by generations of educated people who have discerned fundamental political, moral and spiritual deficiencies in their societies (see above). Inevitably, neurosis was associated with 'cultural crisis' or the 'crisis of civilization' by the generation of nerve doctors who conjured up the notion of 'our nervous age' in late nineteenth-century Europe. Since the time these (often conservative) authors connected nervousness with specific aspects of cultural evolution, neurosis has been seen as a medical and psychopathological sign of civilisation gone astray, and, more specifically, as a manifestation of degeneration. For this reason, a study of neurosis and nervousness has to pay attention to ideologised and legalised prejudices and attitudes amply manifested in racial hygiene ideology.

The metaphor of 'the nervous age' runs like a red thread through the pages of this book, and would keep on running through the pages of another book dealing with the history of neurosis in the latter half of the twentieth century. The only remarkable change in the rhetoric of the nervous age in the post-World War II era was that the concept of 'nervous culture' was partly replaced by the more radical concepts of the 'sick' and 'sane' society (paradigmatically exemplified in the Marxist psychoanalyst Erich Fromm's *The Sane Society*, which appeared in 1955). The great difference between the critics of the 'nervous culture' and those of the sick society was that the first group consisted mainly of

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[74] *Arbetarrörelsen och folkhälsan: En programskrift* (Stockholm: Arbetarnas Bildningsförbund, 1945), 4.

[75] Qvarsell, "Socialmedicinen," 125–48.

conservative members of educated middle class, while the latter group included left-wing members of the educated middle class. In both cases, it was the *Bildungsbürgertum* that created, sustained and modified the discourse on cultural and social pathologies.

CHAPTER FOUR

MASTERS OF PSYCHOMEDICAL REALITY: NEUROSIS AND THE MEDICAL PROFESSION

In the early twentieth century, it was still customary for European physicians who wanted to learn about psychotherapy to consult neurologists, not psychiatrists, most of whom worked in mental asylums.[1] In the 1930s and 1940s, a practising nerve doctor in Stockholm or Gothenburg was still probably trained in neurology at the Serafimer's *Nervklinik*, where a great many Swedish neurologists and psychiatrists worked as interns and assistants from a period of six months to a few years. The lack of psychiatric clinics in Sweden before 1929 naturally increased the importance of the *Nervklinik* for young doctors interested in milder mental disorders. The medical profession also started to pay more attention to neuroses during and after World War I, which had produced a huge number of 'psychiatric casualties'.[2] Sweden remained a neutral country during the war, and Swedish physicians did not have an acute need to pay close attention to 'war neuroses' (*krigsneuroser*). Accordingly, only a few articles on the war neuroses—reviews of 'war literature'—appeared in the Swedish medical journals during and after World War I.[3]

The Great War taught the mental health professionals two crucial lessons. First, so-called war neuroses appeared to be psychological wounds caused by an emotional shock. Second, these wounds could, at least in principle, be healed by psychotherapy. These two wartime lessons had wide implications for the development of the psychosciences in the twentieth century, for if neurosis was indeed a mental wound, then the right person to take care of the wounded individual was someone whose area of expertise was mental illness: the psychiatrist. The dramatic phenomenon of war neurosis paved the way for the expansion

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[1] See, for example, Alfhild Tamm, "Om psykoanalys," *NMT* 5 (1933): 713.

[2] On the war neuroses in World War I and World War II, see Shephard, *A War of Nerves*.

[3] Harald Fröderström, "Krigsneuroserna," *SLT* 16 (1919): 1–20, 33–49; and Hjalmar Eneström, "Psykiska och nervösa sjukdomar hos krigsdeltagare," *ASLT* 16 (1919): 1081–101.

of psychiatric expertise, from the dark and intellectually dissatisfying field of severe psychoses, mental defections and dementias to the more rewarding field of mild mental disorders which were amenable to psychotherapy and other forms of 'soft', non-disciplinary treatment. War neuroses helped psychiatrists find alternatives to a professional life in a mental asylum, while neurologists became specialists in the study of the nervous system. In the first half of the century, a final 'division of labour' between neurology and psychiatry took place in western medicine, when clinical neurologists, aided by an increasingly sophisticated technology, restricted their domain of expertise almost exclusively to malfunctions in the brain and in the nervous system, while psychiatrists assumed the role of experts in the clinical domain of personality disorder.

The diminishing neurological interest in the 'functional nervous disorders' can be illustrated by a survey of conference programs. For example, of thirty-one presentations given at the Second Scandinavian Congress of Neurology in Uppsala in 1924, neurosis was discussed in only one presentation, and even that particular talk had a purely physiological approach to the illness ("Calcium in the treatment of neurasthenia"). The only other presentation that was in any way linked with neurosis was the nerve doctor C. V. Söderlund's talk on Freud ("Freud's doctrine from the neurological point of view").[4] At the Fifth Nordic Congress of Neurology held in Stockholm six years later (in 1930), none of the forty presentations dealt with neurosis (the special theme of the congress was epilepsy).[5] And when the Third International Congress of Neurology was held in Copenhagen on the eve of World War II, there were special sessions devoted to the emerging field of endocrinology, hereditary nerve diseases and the peripheral nervous system, whereas, once again, none of the presentations focused on neuroses.[6]

There was a Cartesian dualism in twentieth-century mental medicine: on the one hand, it was recognised that there were diseases of the brain and the nervous system, but, on the other hand, it was obvious that there were also illnesses of the mind. The fundamental problem was that it was often anything but clear whether a particular illness,

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[4] "Den 2:a skandinaviska neurologkongressen," *SLT* 21 (1924), 709–10. Söderlund's partly critical, partly positive evaluation of psychoanalysis was published in *Läkartidningen* later that same year. See C. V. Söderlund, "Modern neurosbehandling och Freud," *SLT* 21 (1924): 1095–102.

[5] "Den femte nordiska neurologkongressen i Stockholm," *SLT* 27 (1930): 1078–81.

[6] "3. Internationaler Neurologen-Kongress," *SLT* 36 (1939): 826–8.

such as schizophrenia, was one or the other. Concerning neuroses, the 'mentalist' view gradually became dominant, but the established idea that 'functional nervous illnesses' might have an 'organic substratum' lingered on, and in a country such as Sweden, where neurology had a relatively high profile as a medical specialty, neurologists and neurologically-trained nerve doctors remained the foremost neurosis experts until the 1940s when psychiatry, psychoanalysis and psychosomatic medicine all but annexed the clinical field of neuroses.

Neurasthenia as a Cross-Class Illness

At the time Pierre Janet was conceptualising the diagnostic category of psychasthenia in Paris, and Sigmund Freud had started to gather around him his first disciples (the Wednesday evening meetings) in Vienna, things were rather quiet on the northern front. The period between the end of the nineteenth century and the end of World War I was a period of transition in the history of neuroses in Sweden. While older, non-psychological views on neuroses still dominated the discussion of neurosis, these views were also challenged by more contemporary theories that offered new perspectives on mild mental afflictions. A new generation of hypnotherapists, who were also the founders of Swedish psychotherapy, started their professional careers in the early part of the century, while 'depth-psychological' views on neuroses adopted in the 1910s established the framework for the psychodynamic understanding of neuroses in twentieth-century Sweden (see Chapter 6).

At the turn of the century, neurasthenia was the foremost neurosis in western world, including Sweden, where it was discussed at the Nordic Congress of Internal Medicine in Gothenburg in September 1896. In his talk entitled "Neurasthenia and its occurrence in Scandinavian countries," professor Hugo Holsti from the University of Helsinki referred to a situation in Finland and noted that while it afflicted all social classes there, it was more common among the younger generation (between the ages of 16 and 30), workers and women than among the middle-aged, educated people and men, the reason for the latter imbalance being that Finnish women were expected to work hard in the still predominantly agricultural country.[7] Neurasthenia was also more widespread in towns

[7] Hugo Holsti, "Neurastenien och dess förekomst i de skandinaviska länderna," *Hygiea* 58 (1896): 288–91.

and in the southern (more industrialised) part of the country than in the countryside and the north. The illness appeared to be on the rise in Finland. As for its aetiology, Holsti takes into account both psychic and somatic aetiological factors, but in the published report he only refers to somatic factors, such as infectious diseases, anaemia and the use of narcotic drugs (morphine, chloral and cocaine).

According to the conference report, a lively discussion followed Holsti's presentation. One commentator (Dr Hansen) said that he had found neurasthenia to be very common in a small fishing community where people lived in cramped conditions, worked hard, did not eat properly, and were mentally abused by preachers of the worst kind. Preachers, said Hansen, had in fact a major influence on how the illness ran its course in this community.[8] Another doctor (Dr Backer from Norway) mentioned 'religious influence' as an aetiological factor in neurasthenia, and he also observed that young women who had been scared by wild animals develop neurasthenic symptoms. He also referred to masturbation as one of the principal causes of neurasthenia.[9] Next, Karl Petrén, a neurologically-oriented physician from the University of Lund, gave a report on his experiences as a spa doctor at Ronneby Spa in southern Sweden, listing exhaustion, depressed emotions, infectious diseases (e.g. influenza), masturbation and traumas as the most important aetiological factors. Further, the abuse of alcohol by previous generations "predisposes" descendants towards this illness, which is especially common among workers (the theory of the 'neuropathic family' is discernible here).[10]

A further proof that neurasthenia was not restricted to the intellectually overstrained middle classes was provided by Petrén, who later became a professor of medicine. In 1899, he gave a presentation on neurasthenia at the national medical congress, discussing the socio-economic background of his neurasthenic patients at the water cure clinics in Ronneby and Nybro. He observed that 198 of his 285 cases of neurasthenia over the past five years had belonged to the working class (manual workers)—almost seventy per cent of his neurasthenic patients were workers. These numbers did not surprise Petrén, for, as he pointed out in his talk, "the idea that neurasthenia is common

[8] Ibid., 290.
[9] Ibid., 290–91.
[10] Ibid., 291.

among the working classes is, if I am not mistaken, widely-held here in Scandinavia."[11] The fact that figures in Continental Europe were different could be explained by a different patient population: unlike in Sweden, 'external circumstances' at private nerve clinics in Europe made it impossible for manual workers to be admitted as patients—workers simply could not afford to stay at privately-owned clinics. Petrén classified his neurasthenic patients according to sex and social class, and the results can be seen in the following table:

Table 1. *The social differentiation of Karl Petrén's neurasthenic patients at the water cure clinics in Ronneby and Nybro*

SOCIAL DIFFERENTIATION OF PATIENTS	N	THE NUMBER OF THE CASES OF NEURASTHENIA	%
Upper-class males	226	30	13,2 %
Middle-class males	159	21	13,2 %
Working-class males	609	90	14,8 %
Male patients in total	*994*	*141*	*14,2 %*
Upper-class females	302	20	6,6 %
Middle class females	244	16	6,5 %
Working class females	940	108	11,4 %
Female patients in total	*1,486*	*144*	*9,7 %*
Sum total	**2,480**	**285**	**11,5 %**

Source: Petrén 1899.

Petrén acknowledges the difficulties in this classification, especially concerning the category 'middle class'; he includes such groups as primary school teachers and shop assistants in this category, which indicates that his 'middle-class' is in fact closer to 'lower middle class'. Obviously, professional groups such as lawyers, entrepreneurs and academics on the one hand, and high-ranking civil servants, on the other, are classified as belonging to the 'upper class' in Petrén's table. This would explain the otherwise rather peculiar phenomenon that the middle class is underrepresented in this table. Petrén also admits that the relatively high number of neurasthenics among his patients (11,5%) at Ronneby and Nybro gives no conclusive evidence about

[11] Karl Petrén, "Några kliniska rön om neurasteni," *Eira* 23 (1899): 655.

the nation-wide frequency of this illness; it only indicates the number of neurasthenic patients who have stayed at these two spas.

Petrén makes a number of observations based on this table. First, neurasthenia is more common among men than among women. Second, in the case of men, there is virtually no difference in the frequency of neurasthenia among different social classes. Third, in the case of women, there are considerably more neurasthenic patients among the working class than among the middle and upper classes. Compared to other categories, the number of middle- and upper-class women suffering from neurasthenia was much lower, which was a surprising result for Petrén. He explains this anomaly by the lighter work load of upper-class women, but does not weigh up the possibility that 'nervous' upper-class women were more likely to be labelled as hysterics than neurasthenics, which would explain their low representation in the statistics. Instead, he conjectures that the majority of upper-class women are free from the strain which upper-class men have to endure in their "struggle for survival", or, rather, for success. But the working-class women have to struggle as much as the working-class men to make a living, and this explains the fact there are almost as many neurasthenic women among the manual workers as there are neurasthenic men.[12]

It is a commonplace opinion, says Petrén, that neurasthenia is an illness that has its decisive aetiological momentum in the exhausting struggle for survival. It is assumed that modern life is transforming society and making working life more hectic and strenuous. Thus it is said that neurasthenia and nervousness in general have been increasing sharply in recent decades. Petrén thinks this assumption is plausible as far as the educated classes are concerned, but in the case of manual workers it is incorrect: most patients at Ronneby and Nybro live in the surrounding countryside in the south, which is one of the least modernised regions of Sweden. Of his neurasthenic patients, the majority were peasants. They had often fallen ill because of some depressing incident (death of a loved one, for example) or acute infectious disease. Further, bad hygiene, badly-kept houses and the low nutritional value of food are common causes of neurasthenia, as is probably also the excessive drinking of the patients' fathers. Petrén's conclusion is that, in the rural districts of southern Sweden, neurasthenia is not the result of modernisation, simply because it is probable that neurasthenia has been a common disease for centuries in this area. As a matter of fact,

[12] Ibid., 658.

contends Petrén, the modern age is not responsible for *any* increase in the frequency of "nervous degeneration", nor has cultural evolution increased nervousness in Sweden.[13] For Petrén, neurasthenia was an 'anti-modern', rural illness rather than a manifestation of overstrung modernity!

By all accounts, neurasthenia had become a real cross-class illness by the end of the nineteenth century, afflicting both the professional classes in urban metropolises and the 'lower classes' in remote villages. It had made a long journey from George Beard's office in upper-middle class Manhattan to the small fishing villages, workers' communities, and rural districts of Nordic countries. Although not many of Beard's neurasthenic patients in New York had developed their symptoms after confronting wild animals in their natural habitat, neurasthenia was not exclusively a middle-class affliction in the United States either. At the turn of the twentieth century, neurasthenia was the most common reason why Jewish textile workers in New York found themselves on the sick list.[14]

Serafimer's Nervklinik *After Lennmalm*

For more than thirty years (1891–1923), the heart and soul of the Serafimer's *Nervklinik* was Frithiof Lennmalm, professor of neurology at the Karolinska Medical School. His successor in the chair of neurology was Henry Marcus (1866–1944), who was only eight years younger than Lennmalm.[15] His chance of becoming professor of neurology arose only when Lennmalm had reached retirement age in 1923. By that time, Marcus himself was fifty-seven years of age and only eight years away from his own retirement. His Jewish father had emigrated from Germany, but, as his successor, Nils Antoni, assures his readers in his obituary of Marcus, "despite his non-Aryan origins, he had blue eyes, as had his wife and both of his children."[16] In his later years, he and his family converted to Christianity.

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[13] Ibid., 661.

[14] S. Wessely, M. Hotopf and M. Sharpe, *Chronic Fatigue and Its Syndromes* (Oxford: Oxford University Press, 1999), 116.

[15] On Marcus's life and work, see Lars Öberg, "Marcus, Henry Isaac," in *Svenskt Biografiskt Lexicon*, (Stockholm: Norstedts, 1987), Vol. 25, 126–9; and Nils Antoni, "Henry Marcus," *NM* 23 (1944): 1325–7.

[16] Antoni, "Henry Marcus," 1325.

Having had clinical experiences in both neurological and psychiatric work, Marcus warmly welcomed the intimate co-operation between neurologists and psychiatrists. Although he did not share his predecessor's clinical interest in neuroses, he nevertheless contributed to the clinical understanding of neuroses by initiating annual courses in neuroses, which would complement the regular courses in neurology at the Karolinska. The first course in neurosis began in February 1925. Marcus was motivated to take up this initiative because he believed it to be beneficial for future physicians to learn as much as possible about neuroses.[17] This series of lectures, given by academic specialists and nerve doctors in private practice, brought academic and practical medicine closer together. In one particular year, 1929, the course lasted from the end of April to the end of May with two weekly lectures; altogether seventy-five students and physicians attended the course, which is a remarkable number given the fact that the course was not obligatory for the students.

Marcus retired in 1931, and he was succeeded by Nils Antoni (1887–1968), who held the chair in neurology for almost twenty-five years. Like his teacher Lennmalm, Antoni was interested in both 'organic' and 'functional' illnesses. He was also an author of popular books on neuroses and neurological disorders, and although he was critical of psychodynamic theories, he was also attracted to Freud's ideas. Although he was not the most outstanding Swedish neurologist of the twentieth century, he was a powerful representative of official neurology, and through his organisational activities and literary production, both scholarly and popular, had a strong impact on Swedish medicine and culture. He made contributions to the study of brain tumours and the technique of spinal puncture, and, in 1919, he was the first doctor in Sweden to introduce a case of an acute epidemic, encephalitis lethargica, a new nerve disease that puzzled the medical community after World War I (neurologist Oliver Sacks's famous book *Awakenings*, the film version of which came out in the late 1980s, was based on Sacks's medical experiment with post-encephalitic patients in the late 1960s).[18] Antoni also campaigned for the abolition of a law that prevented people suffering from epilepsy from contracting marriage.

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[17] Nils Froste, "Neuroskursen," *MFT* 7 (1929): 278.

[18] Nils Antoni, "Neurologi I. 1910–1954," in *Karolinska Mediko-Kirurgiska Institutets Historia* (Almqvist & Wiksell: Stockholm, 1960), Vol. III:2, 553.

Like his psychiatric colleague Bror Gadelius at the Karolinska (see below), Antoni was well-versed in the humanities and endorsed the virtues of a classical education (*Bildung*). In contrast to his predecessors (Lennmalm and Marcus), he discussed psychoanalysis publicly, and, despite his criticisms and reservations, he maintained that some aspects of psychoanalysis were valuable in clinical work. He became an honorary member of the Swedish Psychoanalytic Society and was involved in the establishment of the psychoanalytically inspired Erica-foundation, which introduced child psychotherapy in Sweden in 1934. To some extent, he was keen on bridging the gap between psychotherapists and neurologists/psychiatrists. In 1937, he established the Swedish Neurological Society, which became a section of the Society of Medicine. His goal was to make the society an 'interdisciplinary' meeting place for neurologically-oriented physicians (internists, physiologists, surgeons, psychiatrists, etc.), but, some decades later, he admitted that the society had not fulfilled his expectations.

When the *Nervklinik* had its 50–year anniversary in April 1937, Antoni gave a speech in honour of the occasion. In his speech, he pointed out that among the many interns (*amanuens*) who had practised at the clinic over the years there were several outstanding neurologists-to-be, including the two immediate successors to Lennmalm.[19] He also noted that the clinic was seen as a kind of living museum, where the same chronically ill patients who were discharged year in and year out in the spring were readmitted in the autumn. Thus generations of Swedish physicians came to know the clinic's old guard: Hanna, Vendla, Nygren and other 'charter members'. "If you would please take pencil and paper, my dear Candidate (*kandidaten*), we can start with anamnesis," is what Vendla used to say to the interns (she could also dictate her present medical condition to the doctor, if needed).[20]

Alfhild Tamm, the first female psychiatrist and the first 'official' or properly-trained psychoanalyst in Sweden, reminiscences about the clinic in 1933. She had worked there as an intern in 1908, and, as she points out in her article, "we had a considerable number of neuroses at our disposal" at the polyclinic.[21] She refers to the difficult working conditions at the polyclinic at the time, noting that under these conditions

[19] Nils Antoni Antoni, "Neurologiska klinikens forntid, nutid och framtid," *Hygiea* 99 (1937): 367.
[20] Ibid., 373.
[21] Tamm, "Om psykoanalys," 713.

it was quite understandable that Lennmalm's therapeutic efforts seldom went beyond attempts to alleviate the most severe symptoms. In her view, Lennmalm was primarily interested in hypnotism, and although he sometimes talked about Freud with her, he "belonged too firmly in the old school to fully endorse Freud's importance".[22] She mentions that psychotherapy was not provided at the clinic, and that she and Julia Kinberg, another young female doctor, used hypnotism occasionally. They also studied Janet, whose ideas they found interesting, but not very helpful with regard to their therapeutic practice. When Tamm was about to travel to Vienna to study psychoanalysis in 1913, Lennmalm told her half-jokingly: "You will never make a breakthrough as a psychotherapist—to do so, you have to be either a professor or a charlatan."[23] After Lennmalm's professorship, the *Nervklinik* developed in the direction of neurophysiological studies, culminating in the establishment of a laboratory for clinical neurophysiology in 1947.

In Sweden, the significance of the *Nervklinik* and the *Nervpoliklinik* for the development of clinical neurology in general, and for the study of neurosis in particular, was crucial. Although a lack of time and space did not allow much room for innovations in the field of therapy, it is evident that through their internships at the clinic, a great many Swedish psychiatrists and 'nerve doctors' gained valuable clinical experience of functional neuroses there. As Henry Marcus points out in his obituary of Lennmalm, Lennmalm created a neurological school where most physicians in Sweden acquainted themselves with the important nervous illnesses.[24] The list of Swedish physicians who worked at the clinic between the years 1887 and 1950 reads almost like a Who's Who of Swedish psychiatry, neurology and psychotherapy.[25] Accordingly, many

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[22] Ibid.

[23] Ibid., 714.

[24] Marcus, "Frithiof Lennmalm," 571.

[25] Here is a list of well-known physicians who worked at the *Nervklinik* as interns, assistants or junior physicians between 1890 and 1950: Jakob Billström (psychotherapist); Nils Antoni (professor of neurology); Iwan Bratt (psychotherapist); Richard Eeg-Olofsson (director of the religiously-oriented psychotherapeutic institute St. Luke Foundation); Alice Hellström (child psychiatrist); Sven Ingvar (professor of medicine); Carl Juhlin-Dannfelt (chief physician); Gunnar Kahlmeter (physician at the Board of Pensions); Eric Kugelberg (professor of neurology); Henry Marcus (professor of neurology); Gunnar Nycander (psychoanalyst and physician at the psychotherapeutic Erica Foundation); Ernst Sahlgren (chief physician); Hakon Sjögren (chief physician); C. V. Söderlund (psychotherapist); Frey Svenson (professor of psychiatry); Alfhild Tamm (psychiatrist and psychoanalyst); Arvid Wallgren (professor of pediatrics); Snorre Wohlfart (chief physician); and Gunnar Wohlfart (professor of neurology).

if not most Swedish doctors working in the field of nervous illnesses could call themselves Lennmalm's, Marcus's or Antoni's pupils. As the only neurological clinic in Sweden until the second half of the twentieth century, the *Nervklinik* had a paradigmatic role in establishing an academic clinical basis for the study of neuroses. The second chair in neurology was established in Gothenburg only in 1950, sixty-three years after the establishment of the chair at the Karolinska. By the early 1960s there were already five chairs in neurology in Sweden, while all the professors had had their training at the *Nervklinik* at the time when Nils Antoni was its head.[26]

Neurosis and the Zeitgeist

After Lennmalm's death in 1924, it was Antoni more than any other academic neurologist who retained a professional interest in neuroses. In his many writings, Antoni often discussed the relationship between somatic (or, organic) and psychic (or, functional) aspects of medicine, arguing that the origins of many neuroses were to be found in a specific but undefined constitutional (physical) deficiency, which makes individuals break down when they can no longer bear their personal misfortunes.[27] He adhered to the then prevailing scientific doctrine of psychophysical parallelism, according to which physical processes have their mental counterparts, but psyche and soma are separate domains that follow their own laws. This means that it is of no use to try to distinguish 'genuinely psychic' neuroses from organic neuroses and vegetative disturbances: the former 'type' of neuroses corresponds to the functioning of the physical organism (cerebral cortex, subcortical regions and, finally, the vegetative system).[28]

In his first popular exposition of nerve illnesses and diseases (*Nervsjukdomar*, 1928), Antoni devoted the most extensive chapter of the book to neuroses, making it clear to the reader that no matter how much he appears to represent a medico-neurological view on neuroses, he is convinced that nervousness is a cultural illness and as such dependent

[26] Nils Antoni, "Att bli neurolog," 247.
[27] Nils Antoni, "Missbrukad neurologi," *SLT* 40 (1943): 2129–30.
[28] Nils Antoni, "Somatiskt och psykiskt i medicinens historia," *SLT* 42 (1945): 2324–5.

on prevailing beliefs and values.[29] In his clinical portrait of the two most common nervous illnesses, hysteria is a 'glaring', dramatic and more pronouncedly 'psychogenic' illness, while neurasthenia is a more dreary, complicated and vacuous malady. In Antoni's exposition, hysteria appears as an illness of melodramatic artists, while neurasthenia is portrayed as an illness of boring civil servants.

Almost twenty years after his first book on nerve illnesses, Antoni, now professor of neurology, published another, larger book, in which he focused on neuroses (*En bok om nerver*, 1946). This time he looked at 'nerves' from many different angles, including inheritance, environment, sex, psychoanalysis, psychic trauma, hysteria, organ neuroses, morality, fantasy, religion, psychotherapy and an 'asthenic pool of symptoms' (psychasthenia, depression, anxiety neurosis, depersonalisation, obsessions and neurasthenia). As Antoni notes in the preface, his book offers the first comprehensive look at neuroses in Sweden, written after more than thirty years of experience with neurotic patients at the Serafimer. He also points out that the book was not initiated by himself, but that he was commissioned to write a book on nerves. The initiator was obviously the prestigious publishing house Albert Bonniers, and the reason they wanted to publish a popular book on nerves, written by the foremost specialist in the field, is quite clear from Antoni's opening words in the Introduction:

> Nervous illnesses are said to be phenomena of the Zeitgeist, a plague that characterises our time. Indeed, there is undoubtedly a lot of talk about nerves going on these days, both in the private and the public sphere; one can find nerves everywhere. So much is done for the nervously ill nowadays; new mental asylums and clinics continue to be established, and polyclinics and private nerve doctors are busy with work, while general practitioners often do not want to have anything to do with nerves. There is constantly something about nerves in the newspapers, especially when something extraordinarily terrible has happened.[30]

Obviously, at the end of World War II, 'shattered nerves' were very much in the air, even in a neutral country such as Sweden. Antoni traces the origins of 'our nervous age' back to Beard's 1880 book on neurasthenia, in which Beard presented this nervous illness as a product of the fast pace of modern city life. But Antoni does not subscribe to

[29] Nils Antoni, *Nervsjukdomar* (Stockholm: Wahlström & Widstrand, 1928).
[30] Nils Antoni, *En bok om nerver* (Stockholm: Albert Bonniers förlag, 1946), 13.

the 'Beardian' view of the 'nervous vulnerability' of 'modern man'; on the contrary, he emphasises that people, including soldiers on the front line, are usually extremely tough, and that it is always a minority that collapses. Still, he acknowledges that those who suffer from neuroses constitute a *large* minority—no less than half of the patient population in the field of internal medicine is plagued by nervous complaints according to some estimations.[31]

Antoni notes that, in contemporary medical science, neuroses are commonly regarded as psychic illnesses or mental afflictions, but he thinks this is true only in so far as symptoms are concerned. True, restlessness, excessive tiredness, anxiety and insomnia indicate *mental* suffering, but this does not mean that such suffering is necessarily *caused* by mental damage. He is reluctant to see neuroses as exclusively psychogenic illnesses and prefers to define neuroses as a reactive condition that arises in association with a specific bodily *or* psychic damage.[32] As if to reprimand the champions of a purely mentalist approach to neuroses, he stresses the 'fact' that "bodily causes play at least as big a role in the aetiology of neuroses as mental causes do".[33] These ideas hark back to his earlier book on nerve illnesses, where he was quite explicit in his statement that 'organic' afflictions can bring about 'functional' symptoms. This time his language is somewhat different—modernised—but the basic message is the same: neuroses may very well be mental maladies, but their aetiological momentum is often physiological rather than psychological in origin. He refers to the importance of the total "psycho-physical constitution" to the genesis of neuroses, and to the idea that "psychic constitution" cannot be isolated from its bodily foundation.[34] He regards mental retardation as a typical source of neurosis, seeing mental retardation itself to be rampant in the population: he claims that between ten to twenty per cent of the population are to some degree mentally retarded. Fortunately, says Antoni, a well-organised and well-aimed sterilisation of the feebleminded can significantly reduce the number of carriers of this defect.[35] Another constitutional factor is "innate psychasthenia", which can result in a lack of concentration and stamina. Lastly, those abnormal character traits that go by

[31] Ibid., 19–20, 392.
[32] Ibid., 394.
[33] Ibid., 22.
[34] Ibid., 200.
[35] Ibid., 19, 379.

the name of psychopathy constitute a form of nervous deficiency that may, for the most part, be genetically determined.[36]

Antoni does not deny that "psychic traumas" are aetiological factors in neuroses, but he holds that the traumatic experience or "stimulus" in itself does not explain the phenomenon. Rather, what is crucial is the impression produced by the experience, and the general rule is that the more long-lasting and overwhelming the impression is, the more probable the onset of neurotic symptoms. And people's "reaction patterns" vary greatly: many children who have experienced psychic traumas grow up to become strong individuals, while others are affected by their unhappy childhood throughout their lives. When one looks at the life history of nervous people, one often finds poverty, alcoholism and endless quarrelling between the parents. Nasty, sarcastic teachers; stern landowners; and bullying officers, are concrete examples of neuroticising factors. "It is not easy to help an overstrained wife living in poverty and worrying about her husband's infidelity," as he points out in his chapter on the methods of treatment.[37] Referring to Freud, he also acknowledges that unhappy sexual experiences at a young age are "probably of great significance" to the outbreak of a nervous illness, although sexual traumas in childhood are hardly common enough to explain all neurotic constitutions.[38] Referring to Janet, Freud and Breuer, he holds hysteria to be a psychogenic neurosis par excellence, and as such its source is in the disturbed connection between consciousness and the subconscious, which makes the "different layers of the personality move in different directions".[39]

In Antoni's hierarchy of neuroses, hysteria is obviously at the very bottom, for he does not hide his aversion to hysterics:

> Without any exaggeration, one can say that the hysterics are the worst kind of people, for they are the ones who provide their fellow humans with the most frequent and most difficult troubles, troubles that not infrequently lead to catastrophes or crimes.[40]

That these worthless individuals are mostly female becomes abundantly clear when Antoni describes how the life of newly-weds can be

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[36] Ibid., 206, 379.
[37] Ibid., 401.
[38] Ibid., 205.
[39] Ibid., 288.
[40] Ibid., 305.

destroyed by a "hysterophilic" young wife, whose reactions to sexual intercourse are unfavourable; who is in a bad mood during her period; and who, in her jealousy, is ill-disposed towards her husband's relatives. Therefore,

> each and every young man should be most emphatically warned against sexual intercourse with hysterically-disposed women, for it can result in a life-long burden and bring ruin.[41]

Antoni couples hysteria with psychopathy by claiming that in some forms of hysteria there is the additional ingredient of 'moral insanity', which makes these women (and also men!) assume the roles of vamps, fortune-hunters and gold-diggers, spreading rumours, writing anonymous letters, intriguing and harassing. He pays lip service to the observation that there are also hysterical men, but the way in which he portrays hysteria leaves little doubt as to whether or not hysteria is a predominantly female malady. For Antoni, hysterical women appear almost as public enemies number one: a hysteric who has been offended cannot be appeased even by the fall of humanity and the destruction of the world! To make his standpoint absolutely clear to the reader, he does not fail to add that many hysterics are also "intellectually inferior" and "deceitful in their acts as well as in their words".[42]

In the chapter where he surveys the principles and methods of treatment, Antoni wonders at the remarkable difference between chronically ill patients and neurotics: the former seldom suffer from anxiety, whereas "all these neurotics are haunted by worries and anxieties about their numerous organ neuroses—and there is nothing wrong with their organs".[43] The message that comes through loud and clear is unambiguous: neurotics, at least a representative portion of them, are often an annoying bunch of whingers who use up precious medical resources with their unwarranted demands for care and attention.

Those Irritating Neurotics

It is quite obvious that when leading physicians such as Antoni started to write about such cultural illnesses as neurosis in popular books addressed

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[41] Ibid., 306.
[42] Ibid., 307, 310.
[43] Ibid., 392n.

to the educated general public, they felt quite free to abandon the more careful and objective medical language that they usually employed, and give full vent to the human inclination to make value-laden observations. Like so many other physicians dealing with neurotics, Antoni had a habit of translating moral categories into clinical labels. In popular writings, morally neutral men of science like Antoni could transform themselves into moralising priests who could not resist chiding the sinful. In his 1946 book on neuroses, Antoni in fact devoted a short, sketchy chapter to moral issues, arguing that the relationship between nerves and morality is one of reciprocal influence and co-dependency. He observed that neuroses are to a large extent 'social illnesses' triggered by the individual's collision with his or her social environment, bringing about frictions and complications that would not be found in a more harmonious milieu.[44]

Antoni's disparaging pronouncements about hysterical women were very much in accord with the still rather patriarchal spirit of the age. In Sweden, the political and social emancipation of women had been going on for more than half a century, but there were still very few female doctors in the 1940s, and the institution of the *Hausfrau* was not yet seriously threatened by social reformers (i.e. most middle-class women stayed at home after marriage to take care of the children and the household).[45] Antoni expressed his conservative view on women's emancipation in a radio presentation in 1953: he stated that the traditional, patriarchal ideals of manliness and womanliness had the power to suppress a great number of deviations and peculiarities which were now bursting forth with overwhelming force, like a pack of rats when the cat is gone.[46]

By reading such a book as 'A Book on Nerves', one can perhaps learn as much about the author as about his subject matter, perhaps even more. It is also a distinct possibility that the opportunity to write about neuroses in a less inhibited and more subjective way had a 'therapeutic' function for the physicians themselves. It could be conjectured that during his long years of clinical encounters with neurotic patients at the Serafimer, Antoni had developed a somewhat sarcastic if not cynical

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[44] Ibid., 362.

[45] Hirdman, "Crisis: The Road to Happiness?" in *Culture and Crisis*, ed. Witoszek and Trägårdh, 155–69.

[46] Nils Antoni, "I ögönspegeln (1953)," in *Under Saturnus ring* (Stockholm: Natur och Kultur, 1968), 180.

attitude towards people whose subjective complaints sometimes indicated that they themselves were responsible for their illness, that they only simulated symptoms, or that their symptoms were related to their intellectually or morally inferior 'constitutions'. But, at the same time, the doctor should not openly show negative feelings towards patients, or belittle their suffering. Medical ethics requires that patients, even nervous patients, be treated with respect, not as worthless riff-raff. But if the doctor cannot help but feel that some of his patients are indeed good-for-nothing wretches, he can release some of his pent-up feelings in popular books where this neurotic riff-raff meets with a just retribution. It would be fascinating to be able to listen to the confidential discussions about the nervously ill that Antoni had with his colleagues; it is quite probable that the language he used in describing (some of) his patients was much more colourful and strong than in his published writings, for the rules of decency forced him to tone down his judgements in public forums.

That the mental structure of a typical neurotic did not exactly appeal to Antoni can be inferred from his statement at the end of his radio presentation in 1953; he ends his talk by declaring that

> during my long career as a doctor, nothing has made as strong an impression on me as the unpretentious stoicism of the simple man faced with the horrible adversities of life.[47]

I am quite certain that Antoni's stoic, simple men (and women) were not neurotics…At the same time, there is little doubt that with his long experience of neuroses, he also made sound clinical observations that merit serious consideration. And there is no indication that his conduct in front of his patients would have been sarcastic or inordinately authoritarian; it may simply be that after thirty years' of clinical work at the *Nervklinik*, he had started to show signs of 'combat fatigue'.

But this is speculation—what is apparent is that Antoni's book, as well as many other books in this genre (popular expositions of nerve illnesses), give ample evidence to the thesis that neurosis was a value-infected diagnosis, which enticed physicians to make statements that reflected their own cherished values and beliefs in a manner largely absent from their discussions of organic nerve diseases. Unlike neuroses, such diseases as multiple sclerosis, Parkinson's disease or meningitis

[47] Ibid., 181.

were not as directly connected with the patients' way of life, their psychic constitution, emotional life, intellect, will or morality. Neuroses, by contrast, were 'contaminated' by 'habits of the heart', which gave these afflictions an extraordinarily subjective character. As we shall see in Part III, doctors at the *Nervklinik* usually linked the onset of neurosis to difficult life situations, which justified an interpretation in which neurosis was not so much an illness as an emotional reaction to adverse circumstances in the private sphere. Neurotics were often sad, unhappy individuals who were tormented by a sense of pain and suffering.

When Antoni retired in 1954, the 'neurosis-oriented' era in Swedish neurology came to an end. Eric Kugelberg, his successor in the chair of neurology at the Karolinska, was a 'modern neurologist' who was oriented towards clinical neurophysiology and who lacked Antoni's appreciation of classical *Bildung*. Kugelberg represented a new type of medical professional; an expert whose public profile was no longer affected by the traditional academic images of a 'great personality' and 'wide learning'. Gunnar Wohlfahrt, the first professor of neurology at the University of Lund, was interested in neurohistological problems and studied the anatomy and pathology of the muscle and the nerves.[48] Another manifestation of a new era in neurology was the work of a woman neurologist, Lisa Welander, who conducted research on muscular dystrophy in the late 1940s and early 1950s.[49] These neurologists showed meagre professional interest in neuroses.

The Expansion of Mental Medicine

In 1912, Frey Svenson, professor of psychiatry at the University of Uppsala, referred to a problem that was to haunt Swedish psychiatry throughout the twentieth century: the low status of psychiatry among physicians and students of medicine.[50] In the hierarchy of medical disciplines, psychiatry remained at the bottom, and this uncomfortable

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[48] Gösta Glimstedt, "Gunnar Wohlfart in memoriam," *Acta Neurologica Scandinavica* 37 (1961): 79–83.

[49] Nils Antoni, "Neurologi I," 558; and Eric Kugelberg, "Neurologi II. 1954–1960," in *Karolinska Mediko-Kirurgiska Institutets Historia* (Almqvist & Wiksell: Stockholm, 1960), Vol. III:2, 563.

[50] Frey Svenson, "Riktlinjer för det svenska hospitalväsendets utveckling" (1912), in *Svenska Psykiatriska Föreningen—en återblick* (Svenska Psykiatriska Föreningen: Stockholm, 1980), 35.

situation was a source of 'chronic' consternation and frustration for psychiatrists. Until 1958, medical studies included only a two-month obligatory course in psychiatry, which meant that those who did not specialise in psychiatry had a limited knowledge of mental illnesses. Frey Svenson wanted to improve the medical and professional standing of psychiatry, and he belonged to a group of chief physicians at different mental asylums who founded the Swedish Psychiatric Society (*Svenska Psykiatriska Föreningen*) in Lund in 1905.[51] Most founding members of the society were driven by a need to reform and modernise institutional mental health care in Sweden, and issues related to medico-scientific research were of secondary importance to them.

The early decades of the twentieth century were a period of professionalisation and expansion for Swedish psychiatry. As psychiatrist Victor Wigert put it in his 1930 article on 'psychiatry and the future', "Our thought patterns need to be applied to ever-widening areas of human activity."[52] For the development of psychiatry as a medical discipline in Sweden, Emil Kraepelin's and his successor's clinic in Munich was of primary importance. Just as many Swedish physicians had made study trips to Charcot's clinic at the Salpêtrière during the last quarter of the nineteenth century, many Swedish psychiatrists travelled to Munich until the outbreak of World War II. Swedish psychiatry was heavily influenced by developments in German-speaking Europe between 1870 and 1940, and, in addition to Kraepelin, Swedish psychiatrists were attracted to Ernst Kretschmer's constitutional typologies as well as to Eugen Bleuler's humane and eclectic approach to insanity at the famous Burghölzli mental hospital in Zurich, Switzerland.

Psychiatrists were not unaware of the major obstacles that stood in the way of 'scientific psychiatry'. In his talk at the meeting of the Psychiatric Society in 1908, Harald Fröderström observed how psychiatry was burdened by

> a conceptual confusion of Babylonian proportions… a horrendous joggling with empty words and phrases, arbitrary neologisms and undigested terms borrowed from physiology.[53]

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[51] Gerdt Wretmark, "Svenska Psykiatriska Föreningen 75 år," in *Svenska Psykiatriska Föreningen*, 7–17.

[52] Victor Wigert, "Psykiatrien och framtiden," *SMT* 7 (1930): 191. Wigert was Gadelius's successor in the chair of psychiatry at Karolinska.

[53] Harald Fröderström, "Den kliniska psykologien," *Hygiea* (1908), Festband, Del. I, 15.

In short, in Fröderström's view the obscurantist language of psychiatrists reflected their obscurantist thinking. Compared with psychiatry, neurology was developing more rapidly as a medical specialty in the first half of the twentieth century, and it was becoming more and more a technology-based discipline which required specialised skills and a need to keep up with the latest discoveries and innovations in endocrinology, bacteriology and brain mapping.[54] The study of organic diseases in the nervous system became more sophisticated and accurate, while psychiatrists found it difficult to determine whether mental illnesses were disorders of the brain or of the mind.

Although academic psychiatrists by and large embraced a somatic approach to mental disorders and liked to convey the picture that biological perspectives on mental problems made psychiatry a 'revolutionary' specialty,[55] a growing gap between psychiatry and the neurosciences became increasingly evident to both parties. Thus, for example, *Acta Psychiatrica et Neurologica*, an inter-Nordic joint publication for neurologists and psychiatrists launched in 1926, was divided into two separate journals in 1961, *Acta Psychiatrica Scandinavica* and *Acta Neurologica Scandinavica*. When one reads the index of the first volumes (1961) of these two journals, one notices that there are a number of articles on neuroses (including depression) in the psychiatric journal, but in the neurological journal there are *none* at all. This indicates that neuroses had all but disappeared from the clinical realm of neurology by the early 1960s, at least as this realm was presented in academic journals.

As to the question of attaining medical expertise in the field of neuroses and having the right to officially represent oneself as a specialist in the field of nervous illnesses (*nervsjukdomar*), the Board of Health required a specialisation in neurology, psychiatry and internal medicine. It is evident that these rules were the result of negotiation between neurologists, psychiatrists and internists, who all claimed to be experts in the field of neuroses. Indeed, during the interwar years, a 'power struggle' between these medical groups characterised the discussion and organisational decisions affecting the care of neuroses.[56] Neurologists

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[54] On the history of neurology in the twentieth century, see Robert B. Aird, *Foundations of Modern Neurology* (New York: Raven Press, 1994).

[55] Victor Wigert, "Psykiatrien och framtiden," 191–2.

[56] On professional conflicts between neurologists and psychiatrists in the United States, see Marvin Stein, "The Establishment of the Department of Psychiatry in the Mount Sinai Hospital: A Conflict between Neurology and Psychiatry," *JHBS* 40 (2004): 285–309.

and internists often formed a united front against what they considered to be an inordinate psychiatrisation of nervous illnesses, and they insisted on the importance of neurological and purely medical education for future nerve doctors and psychotherapists. Psychiatrists in turn emphasised the psychic and socio-psychiatric factors in neurosis and typically formulated their diagnosis as a mild mental illness or 'insufficiency', rather than as an outcome of a 'neuropathy' or of purely somatic afflictions and disorders.

At the annual meeting of the Psychiatric Society in 1917, a committee set out a proposal for a diagnostic classification of psychiatric illnesses. In the proposal, inspired by Kraepelin's classification, there were twenty different diagnostic entities, ranging from manic-depressive psychosis to alcoholism. Neuroses or nervous illnesses were not included as a separate entity—milder mental illnesses were subsumed under the diagnostic categories of 'psychogenic states of reaction', which included 'hysterical psychoses'; and 'psychopathic personalities', which in turn included hysterical paranoiacs, the emotionally labile, mythomaniacs, epileptoids, the impulsive, the lethargic, sexual perverts and those who suffered from obsessions.[57] One of the masterminds behind the new system of classification was Bror Gadelius, the most prestigious and important Swedish psychiatrist in the first half of the twentieth century.

Emotions, Hormones and Neuroses

From early in the century until his death in 1938, Bror Gadelius (1862–1938) dominated academic psychiatry, and it was largely through his efforts that psychiatry attained a relatively high medical and social profile in Sweden. Gadelius was a humanistically- and psychologically-oriented physician who was influenced by the French mental medicine, notably Pierre Janet, whose theory of psychasthenia formed the backbone of his conceptualisation of obsessions (*tvångstankar*) in his 1896 dissertation.[58] He was also a skilful organiser, who helped modernise asylum psychiatry by successfully promoting reforms in mental health care, better education for mental health professionals, and a more rational and humane

[57] "Psykiatriska föreningens årsmöte," *ASLT* 15 (1918): 1131–3.
[58] Gadelius, *Om tvångstankar*.

attitude towards the mentally ill. It was during his professorship that psychiatric research made its first advances in Sweden.[59]

More than any other academic psychiatrist of his time, Gadelius was interested in (normal) psychology, especially but not exclusively in the psychology of emotions.[60] Like Nils Antoni and many other physicians, he subscribed to psycho-physical parallelism, according to which the physico-chemical and psychological aspects of human personality cannot be reduced on to the other: they go in parallel lines without converging into one psychophysical line. And, like Pierre Janet and other French students of psychopathology (such as Charcot, Magnan and Legrain), he was intrigued by the grey zone between psychosis and mental health. His principal contribution to the study of neuroses was his attempt to clarify connections between hysteria and the early stages of schizophrenia.

In his four-volume main work, *Det mänsliga själslivet* (1921–24), Gadelius updates his discussion of psychasthenia by referring to constitutional functional disturbances in the endocrine organs, which he sees as causal factors in a number of innate psychopathies (the two first volumes of this work were published in an abridged English translation in 1933 with the title *Human Mentality*).[61] He is clearly convinced of the crucial importance of hormones for mental health, since in his discussion of the 'general confusion' in neurosis studies he states that the fundamental foundation for such studies in the future will be provided by new insights into the vegetative nervous system and inner secretion.[62] Gadelius, who first examined the role of inner secretion in mental illnesses in an article published in 1914,[63] was convinced that discoveries in endocrinology offer promising prospects for empirical research on the role of endocrine glands as principal 'organs of emotion'. Such

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[59] Torsten Sjögren, "Psykiatri," in *Karolinska Mediko-Kirurgiska Institutets Historia*, Vol. III:2, 698.

[60] In his late article on the psychology of emotions, Gadelius wrote that "since the days of my youth I have devoted interest and attention to the psychology of emotions." Bror Gadelius, "Modern Development of the Psychology of Emotions," *Acta* 8 (1932), 135.

[61] Bror Gadelius, *Det mänskliga själslivet*, Vol. 4 (Stockholm: Hugo Gebers förlag, 1924), 398. Gadelius discusses the role of the endocrine organs in the emotional life at greater length in Bror Gadelius, *Human Mentality in the Light of Psychiatric Experience* (Copenhagen: Levin & Munksgaard, 1933).

[62] Gadelius, *Det mänskliga själslivet*, Vol. 4, 400.

[63] Bror Gadelius, "Sinnessjukdomarna och den inre sekretionen," *Hygiea* 76 (1914): 1249–83.

research might shed light on the mechanism of emotional disturbances in dementia praecox (schizophrenia) and other illnesses.[64] Although he pays lip service to the roles of upbringing and social factors in the pathogenesis of psychopathy, his centre of attention is firmly on the constitution and hereditary deficiency, as he forges links between madness, alcoholism, criminal disposition, prostitution and hereditary factors, including degeneration, which by the mid-1920s had lost much of its explanatory force in European psychiatry. In Gadelius's classification, a great number of female prostitutes, for example, belong to the category of 'lethargics', which in turn is a subclass of the category of moral insanity (Gadelius believes it justifiable to keep on using the term 'moral insanity' in discussions about the nature of moral deficiencies in psychopathy). His other subclasses are swindlers, pathological liars and the anti-social.[65]

Gadelius thought the source of abnormal personalities (psychopathies) and neuroses to be 'constitutional nervousness', or psychasthenia. Psychopathies and neuroses were pathological conditions rather than mental illnesses, and together they constituted the ever-expanding borderland between health and sickness. With this psychiatric framework, which combined the French (psychasthenia, degeneration) and the German ('psychopathic inferiorities') psychopathological traditions, Gadelius contributed to the psychiatric annexation of the neuroses and 'personality disorders', which, while having somatic bases, were emphatically *mental* disorders ('disharmony' in the interaction between the different mental faculties). Although he adopted a somewhat outdated neurological vocabulary—especially 'constitutional nervousness'—he was keen on relating his ideas to the up-to-date language of hormones. In attaching neuroses and psychopathies to what he considered to be a sound somatic basis, moreover a basis that promised to provide exciting prospects for future research on the interaction between body and mind, Gadelius was doing his very best to upgrade the medico-scientific status of psychiatry. It is as if the triumphant emergence of endocrinology had provided a magnificent opportunity for psychiatrists to enter into

[64] Ibid. Gadelius's conceptualisation of the endocrine glands as 'organs of emotion' was influenced by the work of the Swiss neurologist Constantin von Monakow, who had studied the significance of hormones to affects. Gadelius also referred to Walter Cannon, whose research on the adrenaline and the 'emotional reactions' were of paradigmatic importance to the biochemical study of emotions. See Gadelius, *Human Mentality*, 104–8.

[65] Gadelius, *Det mänskliga själslivet*, Vol. 4, 409–10.

alliance with the vanguard of internal medicine.[66] As psychotherapist Poul Bjerre noted in 1934, "bacteriology had its golden age; now it is the study of hormones that is all the rage".[67] (The Swedish Endocrine Society was founded in 1945, and the first lectureship in endocrinology was established four years later. None of the founding members of the society was a psychiatrist.)[68]

At the same time, Gadelius was carving a more ambitious clinical niche for psychiatry. By following or even contributing to medical advances in endocrinology and internal medicine, psychiatrists might become much better equipped to explain scientifically the mechanisms of mental disorders, and to develop therapies that would work. Moreover, a firm psychiatric grip on two major maladies, neuroses and personality disorders, would make psychiatrists, first, a central force in mental hygiene; second, clinical specialists replacing neurologically-trained nerve doctors of the older generation; and, third, behaviour experts in matters of upbringing, pedagogy, familial relations, sexuality and all kinds of social pathology, including prostitution, alcoholism, crime and other forms of 'anti-social' behaviour. A clinical emphasis on abnormalities of every size and shape, on the one hand, and the conquest of the vast field of neuroses, on the other, would help turn psychiatrists into experts in the psychopathology of everyday life, and into medico-moral instructors on how to lead a Good Life. This was no minor achievement in the Era of the Asylum when psychiatry was unable to cure vast patient populations, or even alleviate their sufferings to any significant degree. In his role as a historian of psychiatry, Gadelius painted the former care of the insane in exceedingly dark colours, in order to highlight the 'humane' and 'progressive' treatment of the mentally ill in his own time. This 'Whiggish' interpretation of psychiatric history as the triumph of humanity and enlightenment over prejudice and ignorance was another way of promoting contemporary psychiatry and the institutional care of the mentally ill.[69]

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[66] In 1958, Gadelius's former neurologist-colleague Nils Antoni referred approvingly to Gadelius's interest in the function of endocrine glands, which, to Antoni, exemplified an effort to build a sound bridge between psychiatry and internal medicine. Antoni, "I ögönspegeln," 188.

[67] Poul Bjerre, . . . *och snart står döden och stampar vid vår port: En dag hos själsläkaren* (Stockholm: Albert Bonniers, 1934), 97.

[68] Rolf Luft, "Sektionen för endocrinologi," in *Svenska Läkaresällskapet 175 år*, ed. Stephan Rössner, *Handlingar* 92 (1983), 37–42.

[69] Bror Gadelius, *Vården av sinnessjuka förr och nu. Trenne uppsatser* (Lund: Gleerups

When Gadelius retired in 1929, a distinct period in the history of Swedish psychiatry was coming to an end. The aversion to neuropsychiatry that Gadelius had shown in his earlier career, until the discoveries in endocrinology made him change his attitude towards somatic research on mental disorders, was not exclusive to Gadelius. When one studies the professional careers (including the list of publications) of Swedish academic psychiatrists between the years 1880 and 1930, one can observe that most of them appeared to shun the microscope and laboratory, and did not acquire any specialised skills in the physiology and anatomy of the brain or the nervous system. Rather, their professional interests were in the reorganisation of mental health care, forensic psychiatry and criminology, social medicine, mental hygiene (including sterilisation) and methods of psychiatric treatment (especially after the introduction of dubious shock treatments in the 1930s). It should be noted that the first generation of socially-oriented psychiatrists differed from the post-World War II psychiatrists, who started to look for sociological determinants behind mental disorders (and which led to the 'sick society' thesis in the 1950s and 1960s). Such early twentieth-century social psychiatrists as Frey Svenson were not concerned with the 'pathological' structures of society, but with the anti-social behaviour of the insane and the deviant, and they put a premium on the psychiatrist's duty to protect the social order by taking the mentally ill into custody against their will, if necessary. Thus the function of the mental asylum was not very different from that of prison, as Svenson himself admitted in 1904.[70]

The keen interest in psychology that had characterised Gadelius's work was not shared by most representatives of the new generation of academic psychiatrists, who were occupied with strictly somatic research,

förlag, 1900); "Psykiatriska sjukdomar i historisk belysning," *Hygiea* 70 (1908): 97–118; *Sinnessjukdomar och deras behandling förr och nu* (Stockholm: Hugo Gebers förlag, 1913); *Human Mentality*, Chapter I; *Tro och helbrägdagörelse jämte en kritisk studie av psykoanalysen* (Stockholm: Geber, 1934); "Renessansläkaren och häxväsendet," *Lychnos* 1936. In his recent book, medical journalist Robert Whitaker argues that the treatment of schizophrenic patients in the United States has not improved since the early nineteenth century, when quakers in England (York) and the United States (Pennsylvania) began to develop a form of humanitarian care called moral treatment. Whitaker's thesis is that mentally ill patients probably fare worse today than hospitalised patients did two hundred years ago! See Robert Whitaker, *Mad in America. Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill* (New York: Basic Books, 2002).

[70] Frey Svenson, *Om anstaltvård av sinnessjuka* (Stockholm: Studentföreningen Verdandis småskrifter, 1904), 5.

on the one hand, and with social determinants, on the other. In the 1940s and 1950s, genetically-oriented neuropsychiatry established itself in Sweden, but social psychiatry was also becoming a major orientation with its focus on alcoholism, abortion, socially disadvantaged groups, mental hygiene and so forth. It was this latter group of socially-oriented psychiatrists that kept the academic medical discussion of neuroses alive in Sweden. By the 1950s, psychiatrists had become specialists in both psychoses and neuroses (now conceptualised as milder mental disorders),[71] which meant that psychiatry dominated the whole field of psychopathology. They were unwilling to let an emerging group of mental health experts, clinical psychologists, have the right to become official psychotherapists,[72] because they regarded the professionalisation of clinical psychologists as an intrusion into the legitimate domain of physicians.

"Neurology, Psychiatry's Enemy Number One"[73]

Swedish clinical neurology and psychiatry were like two brothers who, while getting on each other's nerves and scuffling with one another, managed to live under the same roof until it was time for them to leave the home and live on their own. Swedish neurologists often saw the German neuropsychiatric tradition as a model on which to develop a new type of clinical neuroscience that would bring psychiatrists closer to the neurological orientation. But the relationship between German neurologists and psychiatrists was probably not as harmonious as the Swedish neurologists thought it was; it was rather that despite "quite profound professional and, at times, inter-personal conflicts of interest", neurologists and psychiatrists "were forced to co-operate in the frame-

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[71] This development was noted by psychiatrist Torsten Sjögren in his overview of the psychiatric clinic at the Karolinska. Sjögren, "Psykiatri," 697.

[72] On American psychiatrists' attitude towards clinical psychologists, see Roderick D. Buchanan, "Legislative Warriors: American Psychiatrists, Psychologists, and Competing Claims over Psychotherapy in the 1950s," *JHBS* 39 (2003): 225–49.

[73] This is a slightly abridged version of Nils Antoni's statement at the meeting of the Psychiatric-Neurological section at the Society of Medicine in April 1944, which goes as follows: "As a profession, neurology has long been psychiatry's enemy number one, dating back to the time when neurologists here and abroad were stubbornly preoccupied with medical psychology and treatment of neuroses: Charvot [sic], Babinsky, Dejerine, Oppenheim, Lennmalm, Christiansen." Nils Antoni, [Address to the Psychiatric-Neurological Section], *SLT* 42 (1945): 170.

work of their combined—psychiatric and neurological—departments at the universities".[74] Thus rivalry and mutual suspicion were not foreign to German neuropsychiatry, but the significant difference between Germany and Sweden was that in Sweden neurologists and psychiatrists did not co-operate, because both disciplines were institutionally separated from each other. The relationship between Swedish neurologists and psychiatrists was probably more strained than may be inferred by simply surveying medical literature, where conflicts within the profession were given a low profile. For example, Ruben Holmström, chief physician at the Mental Hospital in Malmö, contended that, for a long period of time, it was widely known that, when the Serafimer's *Nervklinik* appointed junior physicians, a candidate's previous work experience in mental health care was considered a *disqualification* and compromising.[75] That neurologists and psychiatrists harboured thoughts of mistrust and suspicion against one another becomes evident when we turn to the statements about psychiatry made by Nils Antoni, the foremost neurologist in Sweden in the 1930s and the 1940s.

Antoni was the first professor of neurology who publicly took up the issue of the strained relationship between neurologists and psychiatrists. The fundamental point he constantly raised was that neurology as a medical discipline was closely related to internal medicine and surgery, and not psychiatry. As he pointed out in 1937, many Swedish neurologists worked in the field of internal medicine, and two of the four professors of medicine at that time were neurologically-oriented (Sven Ingvar and Israel Holmgren). In his opening address to the Eighth Congress of Scandinavian Neurologists in August 1938, he said that "I should particularly like to emphasise the connection between neurology and neurosurgery, which appears to me to be closer than any other medical connection."[76] Nowhere did he mention psychiatry in his address.

In his talk on the occasion of the 50-year anniversary of the Serafimer's *Nervklinik* in 1937, Antoni cast an eye on the on-going expansion of psychiatry, which had "opened the gates of the asylum"

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[74] Klaus-Jürgen Neumärker and Andreas Joachim Bartsch, "Karl Kleist (1879–1960)—A Pioneer of Neuropsychiatry," *HP* 14:4 (2003): 424.

[75] Ruben Holmström, "Psykiatrici och de i vidare mening psykiskt sjuka," *SMT* 10 (1933): 195.

[76] Nils Antoni, "Address on the Opening of the VIII Northern Neurological Congress in Stockholm on August 29th 1938," in *Report on the Eighth Congress of Scandinavian Neurologists*, ed. Ingvar Lossius (Copenhagen: Ejnar Munksgaard Publisher, 1939), 9.

and entered into society itself by paying increasing attention to the external, social ramifications of mental illnesses, as well as to heredity and childhood. In his view, Swedish society was undergoing a thorough psychiatrisation, no less. Modern psychiatry, as he saw it, had transformed itself from a speculatively- and philosophically-oriented discipline into a socially-centred cluster of specialised fields, such as child psychiatry and forensic psychiatry.[77]

A few years later, at the meeting of the psychiatric and neurological section of the Society of Medicine, Antoni announced that

> in the future we shall see how the whole of society will be saturated with psychiatric views, conceptions, methods and activities, not only in the form of the restructuring of the judicial system but also in the domains of youth welfare service, education, school, military and everything else.[78]

Antoni appeared as a critic of 'psychiatrisation', but his statement was not really 'anti-psychiatric', because immediately after making this point about the social expansion of psychiatry, he started to talk about the "recent fruitful phase of psychiatric research" with regard to diagnostics and therapeutics (he mentioned fever therapy, shock therapy and the EEG). It is as if he had wanted to tone down his critical stance towards psychiatry by saying some nice words about what he saw as psychiatric achievements. In 1950, he even declared that "lobotomy is one of the most splendid success stories in psychiatric therapy in recent years".[79] Especially when it came to neuroses, Antoni wanted to build a bridge between neurology and psychiatry, rather than give exclusive rights in this field to neurologists. By the time he gave his talk—1937—it was too late to stop the tide anyway by trying to limit jurisdiction in the field of neurosis exclusively to neurologists. In the interwar years, psychiatrists had established themselves both internationally and in Sweden as experts in *all* mental maladies, including neuroses.

On the same occasion (the 50-year anniversary of the *Nervklinik*), the neurologist and professor of medicine Sven Ingvar gave a talk in which he referred to the tug-of-war between psychiatry and internal medicine that had been going on for years.[80] This "war" had had

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[77] Antoni, "Neurologiska klinikens forntid," 379–80.

[78] Antoni, [Address to the Psychiatric-Neurological Section], 169.

[79] Nils Antoni, "Själslivets patologi," in *Handbok i psykologi*, ed. David Katz (Stockholm: Bonniers, 1950), 429.

[80] Sven Ingvar, "Om de nervöst sjuka," *SLT* 34 (1937): 729–32.

detrimental effects on the care of the nervously ill, who had become more homeless as a result of what he saw as a "fruitless debate". The whole medical area of neuroses had suffered from the lack of uniform nomenclature and the ensuing confusion in the study and treatment of nervous illnesses. Ingvar predicted that the old conflicts between internal medicine and psychiatry were about to be buried, and attributed this positive development to reforms in medical education: the younger generation of physicians was well-educated in both internal medicine and psychiatry. These young doctors would find viable solutions to the questions concerning the institutional care of the nervously ill.[81]

In 1944, Nils Antoni returned to the 'tug-of-war' between psychiatry and neurology (and internal medicine) by observing that "contemporary psychiatry is extremely inclined to include neuroses in [the domain of] psychiatry, both theoretically and practically."[82] At that time, there was a discussion going on in the Society of Medicine's Psychiatric-Neurological Section about 'psychological medicine'. Antoni, who had established the Swedish Neurological Society in 1937, suggested that the section should restructure itself and become the Section for Psychiatry and Psychological Medicine. Neurologists had their own society now, said Antoni, and it would be better for all concerned if the section devoted its activities to neurosis-oriented psychiatry and psychological medicine. Apparently irritated by psychiatrist Victor Wigert's statement that psychiatry did not have any closer ties to neurology than to any other medical discipline, Antoni raised the question of a 'chronic schism' between psychiatry and neurology. Contrary to those who had claimed that such a schism was a purely personal dispute between individual physicians and did not have any topical relevance, he contended that

> the schism is real and it concerns psychiatry's dismissive attitude towards neurology with regard to the question of neurosis. Neurology should not be allowed to be active [in this field] at all according to the proposal that psychiatrists have scribbled at the Board of Health (*Medicinalstyrelsen*).[83]

He claimed further that psychiatrists of the old school preferred to see neurology as an auxiliary science to psychiatry (*ancilla psychiatriae*). "Neurology as psychiatry's little helper! How cute!" snapped Antoni.[84]

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[81] Ibid., 732.
[82] Antoni, [Adress to the Psychiatric-Neurological Section], 170.
[83] Ibid., 171.
[84] Ibid.

In his 1946 book on neuroses (*En bok om nerver*), Antoni again raises the question of the alleged tug-of-war between psychiatry and internal medicine about neurotic clients (*neurosklientelet*). While admitting that the psychiatrist should take the lead in the treatment of depressive conditions, he emphasises that specialists in things somatic should also have a say in the matter. In reality, only a minority of clients goes to see a nerve doctor or a psychiatrist; most neurotics consult either general practitioners, specialists in different branches of internal medicine or, to a lesser extent, neurosurgeons. Many 'ordinary doctors' are emphatically reluctant to take it upon themselves to administer psychotherapy to their patients. For Antoni, this is a harmful attitude, because many neurotic patients could be taken care of by general practitioners with an interest in psychology, and with some training in psychotherapy.[85] Antoni's strategy was two-fold: first, he wanted all doctors to acquire essential psychotherapeutic and psychiatric qualifications required for the treatment of neuroses. Second, he wanted to preclude the emergence of a new specialty, medical psychology, in the field of mental medicine.

As a retired professor and dean of Swedish neurologists, Antoni admitted in 1962 that "psychiatry is necessary for all physicians," and that "psychological anamnesis and psychic status should be found in every neurological record (*nervjournal*)."[86] After the introduction of psychopharmacological drugs in the mid-1950s, psychiatry found a more solid foundation on which to build its medical reputation. Psychiatry became again more closely allied with biological and biochemical research, while its renewed preoccupation with the brain has narrowed the gap between neurology and psychiatry in recent decades.[87] According to some critics, the return of a biological paradigm in mental medicine has resulted in an 'anti-therapeutic' medical ethos which can be summarised with the slogan 'more science, less care'. Some critics even claim that with its extremely shaky empirical and theoretical foundation, biological psychiatry is not so much science as pseudo-science or quasi-science.[88]

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[85] Antoni, *En bok om nerver*, 396.

[86] Antoni, "Att bli neurolog," 247.

[87] Eric R. Kandel, "A New Intellectual Framework for Psychiatry," *The American Journal of Psychiatry* 155 (1998): 457–69; and "Biology and the Future of Psychoanalysis: A New Intellectual Framework for Psychiatry Revisited," *The American Journal of Psychiatry* 156 (1999): 505–24.

[88] For balanced and well-researched critical studies of biological psychiatry and psychopharmacology, see Elliot S. Valenstein, *Blaming the Brain* (New York: The Free

After World War II, Swedish physicians began to lose their status as representatives of a traditional, rather prestigious 'guild', as they became competent but anonymous technicians and experts whose professional life was characterised by 'Sachlichkeit' and specialisation in one field, rather than an inclination to showcase one's wide learning or to enlighten the general public. Doctors such as Nils Antoni, who in public forums had addressed issues that in principle touched the lives of 'ordinary citizens', now belonged to the past. Neurology as a medico-scientific discipline became increasingly 'alienated' after World War II from the patient's life problems, while none of the younger neurologists in Sweden appeared to take any research interest in neurosis.[89] At the same time, neuroses remained one of the most frequently-diagnosed illnesses at the *Nervklinik*.[90] Clinically, neurosis remained a highly relevant illness for neurologists, but they seemed to have very little scientific interest in a malady that was largely impervious to technical or clinical advances. It was only with the rise of pharmacological medicine—tranquillisers and anti-depressants—in the 1960s that made neurosis again a potentially relevant illness for neurologists. But by that time those who provided care for the countless neurotics, and guaranteed that neurosis would remain a high-profile mental malady for another two decades, were not neurologists but psychiatrists, psychoanalysts and clinical psychologists. The neurological era of neurosis studies was over.

Press, 1998); David Healy, *The Antidepressant Era* (Cambridge, MA: Harvard University Press, 1998); David Healy, *The Creation of Psychopharmacology* (Cambridge, MA: Harvard University Press, 2002); David Healy, *Let Them Eat Prozac* (New York: New York University Press, 2004); and Whitaker, *Mad in America*.

[89] See Antoni, "Neurologi I," and Kugelberg, "Neurologi II," for accounts of the research conducted at the *Nervklinik* between the years 1910 and 1960.

[90] Kugelberg, "Neurologi II," 561.

PART II

FROM THE AGE OF NERVOUSNESS TO THE ERA OF PSYCHOCULTURE

CHAPTER FIVE

FEMINITY, SEXUALITY AND CHILDHOOD: SOURCES OF THE NERVOUS SELF

By the end of the 1880s, Swedish middle-class women were infected by the diagnostic virus of hysteria, which European nerve doctors commonly regarded as a female malady. Like most of his colleagues, Krafft-Ebing, for example, saw hysteria as rooted in the very nature of being female—he referred to his French colleague Pierre Briquet, who had claimed (with tongue-in-cheek?) that one half of Parisian women suffered from hysteria.[1] Such assertions were reiterated time and again not only by nerve doctors but by middle-class men in general, and in most cases they were not meant as jokes. The late nineteenth-century observation (put forward especially by Charcot and his pupils) that there were also hysterical *men* gained much less attention, although this suggestion had been made already in the seventeenth century, when Thomas Sydenham had pointed out that men were also susceptible to hysteria. But when the ancient notion that women's illnesses were connected with their reproductive organs was revived in the early gynaecological speculations of the latter half of the nineteenth century, the new anti-woman cultural atmosphere in western Europe made women essentially inferior creatures, deviations from the universal standard of humanity that was White Man. The anti-female language of the nineteenth century was novel, but European 'woman-bashing' has a venerable history, going back to Greek antiquity and Aristotle's characterisation of Woman as a 'deformed male' or 'mutilated male'.

The Swedish linguist Gustaf Cederschiöld gave expression to the stereotypical late nineteenth-century male conception of women in his article on 'Woman's language'. To support his thesis that Woman's language differs from that of Man, he asserted that comparative studies of the mental life of both sexes had conclusively shown that Woman was dominated by feelings and subjectivity, Man by reason and objectivity.[2]

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[1] Krafft-Ebing, *Om friska och sjuka nerver*, 101.
[2] Gustav Cederschiöld, "Om kvinnospråk," *Nordisk Tidskrift* 12 (1899): 417–34.

Like the mind of a child, Woman's mind is impulsive, illogical and incoherent, and these characteristics are displayed in her language: from the grammatical and logical point of view, Woman's language is simply poor. But, Cederschiöld assures his readers, the fact that Woman's nature is dominated by feeling does not imply that it is in any way inferior to Man's rational nature.[3] The idea that Woman is dominated by *Eros*, and Man by *Logos*, was one of the most commonplace prejudices in western cultural hemisphere until the mid-twentieth century, if not beyond. For example, Nietzsche, who is commonly regarded as a paragon of intellectual originality, was tediously conventional in his view of women; he proclaimed, for instance, that "women want to serve and in that they discover their happiness; and the free spirit wants not to be served and in that he discovers his happiness."[4] He also asserted that the women's fight for equal rights was "actually a symptom of a disease: every physician knows that".[5] In the Europe of the late nineteenth century, Nietzsche's skewed, pathologising attitude towards women was *menschliches allzu menschliches* (human, all too human).

At the time Nietzsche published his aphorism (1878), traditional patriarchalism had been revived, on the one hand, by the dissemination of evolutionary theories that seemed to provide evidence of the biological inferiority of women, and, on the other, by middle-class normative codes that put a premium on moral purity and banished all bodily needs of women. This created a situation in which women were kept on a tight leash by a society that sanctioned the suppression of women in the name of science and morality. Such an anti-feminine atmosphere created inevitable tensions, since the social aspirations of the ever-growing middle-class, for whom science and education increasingly replaced religion and traditional hierarchies, included the idea that women should also be emancipated from the shackles of past prejudices and sanctions.

The women's liberation movement was in essence an attempt to realise the political goals that middle-class men had already achieved to a large extent, or were on their way to achieving (the universal right to vote, right to education, liberty to pursue a trade, etc.). Suffragettes and other champions of women's rights who resented male domination

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[3] Ibid., 434.

[4] Friedrich Nietzsche, *Human, All Too Human*. Trans. R. J. Hollingdale (Cambridge: Cambridge University Press, 1986), 159 (aphorism No. 432).

[5] Ibid., 267.

had liberal ideology on their side, but what was against them was a patriarchal cultural code that relegated women to the margins of the public sphere. According to the standard middle-class norm, Woman's duty was to reproduce and support her bread-earning spouse, no matter what. The good woman was the humble obedient wife who was anxious to obey and please. By contrast, those unmarried women, rebellious daughters or protesting housewives who failed to meet the patriarchal criteria for the Good Woman, were routinely labelled as hysterics, and, later, neurasthenics and neurotics. Literary scholar Bram Dijkstra, who has studied the 'iconography of misogyny' in fin-de-siècle culture, argues that "virulent misogyny infected all the arts" at the turn of the twentieth century, and he gives compelling evidence for his thesis by unrolling a flood of paintings, pictures, novels and scientific treatises that amounted to an unprecedented attack on women.[6]

Gynaecological Surgery

In the fin-de-siècle era, the great majority of physicians were men. In Sweden, women were allowed to study and practice medicine in 1870, and the first female physician attained her medical degree in 1888.[7] Medicine was an emphatically masculine profession, and women who worked in the field of health care as nurses, midwives and administrators occupied lower positions in the medical hierarchy. A near-complete male domination in the field of medicine, together with the anti-feminine prejudices, attained a very visible form when the new medical specialty of gynaecology emerged in the mid-nineteenth century. Gynaecologists attempted to cure nervous illnesses through surgical and neurosurgical operations, mainly on women, whose illnesses the medical authorities readily attributed to the "female nervous temperament".[8]

The medical rationale behind gynaecological surgery was based on the theory of reflex neuroses, according to which "any irritated organ [such as the spine, uterus, nose, or stomach] could cause irritation in

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[6] Bram Dijkstra, *Idols of Perversity: Fantasies of Feminine Evil in Fin-de-siècle Culture* (Oxford: Oxford University Press, 1986), viii.

[7] Eklöf, *Läkarens ethos*, 106.

[8] On gynecological surgery of 'hysterical women' between 1850 and 1900, see Ann Daly, *Women Under Knife: A History of Surgery* (London: Routledge, 1991); Ornella Moscucci, *The Science of Woman* (Cambridge: Cambridge University Press, 1990); and Shorter, *From Paralysis to Fatigue*, 69–94.

any other organ in the body, including the brain".[9] In the nineteenth century, the female organs of reproduction were commonly regarded as the physical source of both nervous symptoms and diseases of any other organ, be it the eye, the thyroid, heart, ear, or skin. Thus, gynaecological surgery was a "logical extension of reflex theory" that "exercised a great influence on women's lives".[10] As gynaecology emerged as medical discipline in the latter half of the nineteenth century, the predominantly male gynaecologists wanted to differentiate themselves from obstetrics, and one way to create a professional niche for themselves was to regard Woman as radically different from Man. The construction of Woman as the Other entailed the idea that women had their own typical illnesses, which turned the doctors' medical gaze to the female reproductive organs, the mysterious and yet so fascinating matrix of nervous illnesses. During the early period of the professionalisation of gynaecology, male gynaecologists often presented themselves as experts in such gender-specific illnesses as hysteria, and, alongside neurologists, they were the medical specialists who were most preoccupied with this specifically female malady.

The first gynaecologists won medical attention with their surgical interventions, starting with ovariotomy or 'castration' (the removal of one or both of the patient's ovaries), which became a cornerstone of gynaecological surgery.[11] Other, more extreme interventions into the 'hysterogenic zones' had such technical names as 'clitorectomy' and 'vaginal hysterectomy', and they amounted to a cauterisation or outright extirpation of the clitoris, ovaries or the womb. Surgical treatment was also recommended as a solution to masturbation. In the United States, for example, The Society for Orificial Surgery

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[9] Shorter, *From Paralysis to Fatigue*, 38.

[10] Ibid., 64. From the mid-1880s to the end of the century, the flowering of the so-called 'nasal-reflex neurosis' represented the final phase of the nineteenth century reflex theory. Perhaps the best-known advocate of nasal-reflex theory was the Berlin-based throat-, ear-, and nose specialist Wilhelm Fliess, whose friendship with Sigmund Freud has generated scholarly interest in his medical activities. For a detailed scrutiny of Fliess's nasal theories and his influence on Freud, see Frank J. Sulloway, *Freud, Biologist of the Mind*, 135–237.

[11] On the German medical debate on the value of 'castration' (i.e. removal of ovaries) of hysterical women, see I. Israel, "Ett bidrag till värdet af kastrationsmetoden för botandet af hysteriska fruntimmer," *Eira* 4 (1880): 467–70; and a reply: A. Hegar, "Om kastration vid hysteri," *Eira* 4 (1880): 650–6.

> reported approvingly in the pages of its Journal of numerous cases of circumcision and clitorectomy (as well as a different unnamed operation to 'free' the clitoris) in order to prevent masturbation.[12]

In addition to these drastic methods, which were more like senseless mutilation than surgery, other surgical methods were used, abrading the womb, 'salpingotomien' and 'retroflexio uteri' among them (in these two latter operations, surgical interventions were directed at the anatomical region between the womb and the stomach). For a period of time, it was proposed in the United States that every mental asylum should appoint gynaecologists to investigate and operate generative organs of female patients.

In Sweden, the first chair of gynaecology was established in 1864, and while the more extreme forms of surgical interventions were seldom used, 'nervous women' were not spared surgery based on speculations about the pathogenicity of the womb:

> A diagnosis that on the contrary gained wide and long-lasting influence was the so-called *deviation of the uterus*; especially its positions backwards (*retrodeviation*). The diagnosis was followed by a number of therapeutic methods. The majority of the physicians accepted this diagnosis and only a few seriously contested it. The alleged deviations were thought to cause similar symptoms as the ones mentioned above in relation to normal ovariotomies, i.e. everything from nervous inflictions to headache and coughing. The treatment was in most cases attempts to fixate the position of the uterus by attaching it to the wall of the abdominal cavity, e.g. with nails, stitches, or various forms of so-called pessaries. This was both painful and risky for the patients: many suffered from peritonitis and cases of death were not uncommon.[13]

How did the leading neurologists and gynaecologists in Sweden evaluate such surgical interventions? Frithiof Lennmalm wrote in 1896 that surgery had been used as a treatment for nervous ailments on the basis of misinterpreted indications, and he singled out gynaecologists as a group of physicians who had unwittingly acted as psychotherapists gone astray. He observed that their false, outdated assumptions about hysteria as an illness of the female reproductive organs had led to an upsurge

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[12] Sterling Fishman, "The History of Childhood Sexuality," *Journal of Contemporary History* 17 (1982): 278.

[13] Ulrika Nilsson, *Kampen om kvinnan: Professionalisering och konstruktioner av kön i svensk gynekologi 1860–1925* (Uppsala: Uppsala University, 2003), 432.

in surgical operations in which ovaries and sometimes even wombs of the 'hysterical patients' had been removed. Lennmalm acknowledged that sometimes these surgical interventions had indeed eradicated some of the symptoms through the psychological impact of surgery on the patient's mind, but he stressed the dangers of such a procedure: it was not that uncommon for the nervously ill patient to die after the operation. Fortunately, said Lennmalm, contemporary gynaecologists have, for the most part, abandoned dangerous and unnecessary surgical operations, and they are more aware of the true (i.e. psychogenic) nature of hysteria.[14]

Two years later, the question of the gynaecological approach to nervous illnesses was taken up in an article written by Mauritz Salin, professor of gynaecology at the Karolinska. In his evaluation of the gynaecological scene, Salin is less sanguine than Lennmalm, for he finds with regret that an exaggerated eagerness to operate on hysterical patients—*furor operativus*—is still a major problem in gynaecology, despite the criticisms put forward by some leading gynaecologists. Too many gynaecologists, writes Salin, still entertain the false idea that hysteria is related to the genital organs, and some of his colleagues want to gain fame and collegial recognition by numerous surgical operations on very slight evidence. To give support to his claim that hysteria denotes a pathology of the nervous system, he refers to his neurologist-colleague at the Serafimer, Lennmalm. With regard to hysterical women he also notes that

> these patients became bêtes-noires for doctors. After having exhausted their entire therapeutic arsenal in trying to find a proper cure for these patients, doctors were plagued by their incessant plea for yet another therapeutic try. In desperation, doctors finally sent these patients to a gynaecologist, hoping that he would find an explanation for the mysterious morbid condition in the mysterious genital sphere. In this way, a great number of hysterical women gathered in the gynaecologist's office.[15]

The *furor operativus* of nineteenth-century gynaecology undoubtedly constitutes one of the darkest chapters in the annals of modern medicine. At the same time, we should bear in mind, that, as Janet Oppenheim puts it,

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[14] Lennmalm, "Om sjukdomar, som bero på föreställningar," 127–33.

[15] Mauritz Salin, "De nervösa sjukdomarnas inflytande på den operativa gynekologien," *Hygiea* 60 (1898): 15.

> with hormones and the endocrine system a medical mystery until the start of the twentieth century, doctors in the nineteenth century struggled as best as they could to make sense out of the mood swings that they often witnessed in their female patients.[16]

This is a useful reminder, but one doubts whether many doctors in fact tried their best to understand their patients' 'mood swings', since, at a time when hysteria was already being reconceptualised as a form of nervous pathology, doctors still often relied on outdated speculations about the causal link between the female reproductive organs and 'mood swings', and did not hesitate to operate on their female patients on, as both Lennmalm and Salin pointed out, very slim evidence. Behind the *furor operativus* as well as the whole medical approach to women, there seemed to lie a tacit assumption that there is something pathological in women's biological processes. For the nineteenth-century medical profession, women's bodies were as defective as their minds were inadequate.[17]

Women's Nervousness in the Fin-De-Siècle Era

Historian of medicine Karin Johannisson argues in her study of the 'dark continent' (i.e. Woman) that Woman's situation was first perceived as a problem or a 'question' around 1870, when female emancipation and the notion of female sickliness became social issues. The women's liberation movement increased men's inclination to pathologise Woman, to perceive female behaviour and characteristics that did not fit into the prevailing normative codes as symptomatic. Johannisson plausibly suggests that the anti-feminine mood, which was legitimised by a heavy dose of biologism, was a response to female emancipation. She points out that the popular theory of overstrain was widely used at the turn of the twentieth century to explain female morbidity and to show that women were ill-equipped for higher education.[18]

With the help of evolutionary theories, qualitative concepts such as weakness, submissiveness, and intellectual and moral inferiority, were presented as value-neutral. Johannisson finds it startling how frenetically

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[16] Oppenheim, *'Shattered Nerves'*, 189.
[17] Ibid., 190.
[18] Karin Johannisson, *Den mörka kontinenten. Kvinnan, medicinen och fin-de-siècle* (Stockholm: Norstedts, 1994), 31.

scientists and men of letters took it upon themselves to demonstrate and confirm Woman's biological inferiority. In her view, there is no other period in history in which a more paradoxical picture of Woman was portrayed than the late nineteenth century: Woman was madonna and whore; weak and dangerous; loving and threatening.[19]

Johannisson also suggests that hysterical fits may have been the only acceptable form of revolt against the de-sexualised and 'de-intellectualised' role of middle-class women. For bourgeois women, it appeared to be only though debility or sickness that they could gain attention without transgressing the prevailing moral codes. 'An escape into illness' was also a way of avoiding pregnancies at a time when contraception was not widely used and it was not uncommon to have five or six children (the number of children was highest in the poorest families). The problem for these women was that the benefits of the disease were overshadowed by the enforcement of a cultural stereotype that portrayed women as irrational, emotional, irresponsible and capricious.[20] Thus hysteria was much more than a gender-specific nervous illness; it was to some extent a pattern of behaviour that was adopted by middle-class women who were unhappy with their extremely confined domestic roles. Their 'morbid' minds and 'sick' bodies were a psychomedical expression of an almost 'Taliban-like' social order in which Woman was kept under Man's thumb. Nietzsche (who, being Nietzsche, not only relied on stereotypical assumptions about women) claimed that women who feared that men were terrified of signs of intellect in a woman, were "even ready to deny they have any sharpness of mind at all and deliberately impose on themselves a reputation for *shortsightedness*".[21] Could it be the case that, as Nietzsche suggests, middle-class women, whose livelihood depended on the industry of their spouses, were prepared to denigrate their own minds in order to placate and soothe the male mind, which was already 'overstrained' by heavy demands imposed on the nerves by Modern Life?

What is beyond dispute is that whereas the middle-class woman was supposed to be devoid of any biological needs, except for a need to become a mother, and constitutionally incapable of demanding intellectual work, the under-class became the carrier of forbidden impulses.

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[19] Ibid., 25–26.
[20] Ibid., 79, 160.
[21] Nietzsche, *Human, All Too Human*, 375–6 (aphorism No. 270).

To use an anachronistic idiom, an overdose of sex and drugs and rock'n' roll characterised the 'asocial' type of the under-class woman who was slave to her body. The female prostitute, being contagious both medically (venereal diseases) and morally, was the prototype of this type of woman. Under-class women were often diagnosed as psychopaths, mentally abnormal or inferior, and they provided the much-needed clinical material for psychiatrist Bror Gadelius at the Konradsberg mental hospital in Stockholm. Gadelius wrote in a national encyclopaedia in 1914 that it was not uncommon for a woman who suffered from nymphomania to lapse into prostitution, and that for "humanitarian reasons" it was sometimes necessary to incarcerate the "sick woman" (nymphomaniac) to a mental hospital. This was clearly Gadelius's way of justifying the dubious practice of forcibly incarcerating lower-class women who were labelled as mentally disturbed.[22]

During the fin-de-siècle era it was unwomanly to be intellectually ambitious; sexually active; or insubordinate, and doctors readily pathologised women who were not well-mannered, acquiescent and accommodating. The voices of frustrated women can be heard not in medical literature but in novels and letters written by middle-class women, who were denied access to the public sphere; whose complaints often failed to win sympathy among their doctors; and whose dreams of self-realisation and self-assertion were sabotaged by men who preferred domesticated women with an apron (or sexually active 'illegitimate' lovers and prostitutes with tightly laced corsets) to women with careers and ambitions (and minds) of their own.[23]

In Sweden, the writer Laura Marholm devoted a provocative book to 'Woman's psychology' in 1897.[24] Marholm, a member of the literary intelligentsia (her husband was also a writer) took an incisive make-no-bones-about-it approach to her subject, dissecting the oppressive family dynamics of the bourgeois household without simultaneously championing the female emancipation movement. Quite the contrary, she was an 'anti-feminist' and a critic of modernity (technology, rationalism, materialism) who adhered to the traditional view of Woman as an emotional

[22] Bror Gadelius, "Nymfomani," in *Nordisk Familjebok* (Stockholm: Nordisk Familjeboks förlags aktiebolag, 1914), Band 20, 255.

[23] On late nineteenth-century Swedish novels written by women, see Johannisson, *Den mörka kontinenten*, 231–42.

[24] Laura Marholm-Hansson, *Till kvinnans psykologi* (Stockholm: C. & E. Gernandts förlags-aktiebolag, 1897). For Karin Johannisson's discussion of Marholm's book, see Johannisson, *Den mörka kontinenten*, 236–40.

creature, whose supreme goal in life is to be a Mother.[25] Notwithstanding her reliance on the commonplace assumption that women are ruled by emotions, men by reason, her account of the 'Woman question' is both instructive and perceptive. She argues that modern women are doomed either to idleness or to unproductive and mostly useless work, which has a suffocating effect on their female nature: for the majority of women, to work as a teacher does not bring any satisfaction, but to work as a telephone operator, telegrammist, or "calculating machine" in a railway administration, post office or university administrative office is downright damaging to their female instincts. But marriage is not a safe option either, for even if there is a physical connection between husband and wife, a mental connection is often lacking, and this lack creates a void that can be damaging to both parties. Small wonder, then, that women seek refuge in illness and start to suffer from anaemia, nervousness and hysteria, all of which have their origins in mental depression rather than in somatic conditions.[26]

Marholm herself suffered from mental disorders and was occasionally treated in a mental hospital in Germany, where she lived with her husband at the turn of the century.[27] In her book, she contends that the prevailing cultural atmosphere foments sickliness to the extent that it has become fashionable to be ill. There is a veritable cult of sickliness in modern culture, and illness itself is a cultural achievement.[28] One has learnt to have faith in one's renowned doctor and in the triumphs of his renowned science, observes Marholm. One goes to a spa or sanatorium, drinks spring-water, keeps to a regulated diet, and submits oneself to this or that method of treatment. Especially for the upper classes, sickliness is something noble and refined, while health smacks of the peasantry—it is something coarse and inferior. Sickliness is also a refuge for the anxious daughters of impoverished middle-class families who are in dire straits. One group of women who cannot afford to be ill are working-class women; the livelihood of these women, as well as the livelihood of their families, depends on their sustained ability to work. And a woman who toils in a factory certainly cannot expect upper-class women to show solidarity, or do something about the overwrought circumstances of their fellow women in the lower echelons of society

[25] Marholm-Hansson, *Till kvinnans psykologi*, 264.
[26] Ibid., 106.
[27] Johannisson, *Den mörka kontinenten*, 236.
[28] Marholm-Hansson, *Till kvinnans psykologi*, 219, 221.

(except for patronising gestures of charity). For Marholm, the question of Woman is irredeemably a question of class.[29] In fact, as maids, nannies and domestic servants, the lower-class women made it possible for the upper-class women to become passive, lethargic and sick.[30]

In her book, Marholm describes Woman's psychology in a particular era, the fin-de-siècle period, which came to a definite end with the outbreak of World War I. The Great War changed the stereotypes of Woman as more and more women in Europe entered the labour market and started to provide for their families. In the 1920s, a new type of Woman appeared on the cultural scene, as numerous young women created 'modern' lives for themselves: they were confident, adventurous, independent, assertive and (sometimes) cigarette-smoking women who worked for wages, developed new attitudes towards womanhood and sought entertainment outside their home.[31] Meanwhile, for the majority of working-class women toiling in the factories, shops and in bourgeois and upper-class households, it was business as usual, and in the countryside it was still the Church and the traditional normative codes that to a great extent ruled the life of women (as well as of men).

The Inferior Woman and the Detestable Bourgeois Man

To summarise the stereotypical views of Woman, this is the list of the common prejudices in the fin-de-siècle era:

1. Woman's will is weaker than that of Man: Woman is impulsive and at the mercy of her feelings
2. Woman's intelligence is weaker that that of Man: the cerebral hemispheres of Woman are not as fully evolved as those of Man
3. Woman's nerves are highly unstable, which makes Woman liable to nervous illnesses
4. Woman is a passive creature who reacts rather than initiates: female self-assertion is a pathology (usually a sign of hysteria)
5. Woman's body is defective: the biological phases of Woman's life

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[29] Ibid., 230–31.

[30] Johannisson, *Den mörka kontinenten*, 84.

[31] For an excellent study of changing womanhood in Denmark in the 1920s, see Birgitte Søland, *Becoming Modern: Young Women and the Reconstruction of Womanhood in the 1920s* (Princeton: Princeton University Press, 2000).

resemble ill health (menstruation, pregnancy, childbirth and menopause)
6. Woman is meant to be a Mother: Woman's nerves are fitted for motherhood
7. Woman's sexual desire is much tamer than that of Man: an assertive sexual desire is unhealthy and may be a sign of nymphomania or moral insanity ('psychopathy')
8. Woman's supreme calling is to serve others: selflessness and self-sacrifice are expressions of a biologically determined female altruism

What this all adds up to is that, for (too many) men, femininity was a deeply flawed condition. Of course, there were conflicting male opinions about Woman during this era, and the champion of liberalism, John Stuart Mill, was not alone in arguing that it was the male-dominated society rather than biology that (mostly) explained Woman's inferior position. In Sweden, Dr Anton Nyström was an ardent defender of the autonomy and self-assertion of women, and there were also other Swedish physicians and intellectuals who fought chauvinistic prejudices in Sweden.

It is no coincidence that the critical focus of contemporary scholars is on the culture and mentality of *middle-class* men and women (especially on the allegedly 'rebellious women'). This interest in middle-class pathologies, I propose, may be partly due to the veritable tradition of 'bourgeois bashing' that has found a highly visible niche in academia.[32] According to the current pro-feminist paradigm in the human sciences, the most abominable creature of the last two centuries appears to be the bourgeois man, whose hypocrisy, chauvinism, moralism, misogynism, lust for power, indifference to suffering, racial and social prejudices, and conformism has known no bounds. One of the messages this scholarship conveys is that the bourgeois man being what he was (and is), it is small wonder that there were so many hysterical women in the nineteenth century. Yet, it was not only conceptions of women that changed during the nineteenth and early twentieth centuries; conceptions about the essence of masculinity also changed. As historian David Tjeder has shown in his study of the changing conceptions of the Ideal Man

[32] On the hatred and self-hatred of the bourgeoisie in the nineteenth and twentieth centuries, see Furet, *The Passing of an Illusion*.

in nineteenth-century Sweden, certain ideals persisted throughout the century while others changed, the doctrine of self-control functioning as an "organizing principle of proper masculinity".[33] Therefore, historians should not make sweeping generalisations about the history of manhood and assume that there once existed a unified and unambiguous understanding of masculinity. The very fact that women's bodies and minds began to be pathologised by men in the latter half of the nineteenth century is partly a function of the changing conception of the virtuous man: it was to some extent the conception of man as the gentleman concerned about the sexual purity of women that governed the treatment of the issue of femininity during this period.[34]

Was Female Nervousness a Middle-Class Phenomenon?

In 1900, altogether 717 hysterical patients and 1,428 neurasthenic patients were treated in the public hospitals in Sweden. The sum total of neurotic patients in that year was 2,145. The division of these patients into men and women gives the following result:

Table 1. *The number of hysterical and neurasthenic patients in the public hospitals in Sweden in 1900*

	Men	*%*	*Women*	*%*
Hysteria	72	10 %	645	90 %
Neurasthenia	606	42,4 %	822	57,6 %
Total	**678**	**31,6 %**	**1,467**	**68,4 %**

Source: *Bidrag till Sveriges officiella statistik 1900. Helso-och sjukvården I*, pp. xxvi–xxvii (Tab. No. 13).

[33] David Tjeder, "One Hundred Years of Uncertainty: Changing Conceptions of the Ideal Man, 1800–1900," in *Only Human: Studies in the History of Conceptions of Man*, ed. Arne Jarrick (Stockholm: Almqvist & Wiksell, 2000), 153–90. According to Tjeder, nineteenth-century ideas about the driving forces of men can be divided into four phases: "In the first phase, men were believed, or admonished, to act with an eye to their worth for their community. In the second phase, the idea that it was vanity, especially the will to become beautiful, that governed men's actions became stronger. And in the third phase, men were believed to be spurred by greed and a will to compete with other men. In the fourth phase, men were urged to be driven by a sincere concern for women and their sexual purity." Ibid., 186.

[34] On the construction of modern masculinity, see George Mosse, *The Image of Man: The Creation of Modern Masculinity* (Oxford: Oxford University Press, 1996).

As we can see, hysteria was a predominantly female malady, while neurasthenia was much less gender-specific. Still, women were clearly in the majority even in this latter category. All in all, almost two thirds of all neurotic patients were women. These numbers indicate that while neuroses were much more common among women than among men, men did have their share of nervous afflictions. Tuberculosis, with its various sub-categories, was overwhelmingly the most common disease that required hospitalisation in the early century, but, taken together, hysteria and neurasthenia constituted one of the largest disease categories in hospitals.

In her study of the medical view of women, Karin Johannisson gives a list of the eight most common diagnoses for women between the years 1901 and 1911 in Swedish hospitals. Here is the list of the 'top eight':

Table 2. *The most common diagnoses for women between the years 1901 and 1911 in the public hospitals in Sweden*

	1901	*1911*
Cancer	1 233	1 604
Gynaecological diseases	1 230	1 382
Anaemia	940	777
Neurasthenia	939	1 193
Heart diseases	698	1 248
Gastric ulcer	658	1 262
Eczema	628	837
Hysteria	584	533

Source: Johannisson 1994, p. 106.

This table shows that the absolute number of neurasthenic cases grew slightly during the first decade of the century, while the number of hysterics was on the decline. Taken together, these two major neuroses constituted the most common diagnosis both in 1901 and 1911. Since these numbers indicate the most widely-used diagnoses in public hospitals, it may be inferred that neuroses in Sweden were anything but a middle-class malady, the majority of patients in these hospitals being working-class people, artisans or peasants. And when one turns to the patients of the Serafimer's *Nervpoliklinik*, one can see, first, that neurosis was a very common diagnosis there, and, second, that from being more of a female malady in the early century (70% of all neurotic patients

in 1930 were women), it became a much less gender-specific illness by mid-century (52,5% were women in 1950).[35]

In Sweden at the turn of twentieth-century, the middle-class was still a rather small social class compared with the working class and peasantry (some of whom were quite rich and powerful, of course). In her study of women, children and work in Sweden from the mid-nineteenth century until today, historian Ann-Sofie Ohlander notes that ninety per cent of the population lived in the countryside in the mid-nineteenth century, and although industrialisation, which gathered momentum in the 1870s, brought fundamental changes to Swedish society, it took decades before the traditional role of women as subservient to men began to change.[36] Peasant women and working-class women, who worked hard in agriculture, and in the dairy, textile and paper industries, had the sole responsibility for domestic work and, on average, four to five children. For the majority of Swedish women, life meant work from dawn till dusk with very limited opportunities for rest and recreation. Indeed, if one takes into account women in the countryside, there were at least as many women in mid-nineteenth century Sweden *working full-time* as there are now. But, unlike modern women, women in the first half of the nineteenth century were not legally competent in Sweden. From 1845 onwards, a number of legal reforms started to improve the socio-economic position of women, especially unmarried women. For example, in 1858, unmarried women became legally competent at the age of twenty-five, and the liberal legislation concerning freedom of trade gave women opportunities to become entrepreneurs in 1864. In 1859, women were allowed to study in training institutes for primary teachers, and university gates were opened to women in 1873. But it took half a century before higher posts in the public sector became available to female candidates.[37] Another legal reform of major significance, both practically and symbolically, was the 1858 ban on men's right to physically discipline their wives.[38] According to Ohlander, this

[35] The Serafimer Hospital's Annual Reports.

[36] Ann-Sofie Ohlander, *Kvinnor, barn och arbete i Sverige 1850–1993* (Stockholm: SOU 38/1994), 38.

[37] Ibid., 14–19.

[38] In 1928, a ban on physical discipline in secondary schools came into force, and since 1958 it has been forbidden to physically punish any school children. Finally, in 1979, the law forbidding the parents to discipline their children physically came into force. Ibid., 41.

was the first jurisdictional sign that the patriarchal legislative structure regarding the family had began to break up.[39]

During the decades of the rapid modernisation of Swedish society, the majority of middle-class working women, whose number grew steadily, remained unmarried. There was a simple reason for their decision to remain unmarried: marriage often signified an exit from the working life. Compared with unmarried women, the emancipation of married women was a much slower process, and marriage signified a loss of much of women's autonomy. Only in 1920 did married women gain full legal competence.[40] Small surprise, then, that there were more unmarried women between the years 1870 and 1920 than in any other period covered by official statistics in Sweden; no less than forty per cent of women remained unmarried during this period—in 1920, there were 921,000 unmarried women in Sweden (Sweden had a population of 5,9 million at that time). And, as Karin Johannisson has pointed out, these women could not afford to stick to the role of sick patient, because most of them had to work. Working women and hysteria did not go together very well.[41]

In the interwar years, modernisation brought about fundamental changes in the lives of Swedish women, who were given the right to vote—and the right to present themselves as political candidates—in 1921, as well as the right to apply for higher posts in the public sector in 1923.[42] But, paradoxically, the rising standard of living did not bring with it an increase in the number of working women. Indeed, one of the earliest goals of the Swedish working-class movement had been to emancipate married woman from waged labour, and more than eighty per cent of married women were housewives by the mid-1930s. Thus to a greater extent than ever before, marriage signified an end to women's participation in the public sphere, which also decreased competition in the labour market (which was quite fierce during the economic depression of the early 1930s) and increased the number of children, as well as consumer spending.[43]

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[39] Ibid., 25–26.

[40] Ibid., 20.

[41] Johannisson, *Den mörka kontinenten*, 87.

[42] On women's struggle for political rights in Sweden in general and on the National Association for Women's Franchise in particular, see Josefin Rönnbäck, *Politikens genusgränser. Den kvinnliga rösträttrörelsen och kampen för kvinnors politiska medborgarskap 1902–1921* (Stockholm: Atlas Rönnbäck, 2004).

[43] On women and women's movement in Sweden from the mid-nineteenth century until the mid-twentieth century, see James Rössel, *Kvinnorna och kvinnorörelsen i Sverige 1850–1950* (Stockholm: YFS:s Förlag, 1950).

A major implication of these developments for the phenomenon of neurosis was that although neurosis was not a female malady, the majority of neurotic patients in Swedish hospitals, and probably also in the offices of private practitioners, were women. Furthermore, neurosis transgressed class boundaries and represented the whole female population, not only the middle class. The nervously ill middle-class women have been diligently studied in recent years, whereas the female working class neurotics have been much less visible. This is partly due to the historical fact that middle- and upper-class women articulated their feelings of discontent, consulted well-known nerve doctors, visited clinics, spas and sanatoria, and inspired and irritated many middle-class men, some of whom were physicians and men of letters keen on immortalising some of these bourgeois women. Any serious student of dynamic psychology is familiar with the names Anna O., Dora, Claire, Helene Smith, Sabina Spielrein and Edith McCormick-Rockefeller. By contrast, the nervously ill working-class women and peasants are more or less anonymous, for they can usually be found only in the dusty patient records of a hospital or polyclinic, or as case studies in old medical journals surveyed only by dedicated scholars.

The great exception to the invisibility of lower-class women were of course the working-class hysterics at Charcot's clinic: they were, in a way, the great stars of the hysteria show that went on at the Salpêtrière in the 1880s and early 1890s. But the problem is that these dramatic star hysterics were not very representative of the typical working-class female neurotics, at least in Sweden, where neurotic women were often troubled by mundane worries, such as a husband who was an alcoholic, sick, or violent; work that was extremely wearing; and all kinds of organic diseases and mental strain. They had real problems in their lives, but these problems did not usually make them invalids. Or, rather, they could not afford to become invalids, because they had to bring home the bacon. In 1930, psychotherapist Iwan Bratt, who sympathised with nervous women, made the sweeping suggestion that Woman's neurosis had become Man's punishment: Oppressed by men, women became nervous and lost their ability to love, and men, who regarded women as their personal property, failed to fulfil their burning need for Woman's love. The only way for a man to win a woman's heart was to stop treating her as if she was a piece of property.[44]

[44] Iwan Bratt, *Neurosproblemet i psykoanalytisk belysning* (Stockholm: Natur och Kultur, 1930), 62.

I shall examine the nervous problems of women patients in Part III; suffice it to say here that hysteria notwithstanding, neurosis was not a gender-specific illness in Sweden. Of all neurotic patients, women were in the majority, but there were also a considerable number of men among the neurotics. Therefore, based on my examination of patient records and published sources, I can tentatively conclude that, with regard to nervous illnesses, there was no sharp gender discrimination in Sweden. Incidentally, historian Joachim Radkau has drawn the same conclusion in his study of nervousness in Wilhelmine Germany.[45]

All cultures have their own understanding of illnesses, and as the social and political development of interwar Sweden led to the triumph of the social-democratic welfare state, there emerged a 'social-democratic' conceptualisation of neurosis, as it were. In this environmentalistic conceptualisation, the source of nervous illnesses was decreasingly to be found in the 'neuropathic constitution' and increasingly in the immediate psychosocial environment that predisposed people to neurotic reactions and disorders. After World War I, women were still widely considered to be intellectually and morally inferior to men, but the number of hysterical women were on the decline, and the dissemination of new diagnostic terms, 'neurosis' and 'psychoneurosis', signified a more egalitarian approach to neuroses. Still, women were frequently seen to suffer from specific types of neurosis, and one might wonder whether, for example, psychoanalytic speculations about the role of 'penis envy' in women's neurosis were in any way more 'progressive', not to say scientific, than the older, neurological speculations about the peculiarities of the female brain. In fact, the idea of penis envy was exceedingly chauvinistic, for it entailed the idea that, 'unconsciously', women were frustrated by the fact that they are not men.[46]

Next, I shall turn to the other main source of nervousness: sexuality.

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[45] Joachim Radkau, "The Neurasthenic Experience in Imperial Germany," in *Cultures of Neurasthenia*, ed. Gijswijt-Hofstra and Porter, 199–217.

[46] In Sweden, the psychodynamically-oriented psychotherapist Iwan Bratt, for example, was an advocate of the theory of penis envy. In 1931, he wrote the following: "An aversion to penis (*penisoviljan*) plays an enormous role in woman's neurosis" (because it is woman's reaction to an unconscious yearning for a penis!). Iwan Bratt, "Läkningens dynamik vid en psykoanalytisk kur," *SLT* 28 (1931): 144. I shall examine Bratt's views on neurosis in Chapter 7.

Nervousness and Sexual Counselling

One significant component in neurosis throughout the Age of Nervousness was sexuality. George Beard, the father of neurasthenia, devoted a book to sexual neurasthenia in the early 1880s, emphasising that sexual problems, impotence in particular, constituted a major factor in nervous illnesses. His book, which was translated into Swedish in 1896, set the tone for the later conceptualisations of the relationship between 'weak nerves' and disturbances in the sexual sphere.[47]

Sexuality was not only a medical, but also moral problem. Moralistic judgements with regard to sexuality were rampant in western Europe at least until the 1920s and the 1930s, and physicians, pastors and pedagogues formed an unofficial vice squad that monitored and regulated sexuality, condemning, for example, masturbation either as a sin or as a pathology that weakened and eventually damaged both the nervous system and the brain.[48] Likewise, sexual 'deviations', such as homosexuality, were judged morally or medically (through pathologisation).[49] Physicians were mostly members of the middle-class, and they tended to endorse some variant of a religious-conservative morality that confined sexuality to the institutional setting of marriage, denounced other outlets for sexual desire, and actively searched for ways and means to dampen any 'excessive' sexual urge.[50] By and large, the conservative medical community in Sweden joined forces with the Church in seeing sexuality as a creature from the black lagoon, lying in wait to emerge from the oily water and devour men and women who failed to practice continence or restrict sex to marriage. Reflecting a *Zeitgeist* that was obsessed at least outwardly with the chastity belt rather than with sensual pleasures, the law forbidding the advertising of contraception

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[47] George M. Beard, *Den sexuella neurastenin, dess hygien, orsaker, symptom och behandling* (Stockholm: H. Gebers förlag, 1896).

[48] See Thomas W. Laqueur, *Solitary Sex: A Cultural History of Masturbation* (New York: Zone Books, 2003).

[49] On homosexuality in Sweden during the Age of Nervousness, see Jens Rydström, *Sinners and Citizens: Bestiality and Homosexuality in Sweden 1880–1950* (Stockholm: Stockholm University, 2001) (Also published by the Chicago University Press in 2003).

[50] For a typical restrictive medical view on sexuality, see E. W. Wretlind, "Hvilka maximer böra gälla för läkarens ordinationer inom det sexuella området," *Eira* 11 (1887): 227–38. Wretlind contends, among other things, that a woman with a proper moral education hardly feels any sexual urge at all, even in the morally sanctioned form of marriage.

and its illumination came into force in 1910. This law suppressed liberal sexual policy until its repeal in 1939.

Nonetheless, during the 1920s a more enlightened and liberal attitude towards sexuality emerged, and a veritable flood of sexual literature showed that the people, especially women, had a great need to learn about their own bodily functions, including sexuality. In order to illustrate a typical medical approach to sexuality in the interwar years, Nils Antoni examined 'neurasthenia sexualis' in his contribution to a volume entitled 'Six doctors discuss the sexual problem' (*Sex läkare om sexualproblemet*, 1934). In his chapter, Antoni refers to the psychoanalyst Wilhelm Stekel's thesis that so-called psychosexual infantilism is an important breeding ground for neuroses, and he asserts that individuals who mature slower than average are much more susceptible to neurotic disturbances. He conjectures that, compared with some other races, the somewhat retarded constitutional development of the 'Nordic race', including the psychosexual development, is connected with this race group's evident hypersensitivity to neuroses, specific psychoses and suicide.[51] Thus the Nordic race is disposed towards sexual neuroses that in Antoni's view have the same constitutional foundation as other neuroses. As to the specific, proximate causes, Antoni concurs with many nerve doctors, who see troubles in the sexual sphere as inducing neuroses, but is reluctant to give much weight to sexuality. After all, writes Antoni, there is something called "pulling oneself together" (*upprycknin*g): an interest in a "higher order"—be it private or public—can very well become a fire that consumes that "petty neurosis". Without making it explicit, he concedes here to the psychoanalytic idea of sublimation, a re-channelling of sexual energy (libido) towards 'desexualised', morally and culturally valuable or at least harmless goals.[52]

The Swedish Association for Sexual Education

Nils Antoni belonged to the still large group of physicians who tended to understate the significance of sexuality to human life. But there

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[51] Nils Antoni, "Neurasthenia sexualis," in *Sex läkare om sexualproblemet* (Stockholm: Natur och Kultur, 1934), 158.

[52] In Otto Fenichel's authoritative psychoanalytic study of neuroses, sublimation is defined as a successful psychic defense in which "the original impulse vanishes because its energy is withdrawn in favor of the cathexis [discharge] of its substitute". Otto Fenichel, *The Psychoanalytic Theory of Neuroses* (New York: W. W. Norton, 1945), 141.

was no turning back the tide, as sexology was making headway in the public sphere in western Europe. When the World League for Sexual Reform was founded in Copenhagen in 1928, it inspired the Norwegian-born journalist and social activist Elise Ottesen-Jensen and her physician-friends to found the Swedish Association for Sexual Education (*Riksförbundet för Sexuell Upplysning*) in 1933.[53] Starting with Stockholm, the society established a number of information offices around Sweden. Around the same time, the first municipal information offices for sexual enlightenment were established in Stockholm and a few other towns. Among the *Riksförbundet*'s and the municipal offices' clientele, neuroses constituted a common affliction. In their report of the activities of the *Riksförbundet* during its first two years, Nils Nielsen and Elise Ottesen-Jensen write that "more than half of the clients suffered from difficult nervous afflictions and mental conflicts".[54]

In his report of the activities of the municipal information offices, Olof Johnsson observes that the great majority of women who visit his office in Lund belong to the middle classes (bourgeoisie, academics, civil servants), and only a few of them are not married. Conversely, the working class is represented by only a handful of 'emancipated' women, and the particular group that these offices are mainly targeted at, namely overstrained wives of workers with many children, "are conspicuous by their absence".[55] Johnsson attributes his own lack of contact with working-class women to the near-total indifference to sexual enlightenment on the part of the municipal social welfare services. Even the medical community in Lund does not seem to take any interest in providing public information about methods of contraception. He concludes that psychic inhibitions and moral prejudices towards things sexual still have a powerful grip on women in general and working class women (and women from the countryside) in particular.[56]

Simultaneously with the establishment of the Swedish Association for Sexual Education, a group of mainly left-wing Swedish physicians founded the Popular Journal of Sexual Enlightenment (*Populär Tidskrift för Sexuell Upplysning*) in association with their Norwegian and Danish

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[53] On the early history of the *Riksförbundet*, see Lena Lennerhed, *Sex i Folkhemmet: RFSUs tidiga historia* (Uppsala: Gidlunds förlag, 2002). See also Elise Ottesen-Jensen, "Riksförbundet för Sexuell Upplysning," *PTSU* No. 2 (1933): 56–61.

[54] Nils Nielsen and Elise Ottesen-Jensen, "Riksförbundets sexualrådgivningsbyrå," *PTSU* Nr. 6 (1935): 269.

[55] Olof Johnsson, "Var erhåller man råd i sexualspörsmål? De kommunala rådgivningsbyråerna," *PTSU* No. 6 (1935): 265.

[56] Ibid.

colleagues (the journal was separately published in Norway and Denmark). The group actively engaged in the society and in the journal was small, and while they were independent of each other in principle, the goals of the society and the journal coincided. The members of this group attempted to sever the alleged connection between neurosis and 'immoral' sexual behaviour, but they also supported compulsory sterilisation of the 'feeble-minded' and the mentally ill, which shows that racial hygiene ideology found support across a wide political spectrum, from the conservative right to the radical left (this was true of other western-European countries as well).[57] In a racial hygiene book published by a socialist publisher and co-written by Karl Evang, one of the editors of the Popular Journal, the positive attitude of socialism towards a 'scientifically' motivated racial hygiene was emphasised.[58] Elise Ottesen-Jensen, the champion of sexual enlightenment, even advocated 'active euthanasia' as a prophylactic against feeble-mindedness in the 1920s (but by the 1930s, she had ceased to advocate euthanasia, and did not show any particular interest in racial hygiene).[59]

As its title indicates, the *modus vivendi* of the Popular Journal was to enlighten the general population, which was still quite rightly considered to be rather ignorant of matters related to sexuality. This practical aspect of the journal was also stressed in the preface to the first issue, in which the editor of the journal, psychoanalyst Nils Nielsen, referred to the prevailing 'barbarism' in the sexual sphere. Nielsen complained that the most natural instinct of all, sexual instinct, was almost everywhere treated with secrecy, prejudice, repression and false instructions.[60] Although the journal was not strictly speaking psychoanalytic, a number of psychoanalysis-inspired articles were published in it during its five years of existence (1932–1936). Many contributors were also inspired by socialism, and the conservative opponents of the journal thought of it as a vehicle for socialist agitation (from 1934 to 1936 the journal was published by the well-known association of leftist intellectuals called Clarté). The journal succeeded in reaching a wide audience: the twenty-six issues in all of the journal sold more than

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[57] "Sexualfrågor inför riksdagen," *PTSU* No. 2 (1936): 62–3. See also Nils Nielsen, *Sexualkunskap* (Stockholm: Riksförbundet för Sexuell Upplysning, 1936).

[58] Karl Evang and Ebbe Linde, *Raslära, raspolitik, reaktion* (Stockholm: Clartés Förlag, 1935).

[59] Lennerhed, *Sex i Folkhemmet*, 49–54, 112–21.

[60] [Nielsen, Nils], "Anmälan," *PTSU* Nr. 1 (1932): 4.

300,000 copies, which was quite an achievement in a country with a population of six million people. When one surveys the contents of these twenty-six issues, one quickly notices that while practical health-related questions were dominant, these questions were often related to the larger social framework or to psychoanalytic theories—or, both. Still, the basic approach to questions related to the methods of contraception, birth control, pregnancy, menstruation, abortion, masturbation, impotence, homosexuality,[61] sex hormones, divorce, venereal diseases, the psychology of sexuality and the sexual enlightenment of children was emphatically pragmatic and down-to-earth. The explicit objective was to make the 'scientific' results of sexual research accessible to the general public.

From 1932 onwards, Sweden was ruled by the social-democrats, whose aspiration to develop an egalitarian, rationally functioning welfare state contributed to a cultural climate that was increasingly supportive of the kind of public enlightenment represented by the journal and the *Riksförbundet*. The 'sexual question' began to be addressed even in the official reports of the state: in 1936, the government appointed the world's first governmental commission into sexuality, and the law forbidding homosexual contacts was repealed in 1944 (and, in 1955, Sweden became the first country in the world to incorporate compulsory sex education into the curriculum in state schools). In the cultural atmosphere of increasing (hetero-)sexual liberalism, the *Riksförbundet*'s work was endorsed not only by leftist physicians and social-democratic politicians, but also by reformist sociologists, psychologists, architects and other members of the *Bildungsbürgertum* who wanted to enlist in the fight against social evils. The political urge for reforms in the spheres of sexuality and the family was reinforced by a burning demographic issue: the sinking birth rate since the late nineteenth century. This alarming trend called for governmental action, and Gunnar and Alva Myrdal's book 'The Demographic Crisis' (*Kris i befolkningsfrågan*, 1934) became probably the most widely-discussed book among politicians and the educated middle-classes in Sweden in the 1930s. In general, the main objects of Swedish sexual politics from the mid-1930s onwards were youth and, in particular, women. The state regarded women as exposed

[61] In the 1930s, punishment for homosexual intercourse was two years of imprisonment. Between the years 1926 and 1930, 145 individuals were punished for sodomy; of these, sixty-seven were put on a probation. Torgeir Kasa and Gunnar Inghe, "Homosexualiteten," *PTSU* Nr. 4 (1933): 35–6.

and vulnerable, and in need of support and autonomy, while men were seen to be beyond the pale—unmanageable and unreliable.[62]

In the Popular Journal, there was a section devoted to Questions and Answers, which showed that many Swedes were still afraid lest masturbation ruined their health; that there were women who were desperately looking for advice on how to get abortion (usually for economic and other external reasons); and that many were ignorant about contraceptives. Some readers gave expression to fears that now seem exotic. One reader, for example, was worried about the possibility of getting so badly stuck with his or her partner during sexual intercourse that they would not be able to be separated from one another without outside intervention (this was, apparently, a quite popular misconception at that time).[63] And we get a glimpse of the sometimes miserable working conditions of those days from a letter written by a 21-year-old, newly-wed woman who had started to feel great pain in her genitals during intercourse. She writes that during her working day in a busy shop she cannot satisfy her bodily needs, and has to wait until the shop is closed before she can go to the toilet.[64] (If we are to believe the neurologist Sven Ingvar, working-class women often had smaller bladders than upper-class women, who were used to suppressing their need to urinate out of prudishness, which gradually made their bladders larger).[65]

Letters sent to the *Riksförbundet* by ordinary people show that problems in the sexual sphere had a direct bearing on their 'nerves'. As Nils Nielsen pointed out in his article on impotence, "many nervous illnesses have their ultimate basis in sexual disturbances, and vice versa".[66] He also wrote that about ninety per cent of impotent men were convinced that their illness was caused by masturbation. Nielsen criticised both quacks and his own colleagues (e.g., the well-known general practitioner Henrik Berg) for promoting false, dangerous and illness-inducing ideas about the hazards of masturbation. Indeed, Dr John Almqvist, for example, attributed impotence and 'prosthetic atonia' to masturba-

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[62] Birgitta Sandström, *Den välplanerade sexualiteten* (Stockholm: HLS Förlag, 2001).
[63] "Frågor och Svar," *PTSU* No. 3 (1936): 144.
[64] "Frågor och Svar," *PTSU* No. 2 (1935): 95–6.
[65] Sven Ingvar, "Nervösa organsjukdomar, de inre organens uppfostran," in John Agerberg et al., *Själens Läkarbok*, 402. Ingvar regards this phenomenon as part of the 'domestication process' of a civilized woman.
[66] Nils Nielsen, "Impotens," *PTSU* Nr. 6 (1933): 23.

tion without any hesitation.[67] In another article, Nielsen argued that the culturally sanctioned promotion of sexual ignorance and guilty conscience with regard to sexuality were strongly supported by the Church of Sweden. For Nielsen and other radical representatives of sexual enlightenment, the Church appeared as a harmful institution that first created deep feelings of anxiety among the flock and then offered spiritual consolation to the terrified members of the Church who had been led to believe that masturbation was a deadly sin.[68] Thus, on the one side there were physicians such as Berg and Almqvist, who conjured up a horrifying medical picture of masturbation, and on the other side, members of the Church who conjured up a horrifying moral picture of masturbation. Although a psychoanalyst, Nielsen did not give any comment on Freud's coupling of masturbation and neurasthenia: in psychoanalytic theory, masturbation ranked as the cause *par excellence* of neurasthenia.

While impotence was a common and distressing problem for men, frigidity was typically seen by sexologists as a wide-spread female affliction. Psychoanalyst Wilhelm Stekel, for example, claimed that between forty and fifty per cent of all women were frigid; others suggested that the correct figure was twenty per cent; and some sexologists outdid Stekel by proclaiming that as many as eighty or ninety per cent of women were frigid. In his book on nervousness, the Norwegian psychodynamic psychiatrist Johannes Strømme announced that no less than ninety-five per cent of all women were 'impotent' (i.e. frigid)![69] While frigidity was portrayed by male experts as an extremely common problem for women, among those who consulted the *Riksförbundet* there were many more impotent men than frigid women.[70] One might ask whether the criteria for 'frigidity' were extremely fluid and biased, and whether the

[67] Ibid., 24–5. A typical judgmental medical attitude towards masturbation can be found in John Almqvist's review of an anthology of essays on 'sexual hygiene'. Almqvist condemned masturbation in the name of cultural ideals, self-discipline and psychic development. See John Almqvist, Review of *Sexuell hygien*, *SLT* 24 (1927): 1023–8. In his study of neurasthenic patients in Germany, Joachim Radkau pays attention to the crucial importance of masturbation as a source of sexual anxiety: "Reading the papers of neurasthenics, one can get the impression that onanism was a much bigger problem at that time than militarism or socialism!" Radkau, "The Neurasthenic Experience in Imperial Germany," 208.

[68] Nils Nielsen, "Sexualupplysning som Geschäft," *PTSU* Nr. 1 (1933): 38.

[69] Alfhild Tamm, Review of Johannes Strømme, *Nervøsitet*, *SLT* 23 (1926): 1260.

[70] For example, in 1947 there were 390 cases of frigidity and 891 cases of impotence among the *Riksförbundet*'s clientele. Lennerhed, *Sex i Folkhemmet*, 147–53, 157.

alleged 'coldness' of women was a problem for their sexual partners rather than to these 'frigid' women themselves. One might also wish to know the extent to which the women's 'frigidity' was a consequence of male sexual behaviour…

As befits a group of socially-engaged medical reformers inspired by psychoanalysis, the Popular Journal published articles by the Marxist psychoanalyst Wilhem Reich, who lived in Norway from 1934 to 1939,[71] and by the well-known German sexologist Max Hodann, who was also a Marxist. Not so surprisingly, the journal was sued by the chief of the criminal investigation department in Stockholm for the danger it posed to public morality, and also for its 'commercial' exploitation of sexual malaise and its use of foreign contributors (that is, Reich and Hodann). In their reply, the editors attributed the complaint to bourgeois and Christian sexual hypocrisy, and made a counterattack on their opponents by pointing out that the bourgeois classes did absolutely nothing to help the people in their sexual malaise.[72] The editors also referred to translations of articles written by "the internationally famous German nerve doctors [Reich and Hodann]," whose expertise a police officer, the governor of Stockholm (who decided to take action against the journal after receiving a file of complaint from the police officer) and the bourgeois press were incapable of judging. They declared that it served the interests of reactionary forces in society to use sexual ignorance as a tool to keep people in mental slavery, and submissive to the authorities.[73] The core group around the journal was by no means intimidated by the complaint, and in the end the attempt to put the journal on trial was thwarted.

The last issue of the Popular Journal came out in 1936, but the *Riksförbundet* (which is still active today) started to publish a newsletter, *Sexualfrågan*, in 1937. The newsletter was edited by the *primus motor* of sexual enlightenment, Elise Ottesen-Jensen, who also became the editor of a new journal that saw the light of day in 1950 (*Populär Tidskrift för Psykologi och Sexualkunskap*). A survey of the issues that appeared between the years 1950 and 1958 reveals that while questions related to psycho-

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[71] On Wilhelm Reich's influence on cultural radicalism in Scandinavia, see Leif Longum, "Psykoanalysen og kulturradikalismen: Freud og Reich i skandinavisk kulturkamp 1920–1940," in *Kulturradikalismen*, ed. Bertil Nolin (Stockholm: Brutus Östlings Bokförlag Symposion, 1993), 23–62.

[72] "Polisen eller läkaren," *PTSU* Nr. 6 (1933): 43–8. See also Lennerhed, *Sex i Folkhemmet*, 59–62.

[73] "Polisen eller läkaren," 48.

logical consultation and therapy had now become more important for the *Riksförbundet*, the topics the journal addressed were closely related to the ones discussed in the *Popular Journal* of the 1930s. Sexual enlightenment, birth control, sexual problems in the marriage, homosexuality and critique of the Church and conservative-religious sexual morality were recurring themes in the Popular Journal of the 1950s, as they had already been in the Popular Journal of the 1930s.

Nervous Children

What makes a 10-year-old child or a 35-year-old adult nervous? In his popular exposition of nervousness in children ('My Child is Nervous', 1938), Norwegian psychoanalyst Harald Schjelderup answered: failures in upbringing during the first five or six years of life. Experiences and influences in early childhood, claimed Schjelderup, often laid the foundation for nervous afflictions at a later, mature age.[74] Indeed, "the demonstration of the connection between childhood experiences and neurosis is one of the most significant discoveries of modern psychological and medical research."[75]

This being the case, one could only fight neuroses by trying to influence the parental care of offspring, and by reforming pedagogy and child care services, so that experts and the authorities would apply modern, anti-authoritarian psychological methods and ideas in their work with children. Schjelderup himself was influenced by Wilhelm Reich's radical views of upbringing, and he promoted a liberal, non-intrusive educational approach to children. He also emphasised the importance of the healthy development of sexuality, from the 'oral' and 'anal phases' to the 'phallic phase' in early childhood, the last phase manifesting itself in masturbation. Masturbation was thus a sign of healthy sexuality, which in turn was the best prophylactic of neurosis. Conversely, disturbances in early sexual development might bring about mental disturbances later in life. To illustrate his point, Schjelderup referred to one of his female patients, whose neurosis he traced back to her early childhood, when she had had violent feelings of envy towards her younger brother.[76]

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[74] Harald K. Schjelderup, *Mitt barn är nervöst* (Stockholm: Wahlström & Widstrand, 1938), 14, 23.
[75] Ibid., 59.
[76] Ibid., 116–18.

In Sweden, as in many other countries, psychoanalysis influenced pedagogy and child psychiatry much more than neurology or adult psychiatry. Freud was not the first to theorise about the mental life of children, but his perspective on the crucial importance of the early psychosexual development to mental health became paradigmatic in western medicine and psychology. Psychoanalysts propagated the view that, as compared with the influence of familial relations, especially the mother-child bond, hereditary factors paled into insignificance. Thus, pedagogues, psychologists and physicians who were influenced by psychoanalysis preferred to examine children's family constellations rather than heredity, and they tended to replace the doctrine of the hereditary disposition to neurosis or psychopathy by the doctrine of infant determinism.[77] As psychoanalytic psychiatrist Alfhild Tamm put it,

> the doctrine of the crucial power of heredity and constitution had such a depressing and paralysing impact on many [doctors] that they lost their ability to maintain an optimistic attitude, and, therewith, to treat [their patients] effectively.[78]

The result of this shift of emphasis from heredity to childhood was twofold: first, psychoanalysts fanned the spirit of therapeutic optimism, with its message that healthy relations between children and their parents function as a prophylactics against neurosis. Second, psychoanalysts tended to put the blame on the parents if their offspring suffered from mental disturbances. So-called 'guilty mothers' have fared especially badly at the hands of psychoanalysts, who have blamed them for every problem or deviance in their children.[79] Thus, psychoanalysis represented a more enlightened attitude towards children and childhood sexuality than much of previous mental medicine, but it also tended to develop into a mother-blaming doctrine that saw early childhood as absolutely essential to the future mental development of children. Especially in the 'culturalist' school of psychoanalytic theory, personality was seen as a product of the individual's immediate environment, and early childhood was a 'critical period' in the psychic development of personality.[80] Melanie Klein, a psychoanalyst who studied the putative

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[77] For a critique of the doctrine of infant determinism, see Jerome Kagan, *Three Seductive Ideas* (Cambridge, MA: Harvard University Press, 2000), 83–150.

[78] Alfhild Tamm, [Commentary], *Förhandlingar*, November 15, 1938, 413.

[79] Edward Dolnick, *Madness on the Couch: Blaming the Victim in the Heyday of Psychoanalysis* (New York: Simon & Schuster, 1998).

[80] Psychoanalyst Sandor Lorand's view on early childhood is a paradigmatic example

'pre-Oedipal' phase of children's psychosexual development, suggested that, to make the world a more peaceful place, *all children* should be analysed; she hoped that "child-analysis will become as much a part of every person's upbringing as school-education is now".[81]

Psychoanalysis formed part of the modernisation of education and upbringing in Sweden, but it was not the only theoretical system that was used in pedagogy, psychology and child psychiatry. American behaviourism and developmental psychology, as well as John Dewey's educational philosophy, had an impact on Swedish educational ideology both in the interwar years and in the post-World War II era. In the liberalisation of educational policy, psychoanalysis played a role alongside American models and, later, Jean Piaget's developmental psychology. In the field of pedagogy, it was Alfred Adler rather than Freud who exerted the strongest influence; Adler visited Sweden in 1935 and gave well-received presentations, which strengthened his position in Sweden. The anti-authoritarian educational principles of the British pedagogue A. S. Neill were also enthusiastically discussed in Sweden. Neill, who founded the famous experimental school, Summerhill, in 1921, visited Sweden a number of times, and three of his books were translated into Swedish already in the 1930s. He was influenced by psychoanalysis, and after meeting Wilhelm Reich in Oslo in 1936, he started to incorporate Reichian ideas into his educational principles.[82] Reich saw sexual emancipation as the key to mental and physical health, and his sexual psychology and so-called vegetotherapy inspired Norwegian psychoanalysts and psychologists in the 1930s. His radical views on child rearing and childhood sexuality were also favourably received by a number of Swedish child psychiatrists, psychologists and left-wing intellectuals.[83]

The first information office for parents was opened in Sweden in 1908, and in the following decades an institutional framework for the scientific study of children was developed.[84] In the late 1920s, the first

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of the psychoanalytic infant determinism: "Experience has taught us that the period from birth to the age of five or six is the reservoir from which one's character emerges." Sandor Lorand, "Character Formation," in *Psychoanalysis Today*, ed. Sandor Lorand (New York: International Universities Press, 1950), 208.

[81] Melanie Klein, "The Early Development of Conscience in the Child," in *Psychoanalysis Today*, ed. Sandor Lorand, 74.

[82] A. S. Neill, *Summerhill: A Radical Approach to Child Rearing* (New York: Hart, 1960).

[83] Åsa Bergenheim, *Barnet, libido och samhället* (Stockholm: Höglunds, 1994).

[84] See Palmblad, *Medicinen som samhällslära*.

therapeutic institutions for 'nervous and psychopathic children' were opened on a private initiative, while the shift of attention away from 'bad behaviour' and 'deviancy' to a psychomedical preoccupation with nervous afflictions and maladjustment reflected the liberal pedagogic ideology that had gained momentum in the interwar years.[85] Degenerationism and a general emphasis on hereditary factors gradually gave way to an environmentalist, 'optimistic' approach to children and their development, which was in tune with the nascent ideology of social engineering. Reflecting the new, psychology-inspired *Zeitgeist*, homeopathic therapist Erik Hultén asserted in 1944 that many of the neuroses in school and at home arose because neither parents nor teachers were child psychologists.[86]

A typical representative of the new educational ideology was Torsten Ramer, a child psychiatrist working at Stockholm's information office for questions related to education and upbringing. In a 1937 article describing his advisory work, he laments that the school authorities are "incapable of judging the children from a causative and biological point of view". They judge such problems as 'laziness' and difficulty in keeping pace with tuition and instruction morally, and

> are furthermore so narrow-minded that they hold the all-important task of the school to be an *instillation of knowledge*, while they overlook the factors which *produce personality* [my italics].[87]

In the 1930s, Ramer still found it difficult to convince the authorities of the importance of expert knowledge about upbringing, and of liberal educational principles, yet in post-World War II Sweden it was the 'personality-producing' principle that had a field day in education, while the 'knowledge-instilling' orientation diminished in importance. Ramer gave scientific justifications for his views: by teaching parents to become less demanding and authoritarian, and by actively monitoring the private sphere of citizens, the experts would be in a better position to prevent neuroses and help children adjust to their environment. Ramer's was the voice of a behaviour expert, who in the following decades would come to play an increasingly dominant role in guiding parents and teachers in their respective duties.

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[85] Roger Qvarsell, "Från vanart till psykopati," *Lychnos* 1985, 167–88.
[86] Hultén, *Nervsjukdomar*, 7.
[87] Torsten Ramer, "Giving Advice in Questions of Education and Upbringing, A New Form of Prophylaxis," *ACTA* 12 (1937), 473.

Another psychiatrist, Erik Goldkuhl, represented the spirit of social engineering with his suggestion that all children should be subjected to a psychological and psychiatric assessment that would help determine their future prospects and the line of work that would be most suited to them. If all citizens could find the occupation that suits them best, it would be profitable not only from the moral and humane perspective, but also economically, because it would increase the efficiency of the nation and, therewith, the standard of living and the subjective feelings of contentment. For this reason, each citizen should be regularly subjected to a mental-hygienic control, starting from the first grade in elementary school.[88]

It is worth noting that it took some time before the liberal ideals of upbringing and education made any difference at the 'shop-floor' level—at home or in the class-room. This is how Ingmar Bergman describes his school in the 1930s:

> It was an institution, a storage place, based on an unholy alliance between authorities and family. The stink of boredom was sometimes penetrating, sometimes suffocating. The class was a miniature reflection of pre-war society; indolence, indifference, opportunism, sucking-up, bullying and a few confused flashes of revolt, idealism and curiosity. But anarchists were kept in place by society, school and home. Punishments were exemplary and often affected the offender for life. The teaching methods largely consisted of punishments, rewards and the implanting of a guilty conscience.[89]

After stating that many of the teachers at the time were National Socialists, Bergman goes on to note that "naturally there were exceptions; some teachers and pupils were gifted and irrepressible people who opened doors and let in air and light."[90] In the 1930s, the traditional educational ideology that emphasised obedience and discipline was gradually challenged by an ideology that encouraged a freer expression of one's self. Notwithstanding Bergman's rather grim view of authoritarianism in schools, the times had changed since 1891 when Dr Selldén, a specialist in nervous illnesses, proclaimed that children must be taught to be obedient and keep themselves (and especially

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[88] Erik Goldkuhl, "Aktuella önskemal beträffande den psykiska hälsovården i Sverige," in *Om sjukdom och sjukvård. Studier tillägnade Malte Ljungdahl* (Lund: Gleerup, 1947), 209.
[89] Bergman, *The Magic Lantern*, 113.
[90] Ibid.

their urges) in check.[91] Selldén and other physicians who championed respect for law and order as a cornerstone of child education had begun to look anachronistic by the time Ingmar Bergman graduated from *gymnasium*.

Institutionalisation of Child Therapy

A psychoanalytically-oriented child therapy was institutionalised in Sweden in 1934, when the retired teacher Hanna Bratt founded the Erica Foundation (*Ericastiftelsen*), which later (in the mid-1950s) was given an official status as the first academic child therapeutic training institute in Sweden (the institute is still running).[92] Bratt was influenced by Neill's anti-authoritarian pedagogy and by the child therapeutic work of the Institute of Child Psychology in London, where Bratt had made a study trip in 1933. After returning from London, Bratt contacted psychoanalyst Gunnar Nycander, who introduced her to the members of an unofficial 'Nerve Club' (*Nervklub*), a group of nerve doctors who gathered at the home of Jakob Billström to discuss matters related to neuroses and their treatment. Nycander, who later left the psychoanalytic movement, became interested in Bratt's ideas, and when the Erica Foundation was established, he became its medical representative.[93]

Initially, the therapeutic activities of the Erica Foundation were evaluated quite critically by the medical establishment, which was suspicious of the co-operation between laymen and physicians at the institute. In 1936, Bratt and Nycander managed to make the foundation appear more respectable when they persuaded Nils Antoni, the prestigious professor of neurology, to become the foundation's 'inspector'. Nycander had worked as an intern at Antoni's *Nervklinik* at the Serafimer, and his former chief was obviously quite sympathetic towards Nycander's 'psychogenic' perspective on neuroses.[94] Antoni's support made Bratt's project less controversial for the medical establishment. Indeed, the foundation gained support from certain other leading physicians as well,

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[91] Selldén, "Om vår tids nervsvaghet," 24.

[92] Bergenheim, *Barnet, libido och samhället*; Per Magnus Johansson, *Freuds psykoanalys*, Band 3: *Arvtagare i Sverige del 2* (Göteborg: Daidalos, 2003), 187–201.

[93] On the life and work of Gunnar Nycander, see Johansson, *Freuds psykoanalys*, Band 3, 111–85.

[94] In a meeting at the Society of Medicine in early 1935, Antoni called Nycander "a good psychoanalyst". Nils Antoni, [Commentary], *Förhandlingar*, January 29, 1935, 47.

and it also started to receive public funding from the state and the city of Stockholm, which guaranteed its economic stability.

The main objective of the Erica Foundation was to advance the mental health care of children and youth (between the ages of 3 and 18). In practice, the foundation received young, mostly middle-class and upper middle-class patients from paediatricians, psychiatrists, neurologists and general practitioners, who sent nervous or disturbed children for consultation to the foundation's office. In addition to its therapeutic work, the foundation organised training seminars for professionals in the fields of pedagogy, psychology and therapy. In Hanna Bratt's formulation of the method employed at the foundation, the principal goal was to help the young patient by establishing a bond of trust between doctor and child, which was a precondition for 'X-raying' the mental life of the child (*själslivets röntgenfotografering*).[95]

In 1938, Nycander gave a presentation on the foundation's activities to the Society of Medicine, emphasising environmental factors in the formation of emotional disturbances among his clientele, and claiming that seventy-five per cent of Swedish children lived in a more or less "defective milieu".[96] He also referred to a remarkable therapeutic success at his institute: in a follow-up study of the mental health of children treated at the Erica Foundation, eighty-four per cent of the young patients were found to be symptom-free, or their condition had "improved". His presentation was rather favourably received by his audience, although some commentators pointed out that Nycander's therapeutic success was probably due to the fact that children develop all the time and they can quite naturally be released of their symptoms as they grow older. As a psychoanalyst, Nycander was especially interested in the psychosexual development of children, and in 1942 he suggested that the authorities should consider establishing a "research institute for sexual science".[97] Such an institute would undertake psychological investigations of children, in order to find ways of preventing the disturbed and perverted development that results in psychopathy, psychic traumas as well as homosexuality and other perversions. Nycander's

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[95] Hanna Bratt, "Ericastiftelsen," in *Psykologien upptäcker människan* (Stockholm: Kooperativa förbundets bokförlag, 1945), 91.

[96] Gunnar Nycander, "Om verksamheten vid Erica-stiftelsens läkepedagogiska institut," *Förhandlingar*, November 15, 1938, 408–10.

[97] Gunnar Nycander, "Homosexualitetens samhällsfarliga yttringar," *SLT* 39 (1942): 651.

ideas represented infant determinism, and a rather conservative psychoanalytic explanation of sexual deviancies (e.g. homosexuality was a perversion), but, as we shall see, a more radical psychoanalytic approach to the problem of maladjustment emerged in the 1940s.

Therapeutic Experiments in a 'Children's Village'

In addition to the moderate application of psychoanalytic methods at the Erica Foundation, there were also advocates of a more radical, Reich-inspired psychoanalytic approach to child therapy. The most famous Reichian child therapist in Sweden was the psychiatrist Gustav Jonsson (1907–1994), who became head of the psychotherapeutic 'children's village' in Skå-Edeby near Stockholm in 1947 (later in his life, he was commonly known as 'Skå-Gustav').[98] Jonsson had established contacts with leftist Freudians when he studied medicine in Uppsala, and in the mid-1930s, when he worked at the Karolinska Institute's Paediatric Clinic at the Hospital of Norrtull in Stockholm, he became increasingly critical towards the vaguely-defined and value-laden term 'psychopathy'. His embracing of Reich's theories left its mark on his approach to childhood and mental health, while his further reading of the Critical Theory of the Frankfurt School (Adorno, Horkheimer, Fromm), as well as his friendship with the Norwegian Reichian analyst Nic Waal (previously Nic Hoel), convinced him of the crucial role played by pathogenic social structures in the development of personality. Following Reich, he saw society's suppression of healthy sexuality as the main aetiological factor in neuroses.[99]

When he assumed his post as the chief physician of the new psychotherapeutic institute for children ('children's village') in Skå-Edeby in 1947, Jonsson started to employ radical psychoanalytic methods in the therapy of 'nervous children who have been damaged by their milieu'. The first proposal for the description of the institute's clientele had been 'nervous and *psychopathic* children', but as the validity of the concept of psychopathy had been questioned early on by Jonsson

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[98] On Gustav Jonsson's life and work, see Bergenheim, *Barnet, libido och samhället*; Åsa Bergenheim, "Skå-Gustav och barnpsykiatrin," in *Hur skall själen läkas?*, ed. Eriksson and Qvarsell, 183–214; Kerstin Vinterhed, *Gustav Jonsson på Skå: En epok i svensk barnavård* (Stockholm: Tiden, 1977).

[99] Bergenheim, *Barnet, libido och samhället*, 265–70.

and by some of his like-minded colleagues, the term was not used at Skå-Edeby.[100] At the beginning, Skå-Edeby was seen as a humane and psychologically up-to-date institute, and it was supported financially by the city of Stockholm. But it did not take long before rumours and anecdotes about the extraordinary conditions at the institute started to circulate in the media, and the authorities in Stockholm began to pose critical questions about the methods in use there. The authorities even weighed up the possibility of closing down the institute, but at that point Jonsson and his colleagues received strong support from a group of Norwegian and Danish physicians, who vouched for the institute and pleaded for the cause of an "important medico-pedagogic experiment". After a thorough investigation into the circumstances at the institute, it was decided by the responsible authorities in the city of Stockholm that there was no need to close down the institute, and that the therapeutic experiment should be allowed to continue there. Thus the institute narrowly escaped sudden death, and Jonsson remained head of the institute. But this was only the first of the numerous incidents and scandals at the institute that in the 1950s and the 1960s kept the 'children's village' in the headlines.[101]

What, then, was it about the 'children's village' that created such a debacle? Surely not the 'anti-authoritarian' approach in itself? After all, liberal educational ideology was gaining ground in early post-war Sweden, and the psychotherapy of children was no longer a novelty. Obviously, the therapists at the 'children's village' took it to heart not to deceive children for the sake of prudery, and they tried to avoid patronising moralism. Therefore, it was not anti-authoritarianism that was a problem in itself—the problem was that it was coupled with what seemed to be a thoroughly sexualised interpretation of children's behaviour. No matter what the children said or did, their behaviour and personality were interpreted and presented in sexually laden Freudian and Reichian terms. Wherever the staff at the institute looked, they saw castration anxiety, penis envy, fear of masturbation, sexual complexes and all kinds of sexual symbols. In their intimate discussions with children, the therapists did not only enlighten their young clientele about sexuality,

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[100] A colleague of Jonsson, Bo Gerle, published a book on the "bankruptcy of the concept of psychopathy" in the same year that Jonsson began his therapeutic activities at the 'children's village'. See Bo Gerle, *Psykopatibegreppets bankrutt* (Lund: Gleerupska Univ.-Bokhandeln, 1947).

[101] Bergenheim, *Barnet, libido och samhället*, 270–3.

they also tried to encourage children to have frank discussions about their own sexuality. As historian Åsa Bergenheim notes, many children rejected the offer to discuss their sexual behaviour, but a manifestation of reluctance or aversion did not always discourage the therapists, who kept on pressing the children in order to make them talk. Thus, for example, the therapists did not always take no for an answer when they asked the children whether they masturbated or not. For the staff, masturbation was a sign of healthiness, and if a child maintained that he or she did *not* masturbate, it could be interpreted as a pathological symptom ('strong psychic inhibition'). Sometimes the adults told the children about their own sex lives. In a Reichian spirit, the therapeutic goal was not sublimation but the release of sexual energy.[102]

Bergenheim gives an account of an eight-year-old girl, whom a male therapist saw as suffering from penis envy, because the girl had an elder brother. In his discussion with the girl, the therapist announced that there were many girls who were envious of their brothers' penises, but the girl did not want to listen to him. The therapist insisted on talking about the 'penis complex' to the young girl-patient, who could no longer bear to hear his insistent and repetitive interpretation and became furious with him. Her strong reaction was interpreted as another manifestation of her penis envy and its link with her brother. Sometimes the therapists used words that even the often cruelly-treated children themselves, many of whom were quite disturbed, found offensive: the children were asked, for example, if they had seen their parents 'screw' (*knulla*), and the boys were asked if they tended to 'jack off' (*runka*) frequently. According to Bergenheim, patient records show that children sometimes reacted to such questions with anger and irritation. Here is a small excerpt: The therapist: "Have you ever seen your mom and dad screw?" The child: "You filthy swine. This was too filthy."[103]

Apparently, the therapeutic idea behind such an interventionist approach was to relax the sexual tension in children, to 'de-dramatise' sexuality and to create a bond of trust between children and adults. In order to create such a bond, the traditional psychoanalytic distance between patient and analyst was abandoned in favour of a policy of mutual openness and intimacy. But in their (blind?) faith in the particular psychodynamic interpretative framework that they endorsed,

[102] Ibid., 287–309.
[103] Ibid., 292.

the therapists read their own thoughts into children, and held to the questionable view that a person who refuses to accept an interpretation is impeding progress. Hence the behaviour of a child who was reluctant to open his or her mind to the adults was easily pathologised—or, rather, it was a question of a *further* pathologisation of an already disturbed child.

The fundamental problem with these Freudian and Reichian methods was (and is) that they were long on interpretation and short on evidence. Psychoanalysts have traditionally been judges of their own truth and of the criteria for their own validity, and this disinclination to engage in a scientific dialogue with 'outsiders' has meant that psychodynamic schools developed into belief systems that promulgated undisputed doctrines immune to empirical tests and criticisms.[104] Thus, at Skå-Edeby, perspectives on such questions as sexual abuse and woman's frigidity were strictly confined by a reliance on psychoanalytic doctrines that were more or less immune to empirical refutation. For example, the possibility was not seriously weighed up that the problem of incest might be related not only to the children's alleged 'incestuous wishes' towards their patients, but also to the actual sexual abuse of children by adults (it seems that many girls at Skå-Edeby had been sexually abused by their fathers, step-fathers and other men).

The staff did not seem to be particularly worried about children's painful memories of sexual abuse, especially if it was the father or the step-father who had been the culprit. It was not uncommon to blame the victim for the incident; to see the girl's relation to her father as an 'ambivalent expression of the father fixation'; or to evaluate sexual contacts between children and adults positively (a rape can have a positive effect, in that it awakens sexual emotions in a girl, which in turn shows her the way to healthy interactive contacts…).[105] It simply did not seem to have occurred to the therapists that sexual abuse, even if it was not very violent, might have something to do with the disturbed behaviour of their young patients. A similar disregard for the problem of sexual abuse could also be found at The Swedish Association for Sexual Education during these decades.[106] It seems that, as a social, psychological and medical problem, sexual abuse was still bubbling

[104] For a perceptive (and witty) analysis of psychoanalysis as a belief system, see Ernest Gellner, *The Psychoanalytic Movement* (London: Fontana Press, 1993).
[105] Bergenheim, *Barnet, libido och samhället*, 299–305.
[106] Lennerhed, *Sex i Folkhemmet*, 172.

under and would not fully emerge until the emergence of the gender perspective on sexuality in the 1970s.[107]

It was unfortunate for the abused children at the 'children's village' that, in their conviction that 'sexual inhibition' was the root of all evil, Gustav Jonsson and his staff were incapable of siding with children in a matter that arguably played a major role in their suffering. As a consequence, children who refused to talk with the adults about sexual issues were often seen to suffer from sexual inhibition. Paradoxically, in their pronounced anti-authoritarianism and positive striving to create a bond of trust between children and adults, there was an element of totalitarianism and fanaticism in the therapeutic activities at Skå-Edeby. The therapists appeared to see no individual children with individual problems, but rather a mass of children with sexual traumas or sexual disturbances, to whom a single interpretative framework could be applied, and whose personal integrity could be violated in the name of therapy. During the 1950s, the therapeutic methods at the 'children's village' became less interventionist, and a child's capacity for 'reality adjustment' rather than 'healthy sexuality' became the desired goal.

In the early 1960s, Gustav Jonsson published a paper on teenage 'sexual girls' (*sexualflickor*) whose problem was promiscuity, not sexual inhibition.[108] He observed that a number of these 'lower-lower-class' girls had stepfathers, and that he and his co-workers had found several instances of incest among these girls. Perhaps to avoid a moralising tone, he applied psychologising jargon to these cases, surmising that there were "unconscious psychological processes" at play in the relationship between fathers and daughters, and announcing that one should not put too much emphasis on the evidence pointing to a causal link between these girls' promiscuous behaviour and their incestuous ties

[107] The problem of incest was by no means foreign to Swedish physicians. In the 1930s, Torsten Sondén and a group of three physicians studied criminals who had been sentenced to prison because of incest. In a study published in 1943, the group concluded that incest was most common among the lower classes, and that it was related to overcrowded housing, alcoholism and social problems, on the one hand, and mental abnormalities and defects (e.g. low intelligence), on the other hand. See Olof Kinberg, Gunnar Inghe and Riemer Svend, *Incestproblemet i Sverige* (Stockholm: Natur och Kultur, 1943). See also Torsten Sondén, "Die Inzestverbrechen in Schweden und ihre Ursachen," *ACTA* 11 (1936), 379–401.

[108] Gustav Jonsson, "Flickor på glid: Promiskuitet hos flickor i 12–16 årsåldern," *Psykisk Hälsa* 1 (1960): 9–23.

to their fathers.[109] He referred to the "latent incestuous father fixation" of these girls, which indicates that despite his long experience with 'nervous children' at Skå-Edeby, he still ignored the role of sexually abusive adults, and located the problem in the psyche of the child. That Jonsson's attitude towards his young patients was anything but unique among psychodynamically-oriented therapists perhaps tells us more about the state of child psychiatry fifty years ago than we might care to know.

Jonsson and his psychotherapeutic approach to the troubled children have had their avid defenders, whose arguments in favour of his methods are sometimes quite sound and plausible.[110] When I myself learnt about his therapeutic methods I could not help thinking of the Austrian writer Robert Musil, who saw the lack of a sense of modesty and proportion as a typical characteristic of otherwise intelligent people whose ideas he saw as representing 'higher stupidity' (*eine höhere Dummheit*).[111] Following Musil, I am inclined to conclude that the well-meaning therapists working at Skå-Edeby lacked the all-important sense of proportion, thus embodying Musil's higher stupidity. A less benign judgement on these therapists is that the kind of stupidity they represented was in fact not high at all.

Reichian psychotherapy of children was not the only offshoot of the modern therapy culture that proffered 'facts' which were often unfounded, and therapies which did not work. The obvious discrepancy between the pronounced therapeutic goals of the professional caretakers of the soul and their actual achievements has not prevented the expansion of a veritable therapy industry in the western world, including in Sweden. In most cases, new therapies that entered the psychomedical field after World War II were directed at the apparently growing population of the nervously ill. The suggestion that the Swedes were particularly prone to nervous ill-health was contested by the optimistic social engineers of the welfare state, but the more general idea that the Swedes were dour, suicidal Lutherans plagued by guilt, feelings of inferiority, the breakdown of connections (*Gemeinschaft* turning into

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[109] Ibid., 17–18.

[110] See, for example, Vinterhed, *Gustav Jonsson på Skå*.

[111] Robert Musil, "Über die Dummheit" (1937), in *Gesammelte Werke 8* (Reinbek: Rowohlt, 1981), 1270–91.

Gesellschaft) and increasingly stressful living conditions in urban centres persisted, leading into the dissemination of health ideology that put the premium on the treatment and prevention of mental maladies.[112]

The expansion of the Swedish welfare state regime favoured many professionalised occupations, psychologists and psychotherapists among them. Even if their therapeutic practice was scientifically unfounded and yielded meagre results, it did not seriously undermine the behaviour managers' claims to expertise, especially in the realm of neuroses. In the next chapter, we shall examine the short pre-history of the professionalised therapy culture which has promoted psychological risk-reduction and 'healthism' as preconditions for social progress in Sweden. The therapeutic 'children's village' discussed above was an early and rather extravagant representative of a publicly-funded psychotherapeutic profession. As we shall see, during the period under survey (1880–1950), remedies for nervousness were mainly provided by private therapeutic entrepreneurs rather than by the public sector.

[112] See E. M. Rigné, *Profession, Science and State—Psychology in Sweden 1968–1990* (Göteborg: Göteborg University, 2002); and "Discontent and the Rise of Psychology," in *Modernity and Its Discontents*, ed. Pietikainen, 85–101.

CHAPTER SIX

REMEDIES FOR NERVOUSNESS

During the fin-de-siécle era, it was hypnotism that was probably the most controversial if not widely-used method of healing, also in Sweden. Hypnotism contributed to the breakthrough of modern neuroses because of its use as a therapeutic method in the diffuse field of psychological and psychosomatic ailments. In providing a remedy for functional neuroses, hypnotherapists boosted their own therapeutic status and buttressed the phenomenon of neurosis. If neurology was the official channel through which neurosis entered Sweden and made Swedes neurotic, the unofficial channel was provided by private practitioners who specialised in hypnotherapy. Therefore, my account of the Swedish history of remedies for nervousness begins with the fine art of hypnosis.

Otto Wetterstrand and the Golden Age of Swedish Hypnotism

In the mid-1880s, hypnotism gained medical attention in Sweden, as it did throughout western Europe.[1] Medical interest in hypnotism was revived and legitimated by Charcot, who began to study the relationship between hysteria and hypnotism at his clinic in Paris in the late 1870s. For a few years, a number of Swedish doctors used hypnosis in private consultation rooms, hospitals and spas, and wrote about it in medical journals and newspapers.[2] Among the Swedish hypnotherapists, Otto Wetterstrand was the one who gained international reputation as a gifted healer. In 1886, when he was a district medical officer in a poor

[1] Alan Gauld, *A History of Hypnotism* (Cambridge: Cambridge University Press, 1992).

[2] For an overall view on hypnotism in Sweden between 1880 and 1900, see Luttenberger, "Hypnotisörernas tid." I shall not discuss all those Swedish authors who practised hypnotism during these years; those who are interested in the history of hypnotism in Sweden, and who can read Swedish, should consult Luttenberger's article as well the medical journal *Eira*, which published a number of papers on hypnotism in the 1880s.

neighbourhood in Stockholm, he read a newly-published book by the famous French hypnotherapist Hippolyte Bernheim (probably *De la suggestion et de ses applications á la thérapeutique*, 1886), which aroused his interest in this 'new version' of hypnotism.[3] In the spring of 1887, he tried out Bernheim's suggestive technique on his patients, with considerable success. A year later, he devoted his medical practice entirely to hypnotherapy, becoming the most renowned Swedish hypnotherapist of all time.[4] As a district medical officer, he had treated mainly poor people, but as a successful hypnotherapist he could establish a private practice in the fashionable part of central Stockholm.

By all accounts, Wetterstrand was not your run-of-the-mill healer. In his obituary of his mentor, psychotherapist Emanuel af Geijerstam referred to Wetterstrand as a "combination of a genius and a child … [He was] too good for this world."[5] Another pupil of Wetterstrand, Poul Bjerre, wrote that "he became the foremost authority for the cosmopolitan neurosis clientele,"[6] and historian Henri F. Ellenberger observed that Wetterstrand's "strange methods gave rise to a legend depicting him as an extraordinary modern wizard."[7] In his history of hypnotism, Alan Gauld in turn describes Wetterstrand as "a considerable name in European hypnotism," whose "reputation as a wonder healer spread rapidly, and patients flocked to him from all over Sweden, indeed from abroad."[8]

What these characterisations add up to is that Wetterstrand was an exceptionally talented hypnotiser. Apparently, he was able to establish a bond of trust between himself and his patient, and to apply hypnosis to all kinds of ailments, from hysteria, melancholia and homosexuality to epilepsy, alcoholism and menstrual troubles. Furthermore, there seemed to be no limit to his patience and perseverance: in one case, he tried unsuccessfully to hypnotise one of his patients time and time again until, after seventy futile attempts, he finally succeeded in hypnotising

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[3] As a medical student, Wetterstrand attended the hypnotist Carl Hansen's public shows in Stockholm in 1864. Luttenberger, "Hypnotisörernas tid," 103.

[4] For a short biography of Wetterstrand, see Ibid. See also Poul Bjerre, "Wetterstrand och Nancyskolan," in *Studier i själsläkekonst* (Stockholm: P. A. Norstedt & Söners Förlag, 1914), 57–90; and *Räfst- och rättarting* (Stockholm, Centrum, 1945), 85, 105.

[5] Emanuel af Geijerstam, "Otto G. Wetterstrand," *ASLT* 4 (1907): 817–18.

[6] Bjerre, "Wetterstrand," 67.

[7] Ellenberger, *The Discovery of the Unconscious*, 88. Ellenberger relies on the book published by Poul Bjerre, who took over Wetterstrand's practice when he died in 1907.

[8] Gauld, *A History of Hypnotism*, 346.

her.[9] His 1889 book on hypnotism was translated into German and English, and he published a number of articles in the leading Swedish medical journal *Hygiea* as well as in *Zeitschrift für Hypnotismus* ('Journal of Hypnotism').[10] He is one of the most internationally famous Swedish physicians of all time, and was certainly more well-known in late nineteenth-century Europe than any other Swedish physician, including all the professors at the Karolinska Medical School. From 1887 to the end of his life in 1907, he practised hypnotism or 'hypnotic suggestion', to which he once referred to as "the most magnificent psychological discovery of the century".[11] Like hypnotherapists in private practice in general, he had a clinical, 'psychotherapeutic' approach to nervous illnesses, and had little ambition to become engaged in medical research. It was largely through his high-profile work that hypnotherapy, and, by extension, psychotherapy, were established in Sweden.

Wetterstrand became famous for his therapeutic success with alcoholism[12] and drug addiction, on the one hand, and his technique of 'prolonged sleep' on the other. As an adherent to the so-called Nancy school of hypnotism (Bernheim, Liébeault, etc.), he laid stress on suggestion in his practice, arguing that "it is through a *thought* that we create our health or illness".[13] This is remarkably close to the aforementioned 'Möbius-Lennmalm theory', according to which pathological 'representations' are responsible for neuroses, which can be cured through the therapeutic use of other, health-inducing representations.

Wetterstrand's therapeutic tour de force was the method of 'prolonged sleep', which he started to use in the early 1890s, and which he described for the first time in a paper published in *Zeitschrift für Hypnotismus* in 1892. He claimed that this method was especially useful in cases of hysteria, 'hystero-epilepsy' and epilepsy. In his 1899 article on prolonged sleep, he takes as his starting point the assumption that the deeper the sleep,

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[9] Otto Wetterstrand, "Om hypnotismens betydelse," *Julqvällen*, 1889, 19; "Några ord om den hypnotiska behandlingen," in *Hypnotismen bedömd af fackmän* (Upsala: Akademiska bokhandeln, 1893), 63.

[10] Otto Wetterstrand, *Hypnotism and Its Application to Practical Medicine* (New York: G. P. Putnam's Sons, 1897).

[11] Wetterstrand, "Några ord," 64.

[12] In 1902, after fifteen years of hypnotherapeutic work, Wetterstrand stressed the applicability of hypnotism to alcoholism. This was not an irrelevant statement, for alcoholism was a major 'folk disease' (*folksjukdom*) in early twentieth-century Sweden. See Otto Wetterstrand, "Förord," in John Duncan Quackenbos, *Hypnotismen såsom medel till själens och moralens odlande* (Stockholm: Adolf Bonnier, 1902), 4–5.

[13] Wetterstrand, "Om hypnotismens betydelse," 18.

the more certain the successful outcome of the treatment—a deep, somnambulic sleep in itself has curative effects. His originality in using the method of somnambulic sleep was that, depending on the case, he prolonged the sleep to days, sometimes weeks (four weeks was the longest period any of his patients was in a hypnotic sleep). He writes that the more severe forms of hysteria are especially well-suited for this "somewhat time-consuming treatment".[14] A precondition for the successful use of prolonged sleep is that the patients should never be left alone, and should always have a rapport with someone whom they trust and who could feed them without waking them up. He assures his readers that he has not found the slightest sign of discomfort in his patients once they have been woken up: all the patients who have slept for days or even a few weeks have stated that they feel as if they had slept only for a few hours.

It seems that Wetterstrand preferred the method of prolonged sleep to the conventional suggestion therapy when he encountered more severe forms of neuroses, accompanied by fits of mania and hallucination. By the early 1890s he had developed his hypnotic technique to the extent that he was able to induce the previously recalcitrant nervously ill patients into deep somnambulic sleep, which saved him the trouble of trying to use the method of explicit suggestion with these neurotics. By 1899, he had treated twelve cases of 'difficult hysteria' with prolonged sleep. He claims that ten of these twelve hysterics became totally cured; one patient remained the same, except that his or her mental state became somewhat more balanced; and one patient had a relapse after a few months (requiring new treatment). One of these hysterical patients was Sigmund Freud's former patient Emmy von N., who came to Wetterstrand's clinic in 1893 via Auguste Forel in Zurich, and whom Freud had unsuccessfully treated with his and Breuer's 'cathartic method'. The patient's case history is described in Breuer's and Freud's *Studies on Hysteria* (*Studien über Hysteria*, 1895).[15] Wetterstrand was becoming more and more convinced that hysteria could be definitely cured by way of prolonged sleep.[16]

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[14] Otto Wetterstrand, "Om långvarig sömn särskildt vid behandling af hysteriens svårare former," *Hygiea* 61 (1899): 527.

[15] Ibid., 531–2. On the Case of Frau Emmy von N., see Josef Breuer and Sigmund Freud, *Studies on Hysteria* (1893–1895), in *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (London: The Hogarth Press, 1978), Volume II, 48–105. See also Ola Andersson, "A Supplement to Freud's Case History of 'Frau Emmy v. N.' in *Studies on Hysteria* 1895," *Journal of European Psychoanalysis* No. 17 (2003), 139–49.

[16] Wetterstrand, "Om långvarig sömn," 532.

In 1891, the alleged success of Wetterstrand's hypnotic treatment of drug-addicts was questioned by the Swiss doctor Robert Binswanger, who in a medical conference in Germany insinuated that Wetterstrand had been fooled by patients who continued to use narcotic drugs secretly. Two physicians published (separate) rejoinders to Binswanger's critical remarks, supporting Wetterstrand's therapeutic claims; one of them was a Swedish provincial doctor, Strickert Landgren, whose dependency on morphine Wetterstrand had successfully cured.[17] Wetterstrand was well aware of the accusations directed at hypnotism as a method, and in 1894 he stressed the point that of all the thousands of patients hypnotised by himself and his respected colleagues (Liébeault, Bernheim, Moll, the Dutch physicians van Renterghem and van Eeden, etc.), none had been damaged in any way physically or mentally. However, by the mid-1890s hypnotism was already on a slow decline in Europe as many leading physicians adopted a critical attitude towards the method, fuelled by news and rumours of the motley crew of laymen and charlatans recklessly misusing hypnosis.

Wetterstrand maintained his hypnotic practice until his death in 1907. His pupil, Poul Bjerre, took over the practice and, for decades, tried to legitimate psychotherapy as a medical specialty in Sweden (on Bjerre, see below). In his obituary of Wetterstrand, Emanuel af Geijerstam writes that in the light of Wetterstrand's international acclaim and his innovativeness in developing therapeutic methods, it is painful to see that in his home country he appears to have been almost forgotten: he received no official recognition from any of the three medical faculties in Sweden, and he was not given an opportunity to give classes about hypnotherapy to medical students[18] (except for the presentations at the Karolinska Institute in autumn 1889).

Why did Wetterstrand remain a marginal figure in Swedish academic medicine?[19] Poul Bjerre believes his mentor's case histories were "extraordinarily naïve",[20] while Geijerstam conjectures that leading physicians had two principal reasons for their sceptical attitude towards Wetterstrand's work: first, he was thought of as having exaggerated his therapeutic achievements; and, second, because of his inadequate neurological education, his diagnoses were considered unreliable. His claims

[17] Luttenberger, "Hypnotisörernas tid," 115.
[18] Geijerstam, "Otto G. Wetterstrand," 816.
[19] Frans Luttenberger illustrates the unfriendly medical attitude towards hypnotism in Luttenberger, *Freud*, 166–71.
[20] Bjerre, "Wetterstrand," 81.

about the successful hypnotherapeutic treatment of epileptics aroused suspicion among his medical colleagues, but Geijerstam correctly points out that he was not the only hypnotherapist who declared therapeutic success in cases of epilepsy. According to Geijerstam, Auguste Forel may have been right in his opinion that Wetterstrand's epileptic cases suffered from 'hysteroepilepsy' rather than 'epilepsy proper'.[21]

The Decline of Hypnotism

Wetterstrand's professional identity as a hypnotist and private practitioner without any institutional affiliations excluded him from the official circles of medicine, and although he wanted to distinguish hypnotism from animal magnetism and mysticism, even preferring to call hypnotism 'suggestive therapy', neither he nor any other hypnotherapist managed to legitimate hypnotism as a respectable clinical method in Sweden. By the 1890s, there were many 'cranky' proponents of spiritualism, who coupled hypnosis with paranormal phenomena, and this association with spiritualism was damaging to the scientific reputation of hypnotism. Furthermore, at a time when neurologists and other representatives of academic medicine were not exactly thrilled by the meagre therapeutic arsenal at their disposal, Wetterstrand's and other hypnotherapists' claims of therapeutic success may have appeared insolent and irritating. On top of this, Charcot's and the Salpêtrière school's fall from grace in the 1890s did not go unnoticed in Sweden, where most physicians had learned about hypnotism through Charcot's writings and teachings. With the collapse of the whole Charcotian construction of hysteria and hypnosis, the shadow of doubt fell on all hypnotherapists, regardless of whether they adhered to the Salpêtrière School or the Nancy school.

If we are to believe the general practitioner Henrik Berg, hypnotism went out of fashion in Stockholm after only a few years: he claimed that, compared to the situation in the spring of 1889, hardly one-tenth of his patients asked to be hypnotised in the spring of 1890! Berg assumed that the common people's expectations concerning hypnotism were exaggerated to such a degree that it was impossible for physicians to always fulfil them, which had made many people suspicious of "the

[21] Gauld, *A History of Hypnotism*, 487.

whole thing".[22] It seems that many people wanted to be hypnotised out of sheer curiosity, and, once they had had first-hand experience of hypnosis, had no longer particular interest in trying it again. Consequently, the popular demand for hypnotism might have been on the decline already in the early 1890s. In his medical text book of 1903, Berg refers to Wetterstrand and the early enthusiasm for hypnotism in Sweden, and then goes on to say:

> As for today, we are living in a period of backlash (counterreaction). Hypnotism has been pushed aside by radiotherapy [sic!]. But it will certainly re-emerge, and then it will be here to stay, for it will become one of the most blessed remedies of humanity.[23]

Berg predicts that hypnotism, like the Phoenix, will rise from the ashes and bestow its benefits on humankind.

Hypnotism had its golden age in the last two decades of the nineteenth century, from Charcot's famous 1882 lecture on hypnotism to the publication of the last works of the pioneer hypnotherapists in Europe, including Forel, Moll and Vogt in German-speaking Europe. One reason why hypnotism aroused such interest in Europe was that it was not an aspect of therapeutic medicine alone; it was also a part of the late nineteenth-century wave of mysticism and pseudo-scientific studies on paranormal phenomena. Wetterstrand, for example, was a board member of the Swedish Society for Psychical Research, founded in 1890, which attracted members of the nobility, military officers and physicians.[24] Hypnotism appealed to the public imagination, which feeded on the more sensational aspects of hypnosis, especially on the alleged criminal acts committed in the state of somnambulic sleep.

In the early twentieth century, new, non-hypnotic forms of psychotherapy emerged, and the medical and therapeutic interest in hypnotism waned. A rise in psychological, parapsychological and psychoanalytic research removed hypnotism from the centre to the margins of psychological healing, and the neurasthenics and the hysterics began to be treated with a wide variety of both psychological and physical therapies. In this process, waking suggestion or 'psychotherapy' was differentiated from hypnotism and considered to be an effective method of treatment

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[22] Henrik Berg, "Fall af (allmän) kramp behandladt med hypnotism," *Eira* 14 (1890): 310.

[23] Berg, *Läkareboken*, 832.

[24] Luttenberger, "Hypnotisörernas tid," 100–1.

in itself (this view was forcefully advocated by Bernheim, who in his later professional life rejected the 'special state' of hypnosis[25]).[26] Hypnotism declined partly because of the emergence of rival, less authoritarian therapies, but also because there were many doctors who were not that good as hypnotists (Freud among them). Furthermore, as Henri Ellenberger has pointed out, "it became obvious that many patients pretended to be hypnotized when they were not".[27]

Nevertheless, although it managed to penetrate the medical establishment only to a limited degree, hypnotism did not fade away. Sydney Alrutz, the first experimental psychologist in Sweden,[28] experimented with new ideas and techniques, and hypnotism continued to have a shadowy existence at the margins of medicine after World War I. A resurgence of interest in hypnotism began with World War II and 'trauma' studies, and, from the early 1960s onwards, hypnotism has been part and parcel of an exponentially expanded psychotherapeutic industry. In 1966, the Swedish Society for Clinical and Experimental Hypnosis was founded, and, with its membership of more than 900 by the early 1980s, the society had become one of the largest of its kind in the whole world.[29] However, there are no indications that another golden age of hypnotism, comparable to the period between 1880 and 1900, is about to emerge. To some extent, hypnotism will probably continue to haunt the public imagination, but as a medical and therapeutic specialty it had its heyday in the era of 'protopsychotherapy' in the late nineteenth century.

A Legendary 'Proto-Psychotherapist'

At the turn of the twentieth century, the more affluent Swedes suffering from weak nerves had a number of therapeutic options, non-hypnotic talk therapy among them. Often accompanied with physical therapy

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[25] Gauld, *A History of Hypnotism*, 559–67.

[26] On the history of the concept of 'psychotherapy', see Shamdasani, "Psychotherapy."

[27] Ellenberger, *The Discovery of the Unconscious*, 171.

[28] On Sydney Alrutz and his theory of 'nervous emanation', see Ingemar Nilsson, "Sydney Alrutz och nervstrålningens problem," *Lychnos* (1977–78): 10–53.

[29] Lars-Eric Uneståhl, "Hypnos förr och nu," in *Hypnos i teori och i praktik*, ed. Lars-Eric Uneståhl (Örebro: Veje Förlag, 1982). In 1974, the society began to publish its own journal, *Svensk Tidskrift för Hypnos* ('The Swedish Journal of Hypnosis').

and medicine, talk therapy came to assume a more visible role in mental medicine in the late fin-de-siècle era. One of the first 'proto-psychotherapists' in Sweden was the legendary 'Enköping doctor' Ernst Westerlund (1839–1924), the best known and most popular of all Swedish nerve doctors in his time.[30] In his obituary of Westerlund, another nerve doctor, Jakob Billström, claims that Westerlund was "a pioneer in the field of functional nervous illnesses" who was gifted with "unique psychological insight" and "genuinely interested in the patient's illness in all its details, as well as in the personality of the patient".[31] Westerlund worked first as a 'town physician' (*stadsläkare*) in the small town of Enköping and then as a military doctor, and he also had a private practice. His reputation as a healer spread across the country and even abroad, and although patients who flocked to consult him suffered from all possible afflictions, he became renowned for his treatment of neuroses. It seems that he was to the general public in the provinces what Wetterstrand was to the upper and upper middle classes in Stockholm: a wonder healer.

It has been said that Westerlund was one of the first Swedish doctors who took neurotic complaints seriously, and, quite successfully, provided a somewhat authoritarian form of care—appropriate for a military doctor—which made demands on the patients' whole way of life (*regimterapi*). He also experimented with hypnotism, but soon abandoned it in favour of suggestion and persuasion, having no interest in psychoanalysis and other psychodynamic methods. His *regimterapi* consisted of a mixture of pedantically prescribed rest and isolation, promenades, regulation of diet and work. For example, when his patients began the cure of therapeutic promenades, they took only a very limited number of steps (e.g. ten or fifty steps) and did not walk any further. Each day (or, every other day), patients walked a bit further, first on flat land and then, gradually, up the nearby ridge, which was coined 'The Path of Virtue'. The number of steps in these promenades was always carefully calculated to achieve the optimal therapeutic results!

Westerlund was an early advocate of work therapy who usually managed to find the proper mixture of cures for each patient—or so said his admirers, such as Jakob Billström. Patients lived in small nursing

[30] On Westerlund, see Jakob Billström, "Ernst Westerlund," *Hygiea* 86 (1924): 81–90; and Stina Palmborg, *Ernst Westerlund—en läkekonstens storman* (Stockholm: Natur och Kultur, 1939).

[31] Billström, "Ernst Westerlund," 81, 84, 88.

homes or with healthy townspeople in their homes, working unpaid for some of the artisans in town. In this way, writes Billström, Westerlund successfully avoided the danger involved with a larger gathering of neurotics, namely 'psychic infection'.[32] Westerlund himself exemplified a healthy and industrious life style by working from early morning until late in the evening, taking care of his 300 or so patients. Around 1911, at the age of seventy-three, he finally started to reduce his work load. Billström recalls in his obituary that Westerlund once announced that "I am not a man of science, just a therapist". Indeed, he did not write articles in medical journals, publish books in which he might have formulated the principles of his therapy, or make his living in one of Sweden's few urban centres.

What rescued Westerlund, who did not leave behind written sources on which historians so depend, from oblivion was his quite exceptional reputation as a miracle healer, to whom certain academic physicians at places like the Serafimer and the Uppsala University Hospital sent their patients, while others gave voice to their suspicions, regarding him, at least at the beginning, as a medical outsider whose clinical methods came dangerously close to quackery.[33] Although there is no trace of him in the annals of Swedish science, he reached a stage where his clinical work alone guaranteed the survival of his reputation for posterity. Today, there is a Westerlund society in Enköping that cherishes the memory of a doctor whom they regard as the most trusted Swedish doctor ever, and as the first physician to classify neurosis as a separate illness.[34]

Methods of Treatment Around 1900

Late nineteenth-century therapy culture in Sweden was built on the variants of two fundamental forms of physical (water) and psychological (hypnotism, waking suggestion) healing. But there were also other therapies available for the nervously ill. Around 1900, the major therapeutic methods of the practising neurologist and nerve doctor were the following:

Absence from home. A change of scene and a removal from home were considered beneficial to the initiation of the healing process. Sea

[32] Ibid., 88.
[33] Luttenberger, *Freud*, 171.
[34] "20 år med Westerlundsällskapet," *Uppsala Nya Tidning*, April 19, 2004.

voyage or a stay in a seaside town or spa with a pleasant social life was typically regarded as remedial. The mellow Mediterranean climate was especially thought of as curative, and for someone living in Stockholm or Gothenburg it meant a true change of scene—if that someone was affluent enough to take such a trip. There were also a growing number of nursing homes catering especially for the nervously ill. For example, there was an announcement in a Swedish medical journal in 1896 that the Nursing Home 'Cecilia' (*Ceciliahemmet*) would be soon opened in Södertälje (south of Stockholm) for the nervously ill (*nervlidande*) members of the 'educated classes'.[35] In the early decades of the twentieth century, nursing homes for the overstrained experienced a veritable boom, which in part testifies that neuroses, neurasthenia in particular, were fast becoming a national malady in Sweden.[36] Part of the attraction of nursing homes may have been that they offered relief not only to the patient but also to the patient's family—there are indications that sometimes the nervously ill got on the family members' nerves, and, when this was the case, a change of environment may have been remedial not only to the patient but to the whole family.

Dieting. This treatment was considered essential because a delicate stomach or troublesome indigestion was seen as hindering the transmission of important nutrients to the nervous system. Dieting consisted of two basic variants, fattening (overfeeding) and thinning (underfeeding). The popular Weir-Mitchell rest cure, named after the American nerve doctor Silas Weir-Mitchell, included a diet that in the early stages of the cure consisted mainly of milk, and it was regarded as a fattening but soothing diet.[37] Stimulants, including coffee and tea, were to be avoided.

Drugs. The early therapy of nervous illnesses had been primarily pharmacological, reflecting the plausible medical belief that chemical substances and compounds have an effect on the brain and the nervous system. The annoying problem was that these early drugs did not appear

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[35] "Ett hem för nervlidande" [Announcement], *Eira* 20 (1896): 133.

[36] For sour medical comments on the popularity of such nursing homes, see Gunnar Kahlmeter, "On the Results of the Treatment of Neurotic Patients at the Establishments of the Swedish Board of Pensions," in *Festschrift tillägnad Bror Gadelius*, *Svenska Läkaresällskapets Handlingar* 53 (1927): 81; and "Några synpunkter på behandlingen, särskilt anstaltsbehandlingen, av neuroser," in *Festschrift tillägnad Henry Marcus, Svenska Läkaresällskapets Handlingar* 57 (1931): 132–4.

[37] Weir Mitchell's *Lectures on Disease of the Nervous System, Especially in Women* was favourably reviewed in *Eira*. See O. Lindfors, "Den Mitschell'ska metoden för behandling af svårare hysterifall," *Eira* 7 (1883): 742–5.

to have any evident positive effects. Still, doctors in the mid-nineteenth century prescribed large quantities of such dangerous substances as mercury, strychnine and quinine, and such opiates as opium, morphine and codeine. That these substances posed obvious hazards to health gradually dawned upon men of medicine, and, in the late 1870s, physicians in Sweden became more aware of the dangers of addiction when morphine and opium were prescribed to patients.[38] Toward the end of the century the production of synthetic compounds, such as aspirin, veronal (a barbiturate) and sulphonal, replaced earlier drugs. Arsenic and chloroform were also prescribed. Drugs were routinely used as a chemical therapy, and, for the working class patients, they were often the only form of therapy they received. I shall examine the unofficial drug industry later in this chapter.

Electrotherapy. There were three types of electrotherapeutics available: 1) Faradisation (treatment with alternating current); 2) Galvanisation (treatment with direct current), and 3) Franklinisation (treatment with static electricity). Electricity was thought of as especially suitable for treating neurasthenia, which was commonly attributed to the lowering of the energy level.[39] Electricity was seen as a life-giving force that 'charged the batteries' by re-vitalising the nervous system, and it could be applied to virtually any part of the body. Electrotherapy should not be confused with the later electroconvulsive treatment (ECT) or 'electric shocks', which involved the direct mechanical stimulation of the brain with electrodes placed on the temples, and which psychiatrists started to use in the 1940s for alleviating symptoms in mental illnesses (it was discovered that ECT was of some use mainly for people who suffered from severe depression). The nineteenth century electrotherapy meant a low-voltage 'electrical massage' of the skin, and, unlike ECT half a century later, it did not arouse the patients' fear and suspicion.

Hydrotherapy. Water cure was perhaps the most popular form of treatment of the nervously ill at the turn of the century. There were many hydropathic spas all over Europe, including Sweden, where the first 'watering place' was established in 1680.[40] In addition to diverse

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[38] See Mårten Sondén, "Smärre anteckningar om missbruket af morfin, opium och opiipreparat," *Hygiea* 40 (1878): 385–407.

[39] See Anson Rabinbach, *The Human Motor: Energy, Fatigue, and the Origins of Modernity* (New York: Basic Books, 1990); and Killen, *Berlin Electropolis.*

[40] See Elisabeth Mansén, *Ett paradis på jorden: Om den svenska kurortskulturen 1680–1880* (Stockholm: Atlantis, 2001).

water treatments at spas, hot and cold baths and wet packs at home surroundings were also prescribed, especially for those who could not afford to spend time in Marienbad, Vichy or even in local spas such as Ronneby or Sätra. The medical ideology behind hydrotherapy was holistic and 'anti-technological', emphasising the links between body and mind/nervous system, the importance of outdoor exercise, diet, hygiene and, in general, a healthy and wholesome life style. Advocates of hydrotherapy often derided drugs and warned against any kind of stimulants, including coffee. Spas were usually situated in the country side or at the outskirts of a small town, away from the hurly-burly of city life and fast-paced life style. Needless to say, hydropathic spas were not an option for the majority of artisans and labourers; for them, drugs and 'rest' often replaced hydrotherapy, which was tailor-made for the more affluent middle-classes and upper classes. To illustrate: in his report on the activities of the Ronneby watering place (*Ronneby Helsobrunn och Gyttjebad*), Dr Hellman writes that of the 600 persons who stayed in the asylum in 1847, 170 represented the gentry.[41] In the nineteenth century, spas and watering places in Sweden catered especially to the therapeutic needs of people who suffered either from rheumatic ailments or nervous illnesses.[42] When we look at the statistics indicating the diseases that were treated at the spas and watering places in 1900, we can notice that the largest single disease category was 'chronic rheumatism' (17.5%), followed by 'anaemia' (14.5%) and 'other nervous diseases' (including neuroses) (14%).[43] These three disease categories constituted by far the most common afflictions, and, in the following decades, rheumatism and neurosis were the two most common ailments not only in spas and watering places, but also in the clinics and hospital wards run by the Board of Pensions (*Pensionsstyrelse*). Some academic physicians announced in medical journals and newspapers that they would treat 'nerve illnesses' in spas and water cure clinics during the summer. Most of these hydrotherapeutic establishments were open only during the summer until the early twentieth century, when they started to change their character, becoming less focused on water and more on other forms of treatment, or on attracting healthy tourists.[44]

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[41] Hellman, "Anteckningar," 75–85.

[42] Mansén, *Ett paradis på jorden*, 66.

[43] *Bidrag till Sveriges officiella statistik 1900, Helso- och sjukvården I.* LIII (Tab. No. 20).

[44] Professor Salomon Henschen from the Uppsala University's Medical Faculty, for example, announced in one of the spring issues of *Hygiea* that he would treat nervous

Massage. It was thought of as stimulating muscles and, by extension, the nervous system, the blood circulation and metabolism. As many patients were spending most of their days in bed, it was considered necessary to prevent muscular atrophy by a sort of exercise that did not require physical effort on the patient's part. It was a sort of physical therapy that did not make the patient sweat.

Rest. If the nervous system suffered from overstrain, as increasingly seemed to be the case after the invention of neurasthenia as a diagnosis, it was logical to prescribe rest and sleep. The US nerve doctor Weir Mitchell's popular rest cure was based on this simple idea, and on the assumption that patients who are kept in the state of sensory deprivation regain their health in order to escape the boredom that was administered to them. Still, doctors often warned against the adverse effects of prolonged bed rest on health. Rest, massage, electrotherapy and dieting were often prescribed together to create a properly balanced therapeutics.

Self-help. One popular branch of the therapy market consisted of self-help manuals that often presented their messages in a hyberbolic language. For example, an American doctor, Harry Bondegger, specialised in 'relaxation' therapy, and his optimistically-titled book 'Nervousness remedied in two hours' appeared in Sweden in 1910 (*Nervositen bortarbetad på två timmar*).[45] "No longer nervous after two hours of practice!," proclaims Bondegger in the very first sentence of his book, which is not so much a medical manual as a commercial brochure presenting 'relaxation' as a panacea-like magic potion that works miracles. Bondegger relies heavily on the then fashionable theory of nervous energy, announcing that there is a constant inflow of energy into the human organism in the form of light waves, sound waves, taste waves, and waves of fragrance and sensation. In an energistic language, he asserts that will power can be strengthened through the so-called 'Harry Bondegger exercise', which contains the essentials used in all methods of relaxation, and which he vigorously promotes as not only a sure way to health, but also to happiness and wealth.[46] Thus, the 'Harry Bondegger exercise' may not only improve your health, it may also make you rich.

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illnesses from June 4 to the August 4 1890 at the Sätra Water Cure Clinic (*Sätra Brunn och Kallvattenkur*).

[45] Harry Bondegger, *Nervositen bortarbetad på två timmar* (Stockholm: S.G.U. förlagsaktiebolag, 1910).

[46] Ibid., 47.

Bondegger's claims about the remedial effects of his relaxation technique might easily appear ridiculous, but they reflected a therapeutic *Zeitgeist* not exactly characterised by restraint and moderation.

Now I shall take a closer look at three variants of therapeutics that became available to the public during the first half of the twentieth century: quack medicine, psychodynamic psychotherapy and religious cure of the soul (*Seelsorge*).

Tonic for the Nerves

In the early decades of the twentieth century, the pharmaceutical industry was very loosely regulated. Inevitably, then, there were numerous drugs, mixtures and wonder cures available for gullible people, who were led to believe that there was a simple cure for such afflictions as impotence and nervousness. This was also the case in Sweden, where patent drugs were a true medicine of the masses. As medical historian Karin Johannisson has shown, the early twentieth-century popular press in Sweden was filled with advertisements promoting various drugs or cures, which at best functioned as placebos and in many cases probably had no effect at all.[47] There were pharmaceutical and chemical companies such as Pharmacia and Astra, which flooded the market with such compounds as *Energon*, a popular drug that was specifically marketed as a remedy against weakness of the nerves. There were also all kinds of con-men and small-scale pharmaceutical entrepreneurs, who wanted their share of the cake by bringing onto the market all kinds of drugs and gadgets (such as 'electrical belts') that supposedly helped people to get rid of their 'weakness' (impotence), tiredness, depression, anaemia, nervousness, headache, insomnia, digestive troubles, dysmenorrhea and lack of appetite.

These drugs were marketed in much the same way as vitamins later in the century: they allegedly strengthened bodily resistance against diseases (such as tuberculosis, epilepsy and multiple sclerosis) and provided important nourishment to the body. The rhetoric and images in the advertisements fused references to 'scientific evidence' with the

[47] Karin Johannisson, "Bot för en nervtrött generation: Ett läkemedel i idéhistorisk belysning," in *Vetenskap och läkemedel: Ett historiskt perspektiv*, ed. Tore Frängsmyr (Stockholm: Almqvist & Wiksell, 1987), 74–112.

medical utopia of perfect health and inexhaustible strength, and the pursuit of a panacea.[48] Sweden was of course not the only country in which pharmaceutical companies, con-men and quacks flooded the therapeutic marketplace with wonder drugs and elixirs: in his 1885 book on 'sick and healthy nerves', Krafft-Ebing, for example, observed how the daily press in Germany was full of advertisements for all sorts of 'iron preparations' and tonics.[49] Obviously, the Age of Nervousness was also the Age of Nerve Tonics.

There was naturally a public demand for drugs that ostensibly gave nourishment to the nervous system, for otherwise these products would not have found their way into the medicine cabinet of Mr and Mrs Svensson. It was not that foolish to believe that, as there was no effective medical cure for such afflictions as impotence, 'weak nerves' and exhaustion, not to mention tuberculosis or a number of other infectious diseases, all that was left to you, especially if you could not afford to spend time at a sanatorium, spa or private clinic, was to swallow relatively cheap drugs that were presented as a panacea. Besides Energon, there were a host of other, more or less useless drugs, which often had the prefix 'nerve' in them (e.g. Neurasthenin, Nervolin, Nervosin, Nervthé, etc.). These compounds often contained very small doses of strychnine, morphine, opium or other addiction-producing substances aimed at making people crave for more once they had consumed the first sample. There were also such ingredients in them as iron, vinegar and camphor.[50]

In the interwar years, the language of nerves was updated by medical discoveries about the role of hormones in the functioning of the human organism. Inevitably, pharmaceutical companies exploited endocrinology and started to market compounds that allegedly made one's body more hormone-rich. This is how one medical entrepreneur advertised its hormone-increasing tonic 'Titus' in a popular magazine:

> Male vigour, conquered tiredness, better humour, growing capacity to memorise, an increased lust for life, a better nervous system.—All this can be achieved through supplying the hormone-poor body with the necessary components that the tonic Titus (*Titus-Pärlorna*) contains. It is well-known that our mental (*andliga*), psychological (*själsliga*) and bodily (*kroppsliga*) forces are dependent on the body's hormonal supply, and it

[48] Ibid., 102.
[49] Krafft-Ebing, *Om friska och sjuka nerver*, 10.
[50] Johannisson, "Bot för en nervtrött generation," 99–100.

> is also well-known that a state of hormonal deficiency is restored by a proper additional supply of hormones.—Science has demonstrated that a supply of this kind increases the body's own production of hormones and revitalises the human being.[51]

Compounds, mixtures and tonics, such as 'Titus', potentially brought a good profit, for they were cheaply produced and targeted so many maladies that the number of potential customers was extremely large—basically, *anyone* could benefit from swallowing a 'nerve-strengthening' pill every day. The drug market itself benefited from the wide-spread assumption that the early twentieth century was the 'nervous age', and that such nervous illnesses as neurasthenia had become endemic or outright 'national maladies' (*folksjukdomar*). Nils Nielsen, the first editor of the Popular Journal for Sexual Enlightenment, fulminated against 'humbug medicine' that promised to deliver a cure for both impotence and venereal diseases (gonorrhoea), as well as mechanical safety measures against masturbation and ejaculation (one such device was the *pollutionsring* that allegedly prevented involuntary ejaculation). In his article, Nielsen took a closer look at the activities of a shady 'Medical Institute' in Norrköping, which specialised in the 'weakness of the nerves' and 'sexual awakening', and made a profit from the gullibility, ignorance and desperation of people.[52]

Pharmaceutical companies, quacks and con-men certainly took advantage of the prevailing popular conceptions regarding the causal relationship between weak or bad nerves and various annoying symptoms and conditions. That the medical community by and large discounted these drugs did not appear to do serious damage to the industry, and although the legislation in principle prohibited the marketing of such illegal compounds, there were various ways of evading the regulations (e.g. by marketing the drugs not as medical but as 'chemical-technical' items). *Energon* was on the market until the 1950s, by which time claims of its effectiveness against weakness of nerves had been updated by references to vitamins, which had become the standard component in such compounds. Even today, the equivalents of *Energon* are on the drug market, they are only subsumed under the category of 'natural medicine'. A great difference between the early twentieth century and

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[51] "Förbättring genom TITUS-Perlen" [An advertisement], *Vårt Hem* Nr 15 (1935): 38.

[52] Nils Nielsen, "Impotens."

the early twenty-first century is that a hundred years ago there were no medically sanctioned anti-depressants, such as Prozac and Paxil, on the drug market.[53] Today, the pharmacological industry plays a huge role in the psychomedical market-place.[54]

Psychoanalysis and Medicine

> I suffer from a Freud-neurosis and an Adler-neurosis, but I can't bring them together. (A patient of Poul Bjerre)[55]

In 1928, psychoanalytic psychiatrist Alfhild Tamm devoted a paper to the 'resistance against psychoanalysis', contending that psychoanalysis often meets with emotional opposition fuelled by two elements in psychoanalysis: the emphasis on sexuality and the theory of the unconscious psyche. She also ventured to speculate that due to a harsh and cold climate and a thinly-populated land area, the Swedes have developed strong feelings of inferiority, and in trying to keep up with the great civilised nations, or even surpass them in certain areas, the Swedes have had to develop extraordinarily strong defences against these feelings. Now the Swedes are afraid that psychoanalysis might be able to penetrate these defences, unmask the Swedish psyche, and expose their unpleasant feelings to the cold light of day.[56] Another friend of Freud, nerve doctor Pehr Henrik Törngren, complained, in the preface to his 1936 book-length account of the arguments against psychoanalysis, that

> excluding dictatorships and the generation of retired professors, soon the only place [in the world] where an official recognition of Freud is still lacking is *Norden* [the Nordic countries]…For physicians, psychoanalysis is still a dangerous and misleading heresy.[57]

Like Alfhild Tamm, he saw the mentality of the Swedes as a factor in their obstinate resistance to psychoanalysis: "We Swedes are a nation

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[53] For an overview of Swedish pharmacology during the first half of the twentieth century, see Gunnar Ahlgren, "Pharmaconomia svecica," in *Om sjukdom och sjukvård*, 20–35.

[54] See David Healy's studies on the development of psychopharmacology (see Bibliography for details).

[55] Poul Bjerre, "Sjukkassan som folkförstörare," *Samtid & Framtid* 6 (1949): 228.

[56] Alfhild Tamm, "Motstånden mot psykoanalys," *Arkiv för Psykologi och Pedagogik* 7 (1928): 90.

[57] P. H. Törngren, *Striden om Freud* (Stockholm: Albert Bonniers Förlag, 1936), v.

of doubters, suspicious of all novelties."[58] Even Lutheran pastors had understood the value of psychoanalysis better than doctors.[59]

Both Törngren and Tamm, who was the first female psychiatrist and the first 'official' psychoanalytically-trained physician in Sweden, were right in pointing out that psychoanalysis met with resistance in the medical community in the early decades of the twentieth century.[60] The main reason for this opposition was that psychoanalysis could not find a niche in the already-established field of mental medicine in Sweden. In a process where one professional group—neurologists—had created a distinct area of expertise while another—psychiatrists—was well on its way to legitimising its expertise in the whole field of mental disorders, Swedish advocates of psychoanalytic psychiatry had to come to terms with the inconvenient fact that their own authority in these fields remained insignificant. Leading neurologists and psychiatrists in turn-of-the-century Sweden had been influenced by Charcot's neurology, Janet's medical psychology and German neuropsychiatry, and they did not have much sympathy for Freudian theories, which they tended to see as unscientific, implausible and in bad taste. As experts in the field of neuroses, their critical remarks on psychoanalysis in medical journals and at professional meetings had a strong influence on the general medical attitude towards psychoanalysis. For example, in his long chapter on neuroses in 'The Textbook of Internal Medicine' (*Lärobok i intern medicin*), Dr Friberger mentions Freud's name only once in a short paragraph, where he discounts the psychoanalytic theory of hysteria as 'unscientific'.[61]

Small wonder, then, that psychodynamically-oriented physicians, most of whom were private practitioners (and some of whom were more 'Jungian' or 'Adlerian' than 'Freudian'), remained at the margins of the medical profession, and had to defend their expertise against influential critics who in some cases went so far as to label psychoanalysis as a form of quackery. In such an unfriendly climate, psychoanalysis was

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[58] Ibid., vii.

[59] Ibid., 359.

[60] On the history of psychoanalysis in Sweden, see Luttenberger, *Freud*; Per Magnus Johansson, *Freuds psykoanalys*. Band 2: *Arvtagare i Sverige* (Göteborg: Daidalos, 1999); *Freuds psykoanalys*. Band 3; and "Sweden and Psychoanalysis," *Journal of European Psychoanalysis* Nr. 17 (2003): 123–38. On the life and work of Alfhild Tamm (1876–1959), see Johansson, *Freuds psykoanalys*. Band 3, 25–108.

[61] Ragnar Friberger, "Neuroserna," in *Lärobok i intern medicin*, ed. Knud Faber, Peter F. Holst and Karl Petrén (Copenhagen: Gylden Dalske Boghandel/Nordisk Forlag, 1921), 392.

destined to remain at the medical periphery for decades.[62] However, some of the leading psychiatrists and neurologists, Bror Gadelius and Nils Antoni among them, did not necessarily denounce psychoanalysis outright. In general, physicians often found certain aspects of psychoanalysis intellectually intriguing and exciting, but they had a rather low opinion of its therapeutic value and its 'one-sided' focus on sexuality.[63] Lennmalm, Wetterstrand and Gadelius had referred to Freud's pre-psychoanalytic writings already in the 1890s, but they had not examined his theories in detail. Freud began to formulate what became known as psychoanalysis only at the end of the 1890s, and it was left to Wetterstrand's pupils Emanuel af Geijerstam and Poul Bjerre to introduce 'Freud the psychoanalyst' in Sweden. When Wetterstrand died in 1907, Bjerre took over his practice and clientele in central Stockholm, and continued to use hypnosis for a number of years as a method of treatment. Wetterstrand's other pupil, Geijerstam, had opened his private practice in Gothenburg, the second largest town in Sweden, in 1898. They started out as hypnotherapists and pioneered the method of 'waking suggestion' in Sweden in the first two decades of the twentieth century.

The First 'Freudian' Psychotherapist

Emanuel af Geijerstam (1867–1928), who was the first Swedish physician to discuss psychoanalysis, started out as a hypnotherapist, then turned to Freudian psychoanalysis, and, finally, associated himself with

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[62] On the leading psychiatrists' and neurologists' opposition against the proposal that Freud should be awarded with the Nobel prize in medicine, see Carl-Magnus Stolt, "Varför fick Freud aldrig Nobelpriset?" *Svensk Medicinhistorisk Tidskrift* 4 (2000): 75–114. The Medical Nobel Committee evaluated these proposals twice, first in 1929 and then in 1933. In 1929, neurologist Henry Marcus wrote a negative three-page evaluation, and in 1933 it was the psychiatrist Viktor Wigert's turn; in his curt one-page assessment, he wrote that Freud's work lacks scientific confirmation, which is the primary requirement for a discovery to be awarded with the Nobel Prize. As Carl-Magnus Stolt points out, the most eminent critic of psychoanalysis in Sweden was neither Marcus nor Wigert, but the Karolinska professor Bror Gadelius.

[63] The psychoanalytic emphasis on psychic trauma, the role played by the unconscious, and the importance of sexual pathology in the aetiology of neuroses were often accepted to some degree at least, while Freud's pan-sexualism, sectarianism, speculative theories (about the Oedipus complex, penis envy, childhood sexuality, etc.) were often rejected.

the ideas of Jung and the Zurich School.[64] He published many articles in medical journals, mostly on the therapeutic aspects of hypnotism and, later, on psychoanalysis and what he called 'anagogic psychology'. Geijerstam referred to Freud already in his first published article (1902) on a case of sexual disturbance and phobia treated with hypnotism (he hypnotised his patients dozens of times). In fact, the very first reference in his first article is to Freud's 1895 treatise on Anxiety Neurosis. He cautiously observes that in some respects his patient's symptoms fall in with Freud's theory, while in others they do not. Besides Freud, the only reference in this article is to Felix Gattel, a Berlin-based pupil of Wilhelm Fliess who became one of Freud's first disciples.[65] Although he later came to criticise some of Freud's ideas (e.g. on masturbation), his view of psychoanalysis remained mainly positive, and in 1912 he wrote that

> in my opinion there is no doubt that Freud's achievement is groundbreaking, and that in future histories of medicine he will occupy a place of honour, regardless of the ultimate fate of his ideas.[66]

At the same time, Geijerstam still preferred hypnotism to Freudian psychoanalysis or Dubois' therapy of persuasion (which he disliked), because hypnotherapy was more flexible, inclusive and democratic (that is, it was cheaper and did not require the patient to be an educated person) than psychoanalysis or persuasion.[67] He later became a psychodynamically-oriented psychotherapist who championed an eclectic 'Freudo-Jungian' therapeutic approach to neuroses.

As a psychotherapist, Geijerstam often addressed the relationship between neurosis and morality. In an article published in 1918 he claimed that to overcome a neurosis is an ethical problem, because at the core of neurosis one encounters the question of ethics. The principal problem with the neurotic patients is that they "suffer from a startling

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[64] On Geijerstam's life and work, see Johansson, *Freuds psykoanalys*. Band 2, 321–72; and Luttenberger, *Freud*, passim.

[65] Emanuel af Geijerstam, "Fall af egendomligt vita sexualis kombineradt med impulser och fobi, med framgång behandlat af hypnos," *Hygiea* 64 (1902): 691–2.

[66] Emanuel af Geijerstam, "Om hypnotismens ställning till andra former af psykoterapi," *ASLT* 9 (1912): 143.

[67] Emanuel af Geijerstam, "Några psykoneuroser behandlade med hypnos," *ASLT* 10 (1913): 738; "Ett par ord med anledning av läkarkommitténs betänkande 'Alkoholen och samhället'," *ASLT* 10 (1913): 482.

inability and unwillingness to see their own ethical deficiency."[68] These patients retreat from their 'mission' or purpose in life. He saw neurosis as a matter of conscience, and neurotic symptoms as an act of self-punishment.[69] To tighten the moral screw, he notes that the principal characteristic in neurosis is indolence, reluctance to work. Neurotics complain and whine and are not aware of the 'life force' that the 'law of nature' has granted to each and every one of them. The matrix of this life force is in the unconscious, which, as he informs his readers, is not filled with sexual and criminal instincts—on the contrary, there are progressive tendencies in the unconscious that need to be actualised. When Freud says that "the unconscious can only wish" (*das Unbewusste kann nur wünschen*), the anagogic translation of this sentence would be that "in the unconscious there is only progressive striving".[70]

Geijerstam's language quickly slides down the moralistic slope, as he admonishes indolent neurotics who fail to see the great things that reside in their unconscious. Apparently, the task of an 'anagogic analyst' is to provide moral management by raising the patients' awareness of the positive potentialities hidden below the threshold of consciousness. Thus an analyst becomes a secular pastor who looks into the unconscious to find solutions for the moral predicaments of his patients. In a more benign reading of Geijerstam's later writings, one could say he represented moral treatment rather than 'value-neutral' psychoanalysis; or rather, he derived the tools for his therapeutic influence from different tool-boxes: from 'causal' psychoanalysis, Jung-inspired moral treatment, hypnotism and suggestion. Rather than analysing and demarcating boundaries, he was an eclectic who accepted and utilised.

Furthermore, although Geijerstam's moralism became more to the fore when he became an anagogic analyst, he had a rather liberal attitude towards some of the taboo issues of his time, such as masturbation. Unlike most doctors, he was of the opinion that masturbation is not hazardous to health—on the contrary, it is in most cases totally harmless.[71] He even saw 'moral fanaticism' as a pure neurosis.[72] Judging by his published clinical vignettes, many of his patients suffered from

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[68] Emanuel af Geijerstam, "Några ord om Züricherskolans psykoanalys," *ASLT* 15 (1918), 1299.

[69] Ibid., 1337.

[70] Ibid., 1342.

[71] See, for example, Emanuel af Geijerstam, "Något om den nutida psykoterapin i Sverige," *SLT* 22 (1925): 466–7.

[72] Emanuel af Geijerstam, "Några ord om den anagoga psykoanalysen," 606–7.

sexual disturbances, and he talked freely about sexuality, including Freudian views, in his writings. In his last article, published in 1927, he announced that he had not seen a single case of neurosis *without* a disturbance in the sexual life.[73] His frank acknowledgement of the importance of sexuality for mental health manifested a liberal ethos which was still rather rare in the medical profession in the early decades of the twentieth century. One might say that Geijerstam's moral admonitions were not so much directed at his patients' immoral behaviour, as what he perceived as their obstinate refusal to utilise their own 'inner resources' or inherent morality. The parameters of Geijerstam's moral treatment were provided by his ambition to change the thought patterns of his patients, rather than by any righteous indignation at their moral deficiencies.

Geijerstam, who had treated his patients with hypnotism for more than fifteen years before he turned to psychoanalysis, made in 1925 a wry remark on the kind of therapy patients desire:

> Today the neurotics come and beg for hypnosis in order to escape psychoanalysis, just as they used to beg for electricity in order to escape hypnosis.[74]

The nervously ill need help, but at the same time they are afraid "to risk their skin" and let doctors learn the habits of their hearts. To avoid this risk, they seek out quacks, for whom the neurotics comprise the largest clientele. The problem is aggravated by the authorities, who put very little effort into helping those hundreds of thousands of neurotics. What are needed to solve the urgent problem of neurosis are psychoanalytic outpatient clinics with psychiatrically and psychoanalytically trained physicians. The possibility of treating alcoholics psychoanalytically should also be explored.[75] Unfortunately, laments Geijerstam, although psychotherapy is discussed everywhere in the country, and bookshop windows are full of psychoanalytic literature, the younger generation of psychotherapists is unwilling to undertake comprehensive studies of psychoanalysis.

When Geijerstam died in 1928 at the age of sixty-one, he had a solid reputation as a serious and trustworthy psychotherapist. But even

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[73] Emanuel af Geijerstam, "Zur Frage des Verdrängungsproblems," *ACTA* 2 (1927): 5.

[74] Geijerstam, "Något om den nutida psykoterapin," 428.

[75] Ibid., 428–30. Cf. Emanuel af Geijerstam, "Anförvanternas roll i den psykoanalytiska kuren," *SLT* 24 (1927): 1014, where he refers to the need of publicly-funded psychotherapeutic clinics.

though psychodynamic ideas were gaining ground in Swedish intellectual culture, the medical establishment remained indifferent or critical towards psychoanalysis. It was left to his colleague Poul Bjerre, the 'Son of Man', to continue to create a medical niche for psychotherapy.

From Psychoanalysis to Pychosynthesis

Poul Bjerre (1876–1964) is by far the most well-known Swedish psychotherapist of all time, mainly because of his brief involvement with the international psychoanalytic movement. Some of his writings were translated into English, and he also wrote some articles for the psychoanalytic journal *Jahrbuch*.[76] He was not only a famous psychotherapist, but also an author of numerous books and novels; a social commentator; and a sculptor who was inspired more by Nietzsche than Pasteur, or any other medical authority. After his short psychoanalytic period, he developed a psychodynamic belief system which he coined 'psychosynthesis', deriving ideas from dynamic psychology, religion, and western and oriental philosophy. With his psychosynthesis, he aspired to offer Modern Man a guide to spiritual regeneration and wholeness, no less. It has been estimated that between the years 1907 and 1947, when he closed his practice in Stockholm and withdrew to his country house, he had seen about 40,000 patients.[77] He claimed that his patients represented *all* social classes in two countries (Sweden and Finland), and that he was therefore competent to make general statements about the proper therapeutic approach to neuroses.[78]

Like Geijerstam, Bjerre was initially Wetterstrand's pupil, and he took over Wetterstrand's practice when his master died in 1907, continuing to practice hypnotism for a number of years.[79] By the time he attained his medical degree in 1903, he had already published a novel called 'The

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[76] Jan Bärmark and Ingemar Nilsson, *Poul Bjerre—'Människosonen'* (Stockholm: Natur och Kultur, 1983). Bärmark and Nilsson's book is the definitive intellectual biography of Poul Bjerre with its 680 pages, which cover all aspects of Bjerre's life and work. See also Johansson, *Freuds psykoanalys*. Band 2, 281–319; and Luttenberger, *Freud*, passim.

[77] Carl-Magnus Stolt, "'När man är förfärligt ledsen söker man—tror Ni inte det?—människan?' Patienter skriver till doktor Poul Bjerre," *Svensk Medicinhistorisk Tidskrift* 5 (2001): 153–4.

[78] Poul Bjerre, [Commentary], *Förhandlingar*, October 19, 1937, 467.

[79] Poul Bjerre, "Hypnosens väsen," Meddelanden från Institutet för Psykologisk Forskning i Upsala, Nr. 5, *Psyke* 8 (1913): 1–12.

living dream of a Son of Man' (*Människosonens levnadsdröm*, 1900), and a study on his hero Nietzsche (*Det geniala vansinnet* ['An Ingenious Insanity'], 1903). His inclination to poetry, fiction and life-philosophical musings had not escaped the attention of his professor at the Karolinska, the formidable neurologist Salomon Henschen, who for Bjerre embodied the cynical and objectifying researcher and therapeutic nihilist. Henschen once commented on a patient record authored by Bjerre: "Candidate Bjerre writes short stories about his patients. But this is not the point. The point is to stick to the illness."[80] Henschen's objections irritated Bjerre and undermined his already waning faith in the ideal of objective science. When he attained his medical degree, he had all but turned his back on naturalistic and positivistic 'somatic medicine'.

Bjerre became interested in Freud at the time he took over Wetterstrand's hypnotherapeutic practice. He was intrigued by Freud's theories and personality, and in early 1911 he travelled to Vienna to meet Freud in person. He attended a meeting of the Vienna Psychoanalytic Society (Adler gave a talk on 'some psychoanalytic problems' that night) and discussed a case of chronic paranoia with Freud (this case of Bjerre was published in the psychoanalytic *Jahrbuch* in 1912). In his letter to his disciple Karl Abraham, who had met Bjerre in Berlin, Freud wrote:

> Dr Bjerre was in Vienna for a week and at first made things difficult for me by his taciturnity and stiffness, but finally I worked my way through to discovering his serious personality and good mind. I advised him to join the Berlin group as a member, and I hope he will do so[81] (Bjerre was a member of the Berlin Psychoanalytic Society until 1919).

Bjerre, who soon developed an aversion to most people he encountered in psychoanalytic circles, later reminisced about his meeting with Freud:

> I met with two cold, piercing eyes, which gave me the feeling that I was probably much worse as a person than I thought I was.[82]

Immediately after his return to Stockholm in 1911, Bjerre gave a talk on the psychoanalytic method at a meeting of the Society of Medicine. He presented psychoanalysis in a predominantly positive light, referring

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[80] Bjerre, *Räfst- och rättarting*, 67. See also Bjerre, "Wetterstrand," 80.

[81] Sigmund Freud and Karl Abraham, *The Complete Correspondence of Sigmund Freud and Karl Abraham.* Trans. and ed. Ernst Falzeder (London: Karnac, 2002), 125 (January 20, 1911).

[82] Bärmark and Nilsson, *Poul Bjerre*, 257.

(in the expanded published paper) to "Freud's great ingenuity and importance".[83]

In the spring of 1911, Bjerre met Lou Andreas-Salome, who had been a close friend of Nietzsche, in Stockholm. Together they travelled to Germany to attend the third psychoanalytic congress in Weimar later that year. Two years later, they both attended the psychoanalytic congress in Munich, but no longer as close friends. In fact, by 1913 Bjerre was distancing himself from Freud's views and developing ideas that were more in line with those of Jung and other representatives of the Zurich School, who in the autumn of 1913 were on the brink of a total break with the Vienna School. But Bjerre, who was not inclined to submit to the intellectual authority of others (e.g., Jung), did not become a 'member' of the Zurich group either. Instead, he withdrew from the psychoanalytic movement and started to develop his own brand of dynamic psychology. He remained attracted to psychoanalytic practice, which he regarded as a useful therapeutic method in cases of neurosis, but his attitude towards psychoanalysis as a set of theories was much cooler. In particular, he rejected the psychoanalytic emphasis on disturbed sexuality as the principal aetiological factor in neurosis.

The particular type of dynamic psychology that Bjerre created after his short career as a psychoanalytic psychotherapist had strong resemblances to Jung's spiritualised depth psychology. Like Jung, he stressed the prospective, 'healing forces' in the unconscious, and interpreted neurosis as a manifestation of a conflict in life, a negation of life, which leads to disintegration and stagnation—to 'spiritual death'.[84] Thus, at the root of neurosis there is a conflict, neglect and suppression of certain fundamental tendencies in the mental constitution. Due to a triggering impulse, the suppressed conflict bursts out into consciousness in the form of neurotic symptoms, which vary from psychological to physical manifestations of the inner conflict. He was an early advocate of the psychosomatic idea that neurotic patients often somaticise their psychic suffering. Following Jung, he saw neurosis both as a failed attempt to find a solution to the conflict, and as a warning sign forcing individuals to seriously confront themselves and their problems. To the extent that the neurotic individuals are prepared to learn about all aspects

[83] Poul Bjerre, "Psykoanalysen som vetenskap och terapi," *Psyke* 6 (1911): 141–84.
[84] Poul Bjerre, *The History and Practice of Psychanalysis*. Trans. Elizabeth N. Barrow (Boston: The Gorham Press, 1920), 10–12.

of themselves, including the darker and morally inferior aspects, they are able to overcome neurosis and attain psychological equilibrium.[85] If, on the other hand, neurotic 'complexes' and 'false lifelines' have become too firmly ingrained in the mental constitution of patients, it may be too late to help them (Bjerre called this neuroticising process 'mechanisation').[86]

With his talk of 'spiritual death', 'decay' and 'regeneration', Bjerre's language was no longer confined by the parameters of psychoanalysis. When he developed his grand notion of the eternal cycle of Death and Regeneration (*Död och förnyelse*) in the 1910s,[87] he wandered further and further from both psychoanalysis and the medicine of his day, as he himself acknowledged when he announced that as medicine is not a science but an art, it is only natural for a physician to move from psychoanalysis (science) to psychosynthesis (art).[88] The goal of his psychosynthesis is to

> obtain clear understanding of those forces, due to which Man may be built up into a united, harmonious being, bearing witness of the divinity of his innermost nature.[89]

Bjerre founded his psychosynthetic therapy on the Romantic and neo-Hippocratic idea of the healing power of (inner) nature (*vis medicatrix naturae*), of the self-healing abilities of the human psyche. There is, maintained Bjerre, something that can be called the "healing power of nature" not only in the physical but also in the psychic sphere.[90] This is what he meant by 'regeneration', which he held to be a positive counterpart to degeneration and spiritual 'death'. In human life as Bjerre saw it, there are alternating phases of spiritual death and regeneration, and when humans are going through a period of spiritual

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[85] Poul Bjerre, *Hur själen läkes* (Stockholm: Natur och Kultur, 1923), 115–6.

[86] Bjerre illustrates this thesis with two clinical cases; in one case, 'mechanisation' had gone too far, while in the other it had not: due to the 'natural plasticity' of the latter patient, she found a way out of her neurotic cul-de-sac. See Poul Bjerre, "Den neurasteniska tröttheten," *Hygiea* 86 (1924): 417–26, 462–72.

[87] Bjerre presented his theory of the 'dialectical interplay' of Death and Renewal in his book *Död och förnyelse*, the first edition of which was published in 1919: Poul Bjerre, *Död och förnyelse* (Stockholm: Segerbrandska bokförlaget, 1919). He considered *Död och förnyelse*, which he revised a number of times during the next quarter of a century, to be his main work.

[88] Poul Bjerre, "Från psykoanalys till psykosyntes," *Arkiv för Psykologi och Pedagogik* 1 (1922): 31.

[89] Bjerre, *The History and Practice of Psychanalysis*, 12.

[90] Bjerre, *Hur själen läkes*, 108.

death, the psyche is susceptible to neuroses, just as the body is susceptible to infections. Thus all humans have their own rhythms of life, and it is this rhythmicity that is the very foundation of existence.[91] If neurosis is a typical manifestation of the phase of spiritual death or mechanisation, artistic productivity is a supreme manifestation of an "inner tendency towards regeneration and, therewith, psychosynthesis".[92] Being a sculptor and an aesthete himself, it was not surprising that he regarded artistic, 'synthetic' creativity as the opposite to the neurotic, 'mechanical' condition.

As he began to develop his psychosynthesis, Bjerre became more than a psychotherapist attempting to remove symptoms and alleviate mental pain. He saw himself as a moral authority, an expert in the Good Life, whose duty it was to help his patients to find the right values and ethical guidelines that would provide lasting solutions to their problems.[93] In short, psychotherapists had to become secular pastors, administering moral treatment to their 'flock'. In the interwar years, Bjerre's great ambition seemed to be to replace (Lutheran) pastors by spiritually-oriented psychotherapists who would offer a modern, depth-psychologised version of traditional *Seelsorge* ('cure of the soul'). Bjerre's modernised *Seelsorge* would not be confessionally Christian, for in his 'ecumenical' vision western and eastern (especially Chinese) wisdom would be unified.[94]

I shall now give a short account of an important medical debate initiated by Bjerre, which sheds light on the way psychodynamic psychotherapy was promoted by its advocates and perceived by Swedish physicians who encountered neurotic patients in hospitals, clinics, sanatoria and private consultation rooms.

Bjerre's Attempt to Institutionalise Psychotherapy

After World War I, psychotherapy as a medical specialty with its distinct qualifications was discussed at the meetings of the Society of Medicine's Psychiatric-Neurological section, and also in the daily press. While it had become evident that participants in the discussions had wildly

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[91] Poul Bjerre, "Något om den nutida psykoterapin i Sverige—ett genmäle till d:r Emanuel av Geijerstam," *SLT* 22 (1925): 844.

[92] Bjerre, "Från psykoanalys till psykosyntes," 28.

[93] Bjerre, *Hur själen läkes*, 31–3.

[94] Bjerre, "Något om den nutida psykoterapin," 847.

converging views of what psychotherapy was all about, two distinct fronts had emerged, one emphasising psychological knowledge and therapy and the other a more traditional somatic orientation. In the interwar years, psychotherapists in private practice were mostly 'nerve doctors' who had acquired special skills in the study and treatment of nervous illnesses, and members of the Psychiatric-Neurological section of the Society of Medicine had decided that training in psychiatric, neurological and medical (internal medicine) disciplines should be a professional requirement for nerve doctors, who might then use the title 'psychotherapist' in parentheses if they wished to do so.[95] The need for the psychological expertise that Bjerre and a few other doctors emphasised in public forums, failed to have an impact on the official medical view of psychotherapy.

In early 1935, Poul Bjerre and fifteen other physicians tried to establish the Section for Psychotherapy within the Society of Medicine.[96] Their proposal was hotly debated at two meetings attended by almost all the leading figures in the field of neurology, psychiatry and psychoanalysis. In their proposal for the establishment of a psychotherapeutic section, Bjerre and his associates argued that during the past few decades psychotherapy had become an increasingly extensive field of expertise that was relevant not only to psychiatry and neurology, but also to other branches of medicine from gynaecology and internal medicine to dermatology and general practice. Moreover, there were an increasing number of doctors specialising exclusively in psychotherapy, and they were in contact with numerous cultural fields, such as pedagogy, religion, mythology, art, literature, cultural history and sociology. In order to create opportunities for extensive discussions about these larger issues that were part of psychotherapeutic practice, there was a need for a separate section for psychotherapy. The establishment of such a section would also provide the opportunity for the Psychiatric-Neurological section to concentrate on questions other than psychotherapy. The idea for this separate section came from Bjerre, and it was he who contacted his colleagues and urged them to join him in his endeavour.

In its reply to Bjerre's proposal, the Psychiatric-Neurological section—headed by Nils Antoni—informed the Committee of the Society of Medicine that in its special session the members of the section had

[95] Luttenberger, *Freud*, 241–9.

[96] *Förhandlingar*, [Proposal with Regard to a Section for Psychotherapy], January 15, 1935, 12–41.

almost unanimously voted against Bjerre's proposal (only one out of twenty-two members supported the proposal).[97] In their report to the Committee, the Psychiatric-Neurological section made it clear that there were no sufficient scientific grounds to justify the establishment of a separate section for psychotherapy, the development of which was characterised by different schools fighting each other as if they were religious sects, and relying on arguments that were founded on articles of faith and emotional judgements rather than on science. A science-based psychotherapy needed to be in close contact with issues belonging to the wider domain of psychiatric-neurological research. At the end of the report the tone became more conciliatory when it was announced that, since psychotherapy and the study of neuroses demanded the greatest attention, the section had decided to pay more attention to research on neurosis and psychotherapy in its future meetings. However, it would be a great loss for both the Psychiatric-Neurological section and the representatives of psychotherapeutic activity if psychotherapeutic issues were handled in a separate section.[98]

Although he advocated psychological knowledge and proposed that psychotherapy become an independent specialty, Bjerre did not want to legitimate a pure 'lay psychotherapy'. In his view, psychotherapy should retain ties with the medical profession, and this could be attained by forming a group of medical specialists within the Society of Medicine. This circle of specialists would be in charge of developing psychotherapy in the right direction. To ward off the danger of losing all medical control over the neurotic clientele, medical professionals had to remain in leading positions in the psychotherapeutic treatment of neuroses, and the only way they could supervise psychotherapy would be to institute a professional organ with the official competence to deal with these issues.[99] In the ensuing discussion, some commentators cautiously sided with Bjerre and referred to the importance of psychological knowledge for all doctors, while others opposed him and his proposal.

Two weeks later, Bjerre's proposal was again brought up for discussion at the Society of Medicine. The first to take the floor was Nils Antoni, who acknowledged that, in Sweden, Bjerre had been

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[97] *Förhandlingar*, [The Section for Psychiatry and Neurology: Report Submitted to the Committee of the Society of Medicine], January 15, 1935, 10–11.

[98] Ibid., 11.

[99] Poul Bjerre, "Psykoterapeuten—läkare eller laicus?" *Förhandlingar*, January 15, 1935, 26–7.

> to some extent a pioneer and a master particularly of words, who for a long time has met with unsympathetic chill from the leading figures in the medical community who have done their best to impede his work. But, these difficulties hardly give adequate grounds for founding a new section within our Society—the 'Section Bjerre'.[100]

He pointed out that an interest in various currents in psychotherapy and in the study of neurosis was growing fast in the Psychiatric-Neurological section, and that such an interest should be cultivated and not thwarted by the separation of psychotherapy from the section's domain of activities. In his view, Bjerre's dichotomies between psychotherapy and medicine (neurology and psychiatry) were unwarranted. Antoni's comment was followed by a number of other critical comments, given by some of the leading psychiatrists and neurologists, such as Bror Gadelius, Victor Wigert and Henry Marcus.

Bjerre, who seemed to be upset by the lack of collegial support to his proposal, replied as well as he could, claiming that psychotherapists in private practice met with patients whose problems had nothing to do with psychiatry (Bjerre's book on 'a day at the soul-doctor's consulting room' had just been published).[101] He also (rightly) prophesied that in the long run doctors would have to start co-operating with lay therapists, and as an illustration of a nascent trend he referred to the religious Oxford Movement, where pastors more or less worked as psychoanalysts. He repeated his argument that even if the medical community could not prevent laymen from becoming psychotherapists, it might be able to retain control over these laymen.[102] At the end of the meeting, two doctors who had enlisted in Bjerre's cause (P. H. Törngren and Josua Tillgren) took the floor in support of Bjerre. But it was to no avail: when it was time to vote, Bjerre's proposal was turned down by a clear margin (sixty-one out of eighty-six members voted against Bjerre). This was a heavy blow for Bjerre, who had to stay in bed for a period of time after these meetings.[103] He made no further attempts to win support for his views among his medical peers. Many years later,

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[100] Antoni, [Commentary], *Förhandlingar*, January 29, 1935, 44–5.

[101] Poul Bjerre, [Commentary], *Förhandlingar*, January 29, 1935, 59–66; and Bjerre, … *och snart står döden och stampar vid vår port*. In that book, Bjerre wrote about the most typical patient in his consultation room: "The most typical case is simply a human being for whom the vanity of human life is too much to bear, and who reacts with a paralysing disgust to the prospect that this vanity is never-ending" (82).

[102] Bjerre, [Commentary]. *Förhandlingar*, January 29, 1935, 65–6.

[103] Bärmark and Nilsson, *Poul Bjerre*, 450.

his comments on the Society's 'boycott' of medical psychology were still tinged with bitterness.[104]

Bjerre's disappointing defeat at the Society of Medicine did not mean that he disappeared from the psychotherapeutic scene. On the contrary, a year later (1936), Bjerre and a group of like-minded doctors established The Society for Medical Psychology and Psychotherapy (*Sällskapet för medicinsk psykologi och psykoterapi*), which became a national branch of the International General Medical Society for Psychotherapy. And he succeeded in institutionalising his brand of psychotherapy in the early 1940s, when a small group of doctors and pastors founded the Institute for Medical Psychology and Psychotherapy, which had nothing to do either with the Society of Medicine or with 'official medicine' in general. Bjerre was the central figure at the institute, the fundamental aim of which was to realise his own plans and visions. But in time it became increasingly evident that doctors and pastors found it difficult to co-operate, and internal power struggles led to a conflict-ridden situation (see below). Bjerre himself withdrew from the public sphere, closed his private practice in central Stockholm, and spent his remaining years in solitude at his country house in Vårstavi (south of Stockholm). For a few more years he saw patients at his home, but in the early 1950s he put a stop to all his psychotherapeutic activities. In a letter to a friend in 1950, he wrote: "My life's work is completed."[105]

A suspicious medical attitude towards psychotherapy in general, and towards Bjerre's role as the foremost representative of Swedish psychotherapy in particular, became manifest in this debate. Most members of the Society of Medicine appeared to believe that psychotherapy was a scientifically immature medical field, and that its advancement was dependant on its close ties with psychiatric-neurological research on neuroses. Leading psychiatrists and neurologists wanted to control psychotherapy, even if they were reluctantly prepared to accept lay therapy conducted by psychoanalysts who would be supervised by physicians.

Bjerre's tactic had been to try to convince his medical colleagues that the establishment of a separate section for psychotherapy would not undermine the authority of physicians in the field of therapeutics. He

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[104] Bjerre, "Sjukkassan som folkförstörare," 228–9.

[105] "Jag har gjort mitt verk." Bjerre's letter to Signhild Forsberg, November 18, 1950; as quoted in Bärmark and Nilsson, *Poul Bjerre*, 480.

claimed that as an official medical organ within the Society of Medicine, the section for psychotherapy would supervise psychotherapists and control the development of psychotherapy in Sweden. And if the section became the official representative of Swedish psychotherapy in the International General Medical Society for Psychotherapy, it would be in a position to contribute to the development of (non-Freudian) psychotherapy on the international scene. For Bjerre, this was probably the most important reason for his aspiration to found a psychotherapeutic section: it would represent Sweden in the International Society, with which Bjerre was anxious to establish institutional ties.[106] But his persuasive rhetoric did not go down very well at the Society of Medicine's meetings. Eminent professors at the Karolinska made it absolutely clear that, at least for the time being, psychotherapy was not allowed to depart from its psychiatric-neurological base.

It took an additional thirty years before psychotherapy was finally institutionalised in Sweden: in 1950, an unofficial 'Psychotherapeutic Club' was founded, and the Section for Medical Psychology was established within the Society of Medicine in 1964.[107] Coincidentally, it was the year Poul Bjerre died at the venerable age of 88. By the early 1960s, the time was ripe for the official institutionalisation of psychotherapy, which by then had made many inroads into Swedish medicine. This was a time when a new group of non-medical specialists, clinical psychologists, were about to become a major force in the field of neurosis in Sweden. Moreover, psychoanalysis had become a small but integral part of Swedish mental medicine, and psychoanalytic theories had been removed from the margins to the centre of medicine in the guise of psychosomatic medicine, which had its heyday in Sweden from the end of World War II until the late 1960s.

As for 'lay therapy', although psychiatrists apparently felt threatened by the 'intrusion' of medical psychology into their territory, their authority was not seriously undermined by clinical psychologists, who targeted relatively healthy clientele with mild psychological problems. Besides, after fighting the proposal that psychologists could be trained as mental health experts (in the early 1950s), psychiatrists had to accept that

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[106] Bjerre's dealings with the International Society and its president, C. G. Jung, will be examined in detail in Suzanne Gieser's coming study on the history of psychotherapy in Sweden.

[107] Richard Eeg-Olofsson and Kjell Tullus, "Sektionen för medicinsk psykologi," in *Svenska Läkaresällskapet 175 år*, ed. Stephan Rössner, 117–21.

courses in clinical psychology were established in the medical faculties in the late 1950s.[108] But all this lay far ahead in the future in January 1935, when Poul Bjerre made his futile attempt to institutionalise psychotherapy as an independent medical discipline. After his disappointing failure, Bjerre started to co-operate with Lutheran pastors and theologians, who in the interwar years had become more receptive to psychological therapeutics.

The Waning in Power of the Swedish Clergy

The Lutheran Church of Sweden, which had traditionally had an extremely powerful grip on people because of its position as the state church, was losing in social importance and prestige from the mid-nineteenth century onwards.[109] To his congregation, the pastor had been simultaneously a religious authority, a state functionary and a schoolmaster, and all these different roles had become so intertwined that they could hardly be detached from one another. But as a consequence of profound changes in Swedish society, the religious and social aspects of human life had begun to be separated, while the disintegration of the traditional peasant society had led to an increasing privatisation of religiosity, which in turn had contributed to the process by which the professional identity of pastors had become more exclusively religious, and socially more peripheral. From the mid-nineteenth century to the mid-twentieth century, the Lutheran Church was gradually transformed into a specialised social institution, an institution which found its legitimate niche in the private sphere of the Swedes who still needed pastors as masters of rituals on such occasions as marriages, funerals, the christening of children and preparation for confirmation. There was also some demand for pastors as caretakers of the soul.

Concerning the normative power of the Church during this period, one might say that Lutheran pastors found it increasingly difficult to produce such spiritual need (or, anxiety) in people for which they them-

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[108] Bengt Erik Eriksson, "Behövs psykologer?—Psykologins plats i den psykiatriska vården." In *Psykiatrins marginaler*, ed. Qvarsell and Eriksson, 163–80.

[109] Anders Bäckström, "Från institution till rörelse: En studie av Svenska kyrkan igår, idag och i morgon," in *Religion och Samhälle* Nr. 50 (Uppsala: Religionssociologiska Institutet, 1989).

selves proffered relief.[110] As the theologian G. A. Danell expressed it in 1950, it is to some extent correct to say that the Church cultivates a sense of guilt, but such a cultivation has a 'therapeutic purpose', namely to "liberate people from their guilt, which exists regardless of whether they acknowledge it or not".[111] Such a guilt-ridden discourse could only have become firmly established in a 'monocultural', value-monistic and predominantly rural country that was almost one hundred per cent Lutheran.[112] But as this particular Lutheran society was undergoing rapid modernisation, it dawned upon the younger generation of theologians and pastors that the state church had to renew itself and opt for less moralising and normative ways of winning the hearts and minds of people, who were increasingly inclined to believe that it was science rather than the Scriptures that should provide the guidelines for society.[113] The idea that both church and society were in a state of crisis was widespread within the Church in the interwar years, and "the main reason for the crisis in the church was said to lie in the church's loss of contact with the people of that time".[114] As Alva Myrdal, one of the main ideological architects of the 'anti-theological' social-democratic *folkhem*, observed in 1945, religion had to find a proper framework for its adjustment to a society enriched by psychological science.[115] Her message to the Church was blunt: change or perish.

An awareness of the need to face this challenge issued to the Church by the psychological sciences had already arisen earlier in the century. In the interwar years, a more liberal ethos, thanks to some extent to the psychology-inspired archbishop Nathan Söderblom, started to gain momentum in the Lutheran Church. And as part of this modernisation of the Church, an interest in psychotherapy and dynamic psychology

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[110] Janne Kivivuori, *Psykokirkko* (Helsinki: Gaudeamus, 1999).

[111] G. A. Danell, "Skuldkänslan och vägen till befrielse," in *Läkare och själavårdare*, ed. Göte Bergsten and Fritz Lindén (Uppsala: J. A. Lindblads förlag, 1950), 173–4.

[112] In 1930, there were less than 20,000 Swedish citizens who were not members of the Church of Sweden (0,32 per cent of the total population of 6 142,000). In this small group, there were 6,653 Jews (categorised as 'half-Christians'), 4,763 Catholics, 504 Greek-Orthodox, 15 Muslims, and 124 non-demoninationals (*konfessionslösa*). *Statistisk årsbok för Sverige* (Stockholm: Statistiska Centralbyrån, 1945), 17.

[113] Börje Cronholm conjectured in 1942 that an important reason for the lively interest in psychology not only in Sweden but in Europe in general is that state religions (*folkreligioner*) have to a great extent lost their grip on people. Börje Cronholm, "Den psykologiska litteraturen i Sverige," in *Själavård—självård*, 146.

[114] Brodd, *Var Sveriges sak också kyrkans?* 534 [English summary].

[115] Alva Myrdal, "Mer människokunskap i utbildningen," *Social Årsbok* 1945, 156–7.

emerged among theologians and pastors who were inclined to interpret neurosis as a manifestation of spiritual malaise. The objective Christian morality that the Church represented was also seen by the less radical-minded representatives of *Bildunsgbürgertum* as a culturally valuable counterbalance to materialism, socialism and the value relativism of the scientific worldview.[116] Nerve doctor Torsten Lindner, for example, asserted that psychotherapy could never be anti-religious in the sense of being ill-disposed towards religion in its wider meaning.[117] Lindner warmly supported closer co-operation between pastors and physicians, and gave a presentation at the first joint meeting of pastors and physicians in Sigtuna near Stockholm in 1933.[118] At these meetings, which continued to be organised regularly at least until the end of the 1950s, the fundamental psychoreligious question of the 'false' versus 'genuine' sense of guilt and its relation to neurosis was taken up for discussion.[119] This question remained at the centre of attention in the Swedish therapeutic *Seelsorge* for decades to come.[120]

The fact that the 'interdisciplinary' conferences in Sigtuna and elsewhere attracted pastors and nurses more than doctors was one indication of the changing power positions of these groups in Swedish society: doctors had become cultural authorities, whose social prestige and social capital far exceeded that of pastors, who had more to gain in seeking co-operation with doctors than vice versa.[121] When the famous writer and journalist Ludvig Nordström travelled across the country in 1938 in order to collect material for his radio report on the wretched socio-economic conditions in the Swedish countryside, his original plan was

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[116] This concern for the allegedly adverse social consequences of the scientific relativisation of values is manifest, for example, in Agerberg, "Livsåskadning och själshälsa."

[117] Torsten Lindner, "Präst och läkare," *SLT* 30 (1933): 1386–95.

[118] Ibid. See also *Prästen-Läkaren-Sköterskan inför gemensamma uppgifter* (Stockholm: Svenska Kyrkans Diakonistyrelsens bokförlag, 1942). On the historical relationship between religion and medicine, see Roy Porter, "Religion and Medicine," in *Companion Encyclopedia of the History of Medicine*, ed. Bynum and Porter, 1449–68.

[119] See, for example, Sven-Olof Brattgård's report on the conference for physicians, nurses and pastors in Gothenburg in 1950: Sven-Olof Brattgård, "Sjukvård och själavård," *SLT* 47 (1950): 2425–8.

[120] Owe Wikström, *Stöd eller börda? Religionens roll i psykiatri och psykoterapi* (Uppsala: Verbum, 1980), 14–15.

[121] For example, in a conference organised by the Church in Lund in 1946, the majority of 400 attendants were nurses; there were fifty pastors and only fifteen physicians attending the meeting. In his report on the conference, C. A. Wållgren makes a wish that more physicians would show up at the next conference. C. A. Wållgren, "Läkare, sjuksköterskor och präster," *SLT* 43 (1946): 2581.

to have discussions with medical officers (*provinsialläkare*) and pastors of the Lutheran state church, who would have illustrated the possible relationship between housing conditions and the general mental state of the people. (In addition to broadcasting his travel report on the radio, Nordström published a widely-read and much-discussed book entitled 'Filth-Sweden' [*Lort-Sverige*, 1938].) However, after meeting a few ministers, Nordström decided not to have any more discussions with the clergy, whom he came to regard as an increasingly redundant group of traditionalists who constituted an obstacle to social progress. Nordström observed:

> The role of the parsonage is played out, and the position of a pastor is that of an isolated person. Physician has replaced him, and the doctor's house has succeeded the parsonage as a model and a standard [for the local community].[122]

Nordström's increasingly critical view of the social role of the clergy was reinforced by his encounters with physicians throughout the country. "What does the [local] pastor do for the people?" asked Nordström one medical officer in Northern Sweden. The doctor replied: "He hinders development. If he only can."[123]

Religion and Psychoanalysis

In 1927, theologian Tor Andrae (who later became bishop) published a book in which he examined the relationship between religion and psychoanalysis. He evaluates psychoanalysis in rather positive terms, observing that both religion and psychoanalysis lead to a transformation of personality, to a spiritual or mental renewal that expands individuals' perspective, produces a new motive that appeals to their will, and makes them see themselves as part of the "higher order of life".[124] In this rapprochement of secular and spiritual forms of salvation, the psychotherapist becomes a spiritual authority, while religion assumes the role of a therapeutic doctrine that functions as a prophylactic

[122] Ludvig Nordström, *Lort-Sverige* (Stockholm: Kooperativa förbundets bokförlag, 1939), 24–5.
[123] Ibid., 402.
[124] Tor Andrae, *Psykoanalys och religion* (Stockholm: Albert Bonniers förlag, 1927), 30.

against neurosis. Thus religion is, among other things, an enormous psychotherapeutic system that prevents mental malaise and heals the soul of neurotics. Unlike many other religious thinkers, Andrae does not openly declare that secularisation breeds mental and spiritual discontent, or that "for each church that is closed, a new nerve sanatorium has to be opened".[125] Instead, he suggests that, if possible, pastors should acquaint themselves with psychoanalysis and other methods of psychic healing, and that they should learn about the psychology of the 'sick soul'. But he is careful not to identify religion with psychotherapy or medical psychology, because the whole modus operandi of religion fundamentally differs from that of the medical sciences, in that religion aims at something higher than what can be conveyed by such words as 'health' and 'well-being'. The higher significance of religion lies in its ability to produce in humans an altruistic ethos of heroism and generosity, which makes them sacrifice willingly what is dearest to them for the sake of spiritual immortality.[126]

A year later, another theologian, Arvid Runestam (who, like Andrae, became bishop later in life), published a book on psychoanalysis and Christianity. Like his colleague Andrae, his evaluation of psychoanalysis is rather favourable, and he holds the psychoanalytic doctrine of repression to be a valuable tool for shedding light on the inner conflict between moral aspirations and instinctual demands.[127] But where he radically differs from psychoanalysis-inspired physicians and social commentators is in the question of the pathogenesis of neurosis: as a theologian, he advocates the belief that neurosis is not the result of too strict a morality, but, instead, of too *weak* a morality. In neurotic people, the force of morality has been too weak to prevent the 'lower sphere of drives' from taking control of them. But as this control has not been total, the repressed voice of morality has made itself heard, and this nagging of conscience has led to 'mental imbalance' that manifests itself in nervousness. Thus, behind the facade of nervousness one can see guilt.[128] Runestam's main thesis, propounded by many other religious authors before and after him, is that religion guarantees mental health. Conversely, neurosis and other forms of mental or spiritual 'imbalance'

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[125] Ibid., 59.
[126] Andrae 1927, 75–81.
[127] Arvid Runestam, *Psykoanalys och kristendom* (Stockholm: Sveriges kristliga studentrörelse, 1928), 44.
[128] Ibid., 45.

are manifestations of a sense of guilt that arises when amoral 'instincts' gain power over religious morality. It is the suppression of the natural religious-ethical needs, and not of sexuality or other forms of lower instinctual urges, that drive people to nervousness.[129]

Runestam turns the critical secular thesis of a 'life-negating' religion on its head, by claiming that neurotics suffer from a sense of guilt that is triggered by the suppression of innate religiosity. He is not content with proclaiming that innate morality is a 'drive' that one suppresses at one's peril; he also asserts that it is the lack of a strong religious authority that creates the preconditions for neuroses. A nervous modern individual needs to yield to religious authority, to throw him- or herself upon the mercy of a higher power.[130] Obviously, rather than being a radical reformist seeking new ways to renew Christianity, Runestam was a pious clergyman who saw the restoring of the cultural authority of the Church as his mission.

Runestam's and Andrae's books were paradigmatic in the way they addressed the questions of mental health and neurosis; guilt and neurosis; innate religiosity and 'lower instincts'; and religion and modern psychology. In addition to cautious supporters of a more psychologically-oriented *Seelsorge* in the Church, there were also theological critics of psychology. One of them was the Norwegian bishop Eivind Berggrav, who published a polemical article in *Svenska Dagbladet*, a Swedish daily, in March 1932.[131] Berggrav makes it clear to readers that he does not think much of psychology's ability to increase self-knowledge, and he scoffs at what he sees as psychological schematism and "compulsive interpretations" (*tvångstolkning*), which he rather unflatteringly compares with hypochondriasis, using the term 'psychochondria' to refer to what he saw as the ungrounded claims-making of psychology. Instead of empowering us, contends Berggrav, psychochondria weakens us or even "knocks us out", since it effectively damages our powers of judgement. He describes psychochondria as a dangerous infection against which the psyche is quite defenceless. Still, he admits that while psychological "knowledge about the soul" is dangerous to the pastor, it also provides some feasible guidelines for a careful comparison between different 'cases'. This was as far as he was willing to go in affirming the positive

[129] Ibid., 34.
[130] Ibid., 49–50.
[131] Eivind Berggrav, "Psykologi och själavård," *Svenska Dagbladet*, March 6, 1932.

aspects of psychology. Evidently, Berggrav wanted to defend the autonomy of religious *Seelsorge* against what he perceived as the contagious illness of 'psychochondria'.

Religious Caretakers of the Soul

In the late 1930s and the early 1940s, co-operation between pastors and medical psychotherapists was institutionalised with the founding of two institutions, the Institute for Medical Psychology and Psychotherapy and the St. Luke's Foundation (*St. Lukasstiftelsen*). The driving force behind the Institute for Medical Psychology and Psychotherapy was Poul Bjerre, the Nestor of Swedish psychotherapy. This institute trained only physicians and theologians and was not open to any other groups. In a collection of essays published in 1942, the representatives of the institute described their line of work and their whole *raison d'etât*, which centred on the hope that the co-operation between theologians and psychotherapists would bring about reforms in the traditional religious care of the soul.[132] But physicians and theologians found it quite difficult to find common ground, and theologian Gösta Nordquist, Bjerre's favourite pupil, left the institute in 1947, frustrated at his failure to win Bjerre's support for his attempts to raise the medical and scientific standard of the institute, for example, by excluding therapeutically incompetent theologians from the training programmes. There appeared to be many uncritical yes-men in Bjerre's circle who were not willing or able to make the necessary changes at the institute in order to guarantee its continuity. After the atmosphere of mutual distrust had become too much for the ageing Bjerre, the Institute closed its doors in 1948.[133]

Another, more theologically-oriented forum created by Bjerre's group was The Society for Pastoral Psychology (*Sällskapet för pastoralpsykologi*), the prime mover of which was Gösta Nordquist, Bjerre's Sancho Panza. Pastoral psychology, which was originally developed in the United States by A. T. Boisen (1876–1965), testified to the growing influence of psychological thinking on pastoral care and on modern religiosity

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[132] *Själavård—själsvård*. Utgiven av Institut för medicinsk psykologi och psykoterapi. Stockholm: Médens Förlags Aktiebolag, 1942.

[133] Bärmark and Nilsson, *Poul Bjerre*, 451–7. On Bjerre's own comments on the Institute, see Bjerre, *Räfst- och rättarting*, 264–7.

in the western world. In an anthology of essays on pastoral psychology published in 1945, all but two contributors (Bjerre and the internist Josua Tillgren) were laymen, many of them theologians interested in creating a new kind of *Seelsorge* that would be informed by psychodynamic insights, especially those developed by Bjerre and Jung, who was one of Bjerre's unacknowledged theoretical sources.[134] Unlike Bjerre's ill-fated Institute for Medical Psychology and Psychotherapy, the Society for Pastoral Psychology survived until the mid-1950s, but after Nordquist broke with Bjerre in 1947, pastoral psychology was no longer developed by Bjerre or his pupils. The task of training pastoral psychologists was successfully taken up by another psychoreligious institute, the St. Luke's Foundation (*St. Lukasstiftelsen*), which is still running today.

The St. Luke's Foundation was created in 1939 by the religious author Ebba Pauli and the Methodist pastor Gösta Bergsten, along with a small number of kindred spirits, the neurologically-trained psychotherapist Richard Eeg-Olofsson among them. Many of the pioneers at the foundation were members or former members of the Christian Association of Medical Students. It was also associated with the Swedish state church.[135] In 1947, the foundation established a psychotherapeutic training institute, which "has had great significance for psychotherapeutic education in Sweden".[136] The foundation's objective was to spread the core message that spiritual factors are significant for health, and that medical and psychological methods are valuable as a remedy against mental and physical suffering.[137] It seems quite astounding that the latter truism—that medicine helps when one falls ill—had to be underlined by the foundation, but perhaps they wanted to highlight the connection between doctors and religious caretakers of the soul (*själasörjare*) for fear that their project would otherwise be considered a form of quackery (i.e. illegitimate practice of medicine).

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[134] See, for example H. B. Wahlborn, "Vad har en präst att lära av djuppsykologien," in *Pastoralpsykologi* (Stockholm: Natur och Kultur, 1945), 61–84. Wahlborn, a Lutheran minister, relied heavily on Bjerre's psychosynthesis and argued for a liberal, non-judgemental *Seelsorge* that relied especially on Bjerre's and Jung's psychodynamic theories without discarding its religious foundation. See also Richard Eeg-Olofsson, "Pastoralpsykologi," *SMT* 22 (1945): 188–90.

[135] Johansson, *Freuds psykoanalys*, Band 2, 405; Rigné, *Profession, Science and State*, 59.

[136] The training institute was called the Institute for the Healing of the Soul and Psychological Counselling (*Institutet för själavård och psykologisk rådgivning*). See Roger Qvarsell, "Tora Sandström och psykoterapins historia," *Lychnos* 1995, 124.

[137] Karl Ellis Bratt, "St. Lukasstiftelsen," *SLT* 45 (1948): 1900–4.

What the representatives of the St. Luke's Foundation and its psychotherapeutic institute meant by 'the ill' were mostly the nervously ill, who among the institute's clientele comprised the largest group. Indeed, it was neurosis that evidently provided the common ground for a cooperation between doctors and caretakers of the soul. As the hospital pastor Karl Elis Bratt, who had studied at the Institute, put it, "many neurotics seek their way to the St. Luke's Foundation".[138] The therapy that was provided to these neurotics was religiously-oriented psychotherapy, which in its early years was not so much founded on dynamic psychology as on the US psychologist Carl Rogers' 'client-centred' humanistic therapy.[139] The institute had its critics, who thought that it spread 'religious propaganda' among people, but the advocates of the institute replied that its purpose was to help people, not convert them to Christianity.[140] Probably many of those who contacted the institute were in fact looking for a 'religiously-oriented psychotherapy', which was not easy to come by in Sweden, especially after the discontinuation of Bjerre's institute in 1948. Aside from personal consultations, the institute organised conferences, retreats and seminars for medical students, young doctors and pastors. By 1957, the foundation had established nine branch offices in different parts of the country.[141] That the St. Luke's Foundation has survived until this day proves that it managed to carve a niche for the kind of non-intrusive religious psychotherapy that it offers to people with mild mental problems.

The emergence of psychoreligious elements in the Lutheran Church and in medical psychology was part of the larger process of the psychomedicalisation of Swedish society and culture. The representatives of the 'psychochurch' typically propounded the message that 'freethinking', the dismissal of religious values and the 'suppression of innate religiosity', were neurotic symptoms that had their social roots in secularisation. They proclaimed that religiosity or at least 'healthy religiosity' was a precondition for both mental health and the health of society, and that a 'denouncement' of religion in the form of atheism (and agnosticism) was a symptom of neurosis, as well as a sign of

[138] Ibid., 1902–3.
[139] Henry Egidius, "Psykoanalysen i Skandinavien," *Nordisk Psykologi* 28 (1976): 241.
[140] Bratt, "St. Lukasstiftelsen," 1904.
[141] "Motion om statsbidrag till St. Lukasstiftelsen," *SLT* 54 (1957): 1039.

cultural crisis.[142] To be sure, there were many keen medical critics of religion who challenged these contentions, arguing that religions were potentially hazardous to mental health, and that religious morality was one of the most important neuroticising factors in modern society.[143] Inevitably, as the number of practising Christians was diminishing, it had direct bearing on the public discussion of the alleged 'mental-hygienic' aspects of religion.

The Society for Pastoral Psychology closed down its activities in 1954, but not because psychological impulses had grown weaker in Swedish religious culture. On the contrary, the Lutheran Church was transforming itself into a modern therapeutic institute which saw its mission not in telling the sinful Swedes in an authoritative voice how to live their lives, but rather in offering support and consolation to the members of the Church (in 1954, almost all Swedes were members of the Lutheran Church of Sweden). The terrifying concepts of Hell, Sin and the Last Judgement were totally marginalised in the updated psychologised language of churchmen and -women, who aspired to make people healthy and whole rather than righteous, God-fearing moralists wallowing in guilt. Especially in bigger towns, the Lutheran State Church was becoming a therapeutic 'psychochurch' which wanted to heal mental and spiritual wounds and to replace the judgmental God by the therapeutic God who loves, understands and forgives.[144]

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[142] Arvid Runestam, for example, asserted that the modern, secular society suffered from 'moral crisis', and that in a democracy where self-determination has replaced the old authorities—including the Church—, freedom could be a burden rather than a blessing to individuals. See Lars Gunnarsson, "Runestam, Arvid," in *Svenskt Biografiskt Lexicon* (Stockholm: Norstedts, 2000), Vol. 30, 735–41.

[143] One representative of such medical criticism of religion was Per Henrik Törngren. In his *Moralsjukdomen* (1940), he argues that 'moral misconceptions' constitute the hitherto undiscovered foundation of neuroses. Törngren's approach to moral issues was unashamedly atheistic, unlike that of many other contemporary critics of religion and the Church. See P. H. Törngren, *Moralsjukdomen* (Stockholm: Medéns förlags aktiebolag, 1940).

[144] My way of using the concept of 'psychochurch' is derived from the Finnish sociologist Janne Kivivuori's study of the cultural transformation of the Lutheran State Church in Finland. See Kivivuori, *Psykokirkko*.

CHAPTER SEVEN

THE CULTURE OF COMPLEXES

After World War I, many of the alleged medical and socio-cultural hazards to the health of nerves began to be dismissed or re-interpreted by the younger generation of nerve doctors. A paradigmatic representative of a new approach to neuroses was the American nerve doctor Louis E. Bisch, whose book *Be Glad You're Neurotic* appeared as a Swedish translation in 1938.[1] Bisch could not be less worried about most of the aetiological factors which the previous generation of nerve doctors and other specialists had put forward to explain neuroses. Rather than focusing on the negative effects of nervous illnesses on the health of people, he radiated an optimistic, almost care-free attitude towards neurosis, as the title of his book indicates. The reader receives a good idea of his message merely by reading the titles of the fourteen chapters of his book. For example, Chapter One is entitled 'I'm a neurotic myself—and I'm glad of it'; Chapter Two: 'To be normal is nothing to brag about'; Chapter Four: 'Your development into a neurotic was inevitable'; Chapter Nine: 'Of course your sex life is far from satisfactory'; Chapter Eleven: 'How nervous are you, by the way? Try this test'; and Chapter Fourteen: 'Then follow these five simple rules—that's all![2] These 'five simple rules' are as follows:

Study yourself
Stop blaming yourself
Be proud of what you are
Change your failings to opportunities
Make your neurosis fruitful

And then:

BE GLAD![3]

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[1] Louis E. Bisch, *Nervositet är en tillgång* (Stockholm: Natur och Kultur, 1938).

[2] As I have not been able to consult the original American edition of the book, I have translated the titles of these chapters myself.

[3] Bisch, *Nervositet*, 180.

The up-beat message of Bisch's book is: don't worry, be neurotic! Sing if you're glad to be nervous! Dr. Bisch's carefree attitude is quite different from that of Beard, Charcot, Krafft-Ebing, Mantegazza, Hellpach, Janet, Lennmalm, or even such modern psychotherapists as Bjerre and Geijerstam. Bisch's approach to neurosis is the most optimistic and buoyant I have come across, and it contrasts starkly not only with the sombre approach of the earlier generation of European doctors, but also with such serious-minded representatives of the 'modern approach' as the psychoanalyst Otto Fenichel, for whom neurosis was almost a matter of life and death (see his *Theories of Neurosis*, 1945). It is probably no coincidence that Bisch was an American—after all, it is difficult to imagine a German nerve doctor entitling his book 'Be Glad You're Neurotic'—but there is more to this than simply the nationality of the author. Bisch, who also wrote (among other things) a book entitled *Cure Your Nerves Yourself* (1953) and a 'manual' on *How to Get into the Movies* (1936), was in fact an almost prototypical representative of a new psychomedical mentality that blurred the distinction between health and sickness; between sanity and insanity; and between what is normal and respectable and what is abnormal and reprehensible. For him, as well as for an increasing number of his professional peers, neurosis was an integral part of the normal mental constitution of a modern individual, and far from seeking ways and means to get rid of it, one should learn to live with it and even see it as a resource that can be utilised (e.g. in intellectual and artistic work). It was almost as if neurosis was perceived by Bisch as an inevitable product of cultural evolution, a condition of modernity rather than a stigma or an illness.

The road from Beard's office in Manhattan in 1880 to Bisch's office in Manhattan in 1930 was not as long and winding as might be inferred from the kaleidoscopic history of neurosis during these fifty years. Even Beard thought that neurasthenia was a product of civilisation, and he held that those who fell ill represented the very vanguard of social progress. The main difference between Beard and Bisch is that Beard had a predominantly somatic approach to neurasthenia, and that he used mainly electrotherapy as a method of treatment. Bisch, by contrast, had a psychodynamic approach to neurosis, and he relied mainly on talk therapy. These differences can be explained by the fact that Beard's Nervous Age was not yet affected by popularised psychological ideas, whereas Bisch's Nervous Age was becoming suffused with things psychological and psychodynamic.

New York was probably the capital of Psychological Culture in the twentieth century, but the Swedes were rather quick to follow the lead of nervous New Yorkers. In the post-World War I Sweden, the idea of the 'Nervous Age' gradually merged with the emerging culture of complexes, which downplayed heredity and stressed environmental factors, and replaced conservative and/or degrading views about women, sexuality, urban life, the 'lower classes', religion, education and morality, by the more liberal views that contributed to the restructuring of Swedish society.

From the Nervous Age to the Era of Psychoculture

At the turn of the century, Sweden was still a rather 'unpsychological' nation where people were more disposed to study the mechanism of the steam engine than the mechanism of the mind. The mental disposition of the Swedes was discussed in a widely-read book on the 'Swedish mentality' that appeared in 1911.[4] The author, the pioneer statistician Gustav Sundbärg, contrasts the Swedes' developed sense of nature with their undeveloped sense of psychology—their psychological knowledge of human beings was poor. In Sundbärg's view, the idiosyncratic mentality of the Swedes gives a distinctly Swedish stamp of crudeness and maladroitness to human relations and interactions. He devotes a whole chapter to the 'lack of psychology', claiming that the Swedes lack both an *understanding* of human psychology and an *interest* in the study of Man as a psychological creature. Although he holds that the Swedes are talented as thinkers, he also contends that his compatriots are constitutionally underdeveloped when it comes to psychological skills, contrasting the psychologically infantile Swedes with the psychologically sophisticated Danes, who are inclined to study Man rather than Nature. Nobody is more afraid of self-reflection than a typical Swede, whose deepest desire is to flee from himself. On the other hand, the psychological naivety of the Swedes can also function as a bulwark against specific dangers that threaten national health; Danish aesthetics and psychology have reached such levels of sophistication that they smack of degeneration, warns Sundbärg.[5]

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[4] Gustav Sundbärg, *Det svenska folklynnet* (Stockholm: P. A. Norstedt, 1911).

[5] Ibid., 12–15, 26. For later discussions of Sundbärg's theses, see Alfhild Tamm,

In the fin-de-siécle era, Swedish culture was not yet 'contaminated' by psychological literature and thought patterns. But Sundbärg's thesis about the Swedes as an 'unpsychological' people was refuted in the interwar years, when psychological ideas, theories and terms gained a strong foothold in Sweden. 'Weak nerves' and 'nervousness' had been the main terms indicating mental distress for half a century; now these well-established signifiers began to be outshone by the new key-terms 'psychic conflict', 'psychic trauma' and 'complex'. In the 1920s, the nation was undergoing rapid modernisation, which meant that more and more people moved from the countryside to urban centres to educate themselves and to take jobs in the expanding industry. Many villages grew in turn during this era and started to acquire the characteristics of urban centres, largely because modern technology, including the railway, telephone and automobile, changed the traditional infrastructure of the countryside. During the interwar years, the level of education and the standard of living were raised considerably, and when the social-democrats came to power in 1932, an official interest in the 'Knowledge and Management of People' (*människokunskap och människobehandling*) catapulted psychological and psychomedical issues to the centre of attention.

The new authorities saw psychology as a scientific means of educating citizens and teaching them to live correctly as pupils, students, lovers, parents, employees and tax-payers. Psychology as practical, utilisable knowledge was deemed valuable to society, but it was not the case that people were passive receivers of governmental psychological indoctrination. Rather, it seems that segments of the population were actively engaged in acquiring psychological knowledge related to sexuality, human relationships, the choice of occupation, child-rearing, private feelings and attitudes, and perhaps also to questions regarding the 'calibration' or fine-tuning of the personality in ways that would make a person more acceptable and attractive to others, especially to members of the opposite sex and to those higher up in the social hierarchy.

Within a time-span of one decade (from the early 1920s to the early 1930s), so-called psychoculture became established in Sweden. Psychoculture refers here to a socio-cultural phenomenon where individuals interpret themselves and the selves of others by using psychological

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"Vår kulturkris och den psykiska hygienen," in John Agerborg et al., *Själens läkarbok*, 483–521.

and psychodynamic terms and models, and where it becomes an established value or even a norm to employ psychological vocabulary, and to endorse the suggestion that a psychological perspective helps people to 'understand themselves more deeply' and to find some kind of solution to their lives. As the historian of psychology Kurt Danziger has pointed out, the subject matter of psychology has depended on "a culturally embedded tendency to experience much of human life in psychological terms" and on the "expression of the personal core" in the inner life of the individual.[6] In a society imbued with psychoculture, morality, a worldview and the understanding of human life become moulded by psychological values which put a premium on mental well-being, self-realisation as well as on the various risks that potentially threaten to make individuals psychological invalids suffering from psychic traumas, 'dysfunctional' relationships, low self-esteem, 'complexes', excessive demands on the part of authority figures (parents, teachers, employees, politicians, bureaucrats, etc.), 'empty lives' and so forth. In such a society, psychology offers guidance and advice to those who have learned to look for psychological solutions to the problems of everyday-life. As psychiatrist Börje Cronholm, who monitored the psychological scene in Sweden in the early 1940s, observed,

> to a great extent, modern Man formulates his personal problems with the help of these [psychological] terms… What the people pursue in their studies of psychology is… a tool for understanding themselves, their conflicts and their problems, in order to find a remedy for these conflicts and problems.[7]

In the interwar years, Sweden was in the process of becoming a therapeutic society, in which psychomedical values and practices became central tools for what the British sociologist Nikolas Rose has coined the 'government of the soul'.[8] Rose makes the simple but relevant observation that it is no coincidence that psychological expertise has played a very significant role in modern liberal-democratic societies, such as Britain. In his contribution to what he has dubbed the

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[6] Kurt Danziger, *Naming the Mind: How Psychology Found Its Language* (London: SAGE, 1997), 16, 26.

[7] Börje Cronholm, "Den psykologiska litteraturen i Sverige," 147.

[8] Nikolas Rose, *Governing the Soul.* Rose defines his use of the term 'government' as follows: "'Government' describes… a certain way of striving to reach social and political ends by acting in a calculated manner upon the forces, activities and relations of the individuals that constitute a population." Ibid., 4–5.

'genealogy of subjectivity', he has examined how the modern 'psy' sciences have made it possible to "govern human beings in ways that are compatible with the principles of liberalism and democracy".[9] Psychological expertise is non-authoritarian and does not threaten the celebrated values of autonomy, individualism and self-realisation. At the same time, it fabricates, regulates and shapes human subjectivity, helping individuals adjust themselves to the prevailing social order by influencing their ways of thinking and behaving. The 'psy' sciences are not solely 'instruments' of power, because they play a role in the very construction (legitimisation, institutionalisation, justification, etc.) of the management of subjectivity, which occupies a central position in the modern organisation of society. As Rose puts it,

> liberal democratic polities place limits upon direct coercive interventions into individual lives by the power of the state; government of subjectivity thus demands that authorities act upon the choices, wishes, values, and conduct of the individual in an indirect manner. Expertise . . . achieves its effects not through the threat of violence or constraint, but by way of the persuasion inherent in its truths, the anxieties stimulated by its norms, and the attraction exercised by the images of life and self it offers to us . . . Citizens shape their lives through the choices they make about family life, work, leisure, lifestyle, and personality and its expression. Government works by 'acting at a distance' upon these choices, forging a symmetry between the attempts of individuals to make life worthwhile for themselves, the political values of consumption, profitability, efficiency, and social order.[10]

Rose's sociological analysis of the rise of the 'psy' sciences is relevant for understanding the development of psychological expertise in a country such as Sweden, where the social-democratic government laid stress on the importance of scientific knowledge and on the effective governing of the population, or the 'management of people'. In Sweden, careful step-by-step planning was a fundamental component of the social-democratic ideology of social engineering right from the start. A need for applicable, utilisable knowledge demanded quantification of human material, which meant that psychological assessments, evaluations and tests served the purpose of making citizens responsive to the human technologies of management.

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[9] Ibid., vii.
[10] Ibid., 10–11.

Faith in the power of psychology to contribute to human flourishing is succinctly expressed by the behaviour experts in the Preface to a collection of essays entitled 'The Knowledge and Management of Humans' (1954):

> It is not an exaggeration to say that in the not too distant future we shall see psychology transforming our lives to the same degree as the technology based on physical advancements has already done. The twentieth century may be called the century of psychology in the same way as the nineteenth century was the century of the natural sciences.[11]

The belief that psychologists possess the key to better living, was aptly formulated in a statement issued by the Swedish Psychologists' Association not so long ago (in 1985):

> The psychologist knows about the psychological requisites for ordinary life as well as life under strain. The psychologist knows what is good and what is bad for human beings.[12]

As sociologist Eva-Marie Rigné points out, psychological discourse can be as moralising as the old-fashioned moralistic discourse, it is only that instead of focusing on *socially* given rights and wrongs, psychological discourse focuses on "*emotional* rights and wrongs" (italics added).[13] This being the case, spontaneity, authenticity (i.e., 'being true to one's self') and willingness to be talkative and pour out one's feelings became new criteria for health and happiness. People were taught to consider it 'healthy' to communicate their intimate feelings and motivations to others and feel good about such openness. By contrast, particular modes of behaviour (e.g. reluctance to open up and reveal one's intimate feelings) and specific emotional states (e.g. anger, jealousy, resentment and sadness) came to be considered abnormal and indicative of mental anguish or ill-health.[14] To prevent the outbreak of psychopathologies and effect a cure for nervous illnesses, an increasing number of psychoservices (psychotherapies, governmental information offices, self-help

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[11] Ahl Ahlberg et al, *Människokunskap och människobehandling*. 5. ed. (Stockholm: Natur och Kultur, 1954), "Förord."

[12] The SPA, *Vad gör psykologen?* (Stockholm: The SPA, 1985), 1; quoted in E. M. Rigné, *Profession, Science and State*, 37.

[13] Rigné, *Profession*, 215.

[14] Rigné refers to a situation in which "the reserved and practical boys and men who in their own eyes are perfectly allright and conforming to a masculine ideal, become problematic as seen by the women school psychologists and counsellors". Rigné, *Profession, Science and State*, 216n.

literature, etc.) became available in mid-century to alleviate the suffering and unhappiness of Swedes.

The construction of distinctively psychological forms of discontent was in tune with the increasingly secular, rational and pragmatic values of the Swedish society. Psychologised discontent could be managed, if not totally controlled and prevented, by scientific experts who were trained to help citizens, especially women and children, to adjust to their environment. Women were chiefly responsible for the healthy development of children, and they were given the task of bringing up their offspring in a way that would cause as little mental damage to the children as possible. In a situation where the authorities were interpreting the affective relationships within the family in psychomedical terms ('love, when it is not too overwhelming, is a healthy feeling', etc.), psychological expertise became a valuable tool for instilling new, science-based educational principles in the parents and educators, whose duty it was to help produce citizens who were sound in body and mind. The new, more emphatically psychological 'codes of conduct' prompted people to monitor their 'feelings' constantly, give interpretations of their distress, and put their faith in behaviour experts who allegedly knew what was good and what was bad for them. One significant medical effect of the psychologisation of the human condition was the increase in the number of people suffering from neuroses.

Although the older language of nerves and nervousness retained its cultural position in the interwar years, the changes in society and intellectual culture had an impact on the 'semantics' of this traditional language. One might say that, in the 1920s and the 1930s, ideas about neuroses began to be presented in a language that reflected the liberalisation and modernisation of Swedish society. Between the 1880s and World War I, purveyors of the language of nerves had usually been rather conservative, chauvinistic gentlemen who did not have a particularly high regard for the 'lower classes', the cognitive abilities of women, or 'nervous' urban life with its working-class culture, throng and fast pace. But in the following decades the paternalistic figures of the Pastor, the Army Officer, and the Gentleman were moved from the centre of the political and cultural arena and replaced by the figures of the Engineer, the Social Engineer (including behaviour experts), and the People—concerning the latter term, I initially used the term 'citizen' (*medborgare*) instead of 'people' (*folk*) here, but a further reading of the characteristic features of modern Swedish society led me to downplay the importance of the individual citizen and emphasise the collectivist,

organicist aspect of the *Folkhem* ideology, which addressed its message to the unitary folk or people rather than to citizens or individuals.[15]

In the interwar years, a new generation of nerve doctors, psychiatrists, social commentators and journalists started to interpret neuroses in a new light. To simplify, degenerationism, backward-looking conservatism and the French school of nerve-pathology became increasingly outmoded, while environmentalism, forward-looking liberalism (and socialism) and modern psychology (dynamic psychology, behaviourism) came more to the fore. Thus, Johannes Alfvén argued in 1933 that as hysteria was primarily caused by environmental, 'exogenous' factors, it could only be defeated through social reform of child-rearing and upbringing, family life, habits and values.[16] In 1950, Jakob Billström wrote in his book on the 'everyday care of our nerves' that "neurosis can almost be said to be a social illness insofar as its symptoms coincide with the relationship between the self and its surroundings."[17] Thus, in the new conceptualisation of nerves, it was the socio-psychological environment rather than heredity that was considered to be the main determining influence on the nervous system. This emphasis on environmental determinants was especially championed by those who had been influenced by European psychoanalysis and American behaviourism.

Psychology to the Masses

The emergence of psychoculture was facilitated by the publication of popular books on psychology, which started to be produced in surprisingly vast quantities in the 1920s. One of the most active advocates of things psychological in the interwar years was the new publishing house, *Natur och Kultur* ('Nature and Culture'). The publishing house was established in 1922 by the liberal-minded Johan Hansson, who represented an extraordinary mixture of a business-oriented entrepreneur and an Enlightenment figure whose ambition was to educate the general public.

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[15] On the collectivist, organicist aspect of the Folkhemmet ideology, see Zaremba, *De rena och de andra*.

[16] Johannes Alfvén, *Hysterien och dess psykologiska struktur* (Stockholm: Natur och Kultur, 1933), 160–2, 180–81.

[17] Jakob Billström, *Våra nervers vardagsvård*. 1st ed. 1934 (Stockholm: Lars Hökerbergs bokförlag, 1950), 14.

Hansson had wide-ranging interests, psychology among them, and he was keen to show that, contrary to Gustav Sundbärg's claim that the Swedes do not have any interest in psychology, psychological ideas had a fertile soil in Sweden. Thus one of Hansson's ambitions was to give his publishing house a high profile in the field of psychological literature, and his trips to the United States, the promised land of psychoculture, had made him realise that popular psychological literature did not yet exist as a genre in the Swedish publishing market. To fill this niche, *Natur och Kultur* started to publish psychological and psychodynamic books, and Hansson's circle of expert advisers included psychotherapist Poul Bjerre and the psychodynamic physician Iwan Bratt, whose books were published by *Natur och Kultur*.[18]

Natur och Kultur managed to reach a wide audience with its policy of publishing large editions and reprints in specialised series, which kept prices low. One of these series was called *Modern psychology*, and was by and large a success story for *Natur och Kultur*. For example, Poul Bjerre's most popular book, 'How to Heal the Soul' (*Hur själen läkes*, 1923), appeared in four editions and sold altogether 11,000 copies (or, 13,000 copies, if we are to believe Bjerre's own words).[19] Besides Bjerre and Bratt, *Natur och Kultur* published in the 1920s foreign authors such as Charles Baudouin, William McDougall, Alfred Adler, Ernst Kretschmer and Eduard Spranger.[20] In the 1930s and the 1940s, a number of C. G. Jung's writings were published, but the focus was now more emphatically on practical advisory books, which bore titles such as 'Wake Up and Live'; 'How to Win Friends and Influence People'; 'The Art of Living'; and 'You Have to Take it Easy'. Child psychology, a new specialty, was represented by the Swedish pedagogue Stina Palmborg (author of 'Difficult Children', 1935), and the famous Austrian psychologist Charlotte Bühler ('Practical Child Psychology, 1948). Palmborg's second book on children, 'The Blessed Youth' (*Välsignade ungar*, 1939), became a best-seller: altogether 14,000 copies of the book were printed, and it was received enthusiastically by the press.[21] And by the 1940s it was time for large psychological anthologies and dictionaries, the most prestigious

[18] Carin Österberg, *Natur och Kultur. En förlagskrönika* (Stockholm: Natur och Kultur, 1987), 82–3. On Bjerre's reminiscences of his relationship with Johan Hansson and *Natur och Kultur*, see Bjerre *Räfst- och rättarting*, 107–10.

[19] Poul Bjerre, *Räfst- och rättarting*, 152.

[20] Österberg, *Natur och Kultur*, 83–4.

[21] Ibid., 140.

of which was 'Psychological-Pedagogic Encyclopaedia' (*Psykologisk-pedagogisk uppslagsbok*), published in four volumes between the years 1943 and 1946. The book was a great success, as were the three anthologies on psychology and psychopathology that appeared during World War II.[22] In his 1942 overview of psychological literature in Sweden, Börje Cronholm observes that

> especially during the last twenty years a massive flood of psychological literature has swept across the country. An enormous number of books have come out, and they have not only sold well; [but] they have also been read and discussed.[23]

It would be fascinating to know who actually bought all these psychological books and read them, and what they thought of them.

Natur och Kultur was by no means the only publishing house in Sweden that marketed psychological literature, but its role in popularising psychology was instrumental. In his memoirs, Poul Bjerre devoted a chapter to the 'breakthrough of psychology' in Sweden, referring to the pioneering work of *Natur och Kultur* in the psychologisation of Swedish culture.[24] That books on psychology were often reprinted and talked about in the media shows that the Swedes, who had been portrayed as 'psychologically infantile' and 'uninterested in psychology' in Gustaf Sundbärg's book in 1911, had become rather avid consumers of psychological products twenty years later. Besides in psychological literature, this new science of Man was talked about on the radio, in newspapers and general interest magazines. The role of public broadcasting in enlightening the public and disseminating new ideas and values should be emphasised. Radio fulfilled an important social function in Sweden, and it was not only that by the 1930s there was a radio in most Swedish homes, but it was also the case that radio programmes reached a wide cross-class audience. And as one of the major objectives of the public radio was to enlighten and educate the people, presentations on the air by experts in various fields became one of the trademarks of Swedish Radio. Among the experts there were many physicians and specialists in human behaviour, and there is no doubt that their presentations on the air made Swedes more receptive to psychological

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[22] These books were *Människokunskap och människobehandling* ('Knowledge and Treatment of Man', 1941); *Själens läkarbok* ('A Medical Book on the Soul', 1943); and *Levnadskonstens bok* ('The Art of Living', 1944).

[23] Cronholm, "Den psykologiska litteraturen," 145.

[24] Bjerre, *Räfst- och rättarting*, 107–10.

ideas. For example, the radio broadcasting of the psychotherapist Iwan Bratt's lectures received wide attention.[25]

Psychiatrists and nerve doctors who were responsible for promoting psychoculture, were not always happy themselves with the way their patients and the *folk* in general had adopted psychological idioms and thought patterns. Psychiatrist Victor Wigert, for example, complained in 1932 that "tables at book shops are filled with scientific and popular books on 'neuroses', while novels and theatre concentrate with violent energy on psychopathological phenomena."[26] As a champion of 'mental hygiene', he saw this preoccupation with 'morbid' psychology as potentially detrimental to the mental health of the Swedes. As we have seen, leading psychiatrists and neurologists, Wigert among them, did not exactly rally to the psychotherapeutic flag, and what they certainly did not approve of was the suggestion that psychotherapy requires special skills in psychology that can only be acquired through special training. Even psychotherapist Geijerstam had a rather dim view of popular psychology, for he claimed that such literature was harmful rather than useful to neurotic people. He writes:

> Every now and then colleagues come up and ask me to write a popular book so that they would have something to give to a neurotic before they shoo him away. And I would rather not talk about neurotics who come begging for popular literature just because they resist real treatment.[27]

Cultural Popularity of an Inferiority Complex

In 1927, neurologist Nils Antoni made a pertinent comment on the transitory nature of many illnesses and ailments:

> The eighteenth century had its 'vapours', the nineteenth century its migraine and anaemia. The next generation will perhaps be tormented to the same extent by Freudian 'complexes' as our own age is tormented by 'nerves', cold, exhaustion and [high] blood pressure.[28]

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[25] Alfhild Tamm, Review of *Psykoanalysen i populär framställning*, by Federn, Meng and Bratt, *SLT* 27 (1930): 1592. On the early history of public broadcasting in Sweden, see Karin Nordberg, *Folkhemmets röst: Radion som folkbildare 1925–1950* (Eslöv: B. Östlings förlag, 1998).

[26] Victor Wigert, "Den psykiska hälsan måste vårdas!" SMT 9 (1932): 5.

[27] Emanuel af Geijerstam, "Något om den nutida psykoterapin i Sverige," 469.

[28] Nils Antoni, *Nervsjukdomar*, 156.

Antoni was right, even if the most popular complex of all time in Sweden was created not by Freud, but by his one-time disciple Alfred Adler, who argued that feeling of inferiority (and 'organ inferiority') causes neurosis.[29]

In the 1930s and the 1940s, the idea of 'complex' in general and 'inferiority complex' in particular became something equivalent to what 'weak nerves' had been at the turn of the century. References to an 'inferiority complex' became commonplace. Nerve doctor Torsten Lindner, for example, quoted a letter from his patient, a young primary school teacher, who prior to his visit to Lindner thought he was suffering from an 'inferiority complex'.[30] Some years later, his colleague Jakob Billström observed in turn that

> an 'inferiority complex' is a common complaint today. I once overheard a young mother reproaching her seven-year-old son by saying to him: 'But you must know that I have told you not to have any inferiority complexes.'[31]

'Inferiority complex' was one of the most popular psychocultural terms in Sweden from the 1920s to the 1970s. Already in the late 1930s, it had begun to be referred to by a colloquial short-hand term, 'miko' (derived from *mindervärdighetskomplex*, the Swedish term for 'inferiority complex'). In a popular women's magazine, a female professor noted the popularity of 'miko' and made some observations about the use of this colloquial word—apparently, she was inspired to write her article after someone had asked her whether she herself "had a miko".[32] In her 1941 radio presentation, a representative of the Association for Adult Education (Jeanna Oterdahl) focuses on the feelings of inferiority, of which she has given public lectures throughout the country. She notes that lecture halls have been full of people whenever the topic of her discussion has been 'feeling of inferiority', and that the audience has never been more attentive to her words than on these occasions. She believes the reason for this popular interest in 'the sense of inferiority' is that it is

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[29] See Bernhard Handlbauer, *The Freud-Adler Controversy*. Trans. Laurie Cohen (Oxford: One World, 1998).

[30] Torsten Lindner, "Ett fall av grav neuros med gynnsamt förlopp," *SLT* 33 (1936): 827.

[31] Billström, *Våra nervers vardagsvård*, 37.

[32] Alma Söderhjelm, "Har ni miko?" *Husmodern* Nr. 32 (1938): 39–40.

> not only an extremely common phenomenon, but also a phenomenon that is accompanied by so much discomfort that almost everybody is interested in getting rid of it.[33]

What further testified to the central importance of the 'inferiority complex' as a 'national complex' in Sweden was that Nils Antoni devoted his contribution to a collection of psychomedical essays (*Själens läkarbok*, 1943) to this complex.[34]

In addition to the wide dissemination of psychological ideas and terms among the general public from the 1920s onwards, there may be other, more characteristically Swedish aspects in this popular preoccupation with the feelings of inferiority. Poul Bjerre wrote in 1945 that he has often been consulted by depressed people who were tormented by feelings of guilt and inferiority.[35] Following Bjerre, I am tempted to conjecture whether these feelings were part of the Lutheran heritage, which centred on the individual's relationship with God, and which tended to generate feelings of guilt among the Lutherans who had doubts about the purity of their often rather stringent morality. As almost all Swedes were Lutherans until recent decades, it is conceivable that as a secularised version of the traditional Lutheran ethos of guilt and insufficiency, an idea of the inferiority complex stroke a very powerful chord in many Swedes, whose mental habits were shaped by forms of socialisation in which the rhetoric of guilt had traditionally played a conspicuous role. Another factor that may have played a role in the enthusiastic reception of the inferiority complex was the rather widespread assumption that the 'most common vice' among the Swedes was envy, or the 'Royal Swedish Envy', as it was sometimes called.[36] The public cultivation of the less than flattering 'folkloristic' suggestion that the Swedes viewed outstanding individuals with a jaundiced eye may have contributed to the idea that the feelings of envy correlate with the feelings of inferiority. A comparative analysis of the 'life cycle' of the inferiority complex in other Lutheran societies (e.g. Finland, Denmark or Northern Germany) might shed some light on this phenomenon.

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[33] Jeanna Oterdahl, "Mindervärdeskänslor," in *Vardagens psykologi* (Stockholm: Aktiebolaget Radiotjänst, 1941), 154.

[34] Nils Antoni, "Mindervärdeskomplex," in John Agerborg et al., *Själens läkarbok*, 153–80.

[35] Bjerre, *Räfst- och rättarting*, 255–6.

[36] In her presentation on inferiority feelings, Jeanna Oterdahl sees envy as an indication of the "sense of inferiority". Oterdahl, "Mindervärdeskänslor," 162.

But I shall focus next on the ideas of a physician and a psychotherapist who was a paradigmatic representative of the new psychocultural spirit in Sweden.

Iwan Bratt and the Neurotic Culture

One of the most determined advocates of psychomedical ideas in Sweden was Iwan Bratt (1881–1946).[37] He earned his living as a town physician in a small town called Alingsås west of Gothenburg, and, together with his wife Signe, he opened a nursing home for the nervously ill around 1930. Like Bjerre, he popularised psychodynamic ideas, affirmed non-doctrinaire religiosity, and gave cultural interpretations of neurosis. In his obituary of Bratt, psychoanalyst Gunnar Nycander employed Kretschmer's typological jargon in describing Bratt as a "cyclothymic pyknic"[38] (In his earlier writings, Bratt, like many other Swedish doctors, had been influenced by Kretschmer. He even wrote in a letter to the psychoanalyst Paul Federn that it was the rather unpsychoanalytic Kretschmer who had introduced him to psychoanalysis).[39] Nycander also claims that, as a student, and even later, Bratt suffered from severe neurasthenic tiredness which prompted him to consult Emanuel af Geijerstam, who then became his analyst and friend.[40] This positive experience made him study psychoanalysis in Germany with Georg Groddeck, a nerve doctor who was an extreme psychosomaticist (for Groddeck, the Unconscious was the source of both illnesses and accidents). If we are to believe Nycander, Bratt's ideas especially in his earlier writings were subjected to moral reading and proclaimed as absurd and dangerous to 'public morals'. Unfortunately, Nycander does not specify the identity of Bratt's opponents, but it seems plausible to think that his ideas were not very warmly received in the conservative and religious circles.

Bratt 'broke through' in the medical community in 1924 when he published an article in The Journal of Swedish Medical Association,

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[37] On the life and work of Iwan Bratt, see Luttenberger, *Freud*, 331–6.

[38] Gunnar Nycander, "Iwan Bratt," *SLT* 43 (1946): 2770–2.

[39] Luttenberger, *Freud*, 336.

[40] Bratt wrote an obituary of Geijerstam to *Svenska Läkartidningen* (Journal of the Swedish Medical Association), which indicates that he had a close relationship with a pioneer psychotherapist. See Iwan Bratt, "Emanuel af Geijerstam In memoriam," *SLT* 25 (1928): 657–9.

in which he argued that most neuroses arose from disturbances in emotional life. Thus the most appropriate therapeutic method in the treatment of neuroses would be psychotherapy.[41] In 1924, this commonplace idea was still anything but universally accepted by his professional peers, who were not especially keen on psychological interpretation and therapeutics. His article caught the attention of the editorial office of *Dagens Nyheter*, one of the leading newspapers in Sweden, and, in September 1924, the question as to whether Swedish physicians neglected psychotherapy to the benefit of quacks was posed on the front page of the newspaper.[42] In addition to publishing a summary of Bratt's article, *Dagens Nyheter* had asked four doctors to give expert comments on it. This lavish publicity that Bratt's rather uncontroversial article received made him the first psychotherapist after Poul Bjerre to become something of a celebrity in Swedish mental medicine (in the years to come, he treated such famous Swedes as the female writer Karin Boye, who committed suicide). At *Natur och Kultur*, a publishing house that was on the look out for new currents and fashions in the psychomedical field, Bratt was welcomed with open arms. It was surely no coincidence that *Natur och Kultur* published all his six books which represented, and contributed to, modern psychoculture. He became one of the most well-known doctors in Sweden, despite his rather low official status as a general practitioner (town physician) and head of a nursing home in a small provincial town.

Culture and neurosis

Bratt's first book, 'Culture and Neurosis' (*Kultur och neuros*, 1925), was one of *Natur och Kultur*'s best-selling non-fiction books in the interwar years.[43] The book seemed to capture the new spirit of modernity that sought inspiration in urban culture, liberal individualism, non-confessional spirituality, dynamic psychology and a culturalist or environmentalist perspective that downplayed heredity and biology, and emphasised the malleability of humans and the influence of social structures on the development of personality. In its fusion of psychology-informed

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[41] Iwan Bratt, "Om frågeställningen inför vissa sjukdomssymtom och konsekvenserna därav för behandlingen," *SLT* 21 (1924): 841–8.

[42] *Dagens Nyheter*, September 9, 1924. The four doctors consulted by the newspaper were Ada Nilsson, C. V. Söderlund, Josua Tillgren and Johannes Alfvén.

[43] Iwan Bratt, *Kultur och neuros* (Stockholm: Natur och Kultur, 1925).

cultural critique and the Rousseauean-utopian glorification of the great potentialities of 'inner nature', his book was a sign of the new times. The book's subtitle—'On the Necessity of a Transformation of Life Forms'—betrays his adherence to a psychological utopianism that sees inner transformation as the solution to 'cultural crisis'.[44]

In his preface to the book, Bratt explains why he has been occupied for years with the relationship between culture and neurosis: when a doctor searches for the causes of neurosis, he soon finds out that, in most cases, neuroses are triggered by the patients' difficulties in adjusting themselves to their milieu. And as 'milieu' is identical with 'culture', a doctor is forced to become a critic of culture. Here Bratt represents a new kind of 'social psychiatry': instead of blaming the neurotic or psychopathic patients for their 'deviancy' from the established social order and taken-for-granted norms, as Swedish psychiatrists used to do, he sees society as the culprit. Thus Bratt was one of the first Swedish authors who formulated, albeit vaguely and without any clear intellectual framework, the notion of the Sick Society, which had begun to be articulated in the late 1920s and the 1930s by such Freudo-Marxist psychoanalysts as Wilhelm Reich and Erich Fromm (who later wrote a book called *The Sane Society*). But in the mid-1920s, most instances of cultural critique in the west were still rather conservative lamentations about the technology- and rationality-obsessed Modern World that had made life spiritually and morally impoverished (C. G. Jung, for example, represented this older type of cultural critique). Bratt was not a socialist, but he endorsed a radically different view of humans than most of his colleagues in Sweden. To simplify his basic philosophy, he saw the 'inner self' and 'instinctual life' as something to celebrate and embrace rather than suppress and control—as long as the one who celebrated his or her 'instinctual life' was not homosexual: like most of his colleagues, he pathologised homosexuality, by interpreting it as a "compulsion neurosis" that was to some vulnerable people a "contagious illness".[45] Notwithstanding his conventional psychomedical formulation of homosexuality, it was probably his liberal attitude

[44] On psychological utopianism, see Petteri Pietikainen, "Dynamic Psychology, Utopia, and Escape from History: The Case of C. G. Jung." *Utopian Studies* 12:1 (2001): 41–55; "Utopianism in Psychology: The Case of Wilhelm Reich," *JHBS* 38:2 (2002): 157–75; "'The Sage Knows You Better Than You Know Yourself': Psychological Utopianism in Erich Fromm's Work," *History of Political Thought* 24:1 (2004): 86–115.

[45] Iwan Bratt, Review of *En sjukdom som bestraffas*, by Gunnar Nycander, *Hygiea* 97 (1934): 152–8.

towards (hetero)sexuality, more than anything else, that many readers of his book found most appealing.[46]

Bratt's thesis in his book is that as neurosis is a mass phenomenon and a national malady (*folksjukdom*) in Sweden, there must be something wrong in the social arrangements that produce neuroses on a mass scale. He holds two institutions to be particularly harmful to mental health: the Church and the educational system, especially school. In its suppression and condemnation of the sensual side of personality, and in its intolerant attitude in general, the Church (and organised Christianity as a whole) has been one of the principal causative factors in neurosis. However, despite his critical remarks on the damaging psychological influence of organised religion, Bratt was not anti-religious, since he believed that it was not only the suppression of (sexual) instincts and the concomitant formation of complexes that gave rise to neuroses, but that the suppression of the moral and religious side of the personality could also trigger neuroses.[47] Like Jung, Geijerstam, Bjerre and other representatives of 'synthetic' or 'anagogic' psychoanalysis, he believed that there was an innate moral sense in the unconscious psyche, and that a violation of innate morality (e.g. in the form of debauchery or deceit) might result in a conflict between the (immoral) conscious mind and the unconscious, the matrix of moral emotions. In his view, it was the Church, more than any other social institution, that had nurtured the principles of love and compassion in human life.

As for school, Bratt believes it was unfortunate that Sweden used the authoritarian Germany as a model when it developed its educational system. As a result, Swedish schools put a premium on obedience and discipline, which inoculate pupils with fear and terror. Furthermore, in their one-sided stress on the acquisition of knowledge and the cultivation of the cognitive side of the personality, schools have neglected the cultivation of the emotional life of children. In consequence, schools in Sweden are filled with nervous children who are afraid of teachers and anxious about doing their homework properly. In trying to meet all the demands thrust upon them, they have to lead a life that is unnatural for them. Their inner fragmentation makes them nervous, and if the healing powers of nature do not cure them (they often do),

[46] Swedish historian Franz Luttenberger regards Bratt as an important pioneer in the sexual liberation of the 1930s. Luttenberger, *Freud*, 335.

[47] Bratt, *Kultur och neuros*, 80.

these nervous children will grow up to be nervous adults.[48] The reason that schools insist on developing intellectual skills in children is that the core values in society are materialistic: to make money is the ultimate goal in a society run by economistic principles which require people to be engaged in the economic struggle, even if there is no longer an acute need for such an engagement. The economic struggle has become an instinct, a second nature to humans. Betraying his Rousseauean-Romantic frame of mind, he reminds his readers that "people do not understand that the kingdom of heaven is to be searched within themselves and not in the external goods of life."[49] If schools changed their educational principles and took it upon themselves to provide opportunities for the 'gymnastics' and 'orthopaedics' of the emotional life and the will of each individual child, they would make a crucial contribution to the development of people who would be whole, strong, capable and glad.[50]

Bratt's solution to neurotic culture or cultural crisis is the transformation of life, no less.[51] Far from seeing such a transformation as a utopian pipe-dream, he believes that Sweden and the western world stand at the gates of a better world. What is required to enter the New World is a co-operation between instinctual, moral, religious and intellectual forces. In fact, there is a process of transformation going on in the secularised modern world, where both the Church and the family have lost their significance as foundations of society; where married women enter the labour market in increasing numbers; and where more and more children are reared in kindergartens and educated in schools. A manifestation of the on-going transformation is the changing role of physicians and pastors in Protestant countries, where psychologically-trained doctors are replacing pastors as caretakers of the soul (*själasörjare*). This medical annexation of the soul forces pastors to consider new ways of avoiding marginalisation, and, for Bratt, the most natural solution to the challenge of medicalised *Seelsorge* is that pastors start to co-operate with physicians. Pastors have to become medically trained, for it is the only way they can differentiate between somatically and psychically determined illnesses. They also need training in the humanities and psychology in order to understand people who

[48] Ibid., 69–72.
[49] Ibid., 73.
[50] Ibid., 79.
[51] Ibid., 113–26.

consult them in their proper historical and cultural contexts. Should a co-operation between pastors and physicians succeed, the spiritual fragmentation of Protestant countries could be healed by a new spiritual power, medical psychology. As a modernised version of *Seelsorge*, medical psychology would be in a position to make an impact on the future transformation of life.[52]

In Bratt's vision of the Good Life, psychologically-oriented doctors and pastors would together form the vanguard of social change and the spiritual power that would heal neuroses and resolve cultural crisis. It is not clear to the reader how medical psychology à la Bratt could actually prevent neuroses and not just (try to) heal them, but what is clear is that in the 1920s his message appealed to many educated Swedes, for whom science was a more trustworthy cultural authority than the Church, but who also shunned radical political solutions that might threaten the foundations of the social order and worsen their own social position. His 'psychomedicalism' notwithstanding, Bratt appears as an enlightened and liberal thinker, who championed individualism, educational reforms and tolerance, but who did not go so far as to propose radical changes in social arrangements (as Wilhelm Reich was to do some years later when he advocated the abolition of the family and the patriarchal social order). And despite his accusations against the Church, he saw reformed religiosity as the supreme value in life. Bratt's vision is a moderate, well-mannered vision that the educated middle-classes could hardly find offensive or extreme. As Jakob Billström put it in his review of one of Bratt's later books, Bratt took pleasure in shocking his readers through his attempts to appear more 'dangerous' than he actually was.[53] Those who might have regarded some of Bratt's ideas as dangerous included conservative churchmen, who did not want to transform the Church into a therapeutic institution, and authoritarian school teachers, who did not want to spoil the child by sparing it the rod. In general, it was the conservative segment of the population that obviously looked with disdain at Bratt's cultural critique. But as the traditional conservatives were becoming a less and less powerful social force in Sweden, it meant that there were more and more people who were on the same mental wavelength as Bratt, as it were. Bratt offered

[52] Ibid., 122–5.
[53] Jakob Billström, Review of *Det svenska missnöjet*, by Iwan Bratt, *Hygiea* 98 (1936): 90.

useful, up-to-date psychological tools for a reformist cultural critique that looked forward rather than backward, as much of Swedish (and western) discourse on 'cultural crisis' had done so-far. It would be too much to claim that his book inaugurated a new, psychology-inspired era in Sweden, but it is certainly the case that it represented a new *Zeitgeist*, a *Zeitgeist* which, to use Bratt's own idiom, 'sought salvation' in psychological well-being.

'Culture and Neurosis' sold very well, and it was well-received by the press. Jakob Billström wrote in his short but positive review of Bratt's book that "this book has become a real best-seller and is much-discussed among the general public."[54] When Billström reviewed Bratt's second book in 1928, he observed that Bratt was now competing with Bjerre in terms of popularity and prestige.[55]

Bratt's later books

After 'Culture and Neurosis', Bratt wrote five more books, all published by *Natur och Kultur*. Here I shall refer briefly to some of the themes that he raises in these books, starting with 'Fragmentation and Unity' (1927) his sequel to 'Culture and Crisis'. In his second book, Bratt examined religion from the psychodynamic perspective and discussed the "transformation of personality" that he saw as being an intrinsic part of the healing process of neurosis. He now defined neurosis as a fragmentation of mental life,[56] and contrasted this with wholeness and unity of personality, which could be achieved through psychoanalytic treatment. Echoing Nietzsche, he referred to the "transformation of values" that would inaugurate a new culture with a new "formation of life".[57]

Neurosis was similarly at the centre of attention in Bratt's next book, 'The Problem of Neurosis in the Light of Psychoanalysis' (1930).[58] On the front cover there is a short blurb that cogently illustrates Bratt's psycho-utopian approach to 'culture and neurosis': "Psychoanalysis,

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[54] Jakob Billström, Review of *Kultur och neuros*, by Iwan Bratt, *Hygiea* 87 (1925): 845.

[55] Jakob Billström, Review of *Splittring och enhet*, by Iwan Bratt, *Hygiea* 91 (1929): 202.

[56] Iwan Bratt, *Splittring och enhet i människans väsen* (Stockholm: Natur och Kultur, 1927), 9.

[57] Ibid., 111–12.

[58] Iwan Bratt, *Neurosproblemet*.

when it is rightly applied, will create healthier and happier people, and give a new form to our whole culture." By now Bratt had read Wilhelm Reich, who became one of his main sources of inspiration for the rest of his life.[59] Not only his views on sexuality as the primary life-giving force, but also, for instance, his later critical comments about the 'patriarchal social order' owe a great deal to Reich's formulations. He may have met Reich in Oslo (the capital of Norway), where Reich lived between 1934 and 1939. He regarded Reich as a psychoanalyst who had done more than others to complete Freud's work.[60] In his new references to the 'basic forces' of life,[61] one can even see connections with Reich's ideas on the crucial significance of the vegetative nervous system that Reich developed in Norway in the 1930s. By now he also adhered more closely to Georg Groddeck's radical psychosomatic ideas, which he discussed and developed in his later writings.

In 1935, Bratt published a book on 'Swedish Discontent'.[62] In the preface to the book he puts forward his main thesis: the roots of our illness are often to be found within ourselves, in our ideals and traditional values that were created under wholly different circumstances. Due to the vicissitudes of history, these values can no longer be regarded as self-evident.[63] In his book, he offers an impressionistic psychoanalytic 'genealogy of the Swedish mentality' that aspires to shed light on the psychic constitution of contemporary Swedes. He sees the Oedipus complex and the authorities' fight against sexuality as prime factors moulding the Nordic mentality, which is more neurosis-prone than the 'Southern', Mediterranean mentality. He contrasts the carefree 'southerners' with the serious-minded Swedes who readily become lost in thought, are tormented by anxiety, and end up being mentally disoriented and sick in their character.[64] "What I believe I have found,"

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[59] However, Bratt does not yet mention Reich by name when he lists his sources of inspiration, which include Freud and his followers (including Reich, for sure), Geijerstam, Bjerre, Groddeck, Kretschmer, Jung, Stekel and the 'Adlerian School'. Bratt, *Neurosproblemet*, 116. As can be seen from this list, Bratt, like his friend and mentor Geijerstam, had an eclectic approach to different psychodynamic 'Schools'. Bratt discussed the significance of Reich's theories to his own understanding of neurosis in a paper published in 1943. See Iwan Bratt, "Om psykoanalysens verkningssätt," *SLT* 40 (1943): 698–708.

[60] Iwan Bratt, "Att bryta vanor," in *Själens läkarbok*, 267.

[61] Bratt *Neurosproblemet*, 9.

[62] Iwan Bratt, *Det svenska missnöjet* (Stockholm: Natur och Kultur, 1935).

[63] Ibid., 3.

[64] Ibid., 27.

writes Bratt, "is that sexual disorganisation is the primary reason for the Swedish discontent."[65] The mood in these passages is similar to that in many of Ingmar Bergman's films, which are not exactly celebrations of the 'Swedish mentality'. Indeed, in his reminiscences of his childhood in a religious home, Bratt's tone resembles that of Bergman in his autobiography *The Magic Lantern*:

> I was a rather nice little boy, but had a very strong feeling that I could not meet the strict demands for righteousness that I had set for myself. Each night I was tormented by a fear of death, because I always had sins on my conscience that I had not confessed to anyone. And was I to die, well then, I would be condemned to eternal damnation.[66]

A synthesis of most of the ideas, theories and assumptions that Bratt had adopted over the years is his last book, published posthumously, entitled 'One Thing Is Necessary' (*Ett är nödvändigt*, 1946).[67] As he states in the preface, the book is the result of his strong need to put into words his own experiences, reactions and reflections as a practising physician. His last book has a distinct 'Brattian' stamp on it, for he makes sweeping statements about morality, sexuality, upbringing and education, mental illness, neurosis, psychosomatic medicine, the mentality of the Inuit people ('Eskimos'), the patriarchal society, the Church and the development of the human personality. What is new in the book is his ambition to see all these phenomena in the context of 'human reactions', by which he means a specific Reich-inspired psychosomatic approach, revolving around the vegetative nervous system and the role it plays in the mental constitution, affecting emotions, reason and the will. His enthusiasm for the vegetative system and Reichian 'vegetotherapy' is apparent in his new understanding of the outbreak of neurosis, which he relates to "disturbances in the normal rhythmics of the vegetative life". Of such disturbances, by far the most important are sexual disturbances.[68]

True to his original thesis about the 'neuroticising culture', which by the mid-1940s had become a more accepted and less radical idea, Bratt conjectured that "seventy-five percent of people who consult physicians are damaged by the spirit of society" as result of the reactionary

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[65] Ibid., 28.
[66] Ibid., 29. See also his short reminiscences of his childhood in Bratt, "Att bryta vanor," 263–4.
[67] Iwan Bratt, *Ett är nödvändigt*.
[68] Ibid., 73.

educational tradition; and that at least fifty per cent of patients suffer from neuroses.[69] And he remained a moderate psycho-utopian to the very end: he stated that the New World is attainable only through an inner transformation, which is triggered by a specific therapeutic "re-education of the organism" leading to a new way of feeling, thinking and willing.[70] But Bratt was not Reich—a few pages after delineating the New Man, he notes that medical psychotherapy has the same purpose as religious influence, namely a re-formation of the 'inner structure', in a way that makes an individual better *adjusted* both to the demands of inner (vegetative) and outer (social) demands.[71] Thus, it is the 'healthy' adjustment to society rather than society's transformation that is the goal of his 're-formation' and 're-education'. With this reformist thesis, he was closer to the contemporary American therapeutic ideology of adjustment than Reich's psycho-utopianism that had as its ultimate goal a thorough transformation of both the structures of the personality and the structures of society.

When Bratt's first book was published in 1925, Sweden was on the threshold of a new psychological culture, a culture in which behaviour experts would be entrusted with the task of educating citizens to right living, and of minimising the damage caused by ignorance, bad parenting, authoritarian education and obsolete normative codes that kept people tradition-bound. By the time Bratt's last book came out (1946), the era of psychoculture had fully emerged in Sweden. Through his popular books and his reputation as a healer, Bratt himself was a pivotal figure in this change towards a more permissive, tolerant and expert-driven culture, in which masters of psychological reality functioned as executors of the enlightened social policy of the developing welfare state. According to the specifically Swedish, state-oriented variant of psychoculture, neurosis was to be eradicated with the help of a scientific, carefully-executed 'management of people' (*människobehandling*). But what actually happened was that in the social-democratic *Folkhem*, neurosis became a more, not less, wide-spread malady.

[69] Ibid., 175–76, 179n.
[70] Ibid., 214.
[71] Ibid., 220.

The Management of Mind

Given the fact that psychology was becoming a more important element in Swedish society, it is quite surprising that the first chair of psychology was established only in 1948 (in Uppsala). But when the door to psychological expertise was unlocked, it signified an expansion of psychology in academia.[72] Within a time span of five years (1948–1953), three more chairs of psychology were established at different universities. In 1990, there were no less than twenty-two professors of psychology in Sweden. The number of psychologists increased quickly in a few decades, making Sweden, according to certain estimates, the second-most 'psychologist-dense' country in the world by the 1980s.[73]

A few years before the institution of psychology as an independent academic discipline, the Psychotechnic Institute (*Psykotekniska Institutet*) had been established at Stockholm University College for the purpose of developing and administering psychological testing, to be used mainly in industry, business and working life in general. As an applied psychology, Swedish psychotechnics was part of the larger scientific management or social engineering of society developed and supported by the welfare state. 'Management' or 'government' of people became one of the catch phrases of the 1940s, and psychology, which until then had been part of the larger field of pedagogy, began to occupy a more central position as a tool for constructing and 'renovating' the 'home of the people' (*Folkhem*).[74] At the Psychotechnic Institute, almost 100,000 tests were conducted between 1944 and 1969 in order to quantitatively determine the practical and intellectual personality traits of people.[75] As the professionalisation of psychology in Sweden goes beyond the scope of this book, I shall not examine this fascinating process here. Instead, I shall examine the psychological ideas of one of the principal public intellectuals of twentieth-century Sweden: Alva Myrdal.

The conviction that psychology would contribute to the production of a 'new edition of humans' became an intrinsic aspect of the ideology

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[72] For an insightful analysis of the ways in which modern psychology found its language, see Danziger, *Naming the Mind*.

[73] Rigné, *Profession, Science and State*, 242–5.

[74] Rikard Eriksson, *Psykoteknik. Kulturell fabricering av personlig identitet* (Stockholm: Carlssons Bokförlag, 1999), 72. See also Valdemar Fellenius, "Praktisk psykologi," in *Handbok i psykologi*, ed. David Katz (Stockholm: Svenska Bokförlaget, 1950), 445–65 (Valdemar Fellenius was head of the Psychotechnic Institute).

[75] Eriksson, *Psykoteknik*, 133.

of Swedish social engineering that was reinforced in the post-war era, when the practical goals of the first generation of *Folkhem* politicians began to be realised. Among the principal architects of the welfare state were Alva and Gunnar Myrdal, who embodied the forward-looking, pragmatic rationalism of Swedish social democracy. National economist Gunnar Myrdal wrote, among other things, an important two-volume book on the discrimination of African-Americans in the United States (*An American Dilemma: The Negro Problem and Modern Democracy*, 1944), while Alva Myrdal, an influential opinion-builder and a model for educated women in Sweden, assigned an important social role to psychology. She studied psychology and pedagogy (e.g. in Geneva under the tutorship of Jean Piaget), worked at a forensic-psychiatric clinic and, from 1936 to 1948, was rector of the Social-Pedagogic College in Stockholm. While still a student, her plan had been to write a licentiate thesis (a sort of proto-version of a doctoral dissertation) on Freud's theory of dreams, but external factors intervened and she gave up her plan. Later in life, she held a number of high-ranking posts in the United Nations and UNESCO, worked as Sweden's ambassador to India, and became a member of the Government in 1966. In 1982, she was awarded the Nobel peace prize (Gunnar Myrdal had already been awarded the Nobel prize in economics in 1974).[76]

In 1945, Alva Myrdal contributed to 'The Social Yearbook' (*Social Årsbok*) with an extensive essay in which she suggests that psychology should be included in the curricula of various educational programmes in different public institutes. The type of psychology she has in mind is empirical social and developmental psychology, a kind of psychology that is considered practical and applicable to various social contexts. Her partisan attitude becomes clear in the very first sentence of her essay:

> Probably the greatest, if also only dimly perceived, revolution in the mode of thinking of our time is the transition from a moralising and judgmental conception of humans to a psychologising and understanding conception.[77]

Myrdal goes on to predict that when this transition is complete, psychology will be seen as characterising the modern epoch in the same

[76] Per Thullberg, "Myrdal, Alva," in *Svenskt Biografiskt Lexicon* (Stockholm: Norstedts, 1989), Vol. 26, 161–72.

[77] Alva Myrdal, "Mer människokunskap," 114.

fundamental way as the 'Enlightenment' or 'Romanticism' characterised their respective epochs. She discerns similarities between the coming age of psychology and the era of Enlightenment, since both of these periods have witnessed the liberation from 'prescientific thinking', exemplified in magic and superstition.[78]

As proof that her own age is becoming the Age of Psychology, Myrdal refers to the proliferation of psychological novels and popular books on psychology; to the growing number of young people who want to study psychology; to the new emphasis on psychological methods at home and in school; to the social welfare services and institutions where an awareness of the need for modernisation is growing; and to the army officers who have discovered the value of what they call 'care of the troops' (*manskapsvård*), and who even demand the recruitment of specially-trained psychologists (in the 1950s, the concept of 'psychological defence' was a widely-used psychocultural term in the Army).[79] And, inevitably, she also refers to the most popular psychocultural 'complex' of her time: "Notions that an inferiority complex can dominate an individual's reactions have started to surface even in the most trivial conversations."[80]

As an acute observer, Myrdal does not fail to notice that "a more psychological approach is breaking through everywhere".[81] She proposes that the established forms of training in social, pedagogical and medical lines of work should be complemented by a state institute for mental hygienic education, where students would be engaged in first-class therapeutic and research activity, and where they would be in close contact with children's authentic environment. The students would also observe the adult 'end-products' of poverty, partial disability, alcoholism, mental illness and criminal life and, if possible, "learn how to observe neurotic adults in their everyday social settings".[82]

Myrdal preferred pragmatic psychological knowledge to theoretically ambitious but impractical psychological systems, such as psychoanalysis. In her view, the onset of neuroses should be prevented by beneficial supervision and by the surveillance of citizens in their social environment. When people go to see a doctor in order to be cured of their

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[78] Ibid.
[79] Eriksson *Psykoteknik*, 164.
[80] Myrdal, "Mer människokunskap," 115.
[81] Ibid.
[82] Ibid., 136.

mental afflictions, it shows that society has already failed in its task of producing healthy citizens. And the duty of psychology is to minimise the number of neurotics, who are a living testimony to the failure of society to create conditions that would make neuroses disappear. The ultimate task is to find a psycho-social equivalent to penicillin, something that would root out one of the major *folksjukdomar* ('national maladies') in Sweden.

Myrdal's views on the importance of applied psychology for the prevention of neuroses was shared not only by psychodynamically-oriented physicians, but also by doctors who did not necessarily endorse psychoanalysis or any other version of dynamic psychology, but who nevertheless argued that psychological insights were valuable in the treatment of neuroses. A number of articles on the value of psychology for medicine was published in The Journal of Swedish Medical Association in the 1940s. One article was written by Arnold Josefson, no friend of psychoanalysis, who observed in 1946 that the general public's hunger for psychotherapy was so strong that they uncritically turned to virtually anybody who claimed to be a 'doctor of the soul' (*själsläkare*). This badly-felt need for a psychological understanding of people's problems, and of human behaviour in general, made it imperative for physicians to learn psychology. He proposed that all medical students should attend compulsory lectures on psychology before they begin their internships at hospitals.[83]

Even though the number of doctors who advocated a more psychological orientation in medicine was growing, the suggestion that psychologists could be trained to work clinically did not find approval in the medical community.[84] In the 1940s, there were only a handful of psychologists working in the field of psychiatry, and none of them was engaged in a therapeutic work, which was the exclusive domain of medically-trained psychiatrists. When an official commission was set up to explore questions concerning the academic education of psychologists in the early 1950s, the medical faculties rejected the suggestion that

[83] Arnold Josefson, "Behöver läkaren orientering i psykologi och dess arbetsmetoder?" *SLT* 43 (1946): 2756.

[84] One psychologist who discussed the negative medical attitude towards the suggestion that properly-trained psychologists should be allowed to work clinically was Torsten Husén. He argued that a clinical common ground for a co-operation between doctors and psychologists would be the therapy of neuroses. Torsten Husén, "Samarbetet mellan läkare och psykologer," *SLT* 45 (1948): 281–7; and "Psykologerna och psykologutbildningen," *SLT* 46 (1949): 2359–69.

psychologists should take a more active role in medicine, or become competent in psychiatry, without medical education. Heads of medical faculties made it absolutely clear to the commission that psychologists should not be allowed to become engaged in therapeutic activity.[85] But the medical resistance against the creation of clinical psychology as an institutional form of psychomedical expertise was to no avail. Clinical psychology was established as an independent discipline in the late 1950s, and by the mid-1960s there were already 350 certified clinical psychologists in Sweden.[86]

In its academic, clinical and popular forms, psychology became an intrinsic component of the post-war Swedish social machinery, and psychologists became behaviour experts who facilitated social changes by helping citizens to cope with new demands and challenges. One of the main reasons why psychological knowledge or claims-making was given such a visible role in Swedish society was that psychologists were perceived by the authorities to be engineers of the soul, who were useful in the socialisation of individuals into a society that was transforming itself. As social scientist Erik Ringmar notes,

> modernization produces shocks because it constantly forces societies to change. Pre-modern societies were not static, to be sure, but in modern societies change is more frequent, more restless, and more dramatic. For a society, change poses a problem since it requires a high degree of flexibility on the part of individuals and groups.[87]

One way of reducing the power of these shocks of modernity was to make individuals and groups more flexible, less prone to neuroses and other debilitations that were considered to be at least partly the reactions of individuals to social changes. In this process, various social institutions and fields of governance became 'contaminated' by psychological ideas and beliefs.

In Sweden, as in the western world as a whole, neurosis and its more colloquial equivalents, such as nervousness or weak nerves, became a symbol of a psychologised malaise 'managed' by behaviour experts. As a result of socio-cultural changes in Sweden, the psychomedical management and treatment of behaviour complemented the traditional moral

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[85] Bengt Erik Eriksson, "Behövs psykologer?" in *Psykiatrins marginaler*, ed. Qvarsell and Eriksson, 163–80.

[86] Börje Cronholm, "Psykologerna," in *Modern svensk psykiatri*, ed. Gunnar Holmberg et al. (Stockholm: Almqvist & Wiksell, 1968), 240.

[87] Ringmar, "The Institutionalization of Modernity," 27.

and legal forms of governing the behaviour of citizens, while a therapeutic, seemingly non-judgmental approach to 'deviancies' replaced the authoritarian control of marginal groups in society. Consequently, neurosis became a widely-applied psychocultural term that signified the extent to which society had failed to produce healthy citizens. Neurosis not only survived the transition from the Age of Nervousness to the Age of Psychoculture, it absolutely thrived in the new, psychology-inspired environment, where people had 'complexes', and where they increasingly suffered from 'psychic conflict' or 'trauma' rather from weak or shattered nerves.[88]

From the 1940s onwards, the new experts in and commentators on the neuroses were psychotherapeutically-oriented psychiatrists, religious care-takers of the soul, clinical psychologists and social workers. Members of these professional groups often identified themselves as promoters and servants of the welfare state, who contributed to the "realisation of the truly humane, caring and care-taking society".[89] Inadvertently, they were following the advice that Alva Myrdal gave in her paradigmatic essay on psychology in 1945:

> In a much more consistent and goal-directed way [than used to be the case], we have to start producing harmonious people in order to establish a culture that is less neurotic.[90]

[88] The origin of the language of psychic or emotional trauma goes back to Charcot and his (one-time) students, especially Pierre Janet and Sigmund Freud. On Janet's late thoughts about 'traumatic reminiscences', see Pierre Janet, "Inledning," in Leonhard Schwartz, *Neurasthenien: De nervösa tillståndens uppkomst, förklaring och behandling* (Stockholm: Natur och Kultur, 1941), 11–22.

[89] Rigné, *Profession, Science and State*, 57.

[90] Myrdal, "Mer människokunskap," 162.

PART III

DOCTORS, PATIENTS AND THE STATE

CHAPTER EIGHT

ON THE SHATTERED NERVES OF DR LENNMALM'S PRIVATE PATIENTS

> A physician who treated me for some time as if my nerves were sick finally said: 'It's not your nerves, it is rather I that am nervous' (Nietzsche, *Ecce Homo*).[1]

So far, this book has not given voice to the patient. I have mainly examined sources which cast light on ideas, assumptions, cognitive commitments and values of one particular group of professionals, physicians. Such a physician-centred approach gives a somewhat one-sided picture of medical history, for it takes two to make a medical encounter. A doctor needs patients, and a diagnosis is always a diagnosis of a living person with whom the doctor is interacting. This is a truism, but it needs to be spelled out and underlined, because patients or, more aptly, sufferers played only a minor role in medical history until the end of the twentieth century. In 1985, Roy Porter published a programmatic article in which he argued for a medical history that is done "from below", from the patient's view.[2] What needs to be done, said Porter, is to start developing a patient-oriented or sufferers' history, a history which analyses sickness experience and response.

Most historians of medicine would probably endorse Porter's very reasonable plea, but they might also point out that it is easier said than done, because we can only learn about patients through the eyes of doctors. As patients' experiences are filtered through the mind and pen of a doctor, the authentic voice of the patient is hardly heard. Porter acknowledged this problem, but he also gave a list of sources which, for a historian, directly reveal the experiences of the sufferer: diaries, letters, recipes, autobiographies and other documents that are

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[1] Friedrich Nietzsche, *Ecce homo*. Trans. Walter Kaufmann (New York: Vintage Books, 1989), 223 [Original German edition 1908].

[2] Roy Porter, "The Patient's View: Doing Medical History from Below," *Theory and Society* 14:2 (1985): 175–98.

valuable records of "pain, self-examination, self-medication, regimen, and resignation".[3]

In this and the following chapter, my intention is to demonstrate how patient records can be employed to shed light on the mental and social reality of 'nervous people', and on the actual use of particular medical concepts, but I shall not make the grandiose claim that patient records show us the clinical reality as it 'really' was. I agree with medical historians Guenter B. Risse and John Harley Warner when they argue that while "the opportunities patient records offer to historians of medicine are substantial," historians should not assume that "these sources provide somehow privileged access to clinical reality."[4] Patient records are very helpful for exploring the relationship between medical theory and clinical practice, but historians have to be very careful in their interpretations of records that were written for a variety of purposes, and usually by different physicians at different times.

In the history of psychiatry, an awareness of the need to do history from below, to listen to the patient, has probably been more acute than in other fields of medical history. During the past two or three decades, a number of studies in the history of psychiatry have focused on the experiences of the sufferer, and the whole field is now considerably less physician-centred.[5] A less iatrocentric approach is particularly relevant in the historiography of neuroses, because nervously ill patients have played a highly active role in the shaping of medical knowledge about neuroses. A detailed study of patient records and personal stories of sufferers (in letters, diaries, memoirs, etc.) indicates that neuroses were not the outcome of a one-way traffic, but of an interplay between two protagonists, doctor and patient.[6]

To a large extent, then, neurosis was the result of a clinical encounter, in which the doctor heavily relied on the patients' own descriptions

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[3] Ibid., 183.

[4] Guenter B. Risse and John Harley Warner, "Reconstructing Clinical Activities: Patient Records in Medical History," *Social History of Medicine* 5:2 (1992): 183.

[5] For Swedish studies in which the patients' experiences are at the foreground, see, for example, Bengt Sjöström, *Den galna vården. Svensk psykiatri 1960–2000* (Lund: Bokbox Förlag, 2000); Lars-Eric Jönsson, *Det terapeutiska rummet* (Stockholm: Carlsson, 1998); and Karin Johannisson, *Tecknen: Läkaren och konsten att läsa kroppar* (Stockholm: Norstedts, 2004).

[6] I agree with Joachim Radkau, who has studied patient records from eight clinics and asylums in Germany, and who writes in his article on neurasthenia that "the researcher gets the impression that neurasthenia stems much more from the medical consultation room than from neurological theory." Radkau, "The Neurasthenic Experience in Imperial Germany," 205.

of their symptoms and complaints, and on their ability to articulate their feelings of ill-health. And as the accuracy of the diagnosis was dependent on the patient's verbal articulation of his or her symptoms, it was the patient's duty to describe the symptoms as precisely as possible. Inevitably, patients from the educated middle-classes were better-equipped to meet the demand for an articulate description of their problems than manual workers, peasants or artisans were. Furthermore, doctors at outpatient clinics and hospitals had very little time for the individual patient, and time-consuming talk therapies were often out of the question for practical reasons. Private practitioners, by contrast, did not need to worry so much about cost-effectiveness, and they were much more inclined to employ psychotherapeutic methods in their consultation rooms. Money can't buy love, but it can buy the physician's undivided attention, and this meant that those with a heavy purse could talk about their problems much more exhaustively than the less affluent, who went to see a busy doctor in a crowded polyclinic or hospital. Patients who were able to tell their stories at their own pace in an unhurried clinical setting undoubtedly often experienced relief and alleviation of their suffering.

In the late nineteenth century, to be nervously ill was rarely something to brag about, and if the doctor belittled the sufferings of nervous patients, the prospect of a cure was not too promising. As Nils Antoni observed in his 1946 book on neuroses, it was not uncommon for a doctor to have a disparaging attitude towards neuroses and to present them as imaginary illnesses.[7] Doctors with such a non-empathic attitude were not different from many laypeople who scoffed at the suffering of the nervously ill. The prevailing assumptions of what was a real disease and what was not can be discerned in the way in which 'nervous people' were perceived in their communities. As you treat others, so you will be treated yourself: if a doctor showed no sympathy for the patient's suffering, the patient had no particular reason to trust the doctor and obey his prescriptions. In 1934, nerve doctor Torsten Lindner noticed, not exactly in a tone of bewilderment, that patients often regarded doctors as their enemies.[8] In a clinical atmosphere of mutual distrust and suspicion, there was little hope of healing the nervous patient. In Sweden, Wetterstrand and other hypnotherapists, on the one hand, and

[7] Antoni, *En bok om nerver*, 392–403.

[8] Torsten Lindner, Review of *Jahresringe Innenansicht eines Menschenlebens*, by Alfred E. Hoche, *Hygiea* 96 (1934): 876.

Lennmalm and his assistants at the Serafimer's *Nervklinik* on the other, represented a new, less stigmatising attitude that placed a premium on healing and on treating the patient as a sufferer, not as a whinger. By all accounts, one doctor who was known for his ability to create a bond of trust between himself and his patients was Frithiof Lennmalm, the one and only professor of neurology in Sweden in his time.

Lennmalm's Private Practice

As we have seen, Frithiof Lennmalm was head of the *Nervklinik* from 1891 to 1923, and throughout these years he also maintained a private practice, which he had established in 1885. He continued to see patients to the very end, and there are more than 30,000 entries in his clinical diary. This document, which is now kept in the archives of the Society of Medicine in the *Riksarkivet* in Stockholm, gives valuable information about the private patients who consulted one of the most eminent Swedish doctors of the late nineteenth and early twentieth centuries. Regarding this document, I have used a sample method, investigating all clinical entries within a similar time-span of two or three months each year (usually the months of March and April). All in all, I have examined 5,281 entries, or 17,2 per cent of all entries.

Unfortunately for us historians, Lennmalm was quite laconic in his descriptions of the complaints of his patients, in many cases writing down only the personal information of the patient—name, age, occupation, place of residence—, diagnosis and a few words on the treatment. Usually, he said very little about the personal history of the patient or of the circumstances surrounding the illness. Here is a typical clinical entry from April 1907: a 48-year-old sea captain; unable to sleep; diagnosis: neurasthenia; treatment: Saltsjöbaden (a spa near Stockholm).[9] Sometimes he did not bother to write anything about symptoms either; he just wrote down the personal information, the diagnosis, and a word on the treatment ('Veronal', 'rest', 'nursing home', 'three months' leave of absence', and so forth).

Lennmalm was indeed a man of few words, but he did usually give just enough information about a case to make the whole scholarly investigation worthwhile. Sometimes he was more talkative and offered

[9] Lennmalm's Clinical Diary, April 4, 1907.

a richer illustration of the patient's personal history and his or her source of problems. And what brings the patients' own perceptions of their problems more to the fore are the occasional letters they sent to Lennmalm, either prior to the consultation or after it. Sometimes the 'patient' did not go to see Lennmalm at all, but only asked for advice in a letter.

In face of the rather scanty information given in Lennmalm's case records, it would be foolish to claim that I have found the authentic voice of the patient in these records. Quite the contrary, occasional letters notwithstanding, the patients' experiences are filtered through Lennmalm, who was not particularly inclined to probe deeply into the personal history of his patients, or to interpret their problems within a larger framework. He was not a psychoanalyst or even an advocate of 'short term psychotherapy'; I see him above all as a trustworthy, paternalistic 'family doctor'-type who radiated confidence and sympathy, but who was not interested in engaging in a more serious dialogue with his clients. It seems to me that, with his benign but reserved 'habitus', he was an exemplary representative of the late nineteenth-century therapist, who cared about his patients and wanted to help them, but who also preferred to keep patients and their problems at arm's length.

Lennmalm's therapeutic style becomes more understandable when we consider the fact that more than a half of his clients suffered from somatic ailments or organic nerve diseases: of the 5,281 entries that I have examined, he used the diagnosis neurasthenia or its equivalent 2,083 times, which means that, all in all, almost forty per cent of his patients in my sample were nervously ill. This number would be even larger if we were to include the diagnosis that he used every now and then to designate a type of headache that was often of psychogenic origin: cephalalgia. But the fact that more than half of his patients were troubled by predominantly somatic afflictions partly explains why he was not that inclined to use the methods of psychological healing. In his preference for prescribing drugs, electricity, massage, rest cure, diet, and a stay in a spa or sanatorium, he was a typical neurologist, who had both nervous patients and patients with organic nerve diseases. While Lennmalm's therapeutic arsenal was rather conventional, sometimes he used hypnotism, or sent his patients to Wetterstrand for a hypnotic treatment.[10] It seems, however, that he was not particularly successful

[10] See, for example, the clinical entry for April 27, 1891 (law student), which ends

with his own hypnotic experiences, because hypnotism remained a marginal method for him.

While 'neurasthenia' remained as solid as a rock in his clinical language, Lennmalm never used the diagnosis 'neurosis' consistently. Instead, he employed such variant terms as 'nervous', 'nervousness', 'nervositas', 'heart neurosis', 'occupational neurosis', 'nervous symptoms', 'shaking neurosis' (*Witterungsneurose*) and 'anxiety neurosis' to denote neuroses that he wanted to differentiate from neurasthenia, on the one hand, and from traumatic neurosis, obsessions (or '*idée fixe*'), melancholy (or depression), hypochondriasis and various phobias on the other. What is striking in his diagnostic categories is that they remained so unaltered from the late 1880s to the early 1920s. The only notable change in his application of diagnoses is the change from 'melancholy' to 'depression' around 1918–19.

The majority of Lennmalm's private patients came from middle- or upper-middle-class backgrounds. There were people from all walks of life and all social positions in his consultation room—from housemaids and labourers to barons and big business men—but the educated middle classes, entrepreneurs and business men dominated his clientele. Among his typical patients were wholesale dealers, students, teachers and civil servants. He also had artists (musicians, actors and actresses) and Lutheran pastors. Most of his patients came from Stockholm, but he also had patients from provincial towns and from the countryside. They were very different from Charcot's star hysterics at the Salpêtrière: there was nothing dramatic or sensational about their afflictions. The colour of their suffering was grey.

What Made Lennmalm's Patients Nervous

Next, I shall give an account of the principal reasons Lennmalm's patients became nervously ill. The patients often gave more than one reason for their nervousness (for example, 'alcoholism' and 'economic difficulties'), and this fact should be kept in mind when reading the following section. I have disentangled the causative factors only in order to give clarity to my exposition. In real life, very few patients either

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with the words "end of hypnotism [with Wetterstrand], no effect". See also the clinical entry for April 15, 1892 (29-year old man).

in Lennmalm's time or nowadays, attribute their suffering to only one source.

1. *Overstrain*

As can be inferred from the fact that Lennmalm used neurasthenia as a diagnostic category so frequently, he considered many of his patients to be overstrained. In fact, overstrain (*överansträngning*) is the single most common cause of neurasthenia among his patients. In the sample, Lennmalm refers to overstrain over and over again, and although most of the people whom he saw as overstrained belonged to the middle classes, there were also exhausted workers and artisans among his neurasthenic patients. Overstrained teachers and students are over-represented among Lennmalm's patients, which suggests that even a hundred years ago the working atmosphere in schools was not ideal, and that the life of learning made demands on the nervous system. Here is a more detailed description of a chronic case of neurasthenia triggered by overstrain: a 35-year-old Master of Arts had suffered from overstrain since 1878 (13 years); since many years unable to read anything, which had prompted him to work as a gardener. Following doctor's instructions, he tried to force himself to read a few months ago, eventually succeeding in reading three hours daily. But then his condition worsened and now he could not read at all anymore, and he had also lost his hitherto excellent physical strength. It is quite obvious that this man suffered and felt disabled by his mental troubles, although there seemed to be nothing seriously wrong with him. Lennmalm prescribed diet and exercise to the patient.[11]

In his inaugural speech in February 1891, Lennmalm had discussed the "most important aetiological reasons for diseases of the nervous system".[12] In his published talk, he emphasises the role overstrain plays in the pathogenesis of functional nervous illnesses. He pays attention to the mental overstrain during childhood and youth, when the brain is developing towards an increasingly complex system. He observes that the less talented children whose intellectual capacities do not match up to their ambition to excel tend to strain their mental powers too much and, in consequence, become nervously ill. Many adults whose work

[11] Lennmalm's Clinical Diary, April 29, 1891.
[12] Lennmalm "Om de viktigaste orsakerna."

requires intellectual efforts also suffer from overstrain, and the reason for this affliction is to be found in the nervousness of the modern age, which puts a heavy load on the nervous system of such groups as civil servants, scientists and business men. Inspired by Spencerian and Darwinian theories of evolution, he refers to

> a wild race, a struggle for life; it is this strife which is continuously going on around us. Some succeed in going through this ordeal undamaged; some fall in battle; some manage to reach their goals, but they have to pay for their success by life-long scars that take the form of more or less serious nervous suffering.[13]

Not even manual labourers are spared from overstrain resulting from excessive physical exertion. Thus large segments of the population are vulnerable to overstrain, which is the most common causal factor in neurasthenia.

Lennmalm's concern with the threat overstrain posed to the public health was shared by his professional peers.[14] In 1913, a private society was founded for the purpose of establishing a rest home for the overstrained. At a meeting in a Stockholm hotel where the plans for the founding of the society called 'Rest Home for the Overstrained' (*Sällskapet Hvilohem för överansträngda*) were discussed, nerve doctor Jakob Billström, who had been Lennmalm's student at the *Nervklinik*, gave a talk that was published as a booklet. This booklet, entitled 'What can be done to the overstrained of our time?' (*Hvad kan göras för vår tids öfveransträngda?*), is to my knowledge the first monograph by a Swedish author which exclusively deals with neuroses. As it was put in the preface to the booklet, Billström addressed "the horrible illness, neurasthenia," in his talk.[15] To convince his audience about the wide significance of nervous weakness, he referred to many "outstanding" physicians' estimation that at least a third of all illnesses were nervous illnesses. As befitted the occasion, he regarded the establishment of small rest homes or convalescent homes as of vital importance to the overstrained. He urged his audience to support the society's work, which could result in the founding of a "national association for the

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[13] Ibid., 271.

[14] For example, general practitioner and an author of a popular medical manual, Henrik Berg, regarded overstrain as the most crucial factor in neurasthenia. See Berg, *Läkareboken 1*, 687–8.

[15] Billström, *Hvad kan göras för vår tids öfveransträngda*.

prevention of nervousness".[16] At the end of the booklet one can find the Society's statutes, the first of which runs as follows:

> § 1. The Society 'Rest Home for the Overstrained' aims at establishing a rest home for people of limited means who suffer from mental or physical tiredness, and who are in need of rest.[17]

Obviously, Billström was not very happy with the therapeutic results of this particular rest home (if it ever was opened), for he returned to the problem of overstrain in his popular book on the 'everyday care of the nerves', which was based on a series of presentations on the radio, and which came out as a book in 1934 (it was reprinted a number of times). In his book, Billström argues that the so-called 'rest homes' are of no real use to the overstrained patients, whose suffering is a neurosis, a disturbance in the emotional life, and not a result of overwork. This is what he had said about neurasthenia already in 1913, but had apparently changed his mind over time about what constitutes a proper cure for the overstrained. Now he claimed that neither rest nor work should be prescribed to the overstrained. Instead, a 'revaluation' of the essentials of human existence, sometimes combined with a change of scene, might sometimes alleviate suffering and prevent the onset of new bouts of suffering.[18]

As sociologist Eva Palmblad has pointed out, the question of overstrain was constantly on the agenda in turn-of-the-century medicine, most medical commentators regarding overstrain as a relatively new phenomenon.[19] As we have seen, Lennmalm, like many other nerve doctors, associated it with 'our nervous age' and saw it as one of the major health hazards of modern society. In his clinical diary, the term overstrain appears more often than any other term designating aetiological factors in neurasthenia.

2. *Work*

Lennmalm's patients often had problems related to the workplace and working conditions. The most common complaint was either overstrain or 'exhaustive work'. We can see how Swedish society was undergoing

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[16] Ibid., 6, 21.
[17] Ibid., 21.
[18] Billström, *Våra nervers vardagsvård*, 52–7.
[19] Palmblad, *Medicinen som samhällslära*, 47.

changes, merely by surveying the occupations of Lennmalm's patients. In addition to the more traditional occupations and professions, such as farmer, merchant, artisan, policeman or pastor, there were also many engineers, cashiers, clerks, civil servants, teachers, lawyers, journalists, insurance agents, railway workers, secretaries, telephonists, telegraphists and businessmen. They represented the modern, industrial Sweden where a growing number of people were wage and salary earners in contradistinction to the traditional, rural Sweden where the majority was engaged in primary production. Most of these 'modern' patients suffered from neurasthenia, which was created as a diagnostic category to denote psychosomatic complaints of the professional brain-worker. It seemed to be the sheer work load or lack of sufficient rest which made these people nervous, overstrained and exhausted.

There were people who did not like their jobs; who had to work during the night; who were afraid of losing their jobs; who were treated badly by their superiors or bosses; and who had no luck in business. (What is striking is the number of post-office employees who were exhausted and did not like their jobs.) For example, there is a 29-year-old woman, a Master of Arts, who has worked as a teacher. She does not like her job, and makes plans to become a journalist. There is a 31-year-old engineer, who is worried about a strike in a bicycle factory where he is the boss. And there is a 40-year-old police officer, who is nervous and insomniac. He is accused of misconduct at the office and believes that everybody talks about him. He also has suicidal tendencies.[20]

These work-related nervous problems appear to me to be very modern, even a topical source of nervousness: today, just as hundred years ago, there are people who, for some reason or other, work too hard; who work long hours; who do not like their jobs; who do not get along with their superiors or colleagues; who feel insecure about their future prospects in their workplace (due to the threat of downsizing, etc.); whose work is too demanding; and whose businesses are going badly. Learning about the work-related problems of Lennmalm's neurasthenic patients makes late nineteenth-century nervous illnesses seem anything but exotic and peculiar.

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[20] Lennmalm's Clinical Diary, April 22, 1908 (Master of Arts); March 16, 1898 (Engineer); January 29, 1923 (Police officer).

3. *The nervous family*

Lennmalm endorsed the French doctrine of 'the neuropathic family' and maintained that one could inherit a predisposition to nervousness from one's parents, either through hereditary mechanisms or through being exposed to the harmful influence of a nervous family member. He sided with the French neurologist Déjérine, who asserted that nervous illnesses were to great extent hereditary diseases, and he clung to the doctrine of the neuropathic constitution until his death.[21] Small wonder, then, that he was an influential supporter of the Racial Biological Institute, which was established in Uppsala in 1922.

One encounters the idea of the 'nervous family' constantly in Lennmalm's clinical diary from the 1890s until his final entries in 1924. Occasionally, he also used a more sinister term, degeneration, when he sought explanations for his patients' nervousness. In 1906, he was consulted by a 33-year-old engineer, who suffered from 'neurasthenia sexualis'. As usual, he did not reveal the exact nature of the engineer's affliction (was he homosexual? impotent? an inveterate onanist? overexcited?). Instead, he made a curt remark: "Degeneration".[22] A 30-year-old woman he treated in 1917 had a "degenerate family. Mother hysterical, brother imbecile."[23] Sometimes the patients' mental afflictions were related to the onset of mental illnesses in a family member, which, in the light of present-day research on the hereditary aspects of such illnesses as the bipolar disorder (manic-depressive illness), is a less outdated observation on Lennmalm's part.

There is no doubt that Lennmalm genuinely believed in the speculative idea that a predisposition to nervousness could be passed from one generation to another via inheritance. Like dementia praecox (schizophrenia) and other psychoses, neuroses were also for Lennmalm and most of his colleagues 'functional' disorders of the brain. An endorsement of the theory of hereditary taint also provided a convenient explanation for patients' ailments: a reference to the 'nervous family' was a simple and quite persuasive way to tell to patients why they suffered from nervousness. Lennmalm also employed an 'environmental' reading of this theory in order to explain how nervous people (usually

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[21] The doctrine of neuropathic constitution was still discussed in Swedish medicine in the 1930s. See, for example, Ragnar Bringel, "Tecken på neuropatisk konstitution," *Förhandlingar*, November 26, 1935, 505–17.

[22] Lennmalm's Clinical Diary, March 3, 1906.

[23] Lennmalm's Clinical Diary, April 12, 1917.

parents) in the patient's environment exerted a harmful influence on the patient. In his environmental interpretation of neuroses, he endorsed the idea that neurosis could also be a socially infectious illness.

4. *Disease, somatic complaints and fear of disease*

A hundred years ago, to fall ill was potentially a much more serious misfortune than it is today, when most infectious diseases can be cured with antibiotics, and surgical operations are much less risky than they were in Lennmalm's time. Among Lennmalm's patients, there were many who had been ill, and many others who were afraid of becoming ill. If today's dreaded (venereal) disease is AIDS, a hundred years ago it was syphilis. Many early twentieth-century inmates of mental asylums suffered from general paresis of the insane, a syphilitic disease which in its tertiary phase would eventually deprive the infected individual of his or her mental faculties. Syphilis all but disappeared when the wonder drug penicillin began to be administered on a mass-scale in the 1940s, but for Lennmalm's patients the only drug that was available (after 1907) was a preparation called Salvarsan, a not very effective drug that also had some unpleasant side-effects (Wagner-Jauregg's malaria treatment against general paralysis of the insane was taken into use after World War I). Among Lennmalm's patients, there were many who suffered from the psychological consequences of a syphilitic disease, or who were afraid of contracting syphilis.

In addition to syphilitic diseases, tuberculosis, influenza and various organic nerve diseases were often fatal a hundred years ago. It was influenza especially that seemed to have a 'functional' effect on the nervous system, and Lennmalm often attributed his patients' nervous symptoms to the after-effects of influenza. And when it came to more general somatic complaints, the pool of symptoms was as rich as it is today. Sleep disorders, headache, gastric disorders, diarrhoea, cramps, tics, ringing in the ears, and pain in different organs or different parts of the body (stomach, heart, back, arms and legs) were the most common complaints. Obesity and, to a lesser extent, emaciation, were sometimes seen by Lennmalm to be serious enough ailments to warrant a note in his clinical diary ("needs to gain 5–10 kilos"; "needs to lose 5–10 kilos", etc.).

Lennmalm's patients expressed all kinds of fears of disease. A fear of syphilis, the most common fear among his patients, was well-grounded, since a century ago syphilitic diseases were rampant. There were men

who so dreaded syphilitic infection that, although they were not looking for same-sex relationships, they preferred to have sexual intercourse with other men rather than with (lower-class) women and prostitutes, whom they saw as carriers of venereal diseases.[24] There were also cases of fear of cancer, which strikes a familiar note today. Another fear that often manifested itself in Lennmalm's patients was the fear of going mad. This fear was exacerbated by nervous symptoms, which the patients would sometimes interpret as the first stages of incipient madness. For example, a 34-year-old woman had symptoms of anxiety neurosis, which Lennmalm attributed to her fear of psychosis. A 29-year-old physician suffered from bad memory and believed he would go mad. Then there was a 60-year-old woman who had been mentally ill and who was afraid of a relapse, and a 60-year-old tradesman who was anxious about having his mentally ill brother-in-law in his house.[25] The idea that madness was hereditary certainly increased anxiety among people who had mentally ill relatives, or who knew that some of their forefathers had been mad. Poul Bjerre, an experienced psychotherapist, noted in 1937 that a great many neurotic patients were afraid they might go mad (and, therefore, the medical care of neurosis should never be located in hospitals).[26]

5. *Other fears and obsessions*

Lennmalm uses the term 'phobia' only infrequently, usually to denote either a fear of going out into public places (agoraphobia) or 'shyness', a social phobia which manifested itself in a fear of speaking in public, eating in public, and so forth. Sometimes the symptoms of his patients indicate intrusions of unwanted thoughts, which Lennmalm and his contemporaries often called 'idée fixe' and which are called nowadays 'obsessions' (or 'obsessive-compulsive disorder', OCD). He had patients who were afraid of bacteria; of poisoning; of impotence; of thieves; and of trains. A 21-year-old student at a School of Nursing is afraid of the sight of blood, which prompts Lennmalm to prescribe "Change of occupation" (and, eventually, hypnotism) as a treatment; a 50-year-old

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[24] Rydström, *Sinners and Citizens*, 133, 139.

[25] Lennmalm's Clinical Diary, April 26, 1902 (34-year-old woman); April 5, 1909 (29-year-old physician); March 23, 1903 (60-year-old woman); April 25, 1908 (60-year-old tradesman).

[26] Poul Bjerre, [Commentary], *Förhandlingar*, October 19, 1937, 469–70.

army officer (major) is anxious because he "is getting married today"; a son of a senile man is afraid that "he will become like his father"; and a Master of Arts is obsessed (*idée fixe*) by his desire to have epileptic seizures. He has wandered from one sanatorium to another across Europe and tried to bring about such seizures by consuming alcohol.[27] A number of Lennmalm's patients had become lost in religious thoughts (*religiös grubbleri*). One such person was a 28-year-old woman who suffered from melancholy; and another was a 30-year-old religious woman who wanted to marry a drunk lout in order to redeem him.[28]

6. *The death or illness of one's nearest and dearest*

Lennmalm was active as a clinical neurologist at a time when death and disease marked the lives of people much more strongly than they do today. Infant mortality was much higher than today while life expectancy was much lower, and various infectious diseases, chronic pains and somatic afflictions occupied a much more central position in life. As death and disease were so visible in people's lives, it meant that they became accustomed to dealing with sudden departures and fatal diseases at an early age. Still, as Lennmalm's clinical diary shows, grief was an ever-present emotion in his patients. It probably says something about the prevailing emphasis then on the need for privacy, that Lennmalm often did not elaborate on the nature of his patients' grief. In a culture that valued discretion with regard to the private sphere, a physician, whose position was not that of a trusted family doctor, did not expect, much less require, his patients to pour out their hearts to him and tell him how they felt about the loss or disease of a loved one. But doctors probably understood very well that to give patients an opportunity to talk about their grief to someone they trusted, might have a beneficial effect on their mental condition.

By far the most tragic and disastrous departures were those of children and spouses. The death of a husband was often a heavy loss to the family, because it usually meant that the family lost its principal breadwinner. Such a loss could have dire consequences for the family.

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[27] Lennmalm's Clinical Diary, May 27, 1919 (21-year-old student); March 24, 1916 (50-year-old army officer); May 12, 1919 (son of a senile man); March 30, 1899 (Master of Arts).

[28] Lennmalm's Clinical Diary, April 25, 1899 (28-year-old woman); April 17, 1897 (30-year-old woman).

Thus, in the sample, there are more notes about the death of a husband than about the death of a wife. The most heart-rending moments of grief are, as might be expected, the departures of children. With one exception, the mourning patients in my sample were all mothers. A century ago, fathers were much less involved in the daily life of their children than they are today, but it would be unwarranted to conclude that they did not grieve over their children's departure (almost) as much as the mothers. It was a cultural norm that men should not show their emotions in public as freely as 'womenfolk', and it was much more unlikely that a father would consult a doctor because of his grief. It is probable that a mourning father was more inclined to seek consolation in alcohol, in the company of friends or in hard work than in face-to-face discussions with a doctor (or pastor). There could hardly be a more universal and timeless cause for nervous affliction than the death or illness of a person to whom one is closely attached.

As I mentioned above, madness was an illness that created anxiety and nervousness among people. Small wonder, then, that when a family member became mad, it had a strong psychological impact on the whole family. In 1897, Lennmalm treated an 11-year-old girl whose mother was mentally ill. He diagnosed the girl as neurasthenic and explained her symptoms through her close relationship with her insane mother. In 1899, Lennmalm was consulted by a 43-year-old clothes merchant, who became nervous when he stayed at home with his mentally ill wife. Another patient, a 26-year-old housewife, had a 'psychotic mother', which made her afraid of madness; and a 73-year-old woman patient of Lennmalm was anxious because of her insane (now deceased?) mother and sister. A more extraordinary case is that of twin sisters: in 1924, Lennmalm is consulted by a 32-year-old housewife whose twin sister, who resembles her very much, has been in a mental hospital in Stockholm (Långbro). Her sister's illness had made her nervous (and prompted her to consult Lennmalm in 1920), but she had gotten rid of her symptoms when the sister regained her health and was able to leave the hospital. For a while, the sister felt better, but now she has become 'anxious', which has also made Lennmalm's patient nervous again. Lennmalm referred her to a nursing home.[29]

[29] Lennmalm's Clinical Diary, March 1, 1897 (11-year-old girl); March 2, 1899 (43-year-old clothes merchant); September 30, 1921 (26-year-old housewife); May 13, 1924 (73-year-old woman); and April 12, 1924 (32-year-old housewife).

One's nerves were not always shattered by the departures or diseases of close relatives. In 1919, Lennmalm was consulted by a student, a young man who had indirectly caused the death of his best friend many years before (when he was sixteen). The death of his friend was an accident, but his feelings of grief and guilt had tormented him so much that he had become deeply depressed. His worried mother sent two letters to Lennmalm, writing that the death of her son's friend totally changed the son's mental disposition: the hitherto cheerful boy with an even temperament (*lynne*) was transformed into a nervous wreck who could not sleep. Now, years after the incident, he had finally been able to regain his composure, the most significant indication of which was his engagement to a young woman. He was also studying. The mother wanted to ask for Lennmalm's advice, especially with regard to her son's career: according to her, the son was a bright young man, but she wondered whether he could stand the strain of intellectual work.[30] Lennmalm replied to her, which prompted the mother to send another letter in which she expressed her gratitude for the doctor's report on her son. The mother ends her letter on a note of cautious optimism, predicting that if her son could be cured of his insomnia, his previous, cheerful disposition would return for good.[31]

7. *Alcoholism and narcomania*

By the late nineteenth century, alcoholism had become a folk disease in Sweden, and both the authorities and large segments of the population wanted to ban alcohol, or at least radically restrict its consumption. Women were active in the temperance movement and were often in favour of a total ban on alcohol. That women by and large agitated against alcohol consumption was not surprising, given the fact that the drinking habits of their sons, lovers, husbands, fathers, brothers, colleagues and bosses often had a direct bearing on their lives. A man who drank too much was a considerable risk to his whole family, and there was ample proof that many Swedish men ruined not only their own lives but also the lives of their families with their excessive drinking.

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[30] A letter of Mrs X to Lennmalm, April 14, 1919. Lennmalm's Clinical Diary, case no. 25042.

[31] A letter of Mrs X to Lennmalm, April 25, 1919. Lennmalm's Clinical Diary, case no. 25042.

Judging by what Lennmalm's patients told him about their problems, alcoholism was indeed a gender-specific problem: there was only one woman among his patients who appeared to drink too much; all other heavy drinkers were men. Sometimes it was Lennmalm's female patient who attributed her nervous problems to her husband's alcoholism. For example, he is consulted in April 1912 by a 37-year-old emaciated woman, whose problems he designates with the word "difficulties" (*ledsamheter*), writing in parenthesis: "husband alcoholic".[32] A typical male patient whose problem was excessive drinking was a 32–year-old coachman who transported—beer. Lennmalm, who diagnosed him as suffering from 'neurasthenia-alcoholism', wrote laconically in his clinical diary: "Nervous. Boozed. A jealous wife."[33] Alcoholism was a problem with numerous medical, social and psychological ramifications, and the patients in Lennmalm's consultation room seemed not to have represented the worst cases of alcoholism, those whose lives were ruined by liquor.

Compared to alcoholism, drug abuse seemed to have been an insignificant problem in Sweden. Among Lennmalm's patients included in the sample, there were only two cases of narcomania, and one case of a misuse of medicine. There were also a few cases of excessive smoking ('nicotinism').

8. *Sexual problems*

Evidently, Lennmalm was not keen on discussing his patients' sexual problems and frustrations. Although he employed the diagnosis 'sexual neurasthenia' quite frequently, he seldom elaborated on the nature of his patients' sexual problems. In his 1891 article on diseases of the nervous system, he devoted one short paragraph to 'sexual excesses' (to be more precise, he wrote two sentences about sexuality). In that paragraph, he noted that while sexual excesses can undoubtedly lead to nervous illnesses, their aetiological significance had "perhaps been exaggerated" (he does not say by whom). But he also conceded that such excesses might give rise to a "particularly difficult form of neurasthenia, the so-called sexual neurasthenia".[34] But instead of elaborating

[32] Lennmalm's Clinical Diary, April 23, 1912.
[33] Lennmalm's Clinical Diary, March 13, 1905.
[34] Lennmalm, "Om de viktigaste orsakerna," 273.

this observation, he turned to another issue (Lennmalm's article was a published version of his inaugural speech, and he probably considered it prudent to remain within the bounds of propriety by not delving too deeply into 'sexual excesses' on such a festive occasion).

In his rather reserved attitude towards the tyranny of Eros, Lennmalm's was not an untypical representative of the 'old school' of clinical neurology (Charcot, for example, was uninterested in the relationship between sexuality and hysteria). Moreover, a marked reluctance to divulge aspects of one's intimate life to other people seemed to characterise the Swedish mentality at that time. When Reinhart Gerling published a book, which allegedly dealt with his own nervousness in 1914, he wrote in the preface to the book:

> In this little book I have described my experiences to my fellow sufferers. I have spoken quite openly about the wide-spread sexual neurasthenia, which is a real cultural illness.[35]

However, contrary to what he announces in the preface, Gerling does not talk about his own nervousness *at all* in the book—his approach to 'sexual neurasthenia' and nervous illnesses as a whole is that of a doctor describing, in a popular book, an illness (not *his* illness) in objective and neutral language. It is only in the two-page preface where he says a few not-too-revealing words about his own nervousness, referring vaguely to overstrain, grief, emotions and "maybe also fanatical abstinence".[36] He does not say a single word about the nature of his sexual neurasthenia, which is quite a feat considering that the title of his book is 'My Nervousness' (*Min nervositet*). Obviously, Gerling and Lennmalm had presuppositions about the need for opacity in the private sphere that are not exactly celebrated today (on the contrary, your reluctance to talk about your feelings in public may be interpreted by behaviour experts as a sign of psychopathology).[37]

Lennmalm's clinical diary indicated that sexuality was indeed a major component in neurosis. That the doctor encountered nervous patients with sexual problems was anything but unusual: in his study of German neurasthenics, Joachim Radkau notes that "the role of sexual frustrations in the patients' experience of neurasthenia is immense; it is

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[35] Reinh. Gerling, *Min nervositet* (Stockholm: Wahlström & Widstrand, 1914), 6.
[36] Ibid., 5.
[37] On the therapeutic ideology that puts premium on the discourse of intimacy, see *Modernity and Its Discontents*, ed. Pietikainen.

clearly the most important point."[38] 'Sexual frustrations' were clearly a gender-specific problem; at least they gave rise to nervous symptoms in men much more often than they did in women. In my sample, there are fifty-three patients who suffered from sexual neurasthenia, and only two of them were women. Characteristically, Lennmalm does not give any information about the sexuality-related problems of these women. The only woman in the sample whose sexual life Lennmalm illustrates in any way was a 39-nine-year-old woman who was still a virgin. Her 'neurasthenia' did not have the epithet 'sexual' in it.[39] Sexual neurasthenia was a diagnosis that Lennmalm applied almost exclusively to men, which tells us something about early twentieth-century normative codes that did not exactly encourage Swedish women to be frank about their own sexual frustrations, especially with male doctors.

On the very few occasions when Lennmalm gives some details about the sexual problems of his male patients, one can see that the source of nervousness was usually either masturbation or impotence.[40] 'Psychic impotence' is the term he occasionally used to stress the psychological nature of this distressing problem, which Poul Bjerre in 1945 characterised as one of the most common problems among his psychotherapeutic clientele.[41] But Lennmalm also had a patient whose 'neurasthenia sexualis' was related to the opposite problem: the patient, a 21-year-old law student, suffered from erections that lasted for several days.[42] But the most common sexual matrix of nervousness in men was not impotence but masturbation, which in late nineteenth-century medicine was commonly considered a sin and a shame: worried mothers consulted doctors if their one-year-old babies were seen to practice onanism![43] It is evident that the horror scenarios depicted in popular medical manuals produced anxiety in men who practised or had practised masturbation. To illustrate, Lennmalm treated a 33-year-old ship's mate and a former onanist who had read medical manuals; a woodwork teacher of unruly children who had a difficult job, and whose nervousness and anxiety were increased by his ruminations on his former habit of masturbation; and a 69-year-old retired policeman who connected his

[38] Radkau, "The Neurasthenic Experience," 207.
[39] Lennmalm's Clinical Diary, April 26, 1918.
[40] Some of the letters that impotent men sent to Lennmalm testify to the degree of intense agony their problem provoked in them.
[41] Bjerre, *Räfst- och rättarting*, 181.
[42] Lennmalm's Clinical Diary, April 5, 1897.
[43] Edv. Braun, "Tidig onani—helsa," *Eira* 3 (1879): 208.

fear of epilepsy to his childhood onanism.[44] In 1923, Lennmalm was consulted by a 'sexual-neurasthenic' who had sent him a letter prior to his visit. In his letter, he wrote that because he had practised onanism as a teenager he was now "a broken man" who "respectfully turns to Herr Professor for advice and help."[45]

Lennmalm also had homosexual male patients. One of them was a 34-year-old teacher who had problems with alcohol, and who had been discharged and fined (it is not clear whether these sanctions were the result of his homosexuality or his drinking). Lennmalm wrote a referral to a home for inebriates. His colleague informed him a year later (1915) that, after a one-year cure, the patient had found a job as a substitute teacher in an elementary school.[46] When a homosexual army officer (lieutenant) consulted him in 1914, he referred him to Emanuel af Geijerstam, a well-known hypnotherapist living in Gothenburg (see Chapter 6). Geijerstam informed Lennmalm that the lieutenant was not amenable to hypnotism. Apparently, the patient tried to find his own way of 'curing himself', for he got married a year later.[47] Hypnotism was tried again, this time with some success, when Lennmalm referred a 35-year-old homosexual farmer to C. V. Söderlund, a psychotherapist. Hypnotism 'improved' the patient's condition, but, a few months after his visit to Lennmalm's office, he was sentenced to one year of hard labour.[48] Homosexual acts between adults (over 21 years of age) were decriminalised in Sweden in 1944.[49]

There are no traces of female homosexuality in the sample, which suggests that female same-sex sexuality was a delicate and concealed issue in Swedish society. Jens Rydström has showed in his historical study of homosexuality in Sweden that homosexual women were rarely prosecuted: of the 2,333 court cases that he has studied,

> only 12 concern same-sex sexuality between women… Lesbian identity was discussed and redefined in the 1930s, and most court cases concerning

[44] Lennmalm's Clinical Diary, April 20, 1895 (33-year-old ship's mate); April 7, 1898 (teacher); and April 22, 1911 (retired policeman).
[45] A letter of K. C. to Lennmalm, March 10, 1923, Lennmalm's Clinical Diary, March 12, 1923.
[46] Lennmalm's Clinical Diary, May 16, 1914.
[47] Lennmalm's Clinical Diary, May 30, 1914.
[48] Lennmalm's Clinical Diary, March 19, 1919.
[49] Rydström, *Sinners and Citizens*, 184–6.

> sex between women are from the 1940s, when the legislators actively sought knowledge about female homosexuality.[50]

As Lennmalm's clinical diary testifies, alongside impotence, it was the 'masturbatory paradigm' that prevailed in Sweden in the late nineteenth and early twentieth centuries. Of all the problems related to sexuality, it was masturbation that appears to have had most relevance for the onset of nervous illnesses.

9. *Problems with relationships*

If women were conspicuous by their absence in the last two categories—alcoholism and sexual problems—they are very much present in the category of nervous problems that had their matrices in 'dysfunctional' relationships. This category is overwhelmingly dominated by nervous women who are either on the process of divorcing their husbands or contemplating divorce; whose engagements have been broken off; who have been in unhappy relationships; whose husbands are unfaithful, violent, drunk and bad-tempered; or who are simply suffering from "an unhappy situation in the family", as Lennmalm often put it. To illustrate: a 49-year-old woman is anxious because she has been divorced by her husband who believed she was mentally ill; a 20-year-old woman suffers from hysterical fits triggered by her broken engagement (she also has a hysterical mother); and a 31-year-old woman has lived for ten years with a man who beats her, and she feels she cannot escape from him. She is in love with a penniless artist who has now abandoned her, and these two men are jealous of each other. Occasionally, she has fits which make her scream her eyes out, and which, as she dutifully tells Lennmalm, disturb the neighbours. Then there is a 28-year-old educated woman who is at loggerheads with her mother, who apparently does not approve of her engagement to a poor sculptor who is out of work. Lennmalm prescribes aspirin to the woman.[51]

A particularly instructive case is that of a 35-year-old woman who was in the process of divorcing her husband, a minister. In March 1903, she went to see Lennmalm and told him that she is scared of

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[50] Ibid., Abstract.

[51] Lennmalm's Clinical Diary, May 6, 1924 (49-year-old woman); March 4, 1900 (20-year-old woman); May 29, 1918 (31-year-old woman); and May 2, 1924 (28-year-old woman).

her husband, and that her headache and nervousness were the result of her husband's behaviour towards her. Lennmalm diagnosed her as suffering from neurasthenia and cephalalgia (headache).[52] Eight months later, he received a letter from the woman's lawyer, who asked him to write a medical certificate referring to the husband's brutal behaviour towards his wife, and stating that her health had improved since she left the husband. In his letter, the lawyer described how the husband, who had a respected social position in his community, wanted to convey the picture that nothing was wrong in their marriage. But at night, he made scenes that testified to his brutality, as a result of which the wife was in a state of constant fear and nervous tension. It seems that the husband's terror had been more psychological than physical, for, as the lawyer acknowledged, there was not much direct evidence of the husband's brutality. Nonetheless, as a result of these nightly scenes, the wife's own behaviour became erratic and uncontrolled, until one day during Christmas of 1901, she left her husband and the parsonage for good (the lawyer did not say where she had gone). The divorce had now been taken to court, and the lawyer wanted to use Lennmalm's medical certificate as evidence against her husband.[53] Lennmalm did write a certificate, the draft of which can be found in his clinical diary. In the draft, he states that the woman had consulted him, and that she attributed her headache and "a number of other nervous symptoms" to her fear of her husband, with whom she was in discord.[54]

Of course, there is no way of determining whether the woman's story is authentic or not, but there is no reason to doubt that her story was fabricated. The very fact alone that she was prepared to divorce her husband, a minister, indicates that their marriage was unhappy (also, they apparently had no children, which might be seen as another indication of discord in the marriage). What this 'case' of neurasthenia reveals is the extent to which external circumstances, in this case an unhappy marriage, triggered 'nervous symptoms' and drove some people to the offices of nerve doctors.

It says something about the very nature of neurosis that this 'neurasthenic' woman does not appear to (most of) us as a 'sick' person, but as a person who has been affected by a bad relationship. Those who

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[52] Lennmalm's Clinical Diary, March 13, 1903.

[53] A letter from the lawyer X to Lennmalm, November 26, 1903, Lennmalm's Clinical Diary, March 13, 1903.

[54] Lennmalm's Clinical Diary, March 13, 1903.

were on the receiving end of maltreatment, brutality and terror were the ones who often consulted doctors, and who were diagnosed as being nervously ill, while the 'perpetrators' shunned doctors and treatment, and, consequently, were not 'nervous'. Thus, with regard to women in particular, neurosis was the victim's or the loser's diagnosis, a diagnosis that doctors employed when they encountered unhappy patients such as the minister's wife, who was 'neurasthenic' only because she could not tolerate her husband's brutality. In parenthesis, it might be added that after seeing Ingmar Bergman's epic film *Fanny and Alexander* (1982), in which a diabolical bishop in early twentieth-century Uppsala marries the widowed mother of Fanny and Alexander and makes their lives a nightmare, one is perhaps more inclined to believe that what the minister's wife told to Lennmalm in 1903 was authentic…

It seems that women often experienced an unhappy relationship more intensely than men, who in general spent much of their time in the public sphere (especially at work) or with friends, and who were not so involved in housekeeping and child-rearing duties as women were. Women, even if they had jobs, were chiefly responsible for all domestic duties, and it is fair to assume that at least a moderate degree of harmony at home was of crucial importance to women. Such harmony was all the more valuable at a time when divorce was rare, and women were expected to endure maltreatment on the part of their husbands, as long as it did not escalate into more aggressive forms of violence. Women were also monitored by the community, including other women, much more closely than men, and their field of legitimate activities was much more restricted than that of men. And a woman who was more self-assertive, independent and sexually active than the normative codes allowed could easily be judged harshly—or pathologised (see Chapter 5). Lennmalm's female patients do not appear to be spoiled hysterics of the leisured class, but sufferers whose emotional life had been devastated to varying degrees by their unhappy experiences with 'significant others', with people who meant a great deal to them. Not infrequently, these people were their husbands.

Compared to women, men's nervous problems were related more indirectly to their personal relationships. In addition to pressures at work and in business, the problems men encountered with other people—including their wives—would manifest themselves as heavy drinking or impotence. And unmarried men who experienced difficulties in establishing sexual relations with women (excluding prostitutes) could easily be plagued by sexual frustrations, which increased their nervousness.

And their mental condition was hardly improved if, because of lack of sexual contact with women, they reverted to masturbation, which was commonly regarded as sinful or detrimental to health. Indeed, one might ask whether some men's sexual frustrations, impotence and alcoholism were caused, or at least exacerbated, by their wives' behaviour (e.g. indirect or verbal aggression).[55] If, for example, a wife constantly refused to have sex with her husband, or expressed her discontent with her life (and her husband) at every turn, then it is hardly surprising that the husband became nervous and took to drinking. The case records suggest that nervous women were victims of male brutality much more often than nervous men were of female aggression, but it would also be naive to assume that women did not have anything to do with men's nervousness. The dynamics of interactive relations are extraordinarily complex and go far beyond the scope of this book, so I shall leave this explosive issue and return to more solid ground.

10. *Economic problems and difficulties in the social environment*

To live in chronic poverty was the harsh reality for many Swedes a hundred years ago, and Swedish doctors routinely saw poverty as one of the principal 'exogenous' causes of neurosis. But as the indigent poor could not afford to consult Lennmalm in his private practice, there is very little indication of poverty in his clinical diary. In my sample, there are only two patients whose nervous problems Lennmalm related to poverty, and neither of them is hardly a typical representative of the indigent. One of them was a 34-year-old Master of Laws who earned his meagre income by giving lectures; and the other was a 64-year-old engineer who suffered from melancholy and a host of organic ailments, and who was "unable to read".[56] Although Lennmalm's patients, most of whom were from the middle-class, were not in general poor, they sometimes had financial problems. Among his patients there were businessmen and merchants whose businesses were not going too well,

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[55] For psychological studies on aggression in girls and women, see Kirsti Lagerspetz, Kaj Björkqvist and Tarja Peltonen, "Is Indirect Aggression Typical of Females? Gender Differences in Aggressiveness in 11- to 12-year Old Children," *Aggressive Behaviour* 14 (1988): 403–14; Kirsti Lagerspetz and Kaj Björkvist, "Indirect Aggression in Girls and Boys," in *Aggressive Behaviour: Current Perspective*, ed. L. Rowell Huesmann (New York: Plenum Press, 1994), 131–50; and Kirsti Lagerspetz, *Naisten aggressio* (Helsinki: Tammi, 1998).

[56] Lennmalm's Clinical Diary, April 18, 1906 (Master of Laws); March 26, 1918 (engineer).

and there were also individuals who had formerly been well-off and whose finances had been damaged by misfortune, such as debilitating diseases and bad investments.

Apart from economic troubles, some of Lennmalm's patients were affected by difficulties in their social environment. There was a 62-year-old man who believed he was misunderstood in his community; a 40-year-old woman who felt unhappy in her new apartment; another, 35-year-old woman who lived in an "unhealthy apartment" (Lennmalm prescribed a "change of apartment" as a treatment); a 67-year-old man who had sold his house and was now regretting the deal; and a 63-year-old woman who felt lonely. Then there were women who wanted to change the courses of their lives and move elsewhere. One such woman, a 49-year-old, obese neurasthenic, wanted to move to London and study music. Lennmalm prescribed "diet etc." and "London" as a remedy for her maladies. A 23-year-old female student in Uppsala attributed her nervousness to exams, a 38-year-old woman to her (apparently) irritating neighbours, and a 43-year-old neurasthenic engineer to his difficult working conditions in Russia (which was then in the midst of a civil war).[57]

A case quite unlike any other in the sample concerns two brothers from an upper-middle-class family who had turned their backs on the respectable bourgeois life. The brothers visited Lennmalm's office individually, probably not on their own initiative. The younger brother (27 years) was possessed by wanderlust and led the life of a vagabond, which prompted Lennmalm to use *vagabondage* as a clinical category.[58] The problem with the older brother (35 years) was that he "owns nothing and does nothing". Lennmalm, who obviously did not have much sympathy for people who lacked ambition, stamina and *arbeitslust*, prescribed "work" to his work-shy patient.[59] It would be intriguing to learn about the later lives of these two prodigal sons.

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[57] Lennmalm's Clinical Diary, April 23, 1895 (62-year-old man); April 23, 1896 (40-year-old woman); April 7, 1924 (35-year-old woman); April 24, 1900 (67-year-old man); April 9, 1900 (63-year-old woman); March 4, 1909 (49-year-old woman); April 14, 1914 (23-year-old student); April 7, 1924 (38-year-old woman); September 21, 1921 (43-year-old engineer).

[58] For a study of a 'disorder' that is called 'dissociative fugue' in DSM, and which is characterised by compulsive travelling and the concomitant, partial lack of memory of these trips, see Hacking, *Mad travelers*. Lennmalm, as usual, is very laconic in his Clinical Diary, but it seems that his vagabond-patient was not suffering from fugue.

[59] Lennmalm's Clinical Diary, March 26, 1915.

11. *Psychic shock, trauma or fright*

Lennmalm was not a depth psychologist who would dwell on the life history of his patients and look for hidden sources of psychic conflicts. Nevertheless, he regarded it as probable that grief and difficulties make heavy demands on the nervous energy (*nervkraft*), and that they also influence the body, especially the circulatory system. A full understanding of the role of hormones was still lacking in the late nineteenth century, but it seems quite certain that, had Lennmalm lived to see the implications of nascent endocrinology to neurology and psychiatry, he would have applied the language of hormones to illuminate the mechanisms of neurosis. But, as he was living in the 'pre-hormonal' era, he had to confess that as yet there were no adequate answers to the question as to how the circulatory system affected the nervous system (that is, the mechanism and function of the endocrine glands was still shrouded in mystery).[60]

Lennmalm wrote a long article on traumatic neurosis in the early 1890s,[61] while in the sample I found seventeen patients who suffered from the aftermath of trauma. It says a great deal about the way this diagnosis was employed at the time that only one of these patients suffered demonstrably from the consequences of a mental wound: a 24-year-old man had had a dream in which he was killed in a war in Greece. The dream was so vivid that it made his heart 'click' and he felt pain in the heart. After the dream, the chest had been tender.[62] All other cases about which Lennmalm gives more detailed information, concern trauma of a *physical* kind. Most of these patients were manual workers, and four of them worked on the railway, which gives further support to the medical observation that traumatic neurosis was frequently caused by railway accidents. A typical example of a railway-related trauma is the following: a 26-year-old railwayman got stuck in a train, which injured him only mildly, but he became very frightened and thought he would die. After the incident, he had had fits of palpitations. Lennmalm prescribed 'work' as a cure for his affliction.[63]

It was probably on Lennmalm's initiative that Jakob Billström studied traumatic neurosis in his medical dissertation, which was supervised by

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[60] Lennmalm, "Om de viktigaste orsakerna," 273–4.
[61] Lennmalm, "Om de s.k. traumatiska neuroserna."
[62] Lennmalm's Clinical Diary, March 28, 1904.
[63] Lennmalm's Clinical Diary, April 9, 1915.

Lennmalm. Billström's material consisted of 103 cases of traumatic neurosis. In an article based on his dissertation, he refers to the statistics showing that traumatic neurosis is anything but an endemic illness in Sweden: among 75,731 cases in which the insurance company *Fylgia* has granted compensation between the years 1892 and 1907, there appeared only thirty-six cases of traumatic neurosis (0,047%), and among 11,632 reports of accidents submitted to the National Social Insurance Board between the years 1903 and 1908, the diagnosis appeared only in 0,129 per cent of the cases. At the Serafimer's Neurological Polyclinic, traumatic neurosis comprised 0,6 per cent of all diagnoses between 1890 and 1908. Between the years 1901 and 1908, hospitals, sick rooms and poor houses in Sweden provided care to altogether 299 cases of traumatic neurosis, while the number of the cases of neurasthenia was 13,305—there were almost forty-five times as many cases of neurasthenia as there were cases of traumatic neurosis in these public institutes! Billström draws the obvious conclusion that it is totally unwarranted to speak of traumatic neurosis as a national malady. He observes further that this illness is on the decline in Sweden.[64]

True to the original neurological conceptualisation of traumatic neurosis, Billström's cases were decidedly not cases of psychic trauma. In all but one case, patients attributed their symptoms to a physical, not psychic, trauma. The only clearly 'psychic case' was a 30-year-old nurse who had witnessed how her patient had jumped over her and rushed through the window, falling from the third floor to the ground (Case No. 101). The nurse was terribly frightened of this incident, and became nervously ill (with the diagnosis 'neurasthenia'). After a few months of sick leave and less demanding duties at work, she recovered completely.[65]

Billström's dissertation demonstrates that traumatic neurosis was an illness that was predominantly related to physical injuries in the workplace. Most patients were male manual labourers whose physical traumas impaired their work performance more or less severely and gave rise to mental symptoms, such as depression, restlessness and anxiety. That in only one case the trauma evidently resulted from a psychic shock shows that in early twentieth-century Sweden, traumatic

[64] Jakob Billström, "Studier öfver prognosen af de traumatiska neuroserna," *Hygiea* 72 (1910): 1130–3.
[65] Ibid., 1407.

neurosis was still a physically-induced illness, in which psychic symptoms were contingent on physical injuries. In the interwar years, under the influence of psychoanalysis and psychosomatic medicine, the concept of trauma underwent transformation as a result of which psychic shock began to be seen as an aetiological factor in neurosis. Then, in the 1970s, traumatic neurosis changed its outlook and name, turning into a disorder that was seen to be caused by a psychic rather than physical shock: post-traumatic stress disorder (PTSD). It first reappeared in a specific context (the Vietnam War) in the 1970s, and it was given official recognition in 1980, when it was included in DSM III.[66] Today, PTSD is an established, if disputed, psychiatric diagnosis.

After this digression from Lennmalm's clinical diary, I shall now go back to his patients and turn to a more colloquial term that Lennmalm employed to denote the kind of 'trauma' that the aforementioned railway worker had experienced: fright (*skrämd*). Man of few words that he was, Lennmalm often did not bother to write down the actual incident which had frightened his patients and made them nervous. Here is an example of his tendency to concentrate on the 'bare essentials': a 23-year-old cleaning woman; hysterical deafness; frightened. Frightened of what?! We shall never know. But when Lennmalm became more talkative, we learn that, as might be imagined, his patients had become frightened for many different, and not always very serious, reasons. For example, a 31-year-old woman was scared by her neighbour's miscarriage; a 17-year-old girl became frightened when a dentist extracted her tooth; a 23-year-old woman was scared of an epileptic's fits; a 28-year-old teacher was frightened when a homeopath, whom he had consulted, told him that his vertigo was caused by a disease in the spinal cord; and a 4-year-old boy had become terribly frightened while walking on a street: he thought one of the buildings would fall down on top of him. Another case involving a child was much more serious: a 10-year-old boy had been trashed by his teacher, as a result of which he had become terribly frightened and had started to stutter.[67]

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[66] See Allan Young, *The Harmony of Illusions: Inventing Post-traumatic Stress Disorder* (Princeton: Princeton University Press, 1995).

[67] Lennmalm's Clinical Diary: March 7, 1908 (23-year-old woman); March 7, 1913 (31-year-old woman); March 27, 1920 (17-year-old girl); March 26, 1909 (23-year-old woman); April 5, 1922 (28-year-old teacher); March 28, 1911 (4-year-old boy); April 18, 1922 (10-year-old boy).

In addition, there are two cases of nervousness following childbirth, and one case of an attempted rape, in the sample. In general, there are many more frightened women than men among Lennmalm's patients, which is probably due at least partly to the prevailing masculine culture that did not easily allow men to display fear and other 'feminine' emotions. But as Lennmalm did not employ the language of psychic or emotional trauma, there are very few cases in the sample that can be categorised as 'traumatic' in the modern sense of the term.

The Language of Nerves

Lennmalm lived in a period of nervous culture, and although he stressed the importance of the 'psychological gaze' for doctors who treated neurotics,[68] the mentalistic language of the psyche and emotions was foreign to him. It was the work of his colleagues in France and German-speaking Europe—Freud, Janet, Jung and other 'dynamic psychiatrists'—that set the stage for the modern psychocultural preoccupation with trauma and psychic or emotional conflict. I have traced the first references to the new language of 'psychic conflict' in Sweden to the early twentieth century; in his popular medical manual, Henrik Berg refers in 1903 to 'psychic traumas' (*psykiska traumar*) as an aetiological factor of nervousness;[69] and Reinhart Gerling, the secretive narrator of his own nervousness, defines 'nervous people' as 'psychically ill' people (*själssjuka*), who suffer from a 'psychic conflict' (*själskonflikt*). Literally, however, *själskonflikt* means 'conflict in the soul', and the term 'psyche' (*psyke*) did not fully appear in the Swedish psychomedical language until some time after World War I.[70]

In the 1910s and the 1920s, the ideas and terms of dynamic psychology had begun to disseminate among professionals in the fields of medicine and mental medicine, and even if for someone like Lennmalm it was in the language of nerves that mental maladies were expressed, the younger generation of doctors were more receptive to new ideas that revolved around the psyche and psychic conflict, rather than the

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[68] Lennmalm, "De funktionella nervsjukdomarnas ställning," 459.

[69] Berg, *Läkareboken I*, 681.

[70] See, for example, Alfvén, *Hysterien*, 661 ('psychic trauma'); and Sven G. Lindholm, "Till belysande av de lungsjukas psyke," *SLT* 18 (1921): 685–8 [in English: 'An Illustration of the Psyche of the Consumptive'].

nervous system and nervous weakness. As historian of psychiatry Mikkel Borch-Jakobsen puts it in his critical study of the origins of 'psychic trauma', "the patients of Janet and Freud quickly learned that what was expected of them were forgotten traumas."[71] With time, neurosis was relieved of its original neurological matrix, the nervous system, and reconceptualised to designate psychic trauma and psychic or emotional conflict. Unlike the patients of Janet and Freud, however, Lennmalm's patients were expected to articulate their problems not in the nascent language of forgotten traumas or conflicts, but in the established language of nerves with which Lennmalm was familiar. In the letters that patients sent to him, one can see how many of them had learnt to interpret their mental and bodily states with the help of 'nervous language'. Words that repeatedly appear in these letters are 'nervous', 'nerves', 'nerve centre', 'nervous system' 'neurasthenia', and 'weakness of nerves'. To give but one illustration, an agent in a telegraph office wrote to Lennmalm in April 1923, explaining his condition as follows:

> The cause of illness is the weakness of nerves and the ensuing difficulty in sleeping. The illness was triggered by overstrain due to *telegraphering* and has continued since about 1906.[72]

In Lennmalm's clinical diary and in his patients' letters, one can also discern a continuation between the older language of nerves and the more recent language of the psyche. Just like people who suffer from depression and anxiety today, Lennmalm's patients were often 'anxious', 'depressed', 'exhausted' and 'overstrained'. And even today people still use the terms 'nervous' and 'neurotic', even though they are only seldom used in clinical contexts. Besides, such diverse complaints as business problems, the strain of exams, family problems or self-imposed standards of superior creativity, are about as common today as they were a hundred years ago.

I would suggest that changes in the language and mentality of people have not been as dramatic over the last hundred years as might be inferred from historical studies of medicine, psychiatry and psychology. I would further suggest that, with regard to sickness and health,

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[71] Mikkel Borch-Jacobsen, "How to Predict the Past: From Trauma to Repression," *History of Psychiatry* 11 (2000): 32.

[72] A letter from Mr H. A. to Lennmalm, April 21, 1923, Lennmalm's Clinical Diary, Case no. 29,646.

the language of professional groups has changed much more than colloquial language. It seems almost as if every generation of mental care professionals has an urge to change and update the prevailing clinical language, whereas 'ordinary people' have no such need. Mr and Mrs Svensson indeed learn to articulate their mental afflictions in terms that are provided by the professional groups through clinical encounters and the media, but they do not necessarily discard the older, established terms, especially terms that are used for expressing fundamental emotional states.

It seems hardly likely that such words as 'anger', 'worry', 'sadness', 'desire', 'jealousy' and 'grief' will disappear in the twenty-first century, not to mention 'love', 'hate', 'fear' and 'shame'. These terms denote emotions that are human universals, and one has to be a fanatical believer in social constructionism to argue that these emotions, and not only the concepts designating them, are environmentally determined.[73] I endorse the belief that suffering is part of the human condition, and that there is also a language of the human condition which, while changing with time, as all languages do, still gives expression to emotions-as-human-universals. Hence, I believe that when future historians read the patient records of Lennmalm or any other late nineteenth-century nerve doctor, they will not be baffled by the words that are used in these records.

While historians need to be extremely sensitive to conceptual changes, an awareness of the historicity of language does not inevitably alienate us from people in the past, who used different words from those we use now, or used the same words differently (e.g. 'melancholy' or 'hysteria'). We can still read and, to some extent, understand Plato and Aristotle, whose questions were determined by context-bound beliefs, presuppositions and intentions, and yet who transcend time and place, just like Shakespeare's dramas or Dostoevsky's novels. Similarly, the language of suffering, even that of people long gone, can find a resonance in us, provided we can decode the basic meanings contained in their language (e.g. in the deeply religious and animistic language of Europeans in the Middle Ages). And the reason the suffering of past peoples is not inexplicable to us, is that their emotional life is not alien to us. Even the ancient Romans mourned their deceased children.

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[73] For a incisive critique of the assumptions of social constructionism, see Steven Pinker, *The Blank Slate: The Modern Denial of Human Nature* (New York: Viking, 2002).

In this chapter, I have examined the suffering of Lennmalm's patients in his private practice. In the next chapter, I shall cast some light on the suffering of the patients at the Serafimer's *Nervpoliklinik*. I shall also make some concluding comments on the doctor-patient relationship, and on the suffering of the patients.

CHAPTER NINE

NERVOUSNESS WITH TEARS: PATIENTS AT THE 'NERVE CLINIC'

> Over the past six months, increasing anxiety. Bursts into tears… Has been nervous for many years; afraid of everything. Heart palpitations, sometimes headache. Economic difficulties. Diagnosis: Neurosis.
> (A medical evaluation of a 39-year-old male shop assistant at the Serafimer's Neurological Polyclinic in May 1925)[1]

This middle-aged man was a prototypical patient at the Serafimer's *Nervpoliklinik*: he exhibited exemplary psychological as well as somatic symptoms of a neurotic, and these symptoms appeared to be connected with his life problems ('economic difficulties'). During the period under survey in this chapter (1915–1950), the *Nervpoliklinik* was visited by thousands of patients who had the same or similar symptoms as this nervous shop assistant.

In this chapter, I shall focus on the way the nervous afflictions of patients were clinically evaluated by physicians working at the *Nervpoliklinik*. Unfortunately, it is impossible to determine who was responsible for a particular case record, because at that time physicians did not sign their records. Patients were probably examined by younger physicians rather than by the busy head of the clinic himself, but the chief physician (first Lennmalm, then Henry Marcus and, from 1931 to 1954, Nils Antoni) was the one who set the tone at the clinic, and his understanding of the nature of neuroses had an impact on the way his staff assessed their patients clinically.

At the *Nervpoliklinik*, the nervously ill constituted by far the single largest category of patients until the mid-twentieth century, and one could say that the polyclinic made neuroses highly visible in the Swedish medical community, as it provided care to a greater number of patients with nervous illnesses than any other clinic at the Serafimer, or, indeed, at any other hospital in Sweden. By way of comparison, at the two Medical Clinics at the Sabbatsberg, another hospital in

[1] Clinical record of the Polyclinic, May 4, 1925, No. 40,433.

Stockholm, neurosis constituted, on average, seven per cent of all cases between the years 1926 and 1933; at one of these clinics, ten per cent of all diagnosed illnesses among women were neuroses. In 1935, almost thirteen per cent of all cases at these two clinics were 'nervous cases' (*nervsjuka*).[2] It says a great deal about the significance of doctors' interpretations of symptoms that, at the Sabbatsberg, there were more than twice as many neurotic men at the Medical Clinic II than there were at the Medical Clinic I.[3]

On the Diagnostic Categories at the Polyclinic

The *Nervpoliklinik* was a busy place, a real 'mass polyclinic'.[4] Each year, thousands of patients visited the clinic, which meant that the time doctors could spend with each patient was very limited—doctors had to be efficient and arrive at a preliminary diagnosis quickly. The interwar years especially were a hectic period at the clinic. In 1930, for example, 3,941 patients consulted doctors at the clinic and the overall number of visits was 12,389. Most patients (80 %) visited the clinic only once or twice, although the doctors were supposed to prompt their patients to stay in contact with the clinic after the first visit, either by personal visit or at least by telephone (the same patient sometimes visited the clinic a number of times to receive electrical, insulin or anti-syphilitic treatment).[5]

What is striking in the nervous diagnoses employed at the clinic is that during this relatively short time span—thirty years—the use of specific diagnoses varied a great deal. Table I illustrates the diagnostic popularity of different neuroses.

These figures might indicate that many neuroses were endemic illnesses of short duration, suddenly affecting people and then disappearing like a thief in the night. Neurasthenia, for example, changed from being overwhelmingly the largest diagnostic category in the whole clinic in 1922 to that of a minor category in 1925—from mountain to molehill

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[2] Arnold Josefson, [Commentary]. *Förhandlingar*, October 26, 1937, 523.

[3] Bengt Boye, "Om neurosfrekvensen hos invärtesklientelet vid Sabbatsbergs sjukhus åren 1926–1933 jämte vårdade fall av suicidalförsök," *NMT* 9 (1935): 252–7.

[4] Ragnar Bringel and Lisa Welander, "Neurosvårdens närmaste behov," *SMT* 13 (1936): 38.

[5] Serafimer's Annual Reports 1915–1950; Bringel and Welander, "Neurosvårdens närmaste behov," 37; Antoni, "Neurologiska klinikens forntid," 376–7.

Table I. *The distribution of different nervous diagnoses at the Neurological Polyclinic*

Diagnosis	1922	1925	1930	1935	1940	1945	1950
Hysteria	36 cases 2,0 %	59 cases 5,0 %	54 cases 4,0 %	46 cases 2,9 %	40 cases 4,9 %	30 cases 9,8 %	18 cases 12,9 %
Neurasthenia	1543 89,1 %	65 5,5 %	1255 93,2 %	534 30 %	158 19,3 %	–	–
Neurosis	84 4,9. %	995 83,7 %	29 2,2 %	170 9,5 %	412 50,4 %	259 84,9 %	96 69 %
Psychoneurosis	54 3,1 %	47 3,9 %	–	1012 56,8 %	201 24,6 %	–	–
Traumatic neurosis	14 0,8 %	24 2,0 %	8 0,6 %	19 1,0 %	6 0,7 %	–	–
Psychasthenia	–	–	–	–	–	16 5,2 %	25 18 %
The sum total of nervous diagnoses	1 731	1 190	1 346	1 781	817	305	139

Source: *Serafimer Hospital's annual reports 1922–1950*

in three years! Then, only five years later, neurasthenia was again by far the largest category, while 'neurosis', the diagnostic giant of 1925, had dwindled to a diagnostic dwarf by 1930. To the uninitiated, these changes might suggest that two epidemics, neurasthenia and neurosis, wreaked havoc in the interwar years, but at different times.

As Ian Hacking has pointed out, disease entities in general and psychopathologies in particular are not stationary, natural or 'indifferent' kind of entities; they are classifications of an 'interactive kind', because they change, overlap with and evolve from a host of earlier classifications.[6] And as I suggest in this book, this statement is especially valid with regard to neuroses. Among neuroses, neurasthenia ruled supreme at the polyclinic for more than thirty years until similar symptoms began to be designated using other diagnostic terms. This is what happened in 1925, when neurosis replaced neurasthenia as the major nervous illness. What is even more extraordinary in medical history is that the declining diagnosis returned with a vengeance only a few years after its demise, as happened at the *Nervpoliklinik* during the latter half of the 1920s. But this triumphant return of neurasthenia was only temporary, as during the following two decades, it was neurosis that established itself as the dominant diagnostic category at the clinic. After sixty years of service, neurasthenia seemed to be on its way out as a diagnosis in 1943, its place having been annexed by neurosis and psychasthenia. The latter term, coined by Pierre Janet in the early century, had, unlike neurasthenia, never become a truly contagious diagnosis, but at the polyclinic it had enjoyed a short career as a middle-sized nervous illness in the 1940s. Unlike psychasthenia, however, neurasthenia was a persistent diagnosis, reappearing in the *Nervklinik*'s annual report in the late 1950s as 'Syndroma neurasthenica', and in the DSM-II in 1968!

One particular illness which has since become a contagious diagnosis not unlike neurasthenia, and which made its first 'official' appearance in 1939 at the polyclinic, was depression, or 'depressio mentis (psychogenic)', as it was usually called in the 1940s. Its diagnostic history at the clinic is somewhat peculiar, for after 1939 and 1940, when it comprised about seven to eight per cent of all cases at the clinic, depression had become an insignificant diagnostic entity by the late 1940s (in 1950, there were no depressed cases in the clinic's annual report). Then, in the

[6] Ian Hacking, *The Social Construction of What?* (Cambridge, MA: Harvard University Press, 2000), 100–24.

early 1950s, a new system for the classification of diseases, authorised by the Royal Board of Health, was introduced in Sweden. In this new system, neuroses were given the generic name 'psychoneuroses' and separated from diseases of the nervous system. Neuroses were placed in the category entitled 'Mental diseases. Psychoneuroses. Pathological personality types' (No. V). The most remarkable difference between this and the previous classification was that neuroses were no longer classified as 'nervous illnesses'. Instead, they were grouped together with psychiatric diagnoses, such as schizophrenia, psychopathy and debility. As a result of the new classification, depression ('reactio neurotico-depressiva') became one of the medium-sized psychoneuroses, which were now officially psychiatric illnesses.

The new classification of diseases was a clear indication of the transformation of neurosis from a neurological to a psychiatric and psychological illness, belonging to the domain of psychomedical expertise. Officially, the new diagnoses were given Latin names, which made them more serious-looking, quasi-exact and incomprehensible to laymen. Under the rubric 'Psychoneuroses', the illness No. 318, for example, was entitled 'Casus psychoneurotici: typi alii, mixti, non definiti'. And the official name of hysteria was 'Reactio hysterica: reactio angoris non indicata'. One cannot help but wonder whether the medical experts who suggested these Latin diagnostic labels were secretly laughing at their verbal acrobatics—but the chances are that they were dead serious about it.

Class and Gender

As we saw in the previous chapter, the majority of Lennmalm's private patients belonged to the middle and upper-middle classes. The socio-economic background of the *Nervpoliklinik*'s patients was quite different, the majority of patients representing the working class and the lower middle class, including artisans, small entrepreneurs and low-ranking officials and civil servants. The lower socio-economic status of the polyclinic's patients, compared to Lennmalm's private patients, meant that economic difficulties (unemployment, debts, poor salaries or low entrepreneurial incomes) comprised a considerable neuroticising factor among the clinic's clientele. Especially during the first half of the 1930s, unemployment was often mentioned in the clinical records as one of the principal sources of anxiety and nervousness. Ragnar Bringel and

Table II. *The proportion of male and female patients at the Polyclinic who suffered from neurosis*

Year	Male	Female
1930	30 %	70 %
1935	32,5 %	67,5 %
1940	34 %	66 %
1945	46,6 %	53,4 %
1950	47,5 %	52,5 %

Source: *Serafimer Hospital's annual reports 1922–1950*

Lisa Welander, two doctors working at the polyclinic, wrote in 1936 that although the labour market had become less tough in recent years, thirty-three per cent of the male patients at the clinic were unemployed; the corresponding figure among female patients was ten per cent.[7] Partly also for economic reasons, the death or illness of a spouse, as well as divorce, was often a serious threat to a family's physical security. As a consequence of the development of welfare services in social-democratic Sweden from the early 1930s onwards, the number of patients who related their suffering to social and economic conditions diminished, but the growing number of divorces meant that economic problems continued to haunt many women patients at the *Nervpoliklinik*.

Women were haunted by a host of other problems as well, and more than two thirds of the patient population at the clinic were women until World War II. The polyclinic's annual reports show, however, that neurosis as a whole became less and less a female illness (or, a cluster of illnesses) during the period under survey.

By the late 1940s, there were almost as many men as there were women among nervous patients. These numbers suggest that, while the number of women suffering from mild mental maladies continued to be higher than the number of afflicted men, a remarkable change in the very nature of neurosis took place during the second quarter of the twentieth century. Hysteria, for example, ceased to be a gender-specific illness: in 1950, eight out of eighteen hysterical patients at the polyclinic were men. When we look at the Serafimer's annual report of 1960, we notice that forty-four per cent of 'psychoneurotic' patients at the

[7] Bringel and Welander, "Neurosvårdens närmaste behov," 36.

Nervklinik were men. With regard to the gender-specificity of neurosis in the post-World War II era, the pattern is clear: women continued to be diagnosed as neurotic more often than men, but the difference between the numbers was no longer statistically significant. The commonplace male prejudice that the nervous system of women was weaker and more fragile than that of men was finally being discredited in practice. Or maybe the reason for the relative 'masculinisation' of neurosis was that in the post-war era it was conceptualised as an outcome of psychic conflict or trauma, rather than of 'weakness' in the nervous system, which by definition made women—whose nervous system was commonly regarded as weaker than that of men—more vulnerable to neuroses. In the nascent psychoculture, the gender-biased language of nerves was being replaced by the more gender-blind language of the psyche.

Nervousness with Tears

A striking difference between Lennmalm's private patients and the *Nervpoliklinik*'s predominantly working-class patients was that the symptoms of the latter group appeared to be psychologically more severe. Like Lennmalm's patients, patients at the polyclinic were typically nervous, anaemic, worried and anxious. They also suffered from headache, sleep disturbances, overstrain, dizzy spells and neuralgic pains here and there. But unlike Lennmalm's patients, these patients were also prone to weeping. Indeed, weeping was one of the most typical 'symptoms' of these patients, especially but not exclusively among women. It may seem as though these patients were less in control of themselves than the middle-class patients who consulted Lennmalm, but a more 'materialistic' explanation for their proneness to burst into tears is that their problems were, on the average, more serious than those of Lennmalm's patients, and that they were more desperate than Lennmalm's patients. This suggestion is supported by the observation that there were more suicidal patients at the polyclinic than in Lennmalm's private consultation room.

Another explanation for the 'weep-proneness' of these working-class patients is that they lacked words to express their anguish—instead of articulating their problems in spoken words, as Lennmalm's private patients were able to do, the less educated people at the *Nervpoliklinik*, lacking the conversational tradition of the educated classes, used

tears instead of words to convey the message that they were suffering. Sometimes the doctor was unable to determine the problem due to the patient's inability to explain verbally what was wrong with him or her. For example, a 24-year-old, unemployed waitress who visited the clinic in August 1930 told her doctor that she was 'nervous', but she could not explain what she meant by that. (One might guess that her nervousness had something to do with her unemployment, but the doctor did not make this obvious connection in his clinical notes).[8]

Yet another explanation for the weep-proneness is that weeping was used intentionally by some patients as a form of rhetoric, in order to persuade the doctor of the severity of their nervous symptoms, and to elicit feelings of empathy from the doctor. If a male worker with a rough exterior burst into tears, it was a sure sign that he had not come to the clinic for nothing. Finally, it is a distinct possibility that Lennmalm's private patients were also prone to weeping without Lennmalm bothering to make notes about it. While it is impossible to determine the reasons why so many of the *Nervpoliklinik*'s patients burst into tears, the fact is that weeping was a very common form of emotional outburst among these nervous patients.

A typical representative of a nervous patient at the polyclinic was a 43-year-old woman who had 'always' been nervous; she cried a great deal, slept badly and was often lost in thought (*grubblar*). She was prescribed regime as a therapy.[9] Usually, doctors at the clinic appeared to be well aware of the connection between patients' nervous symptoms and the difficulties they faced in their everyday lives, but occasionally an obvious connection between nervousness and problems in life seems to have gone unnoticed. For example, a doctor who examined a mother and her 11-year-old daughter in April 1920 wrote about the latter: "Always nervous, cries *without any reason*. Does badly in school" [my italics]. But the mother's clinical record reveals that one child in the family had died two years ago, and that the loss of her child had made the mother "especially nervous".[10] It is astounding that the doctor made no connection whatsoever between the daughter's and her mother's nervousness, and between the daughter's nervousness and the death of her sister or brother.

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[8] Clinical record of the Polyclinic, August 2, 1930, No. 53,768.
[9] Clinical record of the Polyclinic, March 16, 1920, No. 20,560.
[10] Clinical record of the Polyclinic, April 8, 1920, Nos. 20,591 and 20,592.

Another indication of the severity of the symptoms was that signs of psychosis were not uncommon among patients at the polyclinic. Indeed, a number of patients were diagnosed as mentally ill ('psychotic'), and there were many 'borderline cases' which made it difficult for the doctor to determine whether the patient was neurotic or psychotic. If a patient was regarded as mentally ill, he or she was usually diagnosed as schizophrenic ('dementia praecox'), paranoiac or simply 'psychotic'. Two major criteria for symptoms to be considered indicative of a psychosis were hallucinations and obsessive, often persecutory, thoughts which patients experienced as excruciating. For example, a 50-year-old woman told her doctor that she had been unhappily married for eleven years, and that her husband had tried to strangle her. She was diagnosed as 'paranoiac' and sent to a psychiatric clinic.[11] Thus, the doctor thought that the patient was not telling authentic facts about her life, but only expressing her paranoiac state of mind.

Another, more complicated case concerned a 17-year-old boy who was diagnosed as 'psychoneurotic' on his first visit to the polyclinic in January 1935. The boy told the doctor that he had always been contemplative, but in recent years he had become very nervous, and now he saw himself as a 'bad person' who ought to be punished. He also suffered from persecutory ideas, and believed that he could never be 'good'. The boy thought that his agitated state of mind was caused by his (moderately practised) masturbation. When he returned to the polyclinic six months later, his condition had worsened; he was now withdrawn and irritable. This time he was diagnosed as psychotic and referred to a psychiatric clinic.[12] Evidently, if a patient was hallucinating, had delusions and persecutory or otherwise strange ideas, was deeply depressed or anxious, and seemed to lack insight into his or her illness, he or she was held to be mentally ill ('psychotic') rather than merely neurotic. In general, as Nils Antoni pointed out in his historical overview of the *Nervklinik* in 1937,

> psychiatric syndromes play such a big role among these patients that a psychiatric training is necessary for the correct evaluation of them. But, at the same time, these encounters with [psychiatric] patients are precisely what constitutes the psychiatric activity [at the clinic].[13]

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[11] Clinical record of the Polyclinic, September 8, 1930, No. 53,578.
[12] Clinical record of the Polyclinic, January 30, 1935, No. 247 (M = Male).
[13] Antoni, "Neurologiska klinikens forntid," 379.

In the case of the 17-year-old boy, the original, more neurological diagnosis was replaced by a psychiatric diagnosis on his later visit to the clinic. Such diagnostic changes were commonplace. For example, a 39-year-old wife of a miner was diagnosed as neurasthenic when she visited the clinic for the first time in 1936. A year later, she was suffering from psychoneurosis and lumbago, and in 1939 her ailments were labelled as cephalalgia and neurotic vertigo. A year later again (in 1940), she was suffering from neurosis and dyspepsia. Thus within a time-span of four years she had been diagnosed first as neurasthenic, then as psychoneurotic, and, finally, as neurotic. Another patient who visited the clinic in 1940 had been diagnosed as 'neurotic' a year before, but now she was diagnosed as suffering from sleeplessness and neurasthenia. Yet another patient who was neurotic in 1936 and 1937 became a psychopath and a hypochondriac (the latter diagnosis was in parentheses) on her third visit.[14]

Ruben Holmström, chief physician at the Mental Hospital in Malmö, observed in 1933 that

> one practitioner calls depression neurasthenia; another, neurosis; and a third, psychoneurosis. The name [of the illness] does not seem to make much difference, and this [conceptual confusion] is, as a rule, totally based on our ignorance.[15]

What Holmström did not elaborate was the problem of how to make a more accurate diagnosis of the illness in question (in this case, 'depression'). He knew that the boundaries between different mental maladies overlapped and were extremely blurred, making it difficult, if not downright impossible, to develop viable criteria for determining the parameters of a specific illness. Neurosis especially was a tricky illness for doctors, because the medical interpretation of symptoms largely relied on the patients' subjective utterances. In a way, the language of the patient could often be seen as a difficult text, which the doctor had to first decipher and interpret in clinical language, and then contextualise by seeking connections between the subjective symptoms and the patient's case history, including his or her life situation as a whole.

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[14] Clinical record of the Polyclinic, January 2, 1940, Nos. 10 and 17 (F = Female).

[15] Ruben Holmström, "Psykiatrici och de i vidare mening psykiskt sjuka," *SMT* 10 (1933): 196.

Holmström's observation corroborates the statement that, in medical practice, neurasthenia, neurosis, psychoneurosis and psychopathy were interchangeable diagnostic terms, clinical labels that were hastily employed by doctors in a busy polyclinic that received thousands of patients each year. Because of such hectic working conditions, a doctor could not afford to spend too much time on a careful clinical assessment of individual patients, especially when neurotic symptoms were clearly in the foreground. It did not matter too much whether the doctor favoured 'neurosis' over 'neurasthenia', or 'psychasthenia' over 'psychoneurosis', as long as the patient's symptoms were not deemed to be of an organic nature, which would have warranted a closer medical investigation. This, I would suggest, explains why the majority of patients at the *Nervpoliklinik* were neurasthenics in 1922 and 1930; neurotics in 1925; and psychoneurotics in 1935 (see Table I).

In the end, it was rather immaterial which particular diagnosis the doctor preferred, as long as he could provide a cure. And those who were successful in providing a cure seemed to radiate therapeutic optimism rather than scientific rigour. Gösta Ingvarsson, a physician working at the Board of Pensions' department for psychoneuroses at the Hospital in Vänersborg, wrote in 1947 that it is often beneficial to the nervous patient if the doctor avoids negative pathological speech forms, and strives instead to express his message in positive, colloquial terms (e.g. 'temperament' or 'condition'). In the case of neuroses, writes Ingvarsson, the main objective is not to give as exact as possible scientific information to the patient, but "to release his nervous tension and make him leave the consultation room with a liberating smile, singing a merry tune to himself on the staircase".[16] Gunnar Kahlmeter, who had worked at the Serafimer's *Nervpoliklinik*, emphasised in 1927 how in the treatment of neuroses

> the personality of the doctor plays an enormously large role, larger than in other diseases… Whether the doctor employs simple rest cures, combined with medicinal and physical theraphy [sic], or whether he employs direct or masked suggestion, hypnosis, 'persuasion' and 'rééducation', psycho-analysis or 'psycho-synthesis', his personal influence will be the main thing.[17]

[16] Gösta Ingvarsson, "Om språkformen vid terapeutiska samtal," in *Om sjukdom och sjukvård.* 272.

[17] Gunnar Kahlmeter, "On the Results of the Treatment of Neurotic Patients," 81.

A good nerve doctor appeared to be the one who managed to give hope, or positive illusions, to the patient, and a reliable way to influence the illness behaviour of the nervous patient was to treat him friendly and to direct the patient's attention to the prospect of cure.

Psychotherapy in Demand

During the 1930s and 1940s in Sweden, the 'psychoneurological' language of nerves was updated by the language of the psyche and psychic conflict, which laid the therapeutic stress on psychotherapy rather than on traditional physical therapies. In the spring of 1950, a 41-year-old carpenter, who was troubled by a host of somatic ailments (diffuse pains, gastritis) was examined at the Serafimer's Medical Polyclinic, but doctors found nothing wrong with him physically. He then went to the *Nervklinik* and suggested to his doctor that his troubles were psychically determined: there had been difficulties in his family during his childhood, and now he was plagued by economic difficulties. The only light in the darkness of his life was his harmonious marriage. He was diagnosed as suffering from 'cephalalgia & psychoneurosis'. Nils Antoni, head of the *Nervklinik*, referred him to the Board of Pensions' clinic for the nervously ill.[18]

Two years later (in 1952), the carpenter wrote a letter to Antoni saying that he had spent two months at the Board of Pensions' clinic in Nynäshamn, but upon leaving the clinic his condition was exactly the same as it had been upon his arrival: various physical therapies (massage, hydrotherapy, drugs, etc.) dispensed at Nynäshamn had not helped him at all. Recently, he had listened to some popular lectures on neurosis on the radio, and he now wonders whether he should try to regain his health with the help of psychoanalysis and 'psychosynthesis' (the latter term probably referring to Poul Bjerre's brand of psychotherapy). The tone in his letter is nearly desperate: he writes that for three years he has been mostly unable to work, especially during the winter, and that he is very worried about the dire consequences of his invalidism for his family. In his view, his diffuse pains and a very severe headache, as well as his sensitivity to noise, must be psychically determined, because 'external' treatment has not removed his symptoms.

[18] Clinical record of the Polyclinic, No. 469/1950 (M).

Now he wants to get help from a 'soul doctor' (*själsläkare*) in order to learn something about his "probably subconscious problems", and he turns to the "chief of the Serafimer's nerve ward" for advice on how to get this sort of help (psychotherapy, that is). "I don't mind if it takes time and money," writes the carpenter, "for if I can hope to get results, it is worth the cost."[19]

In his short reply to the carpenter, Nils Antoni wrote dryly that neither he nor any other doctor in his clinic provided psychoanalytic or 'psychosynthetic' treatment. Antoni advised him to consult a local general practitioner and obtain a referral to the *Nervklinik* for further examination.[20] As there are no further notes on this 'case' in the patient records, it is possible that the carpenter, who had already visited the *Nervklinik* two years previously, was discouraged by Antoni's statement that he could not expect to receive psychodynamic therapy at the clinic. The chances are that he found a psychotherapist in private practice who was able to help him; it seems that what he was after was simply a connection with another human soul.

The carpenter mentioned in his letter to the *Nervklinik* that he had heard someone giving a presentation on neurosis and its therapy on the radio. He was probably not the only patient at the *Nervpoliklinik* who had taken his or her cue from what was said on air or printed in a newspaper or general interest magazine. The 'mass-media' of the time, the radio and the printed word in particular, disseminated information and opinions about mental medicine among the general public, and popularised psychomedical theories and therapies. In the 1940s, there were more radio receivers in Sweden per capita than anywhere else in the world, and people who listened to the radio programmes were enlightened by at least one 'scientific lecture' per day.[21] Via these popularising lectures on the air, as well as via the printed word, the Swedes learnt about medicine and psychology, which helped them to articulate their problems when they went to see doctors.

From Nils Antoni's reply to the nervously ill carpenter, it may be inferred that psychoanalysis had no place at the *Nervklinik*. Indeed, the polyclinic's patient records show hardly any sign of doctors providing

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[19] A letter to the *Nervklinik*, March 6, 1952. Clinical record of the Polyclinic, No. 469/1950 (M).

[20] Nils Antoni's letter to the carpenter, March 13, 1952. Clinical record of the Polyclinic, No. 469/1950 (M).

[21] On the history of radio broadcasting in Sweden, see Nordberg, *Folkhemmets röst*.

psychoanalytic therapy, or of referrals to the handful of psychodynamically-oriented private practitioners in Sweden. In my sample, only one patient, a sheet-iron worker who was troubled by constant blushing and trembling of the hands, was referred to a psychoanalyst.[22] The psychoanalyst in question was probably Gunnar Nycander, who had done his internship at the *Nervpoliklinik*, and who had estimated that only about ten per cent of the patient population at the clinic were 'psychologically suitable' for psychoanalysis. And those who were 'economically suitable' for psychoanalysis constituted hardly *one* per cent of the clientele.[23]

Like with the carpenter, who inquired about psychoanalysis, the opportunity to discuss their problems at length was probably what many patients wanted. In reality, about ninety per cent of patients at the polyclinic were prescribed drugs. They were also given advice or referred to another clinic or hospital for further examination. Psychotherapy was by its very nature time-consuming, and the staff had no opportunity—even if they had motivation—to spend a large amount of time listening to their nervous patients. Thus it seems that talk therapies were not administered at the polyclinic.

In 1947, a physician who treated neurotic patients in another hospital recommended that the doctor should put questions to the patient, thus reversing what he regarded as the usual pattern of interaction in the doctor-patient encounter, where the patients ask questions and the doctor replies to them.[24] That in 1947 a doctor who treated neurotics considered it radical to suggest that doctors should be more active in trying to understand the problems of their nervously ill patients, tells us something about the nature of doctor-patient relationships in Sweden in the 1940s. Arguably, unless you were a psychotherapist or nerve-doctor à la Poul Bjerre, you were not accustomed to doing something so extraordinary as asking patients questions and, by implication, as putting some faith in the patients' own insight into their suffering. Indeed, a perusal of case studies published by Swedish psychiatrists in medical journals and monographs during the period under survey in this book (1880–1950) shows that psychiatrists routinely spoke of what they did to the patients, as opposed to what they heard from them.

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[22] Clinical record of the Polyclinic, January 3, 1935, No. 38 (M).
[23] Bringel and Welander, "Neurosvårdens närmaste behov," 39.
[24] Ingvarsson, "Om språkformen."

Nervous Children and the Nervous Family

The psychodynamic approach was conspicuous in its absence also with regard to nervous children, whose symptom pool differed considerably from that of adult neurotics. In children, typical signs of nervousness were disobedience, restlessness, ejaculation ('ejaculation praecox') and an inordinately strong self-will, and if such obstinate children were also bed-wetters (suffering from 'enuresis') or nail-biters, they easily fulfilled the criteria for 'infantile neurosis' or 'neuropathy'. The latter diagnosis was frequently applied to children, who were thus regarded as constitutionally disposed to nervousness. And if they had problems at school or in adjusting to the disciplinary demands of the grown-ups, they could be diagnosed as psychopaths. There is of course no way of telling how these children were raised by their parents or guardians, but I have not seen any evidence of doctors making critical notes about the adults who were responsible for these nervous children. In one case, that of a 9-year-old 'psychoneurotic' boy, the doctor made this short remark: "Reared by different foster parents."[25] It was more typical for the doctor to refer vaguely to the 'nervous' mother or father, which suggests that the nervous child had inherited his or her nervousness from the parents. For example, one 12-year-old girl, who had "always been very nervous" and "not like other children", had a nervous father who apparently had passed on his nervous disposition to his offspring.[26]

As we have seen, references to the 'nervous family' were commonplace in Lennmalm's clinical diary, but such references became less and less frequent in the polyclinic's patient records over time. During the interwar years, the concept of the 'nervous family' was to some extent reformulated in Swedish medicine, as a result of which the term no longer necessarily referred to the genetical disposition of nervous patients as much as to the negative influences of environmental factors on the mental constitution or the nervous system. Thus, in the 1940s, a medical reference to a 'nervous father' might have meant that the father was considered nervous, not because of his inherited character traits or his constitution, but because of his recent unhappy experiences (unemployment, debilitating illness, death of a family member, and so forth). Still, regardless of whether the parents of nervous children

[25] Clinical record of the Polyclinic, February 1, 1940, No. 217 (M).
[26] Clinical record of the Polyclinic, April 8, 1920, No. 20, 597 (F).

were 'constitutionally' nervous or not, 'nervous children' themselves were beyond the pale therapeutically, since doctors could not do much except give words of advice or refer the child to another clinic, to a paediatrician or to the child welfare services.

Comedy and Tragedy

Charlie Chaplin, a great comedian and a great moralist, once said something like this: "In a long shot, life looks like a comedy; but in close-up, it looks like a tragedy."[27] I would suggest that Chaplin's observation is especially valid with regard to the lives of many neurotics. Seen from a distance, neurosis may look somewhat silly and wanton, a socio-cultural rather than medical phenomenon that is sustained by the fabricated angst of the urban middle classes—something that makes you laugh when you watch a Woody Allen movie filled with affluent neurotics from Manhattan, for whom a visit to a 'shrink' is part of their weekly schedule. Neurosis is a component of western psychoculture, with its therapeutic ideology of victimhood and psychological vulnerability, and its suggestion that life is full of potential crises and conflicts that require individuals to seek professional help. In a society of experts, the use of diagnoses such as neurosis and its successors, including depression, anxiety disorder and post-traumatic stress disorder, can be seen as a way of legitimising the expertise of professional groups, whose very *raison d'être* is founded on the cultivation of the notion that the human condition can be formulated in terms of psychopathology.

In brief, to the detached commentators on psychoculture, neurosis readily appears as a term that is suffused with questionable or even ridiculous therapeutic ideology. When commentators take a closer look at the phenomenon, they may find it imperative to reconsider some of their assumptions. This is what happened to me when I began to read the *Nervpoliklinik*'s patient records, for I discovered that these working-class and lower-middle-class 'neurotics' were sufferers who felt miserable and unhappy. On closer examination, neurosis began to resemble life in a close-up as Chaplin defined it: there was an element of tragedy in the lives of these nervously ill people.

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[27] Peter von Bagh, *Elokuvan historia* (Helsinki: Otava, 1998), 113 [In English: 'A History of Cinema']. This is a not a direct citation of Chaplin's words.

An illustration of Chaplin's observation is the case of a 38-year-old former sailor, who had established a new career of sort as a street musician, playing the accordion and trying to make a living in a highly competitive racket (evidently, accordion players were not in short supply in the 1930s). Now he was afraid that his powers had began to wane, and he suffered from disturbed sleep and anxiety (he also had a deformed back). He was given the diagnosis psychasthenia, with the sarcastic comment "silly Jämtland-hypochondriac of a psychasthenic type."[28] (Jämtland is a geographical region in Sweden). The idea of a psychasthenic ex-sailor who plays the accordion at small parties and in people's homes may sound quaint and even funny, but—as Chaplin himself knew very well—the life these poor men led brought little reason to laugh.

As already mentioned, the polyclinic's patients appeared to have had, in general, more severe symptoms than Lennmalm's middle-class clients had. This was arguably due to the fact that, as I have already noted, compared to the more affluent 'neurotics', the lives of the polyclinic's patients were harsher and more dependent on the vicissitudes of circumstances and conditions (fluctuations in the labour market, housing conditions, infectious diseases, unbalanced diet, often harsh disciplinary methods applied to 'misfits' and so forth). Therefore, what was called 'neurosis' was usually a term referring to a person's state of mind (with accompanying somatic ailments) when they faced difficulties in life they found hard to cope with. In my sample, people who came to the polyclinic were not suffering from existential malaise or a lack of deeper meaning in their lives; they went to see a doctor because they were unable to work or sleep or concentrate or think clearly or get rid of strange or obsessive thoughts or have conversations with others or stop drinking or stop their husbands from beating them, and so forth. What was characteristic of these people was that they had lost their very zest for life, as Reinhart Gerling notes in his 'pseudoautobiographical' study of nervousness.[29] In the life of these nervous invalids, there was very little sunshine.

Small wonder, then, that the ominous word 'suicide' or 'suicidal' appears in the records every now and then. References to suicide reflected the growing public awareness of this major social and medical

[28] Clinical record of the Polyclinic, March 18, 1935, No. 567 (M).
[29] Gerling, *Min nervositet*, 17.

problem in Sweden—between the late eighteenth and early twentieth centuries, the number of suicides increased manifold, and newspapers, especially the popular press, sometimes gave detailed reports of the circumstances surrounding suicidal acts.[30] In Sweden, the number of suicides reached a peak in 1914, the same year legal restrictions on the purchase of alcohol came into force. The statistical correlation between alcohol consumption and the rate of suicides was evident in Sweden, and it is plausible to assume that men's nervousness and their drinking habits went hand in hand too. What is clear is that many nervous patients, mostly men, were heavy drinkers. The economic crisis and the ensuing mass unemployment in the early 1930s increased the number of nervous men at the polyclinic, and many of these men had sought consolation in the bottle—alcoholism, although of lesser magnitude than it had been in the nineteenth century, was a major social problem and personal tragedy for many families during the period under survey.

Sufferers, Not Malingerers

In the patient records that I have read, I have seen no evidence of the Serafimer's doctors portraying patients as malingerers or disease-mongers eager to conjure up or grossly exaggerate their symptoms, in order to take full advantage of their alleged ill health. What I have seen a few times are sardonic comments, such as that given by one doctor in response to the manifold complaints of a 40-year-old railway worker: "Has all the possible diseases."[31] Apparently, patients who intentionally simulated symptoms constituted a small minority, and this was probably true of the clients of private practitioners as well. Psychotherapist C. V. Söderlund observed in his 1923 article that

> during the 14 years that I have devoted myself to the study of neurosis, I have not been able to prove any *will* to sickness or will to dominate by means of the symptoms, to any higher degree than when people generally make the best possible use of any situation.[32]

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[30] Gustaf Hultqvist, "Några iakttagelser och reflexioner rörande självmorden i Stockholm," *Förhandlingar*, January 13, 1925, 8–19. For a historical study of suicide in Europe, see Ilkka Mäkinen, *On Suicide in European Countries* (Stockholm: Almqvist & Wiksell International, 1997).

[31] Clinical record of the Polyclinic, February 4, 1920, No. 20,462.

[32] C. V. Söderlund, "Psychotherapeutic Notes," *Acta Medica Scandinavica* 4 (1923): 438.

Indeed, there is a substantial difference between simulation/malingering and 'making the best possible use of any situation'. Among the *Nervpoliklinik*'s patients, there were some who expressed their wish to be given a medical certificate in order to gain admittance to the Board of Pensions' clinics, and the doctors seemed to take these cases seriously. Evidently, it was both in the doctor's and the patient's interests to ensure that proper treatment was provided, and that the patient would be able to return to working life after a curative stay at the publicly-funded Board of Pensions' clinics, which targeted people with low incomes.

One patient who was referred to such a clinic was a 35-year-old, unemployed man who visited the polyclinic in January 1935. He was anxious, burst easily into tears, and had a host of somatic symptoms. When the doctor investigated him, he was nervous and trembling. He was given the diagnosis 'neurosis due to unemployment' and the right to receive compensation for one year due to his ill health. The doctor also recommended that the patient should stay for some time at the Board of Pensions' clinic in Nynäshamn.[33] It was through the Serafimer's clinic that many patients found their way to Nynäshamn or to some of the other clinics and hospital departments run by the Board of Pensions, an important player in the drama that was neurosis in Sweden. I shall examine the Board of Pensions' attempt to 'rehabilitate' neurotics in the next chapter.

It is not malingering or disease-mongering that is conspicuous in the *Nervpoliklinik*'s patient records; it is rather the low-key suffering, the greyness of the world of these individuals, which can be discerned in the fragmentary short stories of their lives. The bits and pieces of these sickness narratives are not unlike jigsaw puzzles with missing pieces which make it impossible to 'get the whole picture', but which nonetheless invite some tentative interpretations of the problems these people had to cope with.

A few illustrations, taken from the case records, are in order. First, there was a 22-year-old female 'psychoneurotic' who was depressed, anxious and unable to sleep, and had a father who was suicidal. Her mother, one of her brothers and her fiancé had recently died.[34] Second, a 34-year-old 'psychoneurotic', who was nervous and burst into tears, had a husband who was having an affair with another woman, but

[33] Clinical record of the Polyclinic, January 17, 1935, No. 160 (M).
[34] Clinical record of the Polyclinic, February 3, 1920, No. 20,460.

who was now claiming that it was over. Yet, the husband was never at home in the evenings—he said he was with his friends. The wife wanted to go to a hospital and rest for a while.[35] Third, a 42-year-old depressed wife of a farmer had a husband who beat her up when she tried to talk about the affair he was having with another woman. She did not want to leave her husband.[36] Fourth, a 49-year-old wife of a manual worker with eight children had a husband who was having an affair and who regularly beat her up. She was crying desperately, saying she would kill the other woman.[37] Fifth, a 31-year-old female factory worker had been divorced five years earlier, and now she was a single mother with a 6-year-old child. She suffered from occasional and painful bouts of headache, nausea and dizzy spells which forced her to leave her workplace. She was nervous, pale and trembling, and tormented by a neighbour who screamed and banged on the wall at night time. She called the doctor from her workplace constantly and told him nervously about her problems, threatening to take her life. She was referred to a psychiatric polyclinic, and a few months later was admitted to a rest home.[38]

It was no coincidence that all these sufferers were women. In the early 1920s, more than two thirds of all patients at the polyclinic were women, and many of them gave evidence to the dictum that barbarism begins at home. These women were often brutalised by their violent, unfaithful husbands who sometimes drank heavily and were seldom to be seen at home, not to mention sharing in the domestic responsibilities, such as rearing their children. Women who were in the labour market also worked long hours, first in their workplaces and then at home. A tell-tale sign of the modernisation of Swedish society that came to the fore in the patient records in the interwar years was that the number of divorced female patients grew during this period.[39] Divorced mothers (and also fathers) had to cope not only with the divorce itself, but

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[35] Clinical record of the Polyclinic, January 10, 1940, No. 94 (F).
[36] Clinical record of the Polyclinic, No. 977/1950 (F).
[37] Clinical record of the Polyclinic, November 24, 1915, No. 15,744.
[38] Clinical record of the Polyclinic, October 7, 1950, No. 1197 (F).
[39] During the five-year period 1921–1925, there were, on the average, about 1,600 divorces per year in Sweden. Thirty years later (1951–1955), the number of divorces had grown to 8,600 per year. Small wonder, then, that family consultation offices began to be established in Sweden, first in Stockholm in 1951. See Georg Lundin and Arvid Myrgård, "Hälsovården och socialmedicinen i det moderna samhället," in *Medicinalväsendet i Sverige 1813–1962*, ed. Wolfram Kock (AB Nordiska Bokhandelns Förlag: Stockholm, 1962), 314–15.

also with society's moral disapproval of their 'selfishness', and they also had to struggle with making the ends meet in a male-dominated society where women's wages were considerably lower than those of men. Beyond these moral, social and psychological sources of distress, women suffered from ailments that were related to pregnancy and biological phases, especially menopause.

Compared to women, men were not so much troubled by their family life and their relationships—and to hit a woman was obviously not as terrible an experience for men as it was for women to be hit by men. Men appeared to have problems related to their level of performance in the public sphere (work, economy, prestige) and in their sexual relations. In a society where the honour of a man was largely dependent on his capacity to work and to be in full control of himself and his family, anything that threatened to undermine the foundations of male dignity was a potential source of distress. The man was in most cases the principal breadwinner in the family, and it was his duty to take care of siblings whose livelihood depended on his ability to bring home the bacon. When, for one reason or another, a man failed to fulfil this supreme duty, it was a source of consternation and nervousness for the whole family. Furthermore, diseases and somatic troubles, the psychological and social consequences of ill health, and the fear of disease (especially of syphilis) made many men nervous, as did the diseases and deaths of loved ones.

How Nervousness Becomes an Illness

> I once received a letter from a worker who . . . stayed in bed at the Serafimer Hospital and who revealed to me the conditions of his illness: he described how he had always longed for an opportunity to lie in bed for a few months and just read books in peace (Poul Bjerre in 1949).[40]

People who suffer are not necessarily ill, and people who suffer from bad relationships, personal losses and adversities, or are distressed by their working conditions, sexuality, diffuse fears and dismal future prospects, are less evidently ill than people who have cancer or Parkinson's disease. Is a woman who has become nervous and tense a medical case, because her unfaithful husband beats her or spends his evenings drinking with

[40] Poul Bjerre, "Sjukkassan som folkförstörare," 231.

his buddies? Is a natural (or culturally specific) human reaction to the miseries of life a symptom of illness? Conversely, is a passive, resigned acceptance of one's fate a sign of health? Or is it simply that a medical encounter between doctor and patient necessarily leads to a diagnosis, because both 'actors' play their respective roles in a clinical situation? If these nervous people had gone to see a pastor instead of a doctor, they would not be visible in the patient records or in the Serafimer's annual reports. The very moment they enter the clinic they are expected to behave as an ill person; to articulate their problems in terms of illness and health; and, most importantly, to accept or even endorse a medical interpretation of their problems. Women who are sick and tired of their husbands, or men who are overstrained, know that they must behave as patients, 'symptomise' their life problems and receive medical treatment. I already suggested above that weeping may have been a conscious strategy or a rhetorical device deployed by some of the polyclinic's patients, who wanted to convey the message that they were truly ill and in need of treatment. As sociologist Erving Goffman has argued in his study of the presentation of self in everyday life,

> sometimes the individual will act in a thoroughly calculating manner, expressing himself in a given way solely in order to give the kind of impression to others that is likely to evoke from them a specific response he is concerned to obtain.[41]

Goffman uses the term 'performance' to refer to "all the activity of a given participant on a given occasion which serves to influence in any way any of the other participants".[42]

Following Goffman, I would suggest that to some extent the nervous patients at the *Nervpoliklinik* may have put on an act (weeping, for example) in order to control the conduct of doctors, especially their responsive treatment of these patients. Upon entering the reception hall of the polyclinic, many if not most patients knew that they had to express themselves in a particular way in a face-to-face interaction, in order to convince the other party of the authenticity of their suffering, and this goal could be achieved through assuming the social role of a sick patient with all the performing acts that go with this role. In making this suggestion, I do not mean to belittle the suffering of these

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[41] Erving Goffman, *The Presentation of Self in Everyday Life* (New York: Doubleday Books, 1959), 6.

[42] Ibid., 15.

patients, but only to draw attention to the element of performance which characterises the individual's social role as a patient—i.e. his or her presentation of self in a particular medical setting.

I would also like to suggest that people who had problems in life and who went to see a medical expert at the Serafimer, were predisposed to emphasise or even exaggerate their purely somatic ailments (headache, diffuse pains, dizzy spells, etc.) in order to be taken seriously as a patient. To say that you are nervous and depressed, *and* that you have headache, pain in the arm and stitches in the side justifies your visit to a doctor better than references to your nerves and your state of mind alone. And, as patients often wanted to take a break from the problems surrounding them in their everyday-life, and have a rest in a clinic, sanatorium or nursing home, they were inclined to present their problems in terms of symptoms. If they had gone to see their pastors instead, they would have articulated their problems differently, in moral rather than medical terms, and the 'treatment' they would have expected to receive would have been spiritual *Seelsorge* or something equivalent. The crucial difference between a doctor and a pastor was that the former could write a doctor's certificate, which could function as a ticket to paid sick-leave or a two-month cure at the Board of Pensions' clinics. By contrast, while the pastor's words could perhaps calm your nerves (or, make you feel sinful), you still had to wake up early next morning and drag yourself to your workplace.

The fact that neurosis became a national malady in Sweden shows that it was truly a condition of the 'masses'. It seems to me that in their preoccupation with Charcot's spectacular working-class hysterics and Freud's upper-middle-class neurotics, scholars have overlooked nervousness of ordinary people who did not exhibit dramatic symptoms *à la* Charcot's hysterics or intriguing dreams and fantasies *à la* psychoanalytic neurotics. As this book testifies, neurosis was a rather gray and low-profile illness, characterised in its most dramatic moments by suicidal thoughts and floods of tears, but mostly by undramatic symptoms of sleeplessness, headache, tiredness, depression, anxiety, sorrow, disappointment, frustration and anger—'symptoms' which are part and parcel of the human condition. The unspectacular lives and every-day problems of most neurotic people we have encountered in the preceding chapters have very little to do either with late nineteenth-century hysterias or late twentieth-century psychoneuroses of the Woody Allen-type upper-middle-class neurotic.

It's a Thin Line Between Health and Illness

I have not discussed any single patient at length in this or in the previous chapter. What I have offered, at best, are snap shots or a few pieces of a jigsaw puzzle that are insufficient in constructing the whole illness narrative of these patients.[43] During the period under research in this book, this incompleteness was what characterised the outlook of neurosis, which was a transitory illness requiring perhaps a two-month stay at a nursing home or a number of visits to the *Nervpoliklinik* but, in most cases, not an admittance to a (mental) hospital. The case records of nervous patients are short and usually cover only a relatively short time span, perhaps a few weeks or a few months. This is in stark contrast to many mentally ill patients who sometimes spent most of their adult lives as asylum inmates, leaving behind them traces that have made it possible for later historians to construct a whole illness narrative of individual mental patients.[44] There is no way of telling whether the nervous people we have met in this book remained in poor health for a longer period of time, suffering from neurotic symptoms year in year out, or whether their symptoms disappeared with time. They remain strangers to us, and our lack of contact with the nervous patients of the past is far from being accidental to the phenomenon of neurosis—that nervous patients remain to us more or less shadowy figures is an indication of the shadowy nature of neurosis itself as an illness.

What kind of illness, then, was neurosis—if it was a 'true' illness? If it was a contagious diagnosis rather than a contagious disease, does it mean that people who were diagnosed as nervously ill were not 'truly ill'? This is a thorny question, not least because the term 'neurosis' was applied to denote symptoms varying from mild nervousness to severe depression, from vaguely felt anxiety to suicidal thoughts, from an inability to sleep or concentrate to phobias and obsessive ideas that seriously impaired mental functioning. And there were often puzzling physical ailments in conjunction with 'mental' symptoms: paralysis, cramps, pains, aches, dizzy spells, tics, stitches, jerks, convulsions and so forth. A dilemma that kept on haunting physicians concerned the possible causal link between physical injury or pain and psychological

[43] On illness narratives, see Arthur Kleinman, *The Illness Narratives: Suffering, Healing and the Human Condition* (New York: Basic Books, 1988).

[44] See, for example, Sjöström, *Den galna vården*; and Jönsson, *Det terapeutiska rummet*.

distress: did the patients have a severe headache because they were worried and anxious, or were they worried and anxious because they had a severe headache? If doctors determined that the patient's headache was preceded by purely psychological symptoms, such as anxiety, they were often inclined to diagnose the patient's ailment as neurosis. By contrast, if headache was followed by feelings of anxiety, the determination of the nature of ailment was more complicated, and doctors were inclined to weigh the possibility that the patient was primarily suffering from cephalalgia (headache) or migraine rather than neurosis. Nerve doctors, who were walking a diagnostic tightrope, tended to combine physical and psychological elements when they mulled over the nature of the ailment. For example, doctors might have written in the case record that a patient was suffering from 'cephalalgia of psychogenic origin'.

Recently, two Swedish authors—a physician and a literary scholar—have argued that Franz Kafka suffered from a painful form of headache called Horton's headache (or, cluster headache), and that the nature of his illness sheds new light on his literary production, particularly during the years when his headache was most intense and painful (1913–17).[45] Kafka's descriptions of violent pain and torture in his texts might have helped him to 'act out' his own suffering, thereby giving him at least mild psychological relief from his terrible headache that "cut like a knife through his brain". The authors suggest that Kafka's nightmarish visions during these years most probably stemmed not from his anxiety, but from the physical pain he felt (in a letter of 1922 he writes that "the only truth that is real and indisputable is physical pain").[46] A doctor he consulted in 1916 diagnosed his ailment as 'extreme nervousness' and ordained rest, healthy diet and promenades as a cure. But maybe Kafka was not a psychoneurotic writer, but a writer who suffered from a physical ailment that had direct implications for his mental condition, so much so that one of the recurring themes in his published diaries between the years 1913–17 was contemplation of suicide.

But what about all those neurotic people who suffered from 'psychological pain' without concomitant physical symptoms? Were these people nervously ill? I believe there is no straightforward answer to this question, for it is not only a medical but also a philosophical question.

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[45] T. Ekbom and K. Ekbom, "Dagböcker och brev tyder på att Franz Kafka led av Hortons huvudvärk," *LT* 100:17 (2003): 1540–1.

[46] Quoted in Ibid., 1541.

Philosopher Lennart Nordenfelt discusses two major streams of theories of health and disease, the medical or biostatistical theory and the normativist theory. The proponents of medical theories see health and disease as biological (or, in some cases, psychological) concepts "in the same sense as 'heart' and 'lung' and 'blood pressure' are biological concepts", and assume that there is "nothing evaluative or subjective about the concepts of health and disease". The proponents of normativist theories have a completely opposite view of these issues, for they see health and disease as "intrinsically value-laden concepts" that "cannot be totally defined in biological or psychological terms".[47] Nordenfelt takes a closer look at the particular set of normativist theories that are often called holistic theories. The advocates of these theories look at health at the level of the whole person, and understand diseases as "bodily and mental states of affairs that tend to lead to their bearer's ill health".[48]

Holistic theories focus on two kinds of phenomena: first, on a certain kind of feeling of well-being or suffering, and, second, on the phenomenon of ability or disability. These phenomena are necessarily interconnected, because feelings of suffering can lead to disability to some degree, and, conversely, our understanding of our ability or disability has a direct impact on our emotional state (e.g., feeling of pain and suffering). Nordenfelt's own view is that a "person cannot experience great suffering without evincing some degree of disability,"[49] while the converse relation does not always hold: disability, such as myopia or, to take an extreme case, coma, does not necessarily entail suffering. He concludes that the concept of disability is more essential to the definition of ill health than suffering, which is also extremely important.

From the point of view of medical or biostatistical theories, the typical 'psychogenic' neuroses are hardly accountable, for in denying that health and disease are value-laden concepts, these theories are of no use when one tries to explain why the 'phenotype' of different neuroses has undergone drastic changes over time. Furthermore, as we have seen, it was not that uncommon for the same 'nervously ill' patients, who displayed the same or similar symptoms in their encounters with

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[47] Lennart Nordenfelt, "What is Health?" in *Philosophy Meets Medicine*, ed. Pekka Louhiala and Svante Stenman (Helsinki: Helsinki University Press, 2000), 15.
[48] Ibid., 17.
[49] Ibid., 18.

doctors, to receive different diagnoses each time they were investigated by a doctor—in 1935, an average nervous patient might have been suffering from neurasthenia; in 1937 he perhaps suffered from cephalalgia (headache), and in 1939 exhibited symptoms of psychoneurosis. Yet, the fact that neurosis was a chameleon-like disorder which was in a constant state of transformation and re-interpretation does not prove that neurotic patients were *not* in ill health. When I look at neurosis in the light of Nordenfelt's discussion of suffering and disability, I am inclined to conclude that neurotic patients usually experienced a feeling of pain or suffering, and that this feeling was directly connected with their perception of their disability. And, according to holistic theories, a feeling of suffering and the phenomenon of disability are indications of an illness.

To say that neurosis was indeed a 'real' illness gives an insufficient picture of this elastic entity. But it would be unsound to see it as nothing but a construction either: although the name and the conceptualisation of the illness changed over the decades, there was something in neurosis that remained relatively constant throughout the Neurotic Century, namely its use as a designation for unhappiness, discontent and malaise. And only if one maintains that human nature is thoroughly socially constructed, always created by the socio-cultural conditions of a particular time and place, can one argue that neurosis was a pure construction as an illness. In this book, I have largely endorsed a constructivist reading of neurosis, but I would like to make a crucial qualification concerning the particular type of constructivism that this book represents: while I have argued that neurosis was a contagious diagnosis and a transitory illness that was undergoing constant changes, modifications and reformulations, I have *not* argued that the suffering of the nervously ill was also a socially-determined construction, a linguistic phenomenon ('discourse'), except in the sense that these people used words (and body language) when they described their suffering, and that the semantic contents of words, as anyone who has studied the history of concepts knows very well, are subject to change. I endorse the evolutionary view that under the surface of historical contingencies and a succession of 'linguistic turns' there lies the solid rock of human universals which changes very, very slowly over time (*la longue durée*).[50]

[50] For a study of human universals, see Donald E. Brown, *Human Universals* (New York: McGraw-Hill, 1991). For a discussion of morality from the Aristotelian and

Neuroses are transitory illnesses, but to be occasionally melancholy, distressed or sad is what makes us human. If anything, I believe it is the constant smiling of today's television talk show hosts, rather than the 'negative' emotions of shyness, sadness and anguish of the nervously ill, that in its unnaturalness should worry the psychiatrists.

When nervous patients left the Serafimer's *Nervpoliklinik* after seeing a doctor, the tangible outcome of their visit was that they were usually dispensed drugs which had about as much curative effect as bloodletting a hundred years earlier. What the busy doctor at the polyclinic could achieve was at best to "repair fractures in the facade, not the weaknesses at the very foundation that had caused these fractures".[51] Some patients were referred to another clinic at the Serafimer, some to the clinic for alcoholics or to nursing homes, and about five per cent of the patients (in 1936) were referred to the Board of Pensions' clinics for the nervously ill. As we shall see in the next chapter, the authorities at the Board of Pensions were interested in 'rehabilitating' nervously ill working people, in order to make them productive citizens again.

Darwinian-evolutionary perspectives, see Larry Arnhart, *Natural Right: The Biological Ethics of Human Nature* (Albany, State University of New York Press, 1998).

[51] Bringel and Welander, "Neurosvårdens närmaste behov," 38.

CHAPTER TEN

HOW TO TURN NEUROTICS INTO PRODUCTIVE CITIZENS

As I have shown in the previous chapters, neurosis became a 'national malady' in Sweden in the early twentieth century. Internist Josua Tillgren told a journalist in the daily newspaper *Dagens Nyheter* in 1924 that "neuroses are quantitatively the largest group of illnesses with which doctors are dealing".[1] His opinion was shared by many of his colleagues, who not only marvelled at the expansion of neuroses but also wanted to do something about the alarming epidemic.[2] After the establishment of the Royal Board of Pensions (RBP) in 1914, an institution for the care of the chronically neurotic was high on the agenda of this governmental agency. In 1915, the RBP began to send patients to spas and water cure clinics, and a few years later it opened its first clinic for neuroses and rheumatism.

The state was now actively involved in the fight against nervous illnesses, and the primary goal of these state-financed clinics was to turn neurotic patients into productive citizens. Neurotics, a large group of potential invalids who might become a heavy burden to the national economy, needed to be provided with effective therapy and then swiftly returned to working life. Thus the motivation behind the RBP's clinics was at least as much national-economic and utilitarian as it was medical. It was this principle of utility that characterised both the clinical work at the RBP's clinics and the medical discussion of the proper cure of the neurotics in the decades to come. Sweden was not the only European country where the national-economic aspects of neurosis were taken up for a discussion; in Germany, for example, doctors routinely linked nervousness with the questions of national health and national economy, while in England the incidence of neurosis among workers was a matter of utmost importance, as a 1947 editorial of British Medical Journal

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[1] Josua Tillgren, [Commentary]. "Försummas psykoterapin av de svenska läkarna till fuskarnas fromma?" *Dagens Nyheter*, September 9, 1924, 1.

[2] See, for example, Malte Ljungdahl, "Flykten in i sjukdom," SLT 43 (1946): 3192–207.

makes clear: in the editorial, it was noted that "neurosis is one of the commonest causes of absence from work".[3]

Neurotics as Second-Class Patients

Unlike the somatically ill, who were seldom directly blamed for their illness, the nervously ill were typically seen as second-class patients, a class of lazy pariahs whose inferior character or deficient mental faculties made them vulnerable to neuroses, and to all kinds of more or less imaginary complaints. This is what Drs Bringel and Welander, both working at the Serafimer's *Nervpoliklinik*, proclaimed in 1936:

> Everywhere you can find a specific type of the dregs of society; people who are not somatically ill, criminal or abnormally lazy, but who nonetheless find it difficult to work. These people are neuro- and psychopaths, the unbalanced, the depressed, the spineless, the overnervous [*övernervösa*], much too egocentric or much too dumb. Nobody will employ these people. The poor among them have to choose between illness, beggary or criminality as a way of making a living if they don't want to be dependent on poor relief. As we shall see, those who choose illness are not so few.[4]

The disparaging attitude of these two doctors towards 'neuro- and psychopaths' was shared by many other doctors, including the first chief physician at the RBP, Professor Hjalmar Forssner, who called this group of patients "the parasites of society".[5] Even those physicians who had a more benign attitude towards neuroses were inclined to believe that neurotics had difficulties in adjusting themselves to the 'hard demands' of life, and that these difficulties may manifest themselves as an escape into illness. Indeed, *Flucht in die Krankheit* ('a flight into illness') is an idiom that regularly appeared in medical writings where the nature of neurosis was discussed (sometimes the idiom was reformulated as *Flucht ins Krankenhaus*—a 'flight to hospital'). The bottom line was that people who suffered from neurosis were, in most cases, of inferior quality: they were regarded, on average, as less intelligent than

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[3] Radkau, *Das Zeitalter der Nervosität*; Lerner, *Hysterical Men*; and "Neurosis and Industry." Editorial. *British Medical Journal*, August 16 (1947): 258.

[4] Bringel and Welander, "Neurosvårdens närmaste behov," 36.

[5] Jakob Billström, [Commentary at the Meeting of the Swedish Society for Internal Medicine on 4 May], *NMT* 12 (1936): 1967. For a critique of the disparaging evaluation of the neurotics as 'lazy parasites', see Hillevi Löfvendahl, "Om neurosproblemet," *SLT* 35 (1938): 1566–81.

their fellow humans, and their will power, mental energy and moral strength were seen to be below par. They were commonly perceived as being personally accountable for their despair, and their symptoms of suffering did not often resonate positively in their environment. Obviously, when the state began to make a more concerted effort to provide care for the nervously ill, the principal therapeutic goal was to remove these people from the category of 'parasites' to that of 'productive citizens'. As Bringel and Welander put it, "each and every case that can be rescued [from becoming life-long invalids] is of great economic significance to society".[6]

In a more humane tone, Carl Hulting, medical officer (*distriktsläkare*) in Stockholm, pointed out in 1936 that medical officers, who were in daily contact with nervously-ill people living in towns, had been consulted by many individuals who had exhibited nervous symptoms in the hope of getting a medical certificate from a doctor. Although some patients were obviously malingerers, there was no doubt in Hulting's mind that the great majority consisted of people with a neuropathic constitution, whose distress had been aggravated by unemployment and the ensuing misery. He also noted that doctors who worked in the field of poor relief had encountered neuroses time and again: in the 1933 annual report of Stockholm's poor relief agency, there was a table showing that "no less than 1,713 people received compensation because of neurosis [in that year], at a total expense of 697,766 crowns."[7] He emphasised that even though the economic crisis was no longer as acute as it was in the early 1930s, doctors still frequently encountered neurotic patients. And I would suggest that one reason they encountered so many neurotic patients was that they themselves had helped create a health ideology that was conducive to the contagious spread of neurosis.

What I mean by that is that, in laying stress on the role played by emotions in neuroses, doctors legitimised and consolidated the commonplace perception among people that strong emotions (*sinnesrörelser*) were pathological, which meant that a normal person was someone who never had emotional outbursts. As Gösta Ingvarsson put it, the patients commonly assumed that to become 'emotional' equalled being 'nervous', which in turn equalled being 'sick'.[8] Thus, strong emotions = nervousness =

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[6] Bringel and Welander, "Neurosvårdens närmaste behov," 41.

[7] Carl Hulting, [Commentary], Svenska föreningens för invärtes medicin förhandlingar, 4 May. *NMT* 12 (1936): 1966–7.

[8] Ingvarsson, "Om språkformen," 274–5.

sickness. Ingvarsson regarded this ever commoner tendency among people to pathologise emotions as a threat to the whole nation, because such an unfortunate association between emotions and sickness gave the people an easy excuse to apply for financial compensation from sickness funds, as soon as they considered themselves sick in their nerves. The tendency among people to associate strong emotions with pathology could have significant national-economic consequences!

To illustrate his point about the potentially deleterious economic consequences of the 'morbid emotions' thesis, Ingvarsson refers to women who are in the middle of divorce proceedings, demanding that they are entitled to stay in rest homes as invalids, and have their expenses covered by the sickness fund.[9] Obviously, he was worried lest the pathologisation of human emotions led to a culture of nurtured sickness, which might encourage people to exploit the health care system by presenting their problems in life (such as divorce) as though they were illnesses which needed to be cured. It was as though he was assuming that the medicalisation of the human condition was supposed to make people healthier and happier and morally upright, not miserable disease-mongers. Maybe he had the nagging thought that Swedish medical ideology was responsible for opening a Pandora's Box of psychopathologies, as a consequence of which more and more Swedes were complaining that their emotions made them sick.

Neurosis and Health Insurance Legislation

At the turn of the twentieth century, a number of larger companies in Sweden offered sickness insurance benefits to their employees, but the majority of workers lacked any social insurance. This was a major concern for the newly-established socialist movement, and the workers' discontent did not go unnoticed in parliament. Socially engaged liberals, who for the first time formed a liberal government in 1905, took initiatives to establish a social security system, but their reformist aspirations, supported by the social-democrats, were opposed by other political groups, especially conservative farmers who dominated the upper chamber in the parliament. It took years of intense debate in parliament before the law regarding the compulsory national insurance

[9] Ibid., 275.

pension, which afforded an annual sum based on income at the age of retirement, came into force in 1913. The first national insurance law paved the way for the piecemeal establishment of an extensive social security system after World War I. And when the social-democrats came into power in 1932, the construction of a modern welfare state became the great political project of the whole nation.

The social insurance funds (*sjukkassor*) grew out of voluntary associations founded in the late nineteenth century, and the first Sickness Funds Law was enacted in 1891. But the development in the scope of coverage was slow and stagnant until the mid-1930s. A major reason for this stagnation was that the medical profession was wary of nation-wide health insurance policies and activities. There was a rapid increase in the number of the insured after the new Sickness Funds Law came into force in 1931, but the increase only registered late in the decade, because the law was not completely implemented until 1938. Even after the new law, health insurance was voluntary, but local sickness funds were now financially supported by the state. Consequently, while contacts between the medical profession and the sickness funds grew closer, many physicians disliked the 'interventionist' government policy that was considered a threat to medicine as a free profession. But the medical community's resistance to socialised medicine was neither organised nor determined, and the social-democratic government passed the compulsory National Health Insurance Law in 1947. Prior to the implementation of the new law in 1955, eight years after its promulgation, a medical certificate was sometimes needed in order to become a member in a sickness fund, which meant that people who had problems with their health, or who were older than fifty years of age, often found it difficult to be admitted as members in local offices. Insured workers who were on sick leave were also under tight surveillance by the funds, and if the inspectors found out that the insured had not followed the doctor's orders (e.g. by not staying in bed), their sickness benefits could be withdrawn. And if the drinking habits of the insured were considered hazardous to their health, it could happen that they were denied benefits.[10]

The lack of active resistance to the 'socialising' tendencies in health insurance legislation on the part of the medical profession was largely due to the low population density and the still rather rural character

[10] *Försäkringskasseförbundet*, October 2001.

of Sweden, which kept the number of private practitioners low. Private practice was feasible only in Stockholm and a few other larger cities. As a result of these conditions, the nation's health could be maintained only by publicly financed medical officers. Thus a large part of the Swedish medical profession was in public service, the private sector being relatively small and weak. Swedish health policy and politics was increasingly shaped by the principle that the state has the responsibility towards the sick.[11]

As a result of developments in governmental health insurance policy, a growing number of Swedes who were in employment were entitled to receive sickness allowance benefits when they fell ill or suffered injury. And if they became chronic invalids, they were eligible to a disability pension. In this situation, the medical community and the authorities began to pay attention to the burden the nervously ill constituted to the sickness funds, especially to the larger offices that were unable to keep their individual members under surveillance and ascertain whether the nervously ill were 'really' sick or only simulating the symptoms in order to derive benefits from the system. In his 1930 article on 'neuroses and sickness funds', hospital physician (and surgeon) Fredrik Källmark claims that sickness funds had a directly harmful effect on neuroses, because they enticed people to become sick and make unwarranted claims for compensation. He singles out the "hopelessly hysterical" as the main group which "both consciously and unconsciously exploits the opportunities offered by the sickness funds".[12] Their problem is not so much their dishonesty—most of these hysterics truly believe they are ill—as their constitutional 'weakness of will', for which the appropriate remedy would be the strengthening of their weak will. Another source of concern for Dr Källmark was the magnitude of the problem: he had surveyed a few hundred patient records at his medical polyclinic and discovered that no less than one third of women and one fourth of men were plagued by neuroses. Probably having in mind the promulgation of the Sickness Funds Law (in 1931), he concluded his article by asserting, first, that neurotics form a large group of people who seek medical treatment; second, that these people will become a larger group within the expanded sickness fund system; third, that to a large extent, their recovery will be prevented by their ability to derive economic benefits

[11] *The Shaping of the Swedish Health System*, ed. Heidenheimer and Elvander.
[12] Fredrik Källmark, "Neuroserna och sjukkassorna," *SMT* 7 (1930): 129–33.

through being ill; and, fourth and last, that to increase the supply of care for 'pure' neuroses would be more of a hindrance than a help.[13]

To Dr Källmark, as well to many of his colleagues, the locus of neuroses was not so much a 'psychic conflict', a 'trauma' or a 'functional disturbance in the nervous system' as it was the chronic weakness of the fundamental mental faculty, the will. If a person suffered from weakness of will, then he or she was not a medical case but a case which should be targeted for moral management or 'rearmament'—in other words, a neurotic needs education and training rather than medical care. In fact, Källmark and his like-minded peers claimed that medicine could do a real disservice to neurotics by labelling them as sick and providing them with a medical certificate that entitled them to take time-out from working life, and receive compensation that only confirmed their own desire to exploit their nervous complaints. Indeed, the sickness funds might *increase* the number of neurotics, making neurosis an even more serious national-economic problem than it already was. Even Poul Bjerre, who as a psychotherapist in private practice usually showed empathy towards the neurotics, attacked sickness funds for encouraging people to become ill in order to obtain a medical certificate and the ensuing compensation from a sickness fund. Writing in 1949, two years after the government had passed the compulsory National Health Insurance Law, Bjerre, who detested socialism and everything that smacked of collectivism, predicted that the socialisation of sickness insurance would bring about a new type of neurotic, namely a 'life-long pensioner of the state' (*livsvarig statspensionär*). The title of Bjerre's article says it all: 'Sickness fund as a destroyer of people.'[14]

As medicine in Sweden became increasingly socialised, the state became more active in its efforts to maintain the nation's health and to 'rehabilitate' invalids who were incapable of working (the term 'rehabilitation' came into wider use only in the 1960s, but as the major goal of governmental health policy already in the interwar years was to improve the condition of invalids, I am using this anachronistic but fitting term to discuss developments prior to the 1950s). A few years after the Board of Pensions was founded in 1914, it began to target two specific groups of chronic but not seriously ill invalids whom they wanted to make productive citizens again: rheumatics and neurotics.

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[13] Ibid., 133.
[14] Bjerre, "Sjukkassan som folkförstörare."

The Board of Pension's Clinics for the Nervously Ill

When the Royal Board of Pensions (RBP) was founded, its main function was to pay retirement allowances to persons who were granted a pension because of age or invalidism (at that time, the retirement age was sixty-seven). But the RBP was much more than a money dispenser for the retired, because one of its principal fields of activity became the development of health care by, for example, providing care for those who on account of their illness could be expected to receive a disability pension, but whose condition was such that proper medical treatment could restore their working capacity. It also supported such preventive measures that might decrease the number of invalids and, in general, improve the health of the insured population through the establishment of sanatoria, hospitals, institutes for the crippled (*vanföreanstalter*), financial support to the municipal health care centres, public enlightenment with regard to the fight against tuberculosis and other 'national maladies', and so forth.[15]

Right from the start, nervous illnesses (including neuroses and neuralgias) and rheumatism were the two national maladies or folk diseases with which the medical officers of the RBP were especially concerned. This was understandable, since both neuroses and rheumatism were typically afflictions that made people incapacitated without damaging their health completely. Thus the authorities at the RBP thought it worthwhile to invest in the treatment of these two groups of invalids. The fundamental idea behind the RBP's therapeutic activity was to bring patients back to working life, so that they could provide for themselves wholly or at least mainly. The RBP wanted to make sure that it did not pay retirement allowances 'needlessly' to persons who were not doomed to chronic invalidism. This was the premise of the RBP, and thus its therapeutic *raison d'être* was not grounded in the principle that a humane society has to provide health care for the sick, but rather in the belief that the health of neurotics and rheumatics must be restored in order to safeguard national wealth. It was not considered sufficient to merely improve the condition of the patients; they had to regain their capacity to work and become useful members of society. Neurotics, especially the more difficult neurotic patients who were in danger of

[15] J. A. Andersson, "Pensionsstyrelsens kompetens att handhava sjukvårdande verksamhet," *SLT* 14 (1917): 390–1.

becoming chronic invalids, constituted a national-economic problem that needed to be solved so as to save money and to prevent an unnecessary 'incapacitation' of the population. Those who were thought of as being beyond the pale regarding this fundamental goal were excluded from the category of patients for whom the RBP provided care. This exclusion of patients who could not be expected to become productive citizens was what distinguished the RBP's clinics from other clinics and hospitals. For this reason, under-aged and elderly patients (older than 55 years of age) were excluded, as were also people who suffered from more serious forms of pulmonary tuberculosis or rheumatoid arthritis.[16] This being the case, it was obvious that the mentally ill were also excluded. Furthermore, the RBP's clinics were intended for less affluent patients who could not pay for their care out of their own pockets.

At first, the RBP sent neurotic patients to already existing spas and water cure clinics. These private clinics were a natural first choice, since the greater part of their clientele consisted of the nervously ill and rheumatics. The early therapeutic results were encouraging, but the big problem with the water cure clinics was that they were usually not open throughout the year. Another problem was that these clinics were not suitable for all patients. In 1916, an agreement was made with the water cure clinic in Tranås that, unlike most clinics, was open all year. Two years later, the RBP decided to found its own clinics (in Swedish language, these clinics were called *anstalter* or *kuranstalter*, the direct translation of which would be 'establishments' or 'curative establishments'). The first clinic was opened in Nynäshamn, a small seaside town south of Stockholm, in 1918, and the second in Åre, located in the mountainous area in the north-western part of Sweden, in 1923. Although they were not intended for neurotic patients alone, neuroses formed the bulk of the cases treated in these clinics.

The therapeutic activities were further expanded between the years 1927 and 1931, when the RBP established in-patient departments for its clientele in six different hospitals, which had altogether 370 beds. Of these hospital departments, the one in the General Hospital in Malmö (with sixty beds) was designated exclusively for the treatment of neuroses, while the other five wards provided care for rheumatics. The clientele in Malmö consisted of nervously ill people who also suffered from organic

[16] Anon., "Några ord angående Pensionsstyrelsens sjukvårdande verksamhet," *SLT* 14 (1917): 1529–33.

diseases, or whose ailments were difficult to diagnose. The junior physicians at Malmö were trained in psychotherapy, and psychotherapy was what the department exclusively provided to the patients. An important rationale for these special clinics was that they could be run at a relatively low cost, especially in comparison with public hospitals that were located in the same geographical areas.[17] The duration of the cure was, on average, about sixty days, and those who underwent more than one cure were usually the more difficult cases whose capacity to work was harder to restore. Although the total number of beds had increased to 1,000 by 1937, the supply could not meet the growing demand, and new patients usually had to wait for two or three months before they could be admitted to the RBP's clinics.[18]

At these clinics, the patients received work therapy (sewing, weaving and knitting, woodwork, gardening, etc.), physiotherapy, drugs and psychotherapy. The clinic at Åre was especially designed to function primarily as a psychotherapeutic clinic, providing physical treatment only secondarily. In the early 1930s, the two other clinics—Nynäshamn and Tranås—also became more emphatically psychotherapeutic in their clinical orientation.[19] The question as to the specific form of psychotherapy was of secondary importance, for it all depended on the actual cases; some patients were amenable to persuasion, others to hypnotism, and still others to psychoanalysis.[20] But even if doctors were convinced of the value of psychotherapy as a method of treatment, the more time-consuming forms of psychotherapy were difficult to provide on a larger scale at these clinics. The exception was the department for the nervously ill in Malmö, which was at least in principle a purely psychotherapeutic clinic, treating patients as though they were in the office of a private psychotherapist.[21]

The kind of psychotherapy that was administered at the RBP's clinics was probably closer to moral therapy or persuasion, than to supposedly morally-neutral psychodynamic therapy. Education of the patient's character seemed to be an important therapeutic objective. Fredrik Sundelin, head of the clinic at Nynäshamn, writes in 1936 that

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[17] Gunnar Kahlmeter, [Commentary], *Förhandlingar*, November 2, 1937, 596.

[18] Ibid.

[19] See Fredrik Sundelin, "Om mål och medel ifråga om Kungl. Pensionsstyrelsens sjukvårdande verksamhet," *SLT* 32 (1935): 33–43.

[20] Gunnar Kahlmeter, "Några synpunkter på behandlingen, särskilt anstaltsbehandlingen, av neuroser," in *Festschrift tillägnad Henry Marcus*, *Handlingar* 57 (1931): 136.

[21] Ibid., 137.

in addition to trying to change the patients' physical and psychic "mode of reaction" (*reaktionssätt*), the RBP's clinics attempted to strengthen the patients' will and their sense of moral and social responsibility.[22] This is a real challenge, notes Sundelin, because the doctors are dealing with "constitutionally weak material" that often lacks the very qualities that need to be strengthened. The main objective—to restore the patients' working capacity—is however attainable through a strict regime and work therapy, which would result in the patients being able to provide for themselves, having discovered that, despite their weakness, they are able to work. An awareness of this ability increases their self-confidence, moral strength and courage.[23]

It was cost-effective work therapy rather than time-consuming psychotherapy that was all the rage in mental medicine in the 1920s and the 1930s, becoming one of the standard forms of treatment in mental hospitals—and, quite naturally, at the RBP's clinics. Work therapy was considered beneficial to the nervously ill invalids, who needed to be convinced of their ability to work at least a little, and of doing something useful with their hands, despite their nervous symptoms. To make nervously-ill patients discover their ability to work even for a short period of time was considered to have a plausible curative effect on their condition.

One esteemed physician who had been active in providing work therapy for the nervously ill was Henry Marcus, the retired professor of neurology at the Karolinska. In 1931, a wealthy elderly lady, whose late sister had been interested in neurology, donated 100,000 crowns to the Society of Medicine for the establishment of organised work therapy for the nervously ill.[24] The donation was channelled through a foundation, and, with the help of Marcus, a small 'work shop for the nervously ill' (*arbetsstuga för nervsjuka*) was opened in Stockholm in late 1931. Between the years 1931 and 1936, almost 200 patients, both male and female, worked in this 'outpatient cottage' for about three months at a time. Patients were referred to the work shop by the Serafimer's *Nervpoliklinik*, the Outdoor Relief Office for the Psychically Ill (*Hjälpbyrån*), social workers at hospitals and private nerve doctors. In

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[22] Fredrik Sundelin, [Commentary on Bringel and Welander], *SMT* 13 (1936): 42–3.

[23] Ibid., 43. See also Sundelin, "Om mål och medel," where he refers to an important 'socio-moral' aspect of work therapy that was administered at the RBP's clinics.

[24] Henry Marcus, "Arbetsterapi för nervsjuka," *SLT* 34 (1937): 404–13.

order to downplay the medical atmosphere at the work shop, no drugs or psychotherapeutic therapy were dispensed there. There were about a dozen patients at the cottage at a time, working from ten in the morning to four in the afternoon. Female patients knitted, wove fabric and worked in the kitchen (etc.), while men worked with bookbinding and woodwork. The main goal of such therapy was to instil in patients the conviction that they were capable of work, and not severely ill invalids. Marcus saw the cottage as a supplement to the work therapy that was provided at the RBP's clinics, on the one hand, and to the Serafimer's *Nervpoliklinik*, where doctors could only prescribe drugs and give advice to the great mass of nervously ill patients, on the other.[25] Small wonder, then, that Marcus gave his unqualified support to the idea of developing institutional forms of work therapy in Sweden.

On the Therapeutic Results at the RBP's Clinics

The first study of the therapeutic results at the RBP's clinics was published in 1927 by Gunnar Kahlmeter, who worked part-time as an assistant physician at the RBP. Kahlmeter, who had also worked for more than a year at the Serafimer's *Nervpoliklinik*, firmly believed that neuroses were one of the most common illnesses, and that each and every doctor encountered patients suffering either from a full-blown neurosis or milder symptoms that were triggered by neurosis.[26] In his study, Kahlmeter investigated first fully completed cases from 1915 to 1920, and then cases from 1921 to 1923. Of the patients studied, sixty per cent were women.

The main result of his follow-up study was that, on average, more than seventy per cent of the patients treated in these clinics between the years 1915 and 1923 were more or less completely capable of providing for themselves after the cure. Conversely, only about fourteen per cent of the patients were granted a pension after the cure. Moreover, the therapeutic results in the latter series (1921 to 1923) were considerably better than in the first series (1915 to 1920), which indicated that the staff in these clinics was becoming more skilful and professional. Kahlmeter conjectured that the improved results were probably due to the

[25] Ibid., 407, 411.
[26] Kahlmeter, "Några synpunkter," 129.

establishment of a new clinic (in Åre) which in his view was especially equipped to treat severe cases of neurasthenia. These figures appeared to prove that the RBP's clinics were doing their job fairly well.

Kahlmeter drew a number of conclusions from his follow-up study. First of all, the results in the case of neurasthenia were somewhat better than for other neuroses. Second, so-called 'exogenous' or acquired ('milieu-determined') neuroses showed better results than 'endogenous' neuroses, in which the illness had made its first appearance at an early age and in which the primary cause of neurosis was an inherent vulnerability to nervous illnesses ('neuropathic tendencies'). Third, the results were better for the men than for the women, especially in the 'endogenous group'. Fourth, the results were better among the younger age-groups (up to fifty years of age) than in the older age-groups. Fifth, the results were better the shorter the illness had been prior to the cure. Sixth, those patients who had previously shown energy, inclination to work and strong will-power were much more likely to be cured than those who lacked these qualities. Seventh and last, the results were somewhat better among those who came from urban centres than among those who lived in the countryside, especially with regard to women. Particularly difficult cases were "daughters living at home (*hemmadottern*), who lacked energy or had no need to leave home and earn their living".[27]

To sum up, if you were a young, energetic and work-oriented man living in a town and suffering from an acute 'exogenous' neurasthenia (due to overstrain, worries, adverse circumstances, etc.), your chances of regaining health and returning to working life were much better than if you were an older, lethargic and unmarried woman living in a countryside and suffering from a chronic 'endogenous' neurosis. In another article published in 1927, Kahlmeter presented the same figures and concluded that

> the results are satisfactory, even surprisingly good, and they demonstrate that the Board of Pensions' clinical work has by and large fulfilled its duty, which is to restore working capacity in many cases where it has been lost, and probably would have been lost forever if treatment had not been provided.[28]

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[27] Kahlmeter "On the Results of the Treatment of Neurotic Patients," 87–8.

[28] Gunnar Kahlmeter, "Om Pensionsstyrelsens sjukvårdsuppgifter," *Meddelanden från Medicinska Föreningen* 5:6 (1927): 150.

A few years later, Kahlmeter emphasised that it was only through these clinics that the poor and the less affluent neurotic patients were given the opportunity to seek medical help in an institutional setting. He claimed that the patients themselves praised the care provided in these clinics, which "restored working capacity and zest for life for thousands of patients".[29] He also pointed out that the local municipal authorities and the social welfare officials also expressed their satisfaction with these clinics. Physicians, however, often criticised the RBP for unnecessarily intervening in national public health care, bringing about the superfluous exacerbation of an unwarranted need for help, and disseminating the idea among people that society would take care of each and every person who at the slightest hint might conjure up the idea that their working capacity had been disturbed because of their nervous ailments. According to the critics of the RBP's clinics, the condition of such people deteriorated rather than improved at these clinics, because as pampered patients they tended to become lazy and presumptuous. What this all adds up to is the disability-proneness of the neurotics.[30]

While acknowledging that all forms of social welfare service necessarily create problems by inducing disability-proneness, Kahlmeter rejects these accusations with the argument that the advantages of such social care vastly outweigh the disadvantages. To give support to his argument, he refers to the figures that provide evidence of the usefulness of the RBP's therapeutic activities: over the past fifteen years (i.e. between 1915 and 1930), about eighty-five per cent of the approximately 10,000 cases of neurosis that had been treated at the RBP's clinics were now demonstrably capable of providing for themselves either completely or to a large degree. These figures, writes Kahlmeter, have to mean something in terms of national economic profits.[31]

A few years after Kahlmeter's report of the therapeutic results at the RBP's clinics, another study was conducted, this time by a layman (statistician K. Alderlin).[32] A more detailed and illuminating

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[29] Kahlmeter, "Några synpunkter", 134.

[30] Ibid.

[31] Ibid.

[32] For the summary of his study, see *Betänkande angående Pensionsstyrelsens invaliditetsförebyggande verksamhet*. Stockholm, *SOU*: 23/1937, 23–4. In 1939, Folke Bohman and Gösta Odstedt, two doctors working at the RBP's clinic in Nynäshamn, published a study of the patients treated at their own clinic between the years 1937 and 1938. They presented rather impressive therapeutic results: when the figures of male and

study was published in 1942 by Folke Bohman from the RBP's clinic in Nynäshamn. He had studied patients who had been treated at the RBP's clinics and departments in 1938, and who had not undergone any other cures after that year. His study included neuroses and other 'psychic illnesses' (46 % of all cases), rheumatoid arthritis (36,9 % of all cases), neuralgias, asthma and chronic bronchitis. All in all, Bohman had obtained information from 4,483 cases. As in the two previous studies, 'psychically ill' women clearly outnumbered men: 64,5 per cent of 'psychic cases' were women. Bohman divided psychic illnesses into eleven disease categories, the four largest of which were psychasthenia (35,6 % of all 'psychic cases'), 'simple' neurosis (15,9 %), feeble-mindedness ('oligophrenia') (10,9 %) and hysteria (10,2 %). Bohman, who was fond of Pierre Janet's concept of 'psychasthenia', explained that when he went through the clinical records from 1938, he often encountered the diagnosis 'neurasthenia' and then reclassified these cases either as cases of psychasthenia or of 'simple' neurosis.[33] Therefore, the diagnostic categories that Bohman employed were not authentic, but the results of his reinterpretations of neurasthenic cases.

Bohman's follow-up study showed that sixty-eight per cent of the former patients were completely or almost completely capable of working (3,054 cases), while thirteen per cent were incapable of working and received retirement allowance (592 cases). There were also a considerable amount of people who were either partially disabled (10 %) or incapable of working without receiving retirement allowance (8,6 %).

Within the group of nervous illnesses, the results in the categories of 'simple neurosis' and 'psychasthenia'—which were both originally classified as 'neurasthenia' at the RBP's clinics—were most successful, but Bohman cautions the reader to draw any hasty conclusions about the direct correlation between the improved medical condition of the patients and their capability for work: patients whose condition improved were not necessarily capable of working, and, therefore, to improve

female cases were combined, almost eighty per cent of patients were both improved and capable of work, and less than two per cent of patients were not improved and not capable for work. Therapeutic results were especially good in the categories of psychogenic neurosis, psychasthenia and depression, which together comprised almost sixty per cent of all cases. Folke Bohman and Gösta Odstedt, "Neurosklientelet vid en kuranstalt," *NM* 3 (1939): 2351–4.

[33] Folke Bohman, "Resultaten av K. Pensionsstyrelsens sjukvårdande verksamhet," *SMT* 21 (1944): 126.

one's health was not tantamount to being able to provide for oneself.[34] And rather than express satisfaction at the relatively high number of psychasthenics and neurotics who were capable of working after the cure, he points out that a relatively large number of these patients remained *incapable* of working (8,9 % of neurotics and 15,3 % of psychasthenics). He seeks explanations for this result in the contingent factors that might impair the condition of these patients: other, somatic illnesses might have interfered with the healing process, while personal conflicts, unsolved external problems (such as poverty or unemployment), and bad working conditions might have prevented the psychic recovery of these people. He thinks highly of 'psychasthenics', whom he characterises as "in general dutiful and ambitious in their character," and as people who are "normally used to doing everything they can to provide for themselves."[35]

Bohman made similar observations to those made by Kahlmeter in the 1920s: the younger the patient, and the shorter the duration of illness, the better the therapeutic results. To provide care at an early stage of the illness was of special significance to the therapeutic outcome. Bohman notes that the main difference between the present study and previous studies is that the number of patients who have received retirement allowance is lower (13,2 %) in his study than in the previous studies. But this positive result can be explained partly by the improved situation in the labour market: job opportunities have been on the increase in recent years, as a consequence of which the number of employees applying for retirement allowance has probably decreased. Bohman concludes that the therapeutic results of his study are better than the results of earlier studies, which "clearly demonstrates that the Board of Pensions' therapeutic work, especially with regard to neuroses and rheumatoid arthritis, is of great importance".[36]

To the extent the results of these follow-up studies gave a truthful picture of the situation of the RBP's former patients, the RBP could easily legitimise its therapeutic activities. And legitimisation was very important to the RBP, because the clinics themselves were a burden to the national economy. From the start, the main objective of these clinics had been to turn adult invalids or potential invalids into productive

[34] Ibid., 129.
[35] Ibid., 130.
[36] Ibid., 160.

citizens, and from this point of view their achievements can be evaluated positively. Indeed, in the 1930s, when the question of the proper care of the nervously ill was discussed and debated by the medical profession more often and more passionately than in any other period before or since, the idea of the further development of publicly-funded care of neuroses was raised by the government.

In 1936, Dr Verde, who worked at the RBP's department in Malmö, raised the issue of diagnostic difficulties doctors have to deal with when they encounter nervous patients, and he also discussed the organisational questions that were becoming a burning issue at that time. He argued that the doctors at the RBP's clinics were very familiar with patients and their family members who, often inadvertently and unconsciously, were keen to receive retirement allowance or other financial benefits when they were in touch with the RBP. The situation was aggravated by the municipal authorities' attempt to save money by turning people who were dependent on poor relief—funded by local authorities—into people dependent on state-funded sickness benefit or pension.[37] In this way, the municipalities and the state were easily driven into a conflict of interest, which in turn had a negative effect on the selection of nervous patients sent to the RBP's clinics.

To their dismay, noted Verde, the RBP's doctors discovered all too often that their patients were unfit for the therapy that these clinics were designed to provide. But such patients had often travelled a long way to receive treatment, and humanitarian and medical demands for help required doctors to take care of all patients who had been admitted to their clinics, regardless of the nature of their afflictions. Varde observed that to send an 'unsuitable' patient home too early could mean another psychic trauma for the patient, who had gone often through more than his or her fair share of traumatic experiences in life.[38] He had surveyed 2,000 nervous cases at his department in Malmö, and found that about twenty per cent of these cases could be classified as 'psychotic'; eight per cent as more severe forms of psychopathy; and six per cent as feeble-minded. These three groups of patients comprised about one third of all cases, and, together with the social welfare cases and some cases of somatic diseases, they represented the particular class

[37] On this issue, see also Ljungdahl, "Flykten in i sjukdom."

[38] V. Varde, "Något om Pensionsstyrelsens neurosklientelet och urvalet av detsamma," *NMT* 12 (1936): 1979.

of patients that should never have been admitted to the department. This was in Verde's view a big problem for the RBP's clinics, and he summarised his main point as follows:

> It is not the purpose of the Board of Pensions' nerve clinics to provide a holiday resort for a notorious hospital clientele; to be a reception centre for psychotics who cannot be admitted to mental hospitals; to be a reform school for difficult psychopaths or a home for the retarded; to be a monastery either for those who cannot receive adequate help for their miserable existence from society, or for those who for a short period of time want to escape from the demands of everyday life without having any qualification to receive adequate help; to be a temporary shelter or lunch room for the unemployed; to be a nursing home for the prematurely exhausted; or to be an intermediary station on an individual's way to his or her retirement pension![39]

It was evident to the staff at the RBP's clinics that their clinical work was directed too often at patients who were therapeutically beyond the pale, and whose ailments had very little to do with 'pure' neurosis. The problem, of course, was that to give unambiguous and definite diagnostic criteria for a more severe but not too debilitating neurosis was like squaring a circle—you just could not do it. For a symptom or a set of symptoms to be defined as severely neurotic depended in each case on the interpretation of the doctor who was examining the patient, and as the interpretation in turn depended on the patients' articulation of their (mostly) subjective symptoms, there was no foolproof way in which 'pure neurosis' could be differentiated from other mental maladies, on the one hand, and, at their early stage, from certain somatic diseases, on the other. The problem was aggravated by the recalcitrant attitude of some patients towards organised care: they thought that to go to a RBP's clinic would risk their chances of receiving retirement allowance.[40] And if patients were not particularly keen on restoring their working capacity, it did not exactly improve the prospects of cure. Doctors who worked with neurotic patients were like the shackled prisoners in Plato's allegory of the cave: in front of them, they saw only images cast by the light of a fire. The great difference between Plato's shadowy images and images of neurosis was of course that, for Plato, these images were reflections of something real and substantial (the

[39] Ibid., 1980.

[40] *Betänkande angående Pensionsstyrelsens invaliditetsförebyggande verksamhet*, 19 (Malte Ljungdahl's comment).

'things themselves' or Forms), whereas the shadowy images of what was called neurosis were all that there were. There was no such thing as an essence of neurosis.

How to Develop the Cure of Neurotics

In July 1935, the Swedish government appointed a commission of inquiry into the RBP's clinics for neurotics and rheumatics. The general purpose of such governmental inquiries is to prepare new legislation, and the suggestions that constitute the published report (called the 'SOU', 'Public Inquiries of the State') are then submitted to a number of government agencies, as well as to non-governmental organisations, for comments (*remissyttrande*). These public comments are summarised in the government bill, and used as a basis for the legislative decision. The 1935 report on the *Board of Pensions' activities in the prevention of invalidity* was jointly commissioned by the RBP and the Department of Social Affairs (*Socialdepartement*), and the prestigious members of the commission included the head of the Royal Board of Health (*Medicinalstyrelsen*), the department chief of the RBP and chief physician at the Sahlgren Hospital in Gothenburg.

In June 1936, the commission published its report on the planned establishment of institutions for the care of psychoneuroses, which was then submitted to parliament for a decision to be taken in 1937. The commission proposed the establishment of a nation-wide consulting office (*upptagningsanstalt*) for neurotic patients in Stockholm, defining psychoneurotic symptoms as "manifestations of psychic disturbances" (*själsliga rubbningar*) associated with the often difficult circumstances that were potentially detrimental to mental health (adversities, unhappy working conditions, difficult relationships within the family, poverty, etc.). Due to the psychopathology of neurosis, wrote the commission, the treatment of these invalids is extraordinary difficult, because the goal of such treatment is no other than to change these people themselves—to change their way of reacting and judging.[41]

This governmental report on the RBP's clinics and on the development of the care of psychoneuroses was the subject of a long and arduous debate that broke out at the Society of Medicine in the

[41] Ibid., 55.

autumn of 1937. The Society's Psychiatric-Neurological Section had prepared a proposal for its public comment on the report, and this proposal generated a heated discussion at the Society. Rather than go into all the intricate and sometimes petty details of the dispute that continued for no less than four consecutive meetings at the Society, I shall summarise the different standpoints that surfaced during these hectic meetings. Not surprisingly, these standpoints correlated with the professional specialty of the debaters: a psychiatrist presented psychiatry as the medical discipline that was best equipped to deal with neuroses, while neurologists and internists contested this standpoint and advocated their own expertise, and so forth.

Psychiatric standpoint

Victor Wigert, professor of psychiatry at the Karolinska, was the most prestigious psychiatrist present at these meetings, and his enthusiastic involvement in the debate reflected his conviction that psychoneuroses were one of the most common illnesses in Sweden, and that they posed a serious threat to the health of the nation.[42] Wigert had encountered neuroses when he had worked part-time at the Outdoor Relief Office for the Psychically Ill (*Hjälpbyrån för psykiskt sjuka*) as a young doctor in the late 1910s and the early 1920s, and after his study trip to the United States in 1930 he had become a champion of mental hygiene ideology, writing and lecturing about the ways in which the onset of mental ill-health could be prevented.[43] In his proposal for comment, Wigert agreed to a large extent with the ideas presented in the governmental report, and his advocacy of "special departments for the psychically ill at central hospitals" implied that he wanted to exclude neurological cases with an organic substratum from these departments. In his view, they should be reserved for psychoneuroses, purely psychological

[42] Victor Wigert, [Commentary], *Förhandlingar*, October 19, 1937, 460.

[43] See Victor Wigert, *Om psykisk hälsovård*. Svenska föreningens för psykisk hälsovård småskrifter, Nr. 1 (Stockholm: Albert Bonniers förlag, 1932); and "Mentalhygienen, dess mål och möjligheter," *Förhandlingar*, May 15, 1934, 112–18. Wigert founded the Swedish Society for Mental Health Care (*Svenska föreningen för psykisk hälsovård*) as an instrument to fight neuroses and mental illnesses (the society did not have much of an impact on public mental health care). On this society and on Swedish mental hygiene in general, see Carl-Henry Alström, "Psykisk hälsovård," *SLT* 40 (1943): 2074–81; and Inghe, "Sociala synpunkter."

illnesses that constituted a much larger group of neuroses than the neurological diseases.[44]

Standpoint of neurologists and internists

Wigert's psychiatric standpoint was contested by the Society for Internal Medicine (*Föreningen för invärtes medicin*), which in its own comment on the care of psychoneuroses predictably placed the emphasis on the physicians' competence in neurology.[45] According to internists, psychiatrists did not have sufficient competence to be in charge of the care of neuroses, and thus the appropriate form of care should not be a polyclinic run by a psychiatrist, but a neurological department in a central hospital, to which a polyclinic would be affiliated. Internist Isak Jundell elaborated on this point in his comments, suggesting that such departments should be headed by internists or neurologists, who would consult psychiatrists *if needs be*. Psychiatrists' expertise was valuable, admitted Jundell, but they were mainly working at mental hospitals, whereas neurotic patients required a different kind of institutional care.[46]

Nils Antoni, professor of neurology, gave a number of critical remarks on the governmental report, seeing the text as giving far too much emphasis to psychiatric viewpoints. He argued that 'pure' psychiatrists lacked the necessary competence to treat neuroses, because neurotic patients represented the borderline between psychiatry and medicine, especially internal medicine and neurology. Antoni was not a fanatic advocate of the neurologists' right to treat neuroses; he presented rather a moderate neurological standpoint, acknowledging the importance of psychiatry and 'medical psychology' for the care of neurosis, while criticising what he perceived as an inordinately psychiatric stamp on the governmental report. What we need are physicians who would be well-trained both in psychiatry and neurology, suggested Antoni, who contrasted the 'old', outdated psychiatry with the 'new', scientifically-oriented psychiatry that had established close contacts with other medical disciplines, especially internal medicine and neurology.[47] Antoni even

[44] Wigert, [Commentary], *Förhandlingar*, October 19, 1937, 465.
[45] "The Society for Internal Medicine's proposal for a comment," *Förhandlingar*, October 19, 1937, 475–6.
[46] Isak Jundell, [Commentary], *Förhandlingar*, October 26, 1937, 530.
[47] Nils Antoni, [Commentary], *Förhandlingar*, October 26, 1937, 547.

referred to the attitudes of some internists and hospital physicians as reflecting "psychiatry phobia".[48]

Psychotherapeutic standpoint

It was Poul Bjerre who at these meetings vigorously presented the standpoint of a psychotherapist in private practice. Representing his own psychodynamic perspective on neuroses, he championed psychotherapeutic discussions with patients in a 'non-institutional' and non-medical milieu, and rejected the suggestion that the care of neuroses should be connected to hospitals, because admission to hospital would only stir up in patients a needless and very unfortunate fear of going mad.[49] "Neurotic patients should in general be kept a thousand miles away from hospital patients," announced Bjerre, who was obviously rather upset about the idea of placing neurotic patients in hospitals. His conviction was shared by Jakob Kinberg, head of the RBP's clinic at Åre, who wrote in his comments on the report, that in most cases a mere awareness that one has been admitted to an institution which is somehow affiliated with a hospital suffices to make many patients depressed and anxious. Moreover, noted Kinberg, it should be borne in mind that ordinary people see hospitals as places where the sick are not so much helped to regain their health as neutralised and done away with. Accordingly, as long as the sick and their families look with suspicion at hospital departments for the neurotics, to provide care in such an institution would be counterproductive.[50]

Knowing very well that a handful of private psychotherapists and nerve doctors could not offer a satisfactory solution to a wide-spread national malady, Bjerre suggested that the best form of institutional care would be provided by small nursing homes with about ten beds each. In a small institution, neurotic patients would have close personal relations with the staff, which is important for such patients. He was critical of the current medical trend that sought solutions in large institutions, connecting this 'mania' with the contemporary tendency to see large-scale industry as a model on which to build society. He warned that if the care of neuroses was developed along the lines suggested

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[48] Ibid., 573.

[49] Poul Bjerre, [Commentary], *Förhandlingar*, October 19, 1937, 469–70.

[50] *Betänkande angående Pensionsstyrelsens invaliditetsförebyggande verksamhet*, 65 (G. Kinberg's comment).

in the report, it would increase rather than diminish the number of neurotic patients in Sweden.[51] At a later meeting, he lamented that the only thing that the discussants seemed to agree upon was the total neglect of psychotherapy.[52]

Standpoint of child psychiatrists and paediatricians

Predictably, child psychiatrists and paediatricians were of the opinion that as their expert knowledge and skills were indispensable to the study of childhood neuroses, they should be included as experts in the medical care of neuroses.[53] Child psychiatrist Torsten Ramer stated that since "many neurotic symptoms have their roots in childhood," it is child psychiatry, more than any other medical speciality, that "in the future will truly contribute to the prevention [of psychic illnesses] among psychically vulnerable individuals."[54] He claimed that in about thirty per cent of all child psychiatric cases, one could demonstrate a hereditary disposition to psychopathy, neuropathy or psychoses. About forty per cent of the children who were disposed to these constitutional deficiencies were cases in which the deficiency or pathology had been triggered by environmental factors. To the extent child psychiatry could interfere and prevent the later onset of these pathologies among children, the discipline should be of great importance to medicine and society. Child psychiatry, suggested Ramer, should be developed into a "very special discipline" that would have important points of contact not only with psychiatry, neurology and paediatrics, but also with individual and group psychology, criminal psychology and hereditarianism. Ramer ended his promotional talk by suggesting that the Society of Medicine should pay attention to the "fact" that child psychiatry was an integral part of the preventive work in the field of neuroses.[55] His proposal received insufficient support, and, consequently, there were no references to child psychiatry in the public comment on the governmental report, although a number of doctors agreed with Ramer on this issue, Nils Antoni and Jakob Billström among them.

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[51] Bjerre, [Commentary], *Förhandlingar*, October 19, 1937, 470.
[52] Ibid., 565. On Bjerre's later comments on this debate, see Bjerre, *Räfst- och rättarting*, 208.
[53] Dr Lichtenstein, [Commentary], *Förhandlingar*, October 19, 1937, 488.
[54] Torsten Ramer, [Commentary], *Förhandlingar*, October 26, 1937, 518–19.
[55] Ibid., 520.

Aberrant standpoint: On the value of local knowledge

Sten Lagergren, who worked at the Serafimer's *Nervpoliklinik*, argued on the basis of his clinical experience that it is often exceedingly difficult to help patients who have travelled to Stockholm from far away, and who live in a very different environment from town-dwellers. In his view, to treat such patients at places like the *Nervpoliklinik* borders on quackery, because the distance between the clinic and the patients' home district prevents an empirical analysis of the local social and psycho-social conditions. He was convinced that neuroses should be studied in their original environment and placed in the concrete life situations of neurotic people. He pointed out that the model presented in the governmental report was copied from 'mental clinics' abroad, from countries with big cities and districts with a high density of population, which differ considerably from rural countries with a low density of population, such as Sweden, where medical care has traditionally been provided by individual doctors working in the provinces. The point Lagergren was making in his comment was that mental health care was "not dependent on technical or mechanical resources, but rather on the knowledge of people and places"[56]—that is to say, on local knowledge. But, said Lagergren, this is exactly what the report overlooks, and in doing so it overlooks the fact that a polyclinic cannot offer nervously ill patients what they need, namely personal, time-consuming therapy and an opportunity to choose a doctor they prefer, a doctor who would be available for certain also on the patient's next visit. Lagergren did not entertain any illusions about the curative effects of a polyclinic-type care for neurotic patients.

At the end of the third meeting of the Society of Medicine, there were no less than eight different proposals for public comment on the governmental report. After a number of open votings, the proposal written by the internist Jundell received the majority of votes, and the Society of Medicine decided to present Jundell's proposal as its official comment on the report.[57] Jundell, who seemed to be exceptionally skilful at synthesising the differing viewpoints of neurologists, internists and psychiatrists, proposed that 'specialised in-patient departments' with affiliated polyclinics or out-patient departments should be established at central hospitals. His proposal was consensus-seeking and moderate

[56] Sten Lagergren, [Commentary], *Förhandlingar*, October 19, 1937, 487.
[57] *Förhandlingar*, November 2, 1937, 599–601, 605–6.

in tone, highlighting the need for a many-sided training and toning down the report's emphasis on psychiatry that had irritated many non-psychiatrists. Jundell's proposal was so balanced that even Wigert, a psychiatrist, could support it, even though he was unhappy with the suggestion that one year of training in psychiatry would be sufficient for a physician specialising in neuroses. It was at Wigert's request that the words 'at least' were added to the sentence "at least one year of training in psychiatry, medicine and neurology."[58]

The debate on the proper care of neurosis was simultaneously a debate on the 'true' nature of neurosis. Psychiatrist Wigert, neurologist Antoni and psychotherapist Bjerre, for example, had a rather scholastic dispute over the pathogenesis of neurosis, Wigert referring to "constitution and milieu" as factors that made one vulnerable to neurosis, while Antoni stressed "constitutional" and "somatic" factors, and also referred to "personal destiny" or, less opaquely, "individual experiences" leading to a "psychic trauma". Bjerre in turn saw the "unconscious" and its "complexes" as the matrix of neuroses. The two main protagonists in the debate were Wigert and Antoni, both of them professors at the Karolinska, and both vigorously defending their own expertise against what they presented as false arguments put forward by the other party. Thus the discussion about the proper care of 'psychoneuroses' ended up being a debate about which medical specialty should have the right of precedence to study and treat neuroses. The two professional groups that were most engaged in this debate were, predictably, psychiatrists and neurologists. The latter group, backed by internists and other purely medical professionals, were the ultimate winners in the debate, for Jundell's accepted proposal was far less psychiatry-centred than the governmental report, in which psychiatrists were presented as the principal caretakers of psychoneuroses.

Plans to systematically develop the organised care of neuroses did not materialise to the extent they were outlined in the 1937 governmental SOU report, and in the public comments on this report. The outbreak of World War II in 1939 probably thwarted these plans, which might have been too expensive anyway. Although Sweden was neutral during the war, limited national economic resources made it necessary to save money, and the authorities' concern with expenditure made the question of the proper institutional care of neurosis less central for the state. The

[58] Wigert, [Commentary], *Förhandlingar*, November 2, 1937, 589.

department for the nervously ill at the General Hospital in Malmö, for example, was taken into a military use during the war.[59]

The RBP's clinics remained open after the war, and in 1961 there were altogether 576 beds in these clinics and departments.[60] By that time, the RBP had merged with the National Social Insurance Board (*Riksförsäkringsanstaltet*), which had taken over the running of the clinics that now played a relatively minor role in the organised care of neuroses. By the 1960s, neurotic patients were cared for mostly in psychiatric clinics, polyclinics and hospitals, but increasingly also in information offices, family consultation centres, child welfare offices and health care centres at universities. The psychiatric in- and outpatient departments became the most common form of care for neuroses, and the opening of such clinics (first in Lund in 1929 and then at the Serafimer in 1933) meant that a growing number of people suffering from mild mental disorders began to be treated by psychiatrists, for whom the emerging system of clinic-based psychiatry presented welcome opportunity to leave often chronically ill inmates in mental asylums, and work with more acute cases in general hospitals and in affiliation with the medical faculties of universities.

The Psychiatrisation of Neurosis

Perhaps the most important development in the history of neuroses in Sweden during the period under survey was the 'psychiatrisation of neurosis'. In 1950, neurosis as an illness and a diagnostic entity was quite different from what it had been in 1880, and these differences in the conceptualisation of neurosis can be explained largely by the fact that the field of neuroses was annexed by psychiatry during this period. Neuroses in Sweden became predominantly psychiatric illnesses, and the institutional care of neurosis was increasingly provided by psychiatrists.

In the 1940s, neuroses began to be referred to as 'mild psychic conditions of insufficiency', which denoted mental maladies standing on the borderland between health and sickness.[61] As the psychodynami-

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[59] Inghe, "Sociala synpunkter," 85.

[60] Wolfram Kock, "Lasaretten och den slutna kroppssjukvården," in *Medicinalväsendet i Sverige 1813–1962*, ed. Kock, 189–90.

[61] See, for example, Thorsten Sjövall, "Läkarvetenskapen och den psykiska hälsovården," *Social Årsbok* 1945, 47.

cally-inspired belief that 'we are all more or less neurotic' became more widespread, the already rather fragile wall between the neurotics and the healthy came tumbling down. When neurosis became less an illness, and more a slightly abnormal mental condition that could affect anyone, the idea that the right place to treat neuroses was in a hospital became increasingly anachronistic. Still, neurotic patients could very well end up being admitted to mental hospitals, because they mostly consulted psychiatrists, who had a 'natural' inclination to refer all mental cases—even if the symptoms were milder—to mental hospitals. Thus mental hospitals in the post-war era housed not only the mentally ill and demented, but increasingly also neurotics, psychopaths and alcoholics. One could speak of a flood of neurotic patients, who could not be taken care of in an outpatient system, due to the lack of resources (beds, facilities, money, staff, etc.).[62]

When the governmental commission of inquiry into the organisation of medical education (SOU) submitted its report in 1941, the chapter dealing with psychiatry began with the suggestion that psychoneuroses should be given a more visible position in the curriculum of psychiatric education.[63] It was noted in the report that the 'material' in psychiatric clinics gave excellent opportunities for medical faculties to include clinical studies of psychoneuroses in their curricula. Although psychoneuroses were presented in the report as predominantly psychiatric illnesses, allowances were also made for the role of neurology in the study of the 'symptomatology' of these illnesses. The report proposed that psychiatry and neurology might complement each other by focusing on the different (i.e. organic and psychic) sides of psychoneuroses.[64] The report made it clear that the diagnosis and therapy of psychoneuroses demanded an increased psychiatric attention in the future.

That the governmental report on medical education in the early 1940s paid attention to neuroses was understandable, since neuroses were becoming a major psychiatric illness found in great variety not only at clinics, polyclinics and the offices of both psychotherapists and general practitioners, but also at in-patient departments in hospitals and mental hospitals. For example, a separate ward for the nervously ill was

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[62] This issue was raised in the daily newspaper *Dagens Nyheter* in a series of articles published between September 10 and 12, 1952. In these articles, six doctors described the changed situation in mental health care.

[63] *Betänkande med utredning och förslag angående Läkarutbildningen*. Stockholm, *SOU*: 27/1941, 156.

[64] Ibid.

opened at the Beckomberga mental hospital in Stockholm in the mid-1930s, which testified to the overlapping of the hitherto rather separate clinical domains of mental illnesses and neuroses. While more and more psychiatrists were relying on psychological terminology to make sense of neuroses in the post-World War II era, and while neuroses were treated with talk therapies in out-patient clinics, health care centres and information offices, the psychiatrisation of neurosis also brought with it not only a cultural infection of a 'neurosis virus', but also a blurring of boundaries between severe mental disorders and neuroses.

Following the clinical brimming-over of neuroses, many nervously ill patients admitted to mental hospitals were treated with up-to-date psychiatric methods, including electroshock and lobotomy. In 1952, psychiatrist Curt Åmark noted that lobotomy had an "immediate effect on anxiety, which tends to disappear altogether".[65] He recommended lobotomy as a method of treatment for the more difficult cases of anxiety neuroses that were not amenable to psychotherapy or, in some individual cases, to psychoanalysis. In 1962, Peder Björck wrote in his overview of the methods of treatment in psychiatry that lobotomy had improved to some extent the condition of patients who suffered either from "aggressive chronic schizophrenias" or "difficult neurotic states of anxiety," which had been inaccessible to other forms of therapy.[66] In his 1962 account of sterilisation policy, geneticist Nils von Hofsten presented figures indicating the number of sterilisations performed on account of specific diseases or morbid conditions. During the years 1941 and 1953, 1,855 people—mostly women—were sterilised on account of "psychopathy and allied conditions".[67] It is an intriguing thought that psychosurgery was employed as a method of treatment in the case of those 'lower-class' people who exhibited signs of psychopathy, which as a diagnosis was very close to neurosis (psychopathy was actually classified as a neurosis at the Serafimer Hospital from the mid-1920s to the mid-1930s).

The fact that nervously ill patients were subjected to the intrusive methods of lobotomy, electro-shock and heavy drugging in mental

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[65] Curt Åmark, "Om tvångsneurosernas klinik och behandling," *SLT* 49 (1952): 1767.

[66] Peder Björck, "Mentalsjukvården," in *Medicinalväsendet i Sverige 1813–1962*, ed. Kock, 274.

[67] Nils van Hofsten, "Steriliseringarna och aborterna," in *Medicinalväsendet i Sverige 1813–1962*, ed. Kock, 513–27, 722–3.

hospitals, indicated the blurring or overlapping between the two disease categories of neurosis and psychosis. In the late 1950s, the emergence of anti-depressants provided yet another chapter in the multifaceted history of neurosis, as the psychopharmaceutical industry became a major force in the modern development of mild mental disorders. Today's 'neurotics' consume anti-depressants to such a degree that some sceptical students of psychiatry are provoked to see the psychopharmaceutical industry as the main initiator of new mental disorders that makes huge profits from disease-mongering. As the medical journalist Ray Moynihan and his co-writers put it in their recent article on the pharmaceutical industry and disease mongering: "A lot of money can be made from healthy people who believe they are sick."[68]

A Paradigm Change in the Management of Neurosis

Torsten Ramer expressed the sentiments of many Swedish doctors when he observed in 1936 that

> There is a strong flavour of something morbid in the word nervous, which…is unfortunate for several reasons. Therefore, it would be laudable if there were less talk about the nervousness of people.[69]

Obviously, Ramer was glad to leave the Age of Nervousness behind. What he could not foresee was that Nervous Culture was about to change into Psychoculture, which prompted people to locate the source of their malaise in the psyche rather than in nerves. From the mid-1930s onwards there occurred a paradigm shift in Swedish mental medicine, as the language of nervousness was increasingly marginalised, while the language of psychic conflict, trauma and psychogenetic aetiology came more and more to the fore.

Changes in the Swedish sick care system were the result and function of changes in mentality and ideology. In the 1940s, the stress was increasingly laid on the preventive aspects of 'psychic health care' with a concomitant interest in psychosocial questions and psychomedical

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[68] Ray Moynihan, Iona Heath and David Henry, "Selling Sickness: The Pharmaceutical Industry and Disease Mongering," *British Medical Journal* 324, April 13 (2002): 886. See also Ray Moynihan and Alan Cassels, *Selling Sickness: How the World's Biggest Pharmaceutical Companies Are Turning Us All into Patients* (New York: Nation Books, 2005).

[69] Ramer, "Nervositet och uppfostran," 171.

'management' of mental malaise. The 1937 debate at the Society of Medicine signified the last phase in the history of neuroses, in which a purely medical (psychiatric and neurological) approach to these afflictions held sway. In 1937, Poul Bjerre's plea to use (almost) exclusively psychotherapy to treat neuroses was a completely marginal issue, as were the tentative attempts to direct medical attention towards the significance of social-psychological and situational issues in the pathogenesis of neurosis.[70] By the mid-1940s, the tone had become quite different, as work therapy, physical therapies, hereditarianism and the language of soma (the nervous system, brain and dysfunctional organism) were partly replaced by psychotherapy, environmentalism and psychological and psychosomatic language.

One side of the new, socially oriented health care ideology was reformistic: neuroses can be eradicated only if the external preconditions (poverty, unemployment, poor housing, lack of education, etc.) for their outbreak have been removed. Another side of this ideology was interventionist: citizens must be monitored and 'managed' so that problems with adjustment and socialisation can be tackled as early as possible. According to psychiatrist Erik Goldkuhl, who advocated regular 'mental-hygienic' check-ups for each and every citizen, a centralised and extensive 'management of people' (*människobehandling*) would not only imply a moral and humane profit, it would also increase the efficiency of the whole nation on a purely practical and economic level, which in turn "increases both the general and the individual standard of living and feeling of happiness."[71] An officially sanctioned belief in the blessings of the psychomedical management of citizens through surveillance, check-ups, tests and an overall quantification of 'human material', has sinister implications in its anti-liberal conviction that the state can define the parameters of 'positive liberty' and lead the sometimes recalcitrant citizens to the Good Life. In the Swedish ideology of social engineering in the post-war era, the question of the proper care of neuroses began to be formulated in the language of social reformism, which laid stress on the social and social-psychological obstacles to healthy adjustment

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[70] For example, Malte Ljungdahl, head of the RBP's department for the nervously ill in Malmö, was of the opinion that "in many cases, to remove the effect (neurosis) when the cause (poverty and the burden of living) is still there is, unfortunately, a hopeless endeavour." *Betänkande angående Pensionsstyrelsens invaliditetsförebyggande verksamhet*, 67 (Ljungdahl's comment).

[71] Goldkuhl, "Aktuella önskemal beträffande den psykiska hälsovården i Sverige," 209.

on the one hand, and on the need to keep citizens under benevolent surveillance on the other. In a well-managed people's home, neurosis would cease to be a socio-culturally contagious illness.

Was neurosis, then, eradicated from the Nordic *folkhem*? In 1956, 'diseases of the nervous system', including psychoses, feeble-mindedness and neuroses, constituted almost half (48,9 %) of all the cases where a National Insurance pension was granted to 'invalids' because of an incapacitating disease. Neuroses alone were the principal cause of invalidity in almost four per cent of all cases.[72] This indicates that neuroses continued to be endemic in the decades following World War II. The authorities' failure to defeat neurosis may be explained not only by the failure of the health care system to achieve its unrealistic goals, or by social changes that demanded a high degree of mental adaptability from citizens; another factor that should be taken into account is the development of mental medicine itself, which to a large extent revolved around the study and treatment of milder mental afflictions that until the 1980s were usually classified as 'neuroses'.

A study of the final period in the history of neurosis (ca. 1950–1990) is beyond the scope of this book, but there is no doubt that future historians of medicine, psychiatry, psychology and psychoanalysis, as well as social, cultural and intellectual historians, will contribute to our understanding of contemporary history with their research on the further medicalisation and psychopathologisation of the grey area between mental health and mental illness. My own informed guess is that the role of psychomedical experts in the manufacture of mild mental maladies during the past fifty years has been crucial.

[72] Arthur Engel, "Medicinalväsendets aktuella problem," in *Medicinalväsendet i Sverige 1813–1962*, ed. Kock, 674.

CONCLUSION

NEUROSIS AS A CONTAGIOUS DIAGNOSIS

In 1907, a fierce debate broke out in Sweden between the leading psychiatrist and the leading neurologist. Neurologist Salomon Henschen questioned the way in which psychiatrist Bror Gadelius had declared a successful business man mentally ill and had placed him under guardianship. Gadelius in turn was infuriated at Henschen's 'meddling' in psychiatrists' affairs and published an 'Open letter to Professor Henschen' in the Journal of Swedish Medical Association. In his letter, he asked Henschen why he was prepared to isolate an individual with a contagious bodily disease by force, but not 'Mister A.', whom Gadelius had diagnosed as mentally ill.[1] In his reply to Gadelius, Henschen remarked dryly: "Do I need to remind you that [Mister A.] will not infect anyone?"[2]

Henschen was of course right in pointing out the obvious fact that mental illnesses are not contagious diseases, except in the indirect sense that custodial care in a mental asylum may have deleterious effects on the mental state of inmates. But what I have suggested in this book is that while mental illnesses are not contagious, there are contagious *diagnoses* that indicate various kinds of mental maladies, and that these diagnoses serve specific medical and cultural purposes. A medical diagnosis that most clearly fulfils the criteria for a contagious diagnosis is neurosis, including its synonyms and subcategories (hysteria, neurasthenia, psychoneurosis, anxiety neurosis, neurotic depression etc.). They are what the historian of medicine, Karin Johannisson, has called "cultural illnesses";[3] they are also close to what philosopher Ian Hacking has termed "transient mental illnesses"[4] and what historian Edward Shorter sees as "shifting maladies" that reshuffle the "symptom pool".[5]

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[1] Bror Gadelius, "Öppet brev till professor Henschen," *ASLT* 4 (1907): 116.
[2] Salomon Henschen, [Reply to Bror Gadelius], *ASLT* 4 (1907): 122.
[3] Johannisson, *Medicinens öga*.
[4] Hacking, *Mad Travelers*.
[5] Shorter, *From Paralysis to Fatigue*.

The psychodynamic pioneer Pierre Janet was interested in the idea of neurosis as a contagious illness, and in his *Principles of Psychotherapy* (English edition 1924), he observed that 'neuropaths' have a tendency to 'contaminate' people with whom they interact:

> Neuroses and psychoses are not, of course, properly speaking, contagious like infectious diseases; doubtless, imitation and suggestion proper do not play more than a feeble part in the transmission of neuroses. But, nevertheless, there is a fact which we should not disregard, namely, that we very often meet a large number of neuropaths united in the same family or in the same environment…It is a question, to my notion, of an indirect influence of the sick person, who makes social life more difficult and costly by his presence, and it is this increase of expenditure that causes a psychic depression in the other. Whether or not we use the word 'contagion' for these cases, I wish to insist on only one thing. This is that living with certain persons is a condition that frequently determines and encourages neuroses.[6]

As a medical psychologist and therapist, Janet attributed the contagious nature of neurosis to 'psychasthenic' individuals whose very presence "causes a psychic depression in the other", whereas I as a historian have looked more into socio-cultural factors when I have tried to elucidate neurosis as a contagious diagnosis. Therefore, I shall next wrestle with the difficult question of the relationship between modernity and the contagious nature of neurosis.

Neurosis and Modernity

A general precondition for the sudden eruption of neuroses in the 1880s was what is loosely called 'modernity'. During the decades between the unification of Germany (1870) and World War I, western societies were changing rapidly, and the social, political and cultural phenomena that were the main engines of modernity (industrialisation, urbanisation, professional specialisation, antagonism between 'proletariat' and 'bourgeoisie', new technology, etc.) made people 'nervous'. The rise of an urban professional middle class on the one hand, and the emergence in the public sphere of the working class on the other, created a social tension that was conducive to nervous illnesses. Railways, motor

[6] Pierre Janet. *Principles of Psychotherapy*. Trans. H. H. and E. R. Guthrie (New York: MacMillan Co., 1924), 187–8.

vehicles, the telephone, radio as well as female emancipation, political and social reforms and new forms of social interaction (less formality and distance, more emphasis on 'intimacy', 'personality' and 'character') made people 'uprooted', more insecure and less confident about their ability to cope with an increasingly complex reality.[7]

In countries such as Britain, where industrialisation was in full swing already in the late eighteenth century, 'nervousness' became a widespread condition much earlier than in Sweden, where ninety per cent of the population in the mid-nineteenth century lived in the countryside. It was only in the final decades of the nineteenth century that neuroses became endemic in most parts of western Europe. Sweden was dramatically affected by modernisation that gained momentum in the 1870s, and it is no coincidence that late nineteenth-century discourse on hysteria, nervousness and neurasthenia had a great impact on medicine in countries such as Germany, the United States and Sweden, which were all undergoing rapid changes and following the industrial lead of Great Britain.

When Arthur Engel, Director General of the Royal Board of Health, outlined the "current problems in the Swedish health service" in 1962, he coupled modernisation with various social and medical problems, listing an "increasingly busy pace of life"; an unfortunate cultural infatuation with what is sensational and fast-moving; a need for artificial stimulants; a restless rush created by modern means of communication; a huge consumption of drugs; intrusive noise pollution and deterioration of the physical environment (water, air, land), as factors that were potentially damaging to the psyche.[8] These psychological injuries, writes Engel, are especially manifest in the proliferation of psychoneuroses and psychosomatic conditions. He pointed out that

> modern Sweden is a highly industrialised country where the process of urbanisation is far advanced and still in progress. The population is thus more and more exposed to the stress and strain of modern city life. The impact of its restless activity is strong on the human mind, and psychoneuroses and psychosomatic disturbances are common.[9]

Although he articulated his concern using different terms than his late nineteenth-century medical predecessors, whose cultural criticism had

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[7] See, e.g., Radkau, *Das Zeitalter der Nervosität.*
[8] Engel, "Medicinalväsendets aktuella problem," 670–71.
[9] Ibid., 735.

found a paradigmatic expression in the term 'the nervous age', Engel represented the same intellectual tradition, a tradition in which the temptation to present correlations between socio-cultural changes and the mental health of individuals as causal links has been irresistible.

It seems incontrovertible that cultural evolution or modernisation (when we refer to one particular phase of cultural evolution) is part of the phenomenon of neuroses and other cultural illnesses. When landless people (farm labourers, etc.) in Sweden moved from rural areas to urban centres to work in factories, shops, workshops and bourgeois households, it had significant consequences for lives of these people, as well as for Swedish society as a whole. And as waged labourers were vulnerable to economic conjectures, a new kind of material insecurity was added to the emotional insecurity many of these people felt when their social environment changed abruptly (but it should be borne in mind that young men and women who moved to towns appeared to be mostly happy to get out of their restrictive rural environments). Industrialisation affected not only workers, but also members of the *Bildungsbürgertum*, who, like the majority of Swedes, often had their roots in the countryside and traditional ways of living. Industrialisation, the socio-economic backbone of modernity, changed the basis of Swedish society, creating a demand for new technology and business acumen that required new skills and new forms of utilisable knowledge.

A rapidly-developing nation needed, first of all, people who were trained and educated in the natural sciences and applied sciences (engineers, physicists, chemists, biologists, etc.); second, it needed industrialists, entrepreneurs and business men who would raise and invest capital, create jobs and boost the economy; third, it needed teachers, people who would educate future engineers and business men; fourth, it needed lawyers and bureaucrats to fulfil the increasingly complicated legal and administrative functions; and, fifth, it also needed physicians and behaviour experts, people who would 'manage the human material' and provide care for those who could not properly function in a changing society, or whose adjustment to social environment was deemed inadequate.

When I began my research on neurosis, my basic assumption was that 'psychogenic' neurosis and its contemporary successors, especially depression and anxiety,[10] were diagnostic terms that had their external

[10] On the history of the clinical use of the concept of 'anxiety', see *A History of Clinical Psychiatry*, ed. Berrios and Porter, 563–72; and Berrios, *The History of Mental Symptoms*, 263–88.

origins in two related sources, an increasingly fast-paced cultural evolution and psychomedicalisation of the human condition. In the course of my research, I have come across material which indicates that the alleged impact of cultural evolution or modernity on the human condition is not an adequate explanation for the incidence of neurosis. It became abundantly clear to me that neurosis was not a characteristically urban phenomenon; rather, it seemed to be the case that it was often diagnosed differently in the countryside, if it was diagnosed at all in places where it was difficult to find a doctor, and perhaps even more difficult for the patient to start talking about his or her mental distress. In Chapter 4, I referred to Karl Petrén's 'agrarian neurotics', while the following excerpt from a letter sent to British Medical Journal by an English general practitioner in 1947 suggests that even in a highly urbanised country such as England neurosis appeared to be rampant not in the cities but in the countryside!:

> Sixteen years of industrial practice in Liverpool left me with the impression that the figures for neurosis among all cases seen were if anything higher [than those of his colleague whose letter to the editor had been published in an earlier issue of the journal], and I innocently accepted the aetiological factor usually blamed—viz., the speed and high pressure of modern city life. *Experientia docet*.
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> Fifteen months ago I left Liverpool and took up practice in this area [Mildenhall, Suffolk], one of the most thoroughly rural districts in England, where our nearest factory is 12 miles away and all workers are engaged in agricultural occupations. Here, I thought, among the sons and daughters of the soil will be found a minimum of 'nerves' and a maximum of pure unadulterated physical illness. But a very short trial caused me to remark to my partner that I believed there was more neurosis in my country patients than in my former city patients, and the longer I practice here the more I am convinced that this is the truth.[11]

One can of course argue that even if the 'sons and daughters of the soil' were engaged in traditional agricultural occupations, they were nevertheless affected by socio-cultural changes: they usually received at least basic education, read newspapers, magazines and books, listened to the radio, went to the movies, had social interactions with doctors, lawyers, pedagogues and other professionals, made phone calls, drove

[11] H. G. St. M. Rees, [Letter to the editor], *British Medical Journal*, September 20 (1947): 468.

automobiles (and tractors), saw their sons and daughters moving to urban centres to work and study, and so forth. Changes were more dramatic and visible in towns and cities than in rural districts, but even a simple countryman living in Suffolk (or in the backwoods of Sweden) was not living in an insulated island where time had stood still.

Yet, the indisputable fact that neurosis was a common illness in the countryside in countries such as England or Sweden contradicts the suggestion that neurosis was created by urban modernity. It was probably the case that modernity created a mentality and a language that made it possible and acceptable for the common people to talk about their distress and discontent to medical professionals in words and phrases that could be interpreted medically and psychologically. In Sweden, 'guilty conscience', for example, was transformed into 'feelings of inferiority', and, perhaps most importantly, unsatisfactory human relationships became less and less a taboo issue in the encounters between doctor and patient. Sociologist Richard Sennett, and some other critics of this development towards candour and an increasing preoccupation with relationships, have claimed that the modern culture of intimacy is really a *tyranny* of intimacy which requires people to burden their fellow-humans with their intimate feelings and secrets.[12]

What Were the Preconditions for the Rise of Neurosis?

It is a truism that socio-cultural changes make demands on people, and it is indisputable that such phenomena as emigration, unemployment and downsizing make people nervous. As for the less tangible preconditions for the increase of nervousness in the late nineteenth and early twentieth centuries, I would suggest the following:

First, there was the stigma of mental illness. Nobody wanted to become a mental patient locked up in a huge asylum, which was a very frightening place if not a near-equivalent to Dante's Inferno to many people. Hence patients preferred to be diagnosed as 'nervously ill' rather than 'mentally insane'; to be 'nervous' rather than insane

[12] Philip Rieff, *The Triumph of the Therapeutic: Uses of Faith after Freud* (New York: Harper & Row, 1966); Richard Sennett, *The Fall of Public Man* (New York: Vintage Books, 1978); Frank Furedi, *Therapy Culture: Cultivating Vulnerability in an Uncertain Age* (London: Routledge, 2003); and *Modernity and Its Discontents*, ed. Pietikainen.

meant that one could look forward to a badly-needed rest in a hospital, sanatorium, nursing home or health resort. As psychiatrist Bror Gadelius observed in 1907, the mentally ill patient's relatives would fool themselves into thinking that it was not a case of mental illness at all; rather, the sick person was suffering from 'nerve illness', 'a more serious form of neurasthenia', 'nervousness' and so forth.[13]

Second, neurosis as a functional nerve illness was a useful compromise for doctors. Clear cases of simulation notwithstanding, it was evident to doctors that something was wrong with their patients, even though objective symptoms were few and far between. Hysteria, neurasthenia and psychoneurosis were useful diagnoses, in that they provided doctors with medical concepts that were tailor-made for people who suffered from a host of diffuse psychological and psychosomatic symptoms that were seldom life-threatening (risk of suicide notwithstanding). And the development of the therapeutic arsenal was directly linked to the development of neurosis as a diagnostic category. Hypnotism was all the rage in the last two decades of the nineteenth century, and, like hypnotism, emerging forms of 'waking-state' therapies, such as positive persuasion, non-hypnotic suggestion and the nascent psychoanalysis, were directed at neurotic patients.[14] Private sanatoriums, clinics, spas and nerve doctors catered for the changing therapeutic needs of their clientele, which meant that physical therapies gradually gave way to psychotherapy, although such methods of treatment as hydrotherapy, electricity, massage, dieting and rest cure continued to exist side by side with talking cures in the early twentieth century.[15]

The third significant precondition for the rise of neurosis was the age-old assumption, now strongly emphasised by such authorities as George Beard, Krafft-Ebing and, of course, Freud, that nervousness was causally linked to sexuality. Moralistic judgements with regard to sexuality were rampant in most western countries at least until the mid-twentieth century, and physicians, pastors and pedagogues of all persuasions were inclined to regard, for example, masturbation either as a sin or as a major sexual deviancy that weakened and eventually damaged

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[13] Bror Gadelius, "Om vår tids sinnessjukvård och den allmänna meningen," *Förhandlingar*, February 26, 1907, 44.

[14] Gauld, *A History of Hypnotism*.

[15] Edward Shorter, "Private Clinics in Central Europe 1850–1933," *Social History of Medicine* 3:2 (1990): 159–95.

both the nervous system and the brain.[16] Likewise, homosexuality was pathologised or morally condemned—or, both. That 'deviant sexual behaviour' and nervousness were connected in a cultural atmosphere of intolerance is in itself quite understandable; how many homosexuals living in, say, the small town of Norrköping in 1905 (or, 1955) did not show signs of nervousness and anxiety? During the interwar years a more enlightened and liberal attitude towards sexuality began to gain ground in western societies, including in Sweden (see Chapter 5).

Fourth, the lack of medical technology and knowledge (e.g. on the role of hormones in the 'mood swings' of women) meant that 'nervous symptoms', which were later seen to indicate a physical disease or a lesion, were relegated to the category of functional neuroses. As I observed earlier, the failure of the anatomo-clinical method to attribute all neuroses to physical lesions was the major medical precondition for the emergence of these functional nervous disorders. Sometimes advances in medical knowledge could give a definite answer to the question of organic and functional disorders. The most revolutionary medical theory in the late nineteenth century was the germ theory of disease, which made it possible to determine the underlying *aetiology* behind symptoms. For example, immunisation against typhoid fever was introduced in 1897, and, some years later, it was discovered that general paresis of the insane (GPI) was triggered by syphilitic infection. The discovery of the definite organic cause of this horrible disease invalidated the suggestion that GPI was a functional disease. In the early twentieth century, the emerging field of endocrinology demonstrated the significance of hormones for the emotional life, while technological advances, including brain scanning and the electron microscope, helped make further clinical distinctions between organic diseases and, as they began to be called, 'psychogenic' illnesses, such as neurosis.[17] Neurologist Nils Antoni predicted in 1934 that advanced neurological research in general and the study of the functions of the vegetative nervous system in particular would relegate many of contemporary neurotic, psychogenic and hysterical syndromes to the category of organic illnesses.[18]

[16] Laqueur, *Solitary Sex*.
[17] Aird, *Foundations of Modern Neurology*.
[18] Antoni, "Neurasthenia sexualis," 156–7.

Fifth, the medicalisation and psychopathologisation of one's political and ideological opponents and critics was favourable to the cultural spread of neurosis. This pathologising trend became more pronounced in the interwar years when 'neurotic' became a useful term for designating the ideas of someone of whom one did not approve. In Britain, the London *Times* had referred in 1904 to the "more violent suffragettes" as hysterical, while the *Daily Chronicle* saw suffragist protest as "hysterical hooliganism".[19] In Finland, the bourgeois writers and academics, who found it difficult to see any social reasons for the wide-spread discontent of the workers (which led to the Civil War between the socialist 'Reds' and the bourgeois 'Whites' in 1918), tended to use pathologising language to explain the subversive activities of the workers, who were labelled as hysterics or degenerated "born criminals".[20] The method of psychomedicalising people one did not like was applied not only to individuals and groups (such as suffragettes, socialists and the bourgeoisie) but also to whole nations. The psychopathologisation of the 'German mentality', for example, became a veritable psychiatric industry in the United States in the 1930s and the 1940s.

Sixth, the psychologisation of neuroses in the aftermath of World War I, with its phenomenon of 'war neuroses', had a great impact on the future of neurosis.[21] Psychological, psychoanalytic and psychosomatic approaches to mental disorders considerably widened the scope of neuroses, and neurosis came to signify a psychogenic illness that was ideally suited to various methods of psychological healing. Neurologists, who had been specialists in all nerve illnesses in the early history of neurosis, increasingly allowed the domain of 'functional neuroses' to be annexed by psychiatrists and medical psychoanalysts. These two major groups in mental medicine had to make way in turn for 'laypersons' after World War II, when clinical psychologists, a new professional group, started to present themselves as specialists in the field of psychogenic disorders, including neurosis. In the 1960s and 1970s, clinical psychologists managed to break down the medical monopoly over psychotherapy, focusing on the ever-expanding middle ground between mental health and severe mental illness. The rise of clinical psychology was part of

[19] Quoted in Elaine Showalter, "Hysteria, Feminism, and Gender," in Gilman et al., *Hysteria beyond Freud*, 320.
[20] Uimonen, *Hermostumisen aikakausi*, 182–3.
[21] Shephard, *A War of Nerves*.

the larger process of the psychologisation of society, which sociologist Philip Rieff has called 'the triumph of the therapeutic'.[22]

Seventh, and last, psychosomatic medicine was a major factor in the spread of neurosis. During the nineteenth century, weak or exhausted nerves were often linked with 'organic symptoms', such as gastric, heart and intestinal disturbances, and the concept of 'organ neurosis' was applied to denote such symptoms. Advances in the study of the anatomy and physiology of the body consigned the wildest speculations about 'reflex neuroses' to the dustbin, while the emergence of endocrinology clarified the relationship between the emotional life and the regulatory system in the human organism. In the 1930s, the suggestion that there were psychic determinants underlying somatic symptoms was developed by representatives of what came to be called 'psychosomatic medicine'.[23] It is usually associated with the psychoanalyst Franz Alexander and his colleagues at the Chicago Institute for Psychoanalysis, who suggested that there were seven paradigmatic illnesses that had a largely psychological aetiology, such as asthma, peptic ulcer, rheumatoid arthritis and essential hypertension.

Before Alexander and his colleagues undertook a more systematic study of psychosomatic illnesses, such renegade psychoanalysts as Wilhelm Stekel and Georg Groddeck had already claimed that many physical illnesses resulted from psychological disturbances and unconscious conflicts. Stekel coined the word 'somatisation' (*somatisieren*) to denote the 'conversion' of emotional states into physical symptoms, and Groddeck went so far as to claim that not only most illnesses but also accidents are psychological in origin. Another early advocate of the psychosomatic approach to illnesses was the Viennese internist and psychoanalyst Felix Deutsch, whose use of the term 'psychosomatic' (in 1927) found resonance among his professional peers.[24]

The basic idea behind psychosomatic medicine, as developed by Alexander and his colleagues, is that there are psychiatric disorders

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[22] Rieff, *The Triumph of the Therapeutic*. See also Tana Dineen *Manufacturing Victims: What the Psychology Industry is Doing to People* (Montréal: Robert Davies Multimedia Publishing, 2001); and Furedi, *Therapy Culture*.

[23] Shorter, *From Paralysis to Fatigue*; and R. A. Mayou, "Psychological Factors and the Course of Illness," in D. J. Weatherall et al., *Oxford Textbook of Medicine* (Oxford: Oxford University Press, 1984), 24.31–34.

[24] On the history of the term 'psychosomatic', see Edward Shorter, "Somatoform Disorders: Social Section," in *A History of Clinical Psychiatry*, ed. G. E. Berrios and Roy Porter, 476–89.

which reveal themselves as physical disease.[25] Depression, anxiety and hysteria (especially Freud's 'conversion hysteria') have been typically regarded as mental maladies that result from emotional disorders and mimic physical illnesses. In Sweden, psychosomatic medicine broke through in the late 1940s and early 1950s, becoming something of a new medical worldview. The popularity of psychosomatic medicine can be partly explained by the fact that it boosted the status of psychiatry, because medical interest in the intricate interrelationship between psyche and soma offered psychiatrists an opportunity to encroach onto the territory of internal medicine and treat such non-psychiatric illnesses as asthma, peptic ulcer, heart diseases and specific intestinal disorders. Emphasis on the psychological factors in these illnesses benefited psychiatrists, who interpreted neuroses as psychosomatic illnesses.[26] In the post-World War II era, neurosis rode on the crest of a wave of psychosomatic medicine.

Through Which Channels Was Neurosis Passed On?

Neurosis spread rapidly in the population and in culture via the following channels:

a) *The medical community as a whole*. By the late nineteenth century, medicine had become an important social force and a frame of reference for the authorities. 'Medicalisation' entails the idea that medical language and thought patterns are applied to other, non-medical spheres of public and private life. Thus social policy, working life, leisure time, pedagogy, family life, sexuality and morality were increasingly infused with medical health ideology.[27] The rise of neurosis coincided with the rise of medicine as a social force, and advocates of early twentieth-century

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[25] See Franz Alexander, *Psychosomatic Medicine: Its Principles and Applications* (New York: Norton, 1950).

[26] On the professional significance of psychosomatic medicine to psychiatry, see Gunnar Lundquist, "Från hospital till modernt sjukhus," in *Modern svensk sinnessjukvård*, ed. Gunnar Lundquist (Stockholm: AB Modern Litteratur, 1949), 15–18. On the idea that neurosis is a psychosomatic illness, see Thorsten Sjövall, "Den psykosomatiska synen på läkekonsten," *SLT* 55 (1958): 1875–84.

[27] Peter Conrad and Joseph Schneider, *Deviance and Medicalisation: From Badness to Sickness* (Philadelphia: Temple University Press, 1980); and Uta Gerhardt, *Ideas about Illness. An Intellectual and Political History of Medical Sociology* (London: Macmillan, 1989).

mental hygiene were concerned with the prophylactics of nerve illnesses. At a more concrete level, most physicians—and not only neurologists and psychiatrists—treated patients who suffered from neuroses.[28] Moreover, if we are to believe Poul Bjerre, the doctor's suggestions to nervous patients played not an insignificant role in spreading neuroses in the population.[29]

b) *Mental medicine*. Nerve doctors, hypnotherapists, psychotherapists, psychiatrists and psychoanalysts typically saw neurosis either as a nervous illness that was dependent on 'morbid representations' or as 'psychic disorder' (mental wound). From the early twentieth century onwards, new psychomedical specialties claimed jurisdiction over neurosis, which started to appear as a psychiatric and psychological affliction rather than a neurological disorder. Apart from asylum psychiatry, which was mostly preoccupied with severely ill patients, specialists in mental medicine were increasingly treating people who were neither insane nor in full health. This grey zone between severe mental illness and mental health was filled with neuroses and, from the early twentieth century onwards, psychopathy and other 'personality disorders'.[30] Neuroses comprised a large part of the domain of mental medicine as more and more physicians started to explicate the role of psychic conflicts in illnesses that used to be interpreted somatically. Freud's psychoanalysis played a pivotal role in the universalisation of neuroses in its basic assumption that emotions can make us ill. As Geza Roheim, a psychoanalytic anthropologist, put it,

> before Freud we did not understand why human beings behaved the way they did; indeed, we did not even notice that there was anything peculiar about their behaviour.[31]

I would suggest that it was the appearance of psychomedical professionals that was crucial to the spread of neurosis as a contagious diagnosis, not only in Sweden but throughout the western world. True, the

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[28] At the Serafimer Hospital, neurosis was diagnosed not only at the Neurological Clinic and Psychiatric Outpatient Clinic (*Hjälpbyrån*), but also at the Medical Clinic and Polyclinic, Gyneacological Clinic, and Ear-, Nose- and Throat Clinic. See Serafimer's Annual Reports 1880–1960.

[29] Bjerre, "Sjukkassan som folkförstörare," 228.

[30] On the diagnostic development of psychopathy, see Berrios, *The History of Mental Symptoms*, 419–38; and *A History of Clinical Psychiatry*, ed. Berrios and Porter, 633–55.

[31] Geza Roheim, "Psychoanalysis and Anthropology," in *Psychoanalysis Today*, ed. Sandor Lorand, 381.

British doctor whom I quoted above was a general practitioner, not a psychiatrist, neurologist or clinical psychologist, but it is debatable whether neurosis would have become such a common illness without the crucial 'support' of these three professional groups. I believe it was mental medicine that formed, sustained and nurtured beliefs and mental habits that played a significant role in the shaping of 'modern' mentality in the western cultural sphere.

c) *Patients, especially middle-class patients*. Middle-class women and men created and shaped neurosis together with their doctors. Their responsiveness to the language of nerves that their doctors were employing, guaranteed the spread of neurosis to the lower middle classes (artisans, petty officials, tradesmen) and the working class. Workers and craftsmen who wanted to put an end to their mental suffering had no reason to object to a diagnosis that placed the locus of pathology in their shattered nerves. To some extent, patients had already adopted the language of nerves through popular literature, medical manuals, newspapers, medical advertisements, general practitioners and quacks, and they were inclined to accept and endorse a diagnosis that fitted in so well with popular conceptions of nervousness (just as, today, depressed patients find confirmation of their diagnosis in the media).

d) *Media*. Popular books, newspapers, magazines and, later, radio popularised the language of nerves, and this emphasis on the crucial importance of the nervous system for health and mental health made neurosis an illness that tallied well with the popular perception of a causal link between mental suffering and 'weak nerves'. In Sweden, a large number of popular books dealing with some aspect of nervousness were published from the 1880s onwards, and the general public learned to interpret their inner states by using the language of nerves (just as, from the 1920s onwards, they started to learn the language of the psyche and 'psychic conflict'). When radio broadcasting was started in Sweden in the early 1920s, many nerve doctors gave presentations on the air, and their coupling of various life problems and neurosis shaped the psychomedical mentality of the Swedes.

e) '*Unofficial medicine*' *(quacks) and pharmaceutical companies*. A much-discussed problem for Swedish doctors at the turn of the twentieth century was quackery (*kvacksalveri*): for various reasons, many people, especially in the countryside, consulted homeopaths, herbalists, masseurs, 'wisemen' and 'wisewomen' and other healers without medical

degree rather than legitimised physicians, who were often not to be found in small villages.[32] One of the roles these unofficial healers fulfilled was that of a psychotherapist treating people with nervous complaints at a cheap price. Some physicians acknowledged that quacks were often skilful psychotherapists, and that they did a real service to their clients in a country where the demand for psychotherapy exceeded supply.[33] The pharmaceutical industry in turn offered a wide variety of drugs for people who suffered from a lack of nervous energy ('tonics for the nerves'). Drug companies and entrepreneurial 'medicine men' made fat profits out of this 'nerve industry', although, like most drugs and wonder cures produced by the very loosely regulated commercial drug industry, these drugs had no medical effect beyond their function as placebos (see Chapter 6).[34]

As a result of this mechanism of contagion, an illness that had been a predominantly neurological disorder in the 1880s had become an all-round manifestation of psychological and spiritual discontent by the 1920s. Neurosis became a protean disorder that was made up of medical, psychiatric, psychological, psychodynamic, religious and sociological components—there was something in neurosis for everyone.

Groups That Were Infected, in Chronological Order

Italian physician Paolo Mantegazza notes in his book on 'our nervous century' in 1888, that the nervousness of the upper classes has serious social consequences, because it spreads from the upper classes down to the lower classes. In Italy, writes Mantegazza, neurosis has become to some extent a token of social status, since it was a sign of high aristocracy to feel ennui and to announce that one is nervous. He regarded this as hypocrisy and the coquetry of nervousness, claiming that one could write a thick volume on the comic history of nervousness.[35] Studies on the rise of neurosis in other western countries support Mantegazza's

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[32] Eklöf, *Läkarens ethos*; Ling, *Kärringmedicin och vetenskap*.

[33] See, for example, Lennmalm "Om sjukdomar, som bero på föreställningar," 129; Bror Gadelius, [Commentary], *Svenska Läkaresällskapets Förhandlingar*, November 25, 1913, 484; and Geijerstam, "Några psykoneuroser behandlade med hypnos," 760.

[34] Johannisson, "Bot för en nervtrött generation."

[35] Mantegazza *Vårt nervösa århundrade*, 124, 130–1.

thesis that the upper classes, upper-middle-class women in particular, were the *first group* to be infected by neurosis.

That these women were labelled as hysterics may be partly explained by rampant male chauvinism, even misogyny, which at a time when medicine was becoming a more powerful social force easily led to a medically-sanctioned pathologisation of female behaviour, especially behaviour that was considered 'deviant' or irritating by male society. Yet, it is unwarranted to see these women as hapless victims of male authoritarianism. Instead, historical evidence of the clinical encounters between doctors and their female patients indicates that there was a constant negotiation going on between patients and doctors. Doctors would espouse theories they believed would strike a resonance with their middle-class patients, while patients did their best to articulate their symptoms in a way which would accord with the prevailing medical understanding of these illnesses.[36] The success of diagnoses depended on the measure of trust that patients were willing to place in the doctor. Among upper-middle-class patients, 'doctor-shopping' was not that rare a phenomenon, and private practitioners had to be careful lest they displeased their clients with inappropriate diagnoses or therapeutic suggestions. It was a question of finding a proper medical language for designating real or imagined disturbances in the emotional life, not a question of laying bare the laws governing neuroses—there were no such laws, as all nerve doctors knew very well.

The *second* group consisted of working-class women, who were famously subjected to hypnotic experiments by Charcot and his assistants at the Salpêtrière in the 1880s. However, in Sweden, general hospitals had had hysterical women from the 'lower classes' as patients already in mid-century, as the annual reports of the Serafimer Hospital in Stockholm testify. The establishment of the Neurological Clinic at the Serafimer in 1887 made hysteria a more conspicuously cross-class illness (most patients at the Clinic came from the working class or lower middle class).

Hysterical women were followed by neurasthenic men. The next (*third*) group to become nervously ill consisted of upper middle class men (urban brain-workers), who started to suffer from neurasthenia in

[36] For an overview of the doctor-patient relationship, see Edward Shorter, "The History of the Doctor-Patient Relationship," in *Companion Encyclopedia of the History of Medicine*, ed. Bynum and Porter, 783–800.

the early 1880s, first in New York, then in Paris and German cities. They were rapidly followed by men from the lower classes, at least in Scandinavia, where cases of neurasthenia were found almost literally in the middle of nowhere (in remote fishing villages, etc.). Workers, farmers, artisans and petty officials were the *fourth* group to become infected with neurosis.

By the end of the nineteenth century, men and women of all social classes were perceived as being vulnerable to nervous illnesses. Such universalisation of an illness was not unique to neurosis, for a similar process had taken place with regard to hypochondriasis, which changed from being an upper-class illness to a cross-class illness in the course of the nineteenth century. By 1900, hypochondriasis had been deprived of its social exclusiveness, and it had also lost its status as a 'real illness'—it became a term designating, on the one hand, a fear of illness, and on the other, an abnormal tendency to attribute various bodily states and symptoms to a specific illness.[37] And in the late nineteenth century, there also emerged a new diagnosis that was almost exclusively reserved for working-class men: traumatic neurosis.[38] As we have seen, this diagnosis was employed in order to refer to various nervous and physical symptoms following an accident or other physical trauma. And as manual labourers were the ones who most often suffered physical injuries in the workplace, traumatic neurosis was typically a class- and group-specific diagnosis.

After adults from all social classes had become infected with neurosis, it was time for the underaged to become nervously ill on a grand scale (there had already been hysterical children in the late nineteenth century). The *fifth* group to become infected with neurosis were children, who became the object of mental hygiene ideology, psychology-oriented pedagogy and child psychiatry in the interwar years. Psychoanalysis played its role in this psychomedicalisation of children's behaviour, the other major component being the late nineteenth-century doctrine of the 'neuropathic constitution', which stated that there were families in which nervousness and other inferior mental qualities ran in the blood.[39]

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[37] Johannisson, *Kroppens tunna skal*, 117–28.

[38] On traumatic neurosis, see *Traumatic Pasts*, ed. Micale and Lerner; and Killen, *Berlin Electropolis*. For a medical study of traumatic neurosis in Sweden, see Billström, "Studier öfver prognosen af de traumatiska neuroserna."

[39] On the medical doctrine of the 'neuropathic constitution', see Dowbiggin, "Degeneration and Hereditarianism," and *Inheriting Madness*.

It became commonplace to see psychopathies as being triggered by the 'constitution', but the mental-hygienic emphasis on the early prevention of mental disorders made children an object of special interest to mental medicine, which in turn raised public awareness of the need to take into consideration the rights of children.

As discussed above, psychosomatic medicine, which had its heyday in the 1940s and the 1950s, infected a large group of the somatically ill with the diagnosis of neurosis. The somatically ill were the *sixth* group to become neurotic.

Now that adults, children and the somatically ill were infected with neurosis, the next logical step was to draw the conclusion that we are *all* more or less neurotic. This is what psychoanalysts and psychoanalytically-oriented psychiatrists, such as Wilhelm Reich and, in Sweden, Alfhild Tamm announced in the 1930s and the 1940s.[40] This universalisation of neurosis (in the western world) was in line with the speculative claims put forward by psychosomatic medicine. Thus, by the mid-twentieth century, there was virtually no escape from the 'virus' of neurosis. Physicians sometimes estimated that about fifty percent of patients consulting general practitioners (not nerve doctors in clinics or private practice) suffered from neuroses.[41] That at least half of the patient population was seen to be plagued by neurosis testified to how contagious neurosis had become: from a middle-class female malady (hysteria) it had become within a few decades a real 'national malady' (*folksjukdom*) in countries such as Sweden. Talk about an epidemic!

The Fall of Neurosis and the Rise of Depression

By the mid-twentieth century, neurosis, with its increasingly elaborate system of sub-categories and definitions had become an overinclusive term in western medicine and psychiatry. It had become closely associated with psychoanalytically-oriented mental medicine and psychosomatic medicine, and the retreat and decline of both of these 'movements' had direct bearing on the future of neurosis. As a diagnostic term, it had become so overblown and diffuse that it started to

[40] Wilhelm Reich, *Function of the Orgasm*. 1st ed. 1942 (London: Souvenir Press, 1973); Tamm, "Vår kulturkris."

[41] Kahlmeter, "Några synpunkter på behandlingen," 129.

collapse in the 1970s, and the publication of DSM-III in 1980 signalled the deathblow to neurosis as a general diagnostic category. Constructs such as neurosis are "held together by agreements," and "agreements change over time".[42] Thus, especially in American psychiatry, but also globally, neurosis ceased to be a contagious diagnosis in 1980, when DSM-III radically deconstructed the concept and relegated it to the margins of official psychiatry. Neurosis all but disappeared as a medical diagnosis in the late twentieth century, but the decline of neurosis created room for other contagious diagnoses which may be seen as derivatives of neurosis.

Psychogenic depression, formerly known as 'neurotic depression', has now become a major mental disorder. According to the recent report from the World Health Organisation, depression will become the second biggest health problem in the whole world by the year 2020; even today, depression is already the second cause of so-called DALYs in the age category 15–44 years for both sexes combined (DALYs = Disability Adjusted Life Years). In Sweden, depression afflicts about five percent of the population, according to a recent estimate. Thus, depression can be called a new 'national malady' in Sweden.[43]

As a historian of afflictions and diagnoses that occupy the middle ground between health and severe mental illness, it seems to me that the diagnostic popularity of depression is fuelled by psychotherapists of every description and by a pharmacological industry that is efficiently marketing anti-depressants to all age groups. I am inclined to subscribe to the views put forward by critical investigators of psychiatric and psychopharmacological therapeutics, such as David Healy, Jörg Blech, Elliot Valenstein and Mikkel Borch-Jakobsen.[44] Their critical studies on the development of psychiatric theories and therapeutics are important contributions to the historical scholarship on mental medicine, as well as to the contemporary discussion concerning medicalisation. Still, those who insist that depression and other modern mental

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[42] Kutchins and Kirk, *Making Us Crazy*, 23.

[43] Joanna Rose, "Läkemedlen som söker sina sjukdomar," *Forskning & Framsteg* No. 1 (2004): 48–9.

[44] Healy, *The Antidepressant Era*; *The Creation of Psychopharmacology*; *Let Them Eat Prozac*; Valenstein, *Blaming the Brain*; Mikkel Borch-Jacobsen, "How to Predict the Past;" "Making Psychiatric History: Madness as *folie à plusieurs*," *History of the Human Sciences* 14:2 (2001): 19–38; *Folies à plusieurs: De l'hysterie à la dépression* (Paris: Empêcheurs de penser en rond/Le Seuil, 2002); and Jörg Blech, *Die Krankheitserfinder—Wie wir zu Patienten gemacht gewerden* (Frankfurt am Main: S. Fischer Verlag, 2003).

epidemics are true diseases that are amenable to psychopharmaceutical or psychotherapeutic treatment are not necessarily manipulators or naive victims of psychiatric propaganda. There are no simple answers to complex questions—and if there were simple answers, they would probably be wrong.

In addition to depression, such recent diagnoses as burn-out, chronic fatigue and post-traumatic stress disorder are to great extent new expressions of the same symptom pool that characterised neurotic patients a hundred years ago. I hope that future historians of neuroses who study developments in the latter half of the twentieth century will contribute to the on-going discussion about ill-health by elucidating the factors conducive to the current, almost explosive epidemic of depression. It is depression, more than any other 'neurosis', which encompasses a large part of the history of neuroses from the 1950s onwards, and which invites interpretations portraying depression as a prime example of a modern contagious diagnosis.[45] But this is another story, and it needs to be told as a historical narrative that has its starting point in the emergence of modern neuroses in the 1880s.

Final Reflections

Unlike some renowned historians of psychiatry and medicine (such as Karin Johannisson in Sweden and Edward Shorter in North America), who have emphasised the changing nature of 'cultural illnesses', I would rather emphasise the surprisingly invariable nature of the symptoms of what used to be called neurosis. These symptoms, excluding such dramatic symptoms as the sudden paralyses, convulsions, cramps and faintings of the nineteenth-century hysterical women, did not disappear, but remained and were classified under new headings and categories. As we have seen in Chapter 8, a large number of patients who consulted neurologist Frithiof Lennmalm in his private consultation room at the turn of the twentieth century, suffered from overstrain or mental exhaustion (*överansträngning*). Lennmalm diagnosed these people as neurasthenics, and today they would probably be seen to suffer from symptoms

[45] As Janet Oppenheim observes, rather than suffering from neuroses, "unfortunate men and women suffer instead from varying degrees of depression, a category of illness that surely begs as many questions as nervous exhaustion". Oppenheim, *'Shattered Nerves'*, 314.

of depression, burn-out or chronic fatigue syndrome. In her study of 'cultural illnesses' at the hospital in Örebro in the late nineteenth century, Anna Prestjan concludes that even if the nervous illnesses of that period have disappeared, the symptoms have not: tiredness, poor digestion, sleep disorders and depression plague individuals today just as much as they did in the nineteenth century.[46]

There is also a continued interest in the emotional factors in illnesses and, in general, in the mind-body relationship. The old concept of 'somatisation' was revitalised in the 1970s, when Z. J. Lipowsky's work in this field started to win medical attention.[47] A Norwegian professor in social medicine, Peter Hjorth, sees an emerging form of disease in the contemporary world to be *somatoform* diseases (diseases that resemble somatic diseases), such as fibromyalgi, chronic fatigue, chronic pain syndrome, oversensitivity to electricity and so forth. These diseases are characterised by the somatisation of life problems, anxiety and depression.[48] One research programme that I find extremely interesting and relevant focuses on the fact that the people in the lower echelons of society are in a much greater risk to fall ill and have shorter life spans than do people with high socioeconomic status. In fact, every step downward in socio-economic status correlates with poorer health.[49]

Some researchers argue that the psychosocial consequences of being poor and especially of *feeling* poor activate stress responses and increase the likelihood of stress-sensitive illnesses and diseases, such as depression, hypertension and cardiovascular diseases. One promising line of research, exemplified in the work of the British social epidemiologist Richard Wilkinson, suggests that increased income inequality predicts worse health for both the poor and the wealthy.[50] His colleague Michael Marmot, who emphasises the impact of our living conditions on our illnesses, is in agreement with Wilkinson. Marmot argues that autonomy or our own control of our life, as well as love, social capital and the sense

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[46] Anna Prestjan, "Kultursjukdomar i Örebro 1860–1910—exempel på sjukdomsbegreppets relativitet," *Svensk Medicinhistorisk Tidskrift* 2:1 (1998): 75.

[47] Shorter, "Somatoform Disorders," 479.

[48] Jan-Otto Ottosson, *Psykiatrin i Sverige* (Stockholm: Natur och Kultur, 2003), 185.

[49] For an overview of recent studies on the negative impact of psychosocial stressors on health, see Robert Sapolsky, "Sick of Poverty," *Scientific American*, December (2005): 92–9.

[50] Richard Wilkinson, *Mind the Gap: Hierarchies, Health and Human Evolution* (London: Weidenfeld and Nicolson, 2000); and *The Impact of Inequality: How to Make Sick Societies Healthier* (London: The New Press/Routledge, 2005).

of community, are crucial non-medical ingredients of health.[51] The basic message of Wilkinson, Marmot and their colleagues appears to be that the low socioeconomic status has a dramatically harmful influence on health, because the body's homeostatic balance is disturbed by constant psychological and social stress caused by various social and symbolic (signals and cues given by other people) hierarchies that make the poor people feel inferior. That our body's response is pathogenic for continuous psychosocial strain suggests that in many cases neuroses could be explained by chronic stress that suppresses immunity and impairs cognition, as well as the functioning of some types of neurons.[52] These studies help to explain the fact that the majority of the nervously ill in Sweden were people with low socioeconomic status, and, conversely, that people with low socioeconomic status suffered from more serious 'nervous problems' than the people in the wealthier strata of Swedish society. The correlation between poverty and ill health is an extremely important issue and further studies on this correlation may illuminate the psychosocial and physiological mechanisms of both 'modern neuroses' (depression, anxiety, burn-out, etc.) and severe mental disorders, such as schizophrenia.

In conclusion, I would suggest that psychomedical diagnoses are very much dependent on conjecture, on changing professional fashions, personal preferences and collective beliefs. In order to become a popular socio-cultural illness, a diagnosis has to appeal to the collective imagination of people, as well as fit in with and express the prevailing mental habits of people. Neurosis was an appealing term to many professionals and laymen alike, because it was firmly anchored in the popular conception of what the nervous system was like, and what made this system dysfunctional. Moreover, neurosis adapted perfectly to psychoculture, in which the language and rhetoric of the psyche and psychic conflict began to replace the language and rhetoric of nerves. As an illness with extremely diffuse diagnostic boundaries, neurosis could be interpreted as a psychopathological outcome of psychic conflict as much as a neuropathological outcome of shattered (exhausted, overtaxed, weak, degenerated, etc.) nerves, and this adaptability of

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[51] Michael Marmot, *Status Syndrome* (London: Bloomsbury, 2004).

[52] For a recent study of stress-related diseases, see Robert Sapolsky, *Why Zebras Don't Get Ulcers: A Guide to Stress, Stress-Related Diseases and Coping* (New York: Henry Holt and Co., 2004).

neurosis to ever-changing psychomedical and cultural circumstances made it a diagnostic success.

The clinical material used in this book suggests that most people who were diagnosed as nervously ill between the years 1880 and 1950 in Sweden were plagued by tangible troubles and concrete problems, which as psychosocial stressors had deleterious effects on their mental and physical functioning. The reason why neurosis (in the form of neurasthenia and nervous hysteria) emerged in Sweden in the 1880s was not that before the era of modern mental medicine people did not suffer from milder mental maladies, but rather that there were no doctors around the nervously ill who would have conceptualised their responses and reactions to their troubles and problems in distinctly psychomedical terms. Thus my general conclusion is that neurosis was less an illness and more an aspect of the human condition that was medicalised and psychologised through a language and a medical practice that emerged in Sweden in late nineteenth-century neurology, internal medicine and hypnotism, and that this process assumed a more emphatically psychological character during the twentieth century. As the late Roy Porter consistently argued, disease formulations go with circumstances.

Today, neurosis may have quit the stage as a clinical entity, but it has not disappeared from the popular imagination, as anyone who has seen Woody Allen's films can confirm. And I doubt whether the still-persisting talk of 'nervousness', 'bad nerves' and 'nervous breakdown' will disappear in the future. After all, the stuff of our brain is made up of nerve cells, and it seems to me that some variant of the language of nerves must linger on in decades to come, just as the language of genes is similarly here to stay. In February 2004, a doctoral student who had studied the care of the elderly was interviewed in a leading Swedish newspaper. She was asked why it was that the (mildly) depressed, non-educated aged received less assistance in their homes than those with a better education. She replied: "The reason may be that they are not used to talking about 'nerves'. Maybe they lack the mental energy to demand assistance."[53] With its references to 'nerves' and 'mental energy', this part of the interview could have been published in February 1904. Neurosis may have gone, but we still suffer from weak nerves.

[53] *Dagens Nyheter*, February 10, 2004.

BIBLIOGRAPHY

Archival Sources

The Serafimer Hospital's Archives (Serafimerlasarettets Arkiv), the Riksarkivet, Stockholm, Sweden
- The Serafimer's Annual Reports 1880–1960
- Patient records of the Serafimer's Neurological Polyclinic, 1914–1950

Archives of the Swedish Society of Medicine (Svenska Läkaresällskapets Arkiv II), the Riksarkivet, Stockholm, Sweden
- Prof. Frithiof Lennmalm's Clinical Diary 1885–1924

Primary Sources

Agerberg, John. "Livsåskadning och själshälsa." In John Agerberg et al., *Själens läkarbok*, 445–82.

—— et al. *Själens läkarbok*. Stockholm: Natur och Kultur, 1943.

Ahlberg, Ahl et al. *Människokunskap och människobehandling*. 5. ed. Stockholm: Natur och Kultur, 1954.

Ahlgren, Gunnar. "Pharmaconomia svecica." In *Om sjukdom och sjukvård. Studier tillägnade Malte Ljungdahl*, 20–35. Lund: Gleerup, 1947.

Alexander, Franz. *Psychosomatic Medicine: Its Principles and Applications*. New York: Norton, 1950.

Alfvén, Johannes. *Hysterien och dess psykologiska struktur*. Stockholm: Natur och Kultur, 1933.

Almqvist, John. Review of *Sexuell hygien*. *SLT* 24 (1927): 1023–28.

Alström, Carl-Henry. "Psykisk hälsovård." *SLT* 40 (1943): 2074–81.

Åmark, Curt. "Om tvångsneurosernas klinik och behandling." *SLT* 49 (1952): 1751–68.

Andersson, J. A. "Pensionsstyrelsens kompetens att handhava sjukvårdande verksamhet." *SLT* 14 (1917): 390–98.

Andrae, Tor. *Psykoanalys och religion*. Stockholm: Albert Bonniers förlag, 1927.

Anon. "Några ord angående Pensionsstyrelsens sjukvårdande verksamhet." *SLT* 14 (1917): 1529–33.

——. Review of *Om friska och sjuka nerver*, by Richard Krafft-Ebing. *Eira* 9 (1885): 678–79.

——. Review of *Om friska och sjuka nerver*, by Richard Krafft-Ebing. *HV* 1 (1886): 14–15.

Antoni, Nils. Address on the Opening of the VIII Northern Neurological Congress in Stockholm on August 29th 1938. In *Report on the Eighth Congress of Scandinavian Neurologists*, edited by Ingvar Lossius, 7–9. Copenhagen: Ejnar Munksgaard Publisher, 1939.

——. [Address to the Psychiatric-Neurological Section]. *SLT* 42 (1945): 168–72.

——. "Att bli neurolog." *MFT* Nr. 6–7 (1962): 244–7.

——. [Commentary]. *Förhandlingar*, January 15, 1935, 32–34, and January 29, 1935, 43–52.

——. [Commentary]. *Förhandlingar*, October 26, 1937, 545–49, and November 2, 1937, 572–75.

——. *En bok om nerver*. Stockholm: Albert Bonniers förlag, 1946.
——. "Henry Marcus." *NM* 23 (1944): 1325–27.
——. "I ögönspegeln" (1953). In *Under Saturnus ring*. Stockholm: Natur och Kultur, 1968.
——. "Missbrukad neurologi." *SLT* 40 (1943): 2109–30.
——. "Mindervärdeskomplex." In John Agerborg et al., *Själens läkarbok*, 153–80.
——. *Nervsjukdomar*. Stockholm: Wahlström & Widstrand, 1928.
——. "Neurasthenia sexualis." In *Sex läkare om sexualproblemet*, 147–66. Stockholm: Natur och Kultur, 1934.
——. "Neurologi I. 1910–1954." In *Karolinska Mediko-Kirurgiska Institutets Historia*, Vol. III:2, 546–58. Almqvist & Wiksell: Stockholm, 1960.
——. "Neurologiska klinikens forntid, nutid och framtid." *Hygiea* 99 (1937): 353–85.
——. "Själslivets patologi." In *Handbok i psykologi*, edited by David Katz, 419–44. Stockholm: Bonniers, 1950.
——. "Somatiskt och psykiskt i medicinens historia." *SLT* 42 (1945): 2308–25.
Arbetarrörelsen och folkhälsan: En programskrift. Stockholm: Arbetarnas Bildningsförbund, 1945.
Beard, George M. *American Nervousness, Its Causes and Consequences*. New York: Putnam's Sons, 1881.
——. *Den sexuella neurastenin, dess hygien, orsaker, symptom och behandling*. Stockholm: H. Gebers förlag, 1896.
——. *A Practical Treatise on Nervous Exhaustion (Neurasthenia), Its Symptoms, Nature, Sequences, Treatment*. New York: W. Wood & Company, 1880.
——. *Sexual Neurasthenia (Nervous Exhaustion)*, edited by A. D. Rockwell. New York: E. B. Treat, 1884.
Berg, Henrik. "Fall af (allmän) kramp behandladt med hypnotism." *Eira* 14 (1890), 308–10.
——. *Läkareboken I*. Stockholm: Kommanditbolaget Chelius & Co., 1903.
Berger, Paul. *Nervsvaghet (Neurastheni)*. Stockholm: F. & G. Beijer's förlag, 1890.
Bergfors, Georg. "The Swedish National-Character." In *The Swedish Nation in Word and Picture*, edited by H. Lundborg and J. Runnström, 34–38. Stockholm: Hasse W. Tullberg, 1921.
Berggrav, Eivind. "Psykologi och själavård." *Svenska Dagbladet*, March 6, 1932.
Bergman, Ingmar. *The Magic Lantern*, trans. Joan Tate. Harmondsworth: Penguin, 1988.
Betänkande med utredning och förslag angående Läkarutbildningen. Stockholm, *SOU*: 27/1941.
Bidrag till Sveriges officiela statistik för år 1900. Helso- och sjukvården I. Stockholm: P.A. Norstedt & söner, 1900.
Billström, Jakob. [Commentary at the Meeting of the Swedish Society for Internal Medicine on 4 May]. *NMT* 12 (1936): 1967–8.
——. "Ernst Westerlund." *Hygiea* 86 (1924): 81–90.
——. *Hvad kan göras för vår tids öfveransträngda?* Stockholm: C. G. Carlssons Boktr., 1913.
——. Review of *Kultur och neuros*, by Iwan Bratt. *Hygiea* 87 (1925): 845.
——. Review of *Splittring och enhet*, by Iwan Bratt. *Hygiea* 91 (1929): 202.
——. Review of *Det svenska missnöjet*, by Iwan Bratt, *Hygiea* 98 (1936): 89–90.
——. "Studier öfver prognosen af de traumatiska neuroserna." *Hygiea* 72 (1910): 1086–136, 1359–417.
——. *Våra nervers vardagsvård*. 1st ed. 1934. Stockholm: Lars Hökerbergs bokförlag, 1950.
Bisch, Louis E. *Nervositet är en tillgång*. Stockholm: Natur och Kultur, 1938.
Bjerre, Poul. [Commentary]. *Förhandlingar*, January 29, 1935, 59–66.
——. [Commentary]. *Förhandlingar*, 19 October 1937, 467–71, and November 2, 1937, 565–8.

——. "Den neurasteniska trötthetten." *Hygiea* 86 (1924): 417–26, 462–72.
——. *Död och förnyelse*. Stockholm: Segerbrandska bokförlaget, 1919.
——. "Från psykoanalys till psykosyntes." *Arkiv för Psykologi och Pedagogik* 1 (1922): 12–31.
——. *The History and Practice of Psychanalysis*. Translated by Elizabeth N. Barrow. Boston: The Gorham Press, 1920.
——. *Hur själen läkes*. Stockholm: Natur och Kultur, 1923.
——. "Hypnosens väsen." Meddelanden från Institutet för Psykologisk Forskning i Upsala, Nr. 5. *Psyke* 8 (1913): 1–12.
——. "Något om den nutida psykoterapin i Sverige—ett genmäle till d:r Emanuel av Geijerstam." *SLT* 22 (1925): 841–56.
——. *. . . och snart står döden och stampar vid vår port: En dag hos själsläkaren*. Stockholm: Albert Bonniers, 1934.
——. "Psykoanalysen som vetenskap och terapi." *Psyke* 6 (1911): 141–84.
——. "Psykoterapeuten—läkare eller laicus?" *Förhandlingar*, January 15, 1935, 12–27.
——. *Räfst- och rättarting*. Stockholm: Centrum, 1945.
——. "Sjukkassan som folkförstörare." *Samtid & Framtid* 6 (1949): 228–32.
——. *Studier i själsläkekonst*. Stockholm: P. A. Norstedt & Söners Förlag, 1914.
——. "Wetterstrand och Nancyskolan." In *Studier i själsläkekonst*, 57–90.
Björck, Peder. "Mentalsjukvården." In *Medicinalväsendet i Sverige 1813–1962*, edited by. Wolfram Kock, 243–80.
Björnström, Fredrik. "Hvilka äro orsakerna till vår tids sinnessjukdomar?" *HV* 3 (1888): 4–8, 35–8, 74–6, 121–4, 169–72.
——. Review of *Revue de l'Hypnotisme*. *Hygiea* 49 (1887): 273–78.
Bohman, Folke. "Resultaten av K. Pensionsstyrelsens sjukvårdande verksamhet." *SMT* 21 (1944): 123–30, 148–60.
Bohman, Folke and Gösta Odstedt. "Neurosklientelet vid en kuranstalt." *NM* 3 (1939): 2351–54.
Bondegger, Harry. *Nervositen bortarbetad på två timmar*. Stockholm: S.G.U. förlags-aktiebolag, 1910.
Boye, Bengt. "Om neurosfrekvensen hos invärtesklientelet vid Sabbatsbergs sjukhus åren 1926–1933 jämte vårdade fall av suicidalförsök." *NMT* 9 (1935): 252–57.
Bratt, Hanna. "Ericastiftelsen. Ett institut för psykisk hälsovård." In *Psykologien upptäcker människan*, 82–100. Stockholm: Kooperativa förbundets bokförlag, 1945.
Bratt, Iwan. "Att bryta vanor." In John Agerberg et al., *Själens läkarbok*, 259–93.
——. *Det svenska missnöjet*. Stockholm: Natur och Kultur, 1935.
——. "Emanuel af Geijerstam In memoriam." *SLT* 25 (1928): 657–59.
——. *Ett är nödvändigt*. Stockholm: Natur och Kultur, 1946.
——. *Kultur och neuros*. Stockholm: Natur och Kultur, 1925.
——. "Läkningens dynamik vid en psykoanalytisk kur." *SLT* 28 (1931): 138–49.
——. *Neurosproblemet i psykoanalytisk belysning*. Stockholm: Natur och Kultur, 1930.
——. "Om frågeställningen inför vissa sjukdomssymtom och konsekvenserna därav för behandlingen." *SLT* 21 (1924): 841–48.
——. "Om psykoanalysens verkningssätt." *SLT* 40 (1943): 698–708.
——. Review of *En sjukdom som bestraffas*, by Gunnar Nycander. *Hygiea* 97 (1934): 152–58.
——. *Splittring och enhet i människans väsen*. Stockholm: Natur och Kultur, 1927.
Bratt, Karl Ellis. "S:t Lukasstiftelsen." *SLT* 45 (1948): 1900–4.
Brattgård, Sven-Olof. "Sjukvård och själavård." *SLT* 47 (1950): 2425–28.
Braun, Edv. "Tidig onani—helsa." *Eira* 3 (1879): 208.
Breuer, Josef and Freud, Sigmund. *Studies on Hysteria* (1893–1895). In *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, Volume II, 48–105. London: The Hogarth Press, 1978.

Bringel, Ragnar. "Tecken på neuropatisk konstitution." *Förhandlingar*, November 26, 1935, 505–17.
Bringel, Ragnar and Lisa Welander. "Neurosvårdens närmaste behov." *SMT* 13 (1936): 35–44.
Butler, Pierce and Erik Arbin. "Sjukdom och andlig hälsa." *SMT* 33 (1956): 71–5.
C:son Froste, Carl. "Maladie des tics convulsifs." *Hygiea* 56 (1894): 201–14.
Cederschiöld, Gustav. "Om kvinnospråk." *Nordisk Tidskrift* 12 (1899): 417–34.
Charcot, J. M. "Olika nervösa tillstånd föranledda af hypnotism hos hysteriska." *Eira* 6 (1882): 355–57 (originally published in *La France medicale* in 1882).
Cronholm, Börje. "Den psykologiska litteraturen i Sverige." In *Själavård—själsvård*, 145–58.
——. "Psykologerna." In *Modern svensk psykiatri*, edited by Gunnar Holmberg et al., 240–3. Stockholm: Almqvist & Wiksell, 1968.
Danell, G. A. "Skuldkänslan och vägen till befrielse." In *Läkare och själavårdare*, edited by Göte Bergsten and Fritz Lindén, 171–89. Uppsala: J. A. Lindblads förlag, 1950.
"Den 2:a skandinaviska neurologkongressen." *SLT* 21 (1924): 709–10.
"Den femte nordiska neurologkongressen i Stockholm." *SLT* 27 (1930): 1078–81.
Eeg-Olofsson, Richard. "Pastoralpsykologi." *SMT* 22 (1945): 188–90.
Eneström, Hjalmar. "Psykiska och nervösa sjukdomar hos krigsdeltagare." *ASLT* 16 (1919), 1081–101.
Engel, Arthur. "Medicinalväsendets aktuella problem." In *Medicinalväsendet i Sverige 1813–1962*, edited by Wolfram Kock, 667–92, 734–36.
E. P. L. "Nervösa och moraliska smittor." *HV* 4 (1889), 134–9, 149–51.
——. "Om den rådande nervsvagheten hos nuvarande civiliserade människor." *HV* 3 (1888): 222–6, 233–6.
——. "Om nervsvaghetens förebyggande hos vårt folk." *HV* 7 (1892): 107–13.
Ett hem för nervlidande. [Announcement]. *Eira* 20 (1896): 133.
Evang, Karl and Ebbe Linde. *Raslära, raspolitik, reaktion*. Stockholm: Clartés Förlag, 1935.
Fellenius, Valdemar. "Praktisk psykologi." In *Handbok i psykologi*, edited by David Katz, 445–65. Stockholm: Svenska Bokförlaget, 1950.
Fenichel, Otto. *The Psychoanalytic Theory of Neuroses*. New York: W. W. Norton, 1945.
"Förbättring genom TITUS-Perlen" [An advertisement]. *Vårt Hem* Nr 15 (1935): 38.
Förhandlingar. [Obituary of Axel Lamm]. 1889, 210.
——. [The Section for Psychiatry and Neurology: Report submitted to the Committee of the Society of Medicine.] January 15, 1935, 10–11.
——. [Proposal regarding a section for psychotherapy.] January 15, 1935, 12–41.
"Försummas psykoterapin av de svenska läkarna till fuskarnas fromma?" *DN*, September 9, 1924.
"Frågor och Svar." *PTSU* No. 2 (1935): 95–6.
——. *PTSU* No. 3 (1936): 144.
Freud, Sigmund and Karl Abraham, *The Complete Correspondence of Sigmund Freud and Karl Abraham.* Translated and edited by Ernst Falzeder. London: Karnac, 2002.
Friberger, Ragnar. "Neuroserna." In *Lärobok i intern medicin*, edited by Knud Faber, Peter F. Holst and Karl Petrén, 349–99. Copenhagen: Gylden Dalske Boghandel/Nordisk Forlag, 1921.
Fröderström, Harald. "Den kliniska psykologien." *Hygiea* (1908), Festband, Del. I, 1–24.
——. "Krigsneuroserna." *SLT* 16 (1919): 1–20; 33–49.
Froste, Nils. "Neuroskursen." *MFT* 7 (1929): 278–9.
Gadelius, Bror. [Commentary]. *Svenska Läkaresällskapets Förhandlingar*, November 25, 1913, 484.
——. *Det mänskliga själslivet*, Vol. 4. Stockholm: Hugo Gebers förlag, 1924.
——. *Human Mentality in the Light of Psychiatric Experience*. Copenhagen: Levin & Munksgaard, 1933.
——. "Modern Development of the Psychology of Emotions." *Acta* 8 (1932): 135–58.

——. "Nymfomani." In *Nordisk Familjebok*, Band 20, 254–55. Stockholm: Nordisk Familjeboks förlags aktiebolag, 1914.
——. *Om tvångstankar och dermed beslägtade fenomen*. Lund: Lunds Universitet, 1896.
——. "Om vår tids sinnessjukvård och den allmänna meningen." *Förhandlingar*, February 26, 1907, 37–55.
——. "Öppet brev till professor Henschen." *ASLT* 4 (1907): 113–17.
——. "Psykiatriska sjukdomar i historisk belysning." *Hygiea* 70 (1908): 97–118
——. "Renessansläkaren och häxväsendet." *Lychnos* 1936.
——. "Sinnessjukdomarna och den inre sekretionen." *Hygiea* 76 (1914): 1249–83.
——. *Sinnessjukdomar och deras behandling förr och nu*. Stockholm: Hugo Gebers förlag, 1913.
——. *Tro och helbrägdagörelse jämte en kritisk studie av psykoanalysen*. Stockholm: Geber, 1934.
——. *Vården av sinnessjuka förr och nu. Trenne uppsatser*. Lund: Gleerups förlag, 1900.
Geijerstam, Emanuel af. "Anförvanternas roll i den psykoanalytiska kuren." *SLT* 24 (1927): 1012–17, 1034–45.
——. "Ett par ord med anledning av läkarkommitténs betänkande 'Alkoholen och samhället'." *ASLT* 10 (1913): 481–8.
——. "Fall af egendomligt vita sexualis kombineradt med impulser och fobi, med framgång behandlat af hypnos." *Hygiea* 64 (1902): 686–94.
——. "Något om den nutida psykoterapin i Sverige." *SLT* 22 (1925): 427–36, 462–72.
——. "Några ord om den anagoga psykoanalysen." *SLT* 17 (1920): 601–22, 625–45.
——. "Några ord om hypnotismens ställning i den nutida medicinen och om dess teknik." *Psyke* 2 (1907): 150–70.
——. "Några ord om Züricherskolans psykoanalys." *ASLT* 15 (1918): 1297–310, 1329–44.
——. "Några psykoneuroser behandlade med hypnos." *ASLT* 10 (1913): 737–61.
——. "Om hypnotismens ställning till andra former af psykoterapi." *ASLT* 9 (1912): 129–51, 177–92.
——. "Otto G. Wetterstrand." *ASLT* 4 (1907): 815–18
——. "Zur Frage des Verdrängungsproblems." *ACTA* 2 (1927): 5–38.
Gerle, Bo. *Psykopatibegreppets bankrutt*. Lund: Gleerupska Univ.-Bokhandeln, 1947.
Gerling, Reinh. *Min nervositet*. Stockholm: Wahlström & Widstrand, 1914.
Glimstedt, Gösta. "Gunnar Wohlfart in memoriam." *Acta Neurologica Scandinavica* 37 (1961): 79–83.
Goldkuhl, Erik. "Aktuella önskemal beträffande den psykiska hälsovården i Sverige." In *Om sjukdom och sjukvård. Studier tillägnade Malte Ljungdahl*, 207–14. Lund: Gleerup, 1947.
Haerén, M. "Hvilka åtgärder kunna vidtagas att förebygga den bland vårt folk rådande neurastenien och hysterien? [Autoreferat]." *Hygiea* 53 (1891): 337–9.
Hegar, A. "Om kastration vid hysteri." *Eira* 4 (1880): 650–6 [a summary of an article originally published in *Berlin Klinische Wochenschrift*, No. 26, 1880].
Hellman, A. F. "Anteckningar om Ronneby Helsobrunn och Gyttjebad." *Hygiea* 10 (1848): 75–85.
Hellpach, Willy. *Nervositet och kultur*. Stockholm: Hugo Gebers förlag, 1904.
Henschen, Salomon. "Professuren i medicin vid Karolinska Institutet." *Eira* 21 (1897): 690–3.
——. [Reply to Bror Gadelius]. *ASLT* 4 (1907): 117–23.
——. *Selbstbiographie von S.E. Henschen. Die Medizin der Gegenwart in Selbstdarstellungen*. Leipzig: Verlag von Felix Meiner 1925.
Historisk statistik för Sverige. Statistiska översiktstabeller. Stockholm: Statistiska Centralbyrån, 1960.
Hofsten, Nils van. "Steriliseringarna och aborterna." In *Medicinalväsendet i Sverige 1813–1962*, edited by Wolfram Kock, 513–27, 722–3.
Holmberg, Gunnar et al. (ed.). *Modern svensk psykiatri*. Stockholm: Almqvist & Wiksell, 1968.

Holmgren, Israel. *Mitt liv*. Stockholm: Natur och Kultur, 1959.
Holmström, Ruben. "Psykiatrici och de i vidare mening psykiskt sjuka." *SMT* 10 (1933): 193–202.
Holsti, Hugo. "Neurastenien och dess förekomst i de skandinaviska länderna." *Hygiea* 58 (1896): 288–91.
Hultén, Erik. *Nervsjukdomar och deras behandling*. Göteborg: Rammes förlag, 1944.
Hulting, Carl. [Commentary]. Svenska föreningens för invärtes medicin förhandlingar, May 4. *NMT* 12 (1936): 1966–7.
Hultqvist, Gustaf. "Några iakttagelser och reflexioner rörande självmorden i Stockholm." *Förhandlingar*, January 13, 1925, 8–19.
Husén, Torsten. "Psykologerna och psykologutbildningen." *SLT* 46 (1949): 2359–69.
——. "Samarbetet mellan läkare och psykologer." *SLT* 45 (1948): 281–7.
Hutcrantz, J. Wilhelm and Emanuel Bergman. "The Struggle for Race-Improvement in Sweden." In *The Swedish Nation in Word and Picture*, edited by H. Lundborg and J. Runnström, 71–80.
Hypnotismen, bedömd af fackmän, jämte en uppsats i ämnet af Tyko Brunnberg. Uppsala: Akademiska bokhandeln, 1893.
Inghe, Gunnar. "Sociala synpunkter på den psykiska hälsovårdens organisation." *Social* Årsbok 1945, 67–113.
Ingvar, Sven. "Nervösa organsjukdomar, de inre organens uppfostran." In John Agerberg et al., *Själens läkarbok*, 383–416.
Ingvar, Sven. "Om de nervöst sjuka." *SLT* 34 (1937): 729–32.
Ingvarsson, Gösta. "Om språkformen vid terapeutiska samtal." In *Om sjukdom och sjukvård. Studier tillägnade Malte Ljungdahl*, 269–75. Lund: Gleerup, 1947.
Israel, I. "Ett bidrag till värdet af kastrationsmetoden för botandet af hysteriska funtimmer" [A summary of an article originally published in *Berlin Klinische Wochenschrift*, No. 17, 1880], *Eira* 4 (1880): 467–70.
Janet, Pierre. "Inledning." In Leonhard Schwartz, *Neurasthenien: De nervösa tillståndens uppkomst, förklaring och behandling*, 11–22. Stockholm: Natur och Kultur, 1941.
——. *Principles of Psychotherapy*. Translated by H. H. and E. R. Guthrie. New York: MacMillan Co., 1924.
Johnsson, Olof. "Var erhåller man råd i sexualspörsmål? De kommunala rådgivningsbyråerna." *PTSU* No. 6 (1935): 259–65.
Jonsson, Gustav. "Flickor på glid: Promiskuitet hos flickor i 12–16 årsåldern." *Psykisk Hälsa* 1 (1960): 9–23.
Josefson, Arnold. "Behöver läkaren orientering i psykologi och dess arbetsmetoder?" *SLT* 43 (1946), 2747–56.
——. [Commentary]. *Förhandlingar*, October 26, 1937, 520–7.
Jundell, Isak. [Commentary]. *Förhandlingar*, October 26, 1937, 527–30.
Kahlmeter, Gunnar. [Commentary]. *Förhandlingar*, November 2, 1937, 594–8.
——. "Några synpunkter på behandlingen, särskilt anstaltsbehandlingen, av neuroser." In *Festschrift tillägnad Henry Marcus*, *Handlingar* 57 (1931): 129–37.
——. "Om Pensionsstyrelsens sjukvårdsuppgifter." *Meddelanden från Medicinska Föreningen*, 5:6 (1927): 126–30, 149–50.
——. "On the Results of the Treatment of Neurotic Patients at the Establishments of the Swedish Board of Pensions." In *Festschrift tillägnad Bror Gadelius*, *Handlingar* 53 (1927): 81–90.
Källmark, Fredrik. "Neuroserna och sjukkassorna." *SMT* 7 (1930): 129–33.
Kasa, Torgeir and Gunnar Inghe. "Homosexualiteten." *PTSU* Nr. 4 (1933): 3–36.
Katz, David (ed.). *Handbok i psykologi*. Stockholm: Bonniers, 1950.
Kinberg, Olof, Gunnar Inghe and Svend Riemer. *Incestproblemet i Sverige*. Stockholm: Natur och Kultur, 1943.
Klein, Melanie. "The Early Development of Conscience in the Child." In *Psychoanalysis Today*, edited by Sandor Lorand, 64–74.

Kock, Wolfram. *Kungliga Serafimerlasarettet 1752–1952*. Jönköping: H. Halls Boktr. AB., 1952.
——. "Lasaretten och den slutna kroppssjukvården." In *Medicinalväsendet i Sverige 1813–1962*, edited by Wolfram Kock, 158–242.
—— (ed.). *Medicinalväsendet i Sverige 1813–1962*. AB Nordiska Bokhandelns Förlag: Stockholm, 1962.
Köster, Dr. "Höggradig hysterisk förlamning." *Hygiea* 60 (1898): 196–200.
Krafft-Ebing, Richard von. *Om friska och sjuka nerver*. Stockholm: Jos. Seligmann & C:is förlag, 1885.
Kugelberg, Eric. "Neurologi II. 1954–1960." In *Karolinska Mediko-Kirurgiska Institutets Historia*, Vol. III:2, 559–67. Almqvist & Wiksell: Stockholm, 1960.
Lagergren, Sten. [Commentary]. *Förhandlingar*, October 19, 1937, 486–8.
Lamm, Axel. [A translation and an introduction of *Étude expérimentale sur la métalloscopie, l'hypnotisme et l'action de divers agents physiques dans l'hystérie* by Dumontpallier and Magnan]. *Hygiea* 44 (1882): 613–17.
Lamm, Axel. Review of *Etudes cliniques sur l'hystéro-épilepsie ou grande hystérie*, af dr Paul Richer. *Hygiea* 45 (1883): 62–4.
Lennmalm, Frithiof. [Commentary on the regulation of prostitution]. *Förhandlingar*, April 9, 1912, 343–53.
——. "De funktionella nervsjukdomarnas ställning i förhållande till s.k. organiska sjukdomar." *Nordisk Tidskrift* 46 (1923): 449–61.
——. "Neurologiska kliniken." In *Karolinska Mediko-Kirurgiska Institutets historia*, Vol. 3, 483–8. Stockholm: Isaac Marcus' Boktryckeri-Aktiebolag, 1910.
——. "Om de s.k. traumatiska neuroserna." *Hygiea* 55 (1893): 111–63, 223–68.
——. "Om de viktigaste orsakerna till nervsystemets sjukdomar." *Hygiea* 53 (1891): 261–80.
——. "Om lues' betydelse för uppkomsten av kroniska sjukdomar i blodkärlsystemet och nervsystemet." *SLT* 21 (1924): 857–74.
——. "Om sjukdomar, som bero på föreställningar och som botas genom föreställningar." *Hygiea* 58 (1896): 69–138.
Lichtenstein, Dr. [Commentary]. *Förhandlingar*, October 19, 1937, 488.
Lindfors, O. "Den Mitschell'ska metoden för behandling af svårare hysterifall." *Eira* 7 (1883): 742–5.
Lindholm, Sven G. "Till belysande av de lungsjukas psyke." *SLT* 18 (1921): 685–8.
Lindner, Torsten. "Ett fall av grav neuros med gynnsamt förlopp." *SLT* 33 (1936): 824–30.
——. "Präst och läkare." *SLT* 30 (1933): 1386–95.
——. Review of *Jahresringe Innenansicht eines Menschenlebens*, by Alfred E. Hoche. *Hygiea* 96 (1934): 870–7.
Ljungdahl, Malte. "Flykten in i sjukdom." *SLT* 43 (1946): 3192–207.
Löfvendahl, Hillevi. "Om neurosproblemet." *SLT* 35 (1938): 1566–81.
Lorand, Sandor. "Character Formation." In *Psychoanalysis Today*, edited by Sandor Lorand, 207–17.
—— (ed.), *Psychoanalysis Today*. New York: International Universities Press, 1950.
Lorentzen, Dr. "Huru blifva vår tids affärsman nervösa?" [Originally published in *Dansk Sundhedstidende*]. *HV* 14 (1899): 256–60.
Lundborg, Herman. "Ett svenskt rasbiologiskt institut." *SLT* 18 (1921): 185–93.
——. "Industriens försyndelser mot rasen och folkhälsan." *SLT* 17 (1920): 1102–9.
——. "The More Important Racial Elements that Form a Part of the Present Swedish Nation." In *The Swedish Nation in Word and Picture*, edited by Lundborg and Runnström, 24–33.
——. *Rasbiologi och rashygien*. Stockholm: Norstedt, 1922.
——. [A written announcement to the Medical Society]. *Förhandlingar*, August 2, 1921, 247.

Lundborg, H. and J. Runnström (eds). *The Swedish Nation in Word and Picture*. Stockholm: Hasse W. Tullberg Co. Ltd, 1921.
Lundquist, Gunnar. "Från hospital till modernt sjukhus." In *Modern svensk sinnessjukvård*, edited by Gunnar Lundquist, 15–18. Stockholm: AB Modern Litteratur, 1949.
Mantegazza, Paolo. *Vårt nervösa århundrade*. Stockholm: Hugo Gebers förlag, 1888.
Marcus, Henry. "Arbetsterapi för nervsjuka." *SLT* 34 (1937): 404–13.
——. "Frithiof Lennmalm." *Hygiea* 86 (1924): 560–86.
Marholm-Hansson, Laura. *Till kvinnans psykologi*. Stockholm: C. & E. Gernandts förlags-aktiebolag, 1897.
Möbius, P. J. "Über den Begriff der Hysterie." *Centralblatt für Nervenheilkunde* XI (1888): 66–71.
Moreau, (de Tours), J. J. *La Psychologie morbide dans ses rapports avec la philosophie de l'histoire: ou de l'influence des névropathies sur le dynamisme intellectuel*. Paris: Masson, 1859.
Morel, B. A. *Traite des dégénérescences physiques, intellectuelles, et morales de l'espèce humaine*. Paris: Baillière, 1857.
"Motion om statsbidrag till S:t Lukasstiftelsen." *SLT* 54 (1957): 1038–9.
M.-U., E. "Något om den mänskliga urartningen i våra civiliserade samhällen." *HV* 8 (1893): 155–61, 171–5.
Munthe, Axel. *The Story of San Michele*. London: John Murray, 1975.
Musil, Robert. "Über die Dummheit" (1937). In *Gesammelte Werke 8: Essays und Reden*, 1270–91. Reinbek: Rowohlt, 1981.
Myrdal, Alva. "Mer människokunskap i utbildningen." *Social Årsbok* 1945, 114–62.
Neill, A. S. *Summerhill: A Radical Approach to Child Rearing*. New York: Hart, 1960.
"Neurosis and Industry." Editorial. *British Medical Journal*, August 16 (1947): 257–8.
[Nielsen, Nils]. "Anmälan." *PTSU* Nr. 1 (1932): 3–6.
——. "Impotens." *PTSU* Nr. 6 (1933): 18–38.
——. *Sexualkunskap*. Stockholm: Riksförbundet för Sexuell Upplysning, 1936.
——. "Sexualupplysning som Geschäft." *PTSU* Nr. 1 (1933): 30–8.
Nielsen, Nils and Elise Ottesen-Jensen. "Riksförbundets sexualrådgivningsbyrå." *PTSU* Nr. 6 (1935) 266–70.
Nietzsche, Friedrich. *Ecce Homo*. Translated by Walter Kaufmann. New York: Vintage Books, 1989 [Original German edition 1908].
——. *Human, All Too Human*. Translated by R. J. Hollingdale. Cambridge: Cambridge University Press, 1986 [Original German edition 1878].
Nordström, Ludvig. *Lort-Sverige*. Stockholm: Kooperativa förbundets bokförlag, 1939.
Norrbin, Birger. "Sinnessjukdom och sinnessjukvård." *SMT* 14 (1937): 21–33, 77–80.
Nycander, Gunnar. "Homosexualitetens samhällsfarliga yttringar." *SLT* 39 (1942): 644–54.
——. "Iwan Bratt." *SLT* 43 (1946): 2770–72.
——. "Om verksamheten vid Erica-stiftelsens läkepedagogiska institut." *Förhandlingar*, November 15, 1938, 408–10.
Om sjukdom och sjukvård. Studier tillägnade Malte Ljungdahl. Lund: Gleerup, 1947.
Oterdahl, Jeanna. "Mindervärdeskänslor." In *Vardagens psykologi*, 154–69. Stockholm: Aktiebolaget Radiotjänst, 1941.
Ottesen-Jensen, Elise. "Riksförbundet för Sexuell Upplysning." *PTSU* No. 2 (1933): 56–61.
Petrén, Karl. "Några kliniska rön om neurasteni." *Eira* 23 (1899): 651–6, 682–8.
Pfannenstill, S. A. "Nevrasteni och hyperaciditet. Ett bidrag till nevrasteniens symptomatologi." *Nordiskt Medicinskt Arkiv* 32:17 (1891): 1–42.
"Polisen eller läkaren." *PTSU* Nr. 6 (1933): 43–8.
Prästen-Läkaren-Sköterskan inför gemensamma uppgifter. Stockholm: Svenska Kyrkans Diakonistyrelsens bokförlag, 1942.

"Psykiatriska föreningens årsmöte." *ASLT* 15 (1918): 1131–3.
Ramer, Torsten. [Commentary]. *Förhandlingar*, October 26, 1937, 517–20.
———. "Giving advice in questions of education and upbringing, a new form of prophylaxis." *ACTA* 12 (1937): 471–6.
———. "Nervositet och uppfostran." *PTSU* No. 4 (1936): 168–75.
Rees, H. G. St. M. [Letter to the editor]. *British Medical Journal*, September 20 (1947): 468.
Reich, Wilhelm. *Function of the Orgasm*. 1st ed. 1942. London: Souvenir Press, 1973.
Ribbing, Seved. [Commentary on Dr Wretlind's presentation]. *HV* 2 (1887): 321.
———. *Den sexuella hygienen och några av dess etiska konsekvenser*. Stockholm: Albert Bonniers Förlag, 1915.
———. "Läkarevetenskapens och läkareståndets ställning till det moderna samfundet." *Eira* 24 (1900): 34–41.
———. "Per Johan Wising." *Hygiea* 75 (1913): 113–24.
———. Review of *Die Nervenschwäche (Neurastenia)*, by G. M. Beard. *Eira* 7 (1883): 727–8.
Roheim, Geza. "Psychoanalysis and Anthropology." In *Psychoanalysis Today*, edited by Sandor Lorand, 381–95. New York: International Universities Press, 1950.
Rothery, Agnes. *Sweden: The Land and the People*. New York: The Viking Press, 1934.
Runestam, Arvid. *Psykoanalys och kristendom*. Stockholm: Sveriges kristliga studentrörelse, 1928.
Sahlgren, Ernst. "Frithiof Lennmalm." *SLT* 21 (1924): 593–5.
Salin, Mauritz. "De nervösa sjukdomarnas inflytande på den operativa gynekologien." *Hygiea* 60 (1898): 1–25.
Schjelderup, Harald K. *Mitt barn är nervöst*. Stockholm: Wahlström & Widstrand, 1938.
Selldén, Hjalmar. "Är vårt folk hopplöst degenereradt?" *HV* 18 (1903): 107–11.
———. "Några ord om våra nervsvaga." *HV* 9 (1894): 10–11, 19–23.
———. "Om vår tids nervsvaghet." *HV* 6 (1891): 21–6.
———. "Om vår tids predikant-sjuka." *HV* 10 (1895): 209–14.
"Sexualfrågor inför riksdagen." *PTSU* No. 2 (1936): 62–3.
Själavård—själsvård. Utgiven av Institut för medicinsk psykologi och psykoterapi. Stockholm: Médens Förlags Aktiebolag, 1942.
Sjögren, Torsten. "Psykiatri." In *Karolinska Mediko-Kirurgiska Institutets Historia*, Vol. III:2, 693–05. Almqvist & Wiksell: Stockholm, 1960.
———. "Den psykosomatiska synen på läkekonsten." *SLT* 55 (1958): 1875–84.
———. "Läkarvetenskapen och den psykiska hälsovården." *Social Årsbok* 1945, 43–66.
Söderhjelm, Alma. "Har ni miko?" *Husmodern* Nr. 32 (1938): 39–40.
Söderlund, C. V. "Modern neurosbehandling och Freud." *SLT* 21 (1924): 1095–102.
Sondén, Mårten. "Smärre anteckningar om missbruket af morfin, opium och opiipreparat." *Hygiea* 40 (1878): 385–407.
Sondén, Torsten. "Die Inzestverbrechen in Schweden und ihre Ursachen." *ACTA* 11 (1936): 379–401.
Statistisk årsbok för Sverige. Stockholm: Statistiska Centralbyrån, 1945.
Strindberg, August. "Förvirrade sinnesintryck" (1919–20). In *Samlade Skrifter*, Vol. 27: *Prosabitar från 1890-talet*. Stockholm: Bonniers, 1987.
Sundbärg, Gustav. *Det svenska folklynnet*. Stockholm: P.A. Norstedt, 1911.
Sundelin, Fredrik. [Commentary on Bringel & Welander]. *SMT* 13 (1936): 41–4.
———. "Om mål och medel ifråga om Kungl. Pensionsstyrelsens sjukvårdande verksamhet." *SLT* 32 (1935): 33–43.
Svenson, Frey. *Om anstaltvård av sinnessjuka*. Stockholm: Studentföreningen Verdandis småskrifter, 1904.
———. "Riktlinjer för det svenska hospitalväsendets utveckling" (1912). In *Svenska Psykiatriska Föreningen—en återblick*, 27–59. Svenska Psykiatriska Föreningen: Stockholm, 1980.

——. *Själslivets hygien*. Stockholm: Aktiebolaget Ljus, 1909.
Tamm, Alfhild. [Commentary]. *Förhandlingar*, November 15, 1938, 412–14.
——. "Motstånden mot psykoanalys." *Arkiv för Psykologi och Pedagogik* 7 (1928): 80–90.
——. "Om psykoanalys." *NMT* 5 (1933): 712–18.
——. Review of *Nervøsitet*, by Johannes Strømme. *SLT* 23 (1926): 1258–60.
——. Review of *Psykoanalysen i populär framställning*, by Federn, Meng and Bratt. *SLT* 27 (1930): 1591–2.
——. "Vår kulturkris och den psykiska hygienen." In John Agerborg et al., *Själens läkarbok*, 483–521.
Tillgren, Josua. [Commentary]. "Försummas psykoterapin av de svenska läkarna till fuskarnas fromma?" *DN*, September 9, 1924, 1.
Toll, Hugo. *Den personliga hälsovårdens principer*. Stockholm: Albert Bonniers förlag, 1919.
Törngren, P. H. *Moralsjukdomen*. Stockholm: Medéns förlags aktiebolag, 1940.
——. *Striden om Freud*. Stockholm: Albert Bonniers Förlag, 1936.
Varde, V. "Något om Pensionsstyrelsens neurosklientelet och urvalet av detsamma." *NMT* 12 (1936): 1978–80.
Wahlborn, H. B. "Vad har en präst att lära av djuppsykologien." In *Pastoralpsykologi*, 61–84. Stockholm: Natur och Kultur, 1945.
Wållgren, C. A. "Läkare, sjuksköterskor och präster." *SLT* 43 (1946): 2581.
Wetterstrand, Otto. "Förord." In John Duncan Quackenbos, *Hypnotismen såsom medel till själens och moralens odlande*, 4–5. Stockholm: Adolf Bonnier, 1902.
——. *Hypnotism and Its Application to Practical Medicine*. New York: G. P. Putnam's Sons, 1897.
——. "Några ord om den hypnotiska behandlingen." In *Hypnotismen bedömd af fackmän*, 60–66. Upsala: Akademiska bokhandeln, 1893.
——. "Om hypnotismens betydelse." *Julqvällen*, 1889, 18–19.
——. "Om långvarig sömn särskildt vid behandling af hysteriens svårare former." *Hygiea* 61 (1899): 525–34.
Wigert, Victor. [Commentary]. *Förhandlingar*, October 19, 1937, 460–7, and November 2, 1937, 585–90.
——. "Den psykiska hälsan måste vårdas!" SMT 9 (1932): 5–8.
——. "Mentalhygienen, dess mål och möjligheter." *Förhandlingar*, May 15, 1934, 112–18.
——. *Om psykisk hälsovård*. Svenska föreningens för psykisk hälsovård småskrifter, Nr. 1. Stockholm: Albert Bonniers förlag, 1932.
——. "Psykiatrien och framtiden." *SMT* 7 (1930): 191–2.
Wising, P. J. [Commentary on hysteria]. *Förhandlingar*, June 4, 1889, 168.
——. "Om nervpatologiens utveckling under de sista tvänne årtiondena." *Hygiea* 49 (1887): 415–35.
Wretlind, E. W. "Hvilka maximer böra gälla för läkarens ordinationer inom det sexuella området." *Eira* 11 (1887): 227–38.
——. "Om andlig öfveransträngning, specielt genom studiearbete." *HV* 2 (1887): 317–22.
——. "Vår skolungdom och nervositeten." *HV* 20 (1905): 173–7.
"3. Internationaler Neurologen-Kongress." *SLT* 36 (1939): 826–8.

Secondary Sources

Aird, Robert B. *Foundations of Modern Neurology*. New York: Raven Press, 1994.
Almqvist, Kurt and Kay Glans (eds). *Den svenska framgångssagan?* Stockholm: Fischer & Co., 2001.
Andersson, Ola. "A supplement to Freud's Case History of 'Frau Emmy v. N.' in *Studies on Hysteria* 1895." *Journal of European Psychoanalysis* No. 17 (2003): 139–49.

Arnhart, Larry. *Natural Right: The Biological Ethics of Human Nature*. Albany, State University of New York Press, 1998.
Bäckström, Anders. "Från institution till rörelse: En studie av Svenska kyrkan igår, idag och i morgon." In *Religion och Samhälle* Nr. 50. Uppsala: Religionssociologiska Institutet, 1989.
von Bagh, Peter. *Elokuvan historia*. Helsinki: Otava, 1998 [In English: 'A History of Cinema'].
Bärmark, Jan and Ingemar Nilsson. *Poul Bjerre—'Människosonen'*. Stockholm: Natur och Kultur, 1983.
Baur, Susan. *Hypochondria: Woeful Imaginings*. Berkeley: University of California Press, 1988.
Beer, Dominic M. "The Dichotomies: Psychosis/Neurosis and Functional/Organic: A Historical Perspective." *HP* 7 (1996): 231–55.
Berg, Ole. "The Modernisation of Medical Care in Sweden and Norway." In *The Shaping of the Swedish Health System*, edited by A. J. Heidenheimer and Nils Elvander, 17–43.
Bergenheim, Åsa. *Barnet, libido och samhället*. Stockholm: Höglunds, 1994.
——. "Skå-Gustav och barnpsykiatrin." In *Hur skall själen läkas?* edited by Eriksson and Qvarsell, 183–214.
Berggren, Henrik. "Den framåtvända ängeln—Nationalism och modernitet i Sverige under 1900-talet." In *Den svenska framgångssagan*, edited by Almqvist and Glans, 71–86.
Berlin, Isaiah. *The Sense of Reality: Studies in Ideas and Their History*. New York: Farrar, Straus and Giroux, 1998.
Berrios, G. E. *The History of Mental Symptoms: Descriptive Psychopathology since the Nineteenth Century*. Cambridge: Cambridge University Press, 1996.
Berrios, G. E. and Roy Porter (eds). *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders*. London: Athlone, 1995.
Blech, Jörg. *Die Krankheitserfinder—Wie wir zu Patienten gemacht gewerden*. Frankfurt am Main: S. Fischer Verlag, 2003.
Borch-Jacobsen, Mikkel. *Folies à plusieurs: De l'hysterie à la dépression*. Paris: Empêcheurs e penser en rond/Le Seuil, 2002.
——. "How to Predict the Past: From Trauma to Repression." *HP* 11 (2000): 15–35.
——. "Making Psychiatric History: Madness as *folie à plusieurs*." *History of the Human Sciences* 14:2 (2001): 19–38.
Broberg Gunnar and Mattias Tydén. "Eugenics in Sweden: Efficient Care." In *Eugenics and the Welfare State*, edited by Gunnar Broberg and Nils Roll-Hansen. East Lansing: Michigan State University Press, 1996.
Brodd, Birgitta. *Var Sveriges sak också kyrkans? Svenska kyrkans utrikespolitiska aktivitet*. Skellefteå: Norma, 2004.
Brown, Donald E. *Human Universals*. New York: McGraw-Hill, 1991.
Buchanan, Roderick D. "Legislative Warriors: American Psychiatrists, Psychologists, and Competing Claims over Psychotherapy in the 1950s." *JHBS* 39 (2003): 225–49.
Bynum, W. F. and Roy Porter (eds.). *The Anatomy of Madness: Essays in the History of Psychiatry*, Vol. I. London: Tavistock Publications, 1985.
—— (eds). *Companion Encyclopedia of the History of Medicine*, Vol. 2. London: Routledge, 1993.
Caplan, Arthur L. "The Concepts of Health, Illness, and Disease." In *Companion Encyclopedia of the History of Medicine*, edited by W. F. Bynum and Roy Porter, Vol. 1, 233–48.
Carlsson, Carl Henrik. *Medborgarskap och diskriminering. Östjudar och andra invandrare i Sverige 1860–1920*. Studia Historica Upsaliensia 215. Uppsala: Uppsala universitet, 2004.
Colla, Piero. "Race, Nation and Folk." In *Culture and Crisis*, edited by Nina Witoszek and Lars Trägårdh, 131–54.

Collingwood, R. G. *An Autobiography*. 1st edition 1939. Oxford: Clarendon Press, 2002.
——. *An Essay on Metaphysics*. Rev. edition by Rex Martin. Oxford: Oxford University Press, 1998.
——. *The Idea of History*. Rev. edition by Jan van der Dussen. Oxford: Oxford University Press, 1994.
Conrad, Peter and Joseph Schneider. *Deviance and Medicalisation: From Badness to Sickness*. Philadelphia: Temple University Press, 1980.
Cooter, Roger and John Pickstone. Introduction to *Medicine in the Twentieth Century*, edited by Cooter and Pickstone, xiii–xix.
—— (eds). *Medicine in the Twentieth Century*. Amsterdam: Harwood Academic Publishers, 2000.
Dagens Nyheter. February 10, 2004.
Dahlberg, Hans. *Hundra år i Sverige.* Stockholm: Albert Bonniers Förlag, 1999.
Daly, Ann. *Women Under Knife: A History of Surgery.* London: Routledge, 1991.
Danziger, Kurt. *Naming the Mind: How Psychology Found Its Language*. London: SAGE, 1997.
Didi-Huberman, Georges and Maud M. Lavin. *Invention of Hysteria: Charcot and the Iconographie Photographique de la Salpêtrière*. Cambridge, MA: The MIT Press, 2004.
Dijkstra, Bram. *Idols of Perversity: Fantasies of Feminine Evil in Fin-de-siècle Culture*. Oxford: Oxford University Press, 1986.
Dineen, Tana. *Manufacturing Victims: What the Psychology Industry is Doing to People*. Montréal: Robert Davies Multimedia Publishing, 2001.
Dolnick, Edward. *Madness on the Couch: Blaming the Victim in the Heyday of Psychoanalysis*. New York: Simon & Schuster, 1998.
Dowbiggin, Ian. "Degeneration and Hereditarianism in French Mental Medicine 1840–90: Psychiatric Theory as Ideological Adaptation." In *The Anatomy of Madness*, edited by Bynum and Porter, 188–232.
——. *Inheriting Madness: Professionalization and Psychiatric Knowledge in Nineteenth-Century France*. Berkeley: University of California Press, 1991.
——. *Keeping America Sane: Eugenics and Psychiatry in the United States and Canada, 1880–1940*. Ithaca: Cornell University Press, 1997.
Drinka, Georg F. *The Birth of Neurosis*. New York: Simon and Schuster, 1984.
Eeg-Olofsson, Richard and Kjell Tullus. "Sektionen för medicinsk psykologi." In *Svenska Läkaresällskapet 175 år*, edited by Stephan Rössner, 117–21.
Eggeby, Eva. "'…Tills med honom bättre warder…'—Vård och vardag på Danvikens dårhus under 1800-talet." In *Hur skall själen läkas?*, edited by Eriksson and Qvarsell, 47–75.
Egidius, Henry. "Psykoanalysen i Skandinavien." *Nordisk Psykologi* 28 (1976): 236–48.
Ekbom, T. and K. Ekbom. "Dagböcker och brev tyder på att Franz Kafka led av Hortons huvudvärk." *LT* 100:17 (2003): 1540–1.
Eklöf, Motzi. *Läkarens ethos. Studier i den svenska läkarkårens identiteter, intressen och ideal 1890–1960*. Linköping: Linköpings universitet, 2000.
——. "Obehörig psykiatri—Om kvacksalverilagstiftningen och utdefinierandets svåra konst." In *Psykiatrins marginaler*, edited by Qvarsell and Eriksson, 97–130.
Ellenberger, Henri F. *The Discovery of the Unconscious*. 1st edition 1970. London: Fontana Press, 1994.
Elmlund, Peter and Kay Glans (eds). *Den välsignade tillväxten*. Stockholm: Natur och Kultur, 1998.
Eriksson, Bengt Erik. "Behövs psykologer?—Psykologins plats i den psykiatriska vården." In *Psykiatrins marginaler*, edited by Qvarsell and Eriksson, 163–80.
——. "Före psykiatrin—Praktiska omständigheter och kunskapsmässiga sammanhang." In *Hur skall själen läkas?*, edited by Eriksson and Qvarsell, 27–46.
——. *Vägen till centralhospitalet*. Göteborg: Daidalos, 1989.

Eriksson, Bengt Erik and Roger Qvarsell (eds). *Hur skall själen läkas? Om den psykiatriska vårdens förändringar*. Stockholm: Natur och Kultur, 1997.
Eriksson, Håkan. "The Creation of Psychiatric Ill-Health." In *Modernity and Its Discontents*, edited by Pietikainen, 49–68.
Eriksson, Rikard. *Psykoteknik. Kulturell fabricering av personlig identitet*. Stockholm: Carlssons Bokförlag, 1999.
Fischer-Homberger, Esther. *Hypochondrie: Melancholie bis Neurose*. Bern: Hans Huber, 1970.
Fishman, Sterling. "The History of Childhood Sexuality." *Journal of Contemporary History* 17 (1982): 269–84.
Försäkringskasseförbundet, October 2001.
Freidson, Elliott. *The Profession of Medicine*. New York: Dodd & Mead, 1970.
——. *Professionalism—The Third Logic*. Cambridge: Polity Press, 2001.
Furedi, Frank. *Therapy Culture: Cultivating Vulnerability in an Uncertain Age*. London: Routledge, 2003.
Furet, Francois. *The Passing of an Illusion: The Idea of Communism in the Twentieth Century*. Translated by Deborah Furet. Chicago: The University of Chicago Press, 1999.
Gauld, Alan. *A History of Hypnotism*. Cambridge: Cambridge University Press, 1992.
Gellner, Ernest. *The Psychoanalytic Movement. The Cunning of Unreason*. London: Fontana Press, 1993.
Gerhardt, Uta. *Ideas about Illness. An Intellectual and Political History of Medical Sociology*. London: Macmillan, 1989.
Gijswijt-Hofstra, Marike and Roy Porter (eds). *Cultures of Neurasthenia from Beard to the First World War*. Amsterdam: Rodopi, 2001.
Gilman, Sander. "The Image of the Hysteric." In Gilman et al., *Hysteria beyond Freud*, 345–452.
—— et al. *Hysteria beyond Freud*. Berkeley: University of California Press, 1993.
—— et al. Introduction to *Hysteria beyond Freud*, by Sander L. Gilman et al., vii–xvi.
Goetz, Christopher, Michel Bonduelle and Toby Gelfand. *Charcot: Constructing Neurology* Oxford: Oxford University Press, 1995.
Goffman, Erving. *The Presentation of Self in Everyday Life*. New York: Doubleday Books, 1959.
Goldstein, Jan. "Psychiatry." In *Companion Encyclopedia of the History of Medicine*, edited by Bynum and Porter, 1350–72.
Gossop, Michael. *Theories of Neurosis*. Berlin: Springer-Verlag, 1981.
Gunnarsson, Lars. "Runestam, Arvid." In *Svenskt Biografiskt Lexicon*, Vol. 30, 735–41. Stockholm: Norstedts, 2000.
Hacking, Ian. *Mad Travelers: Reflections on the Reality of Transient Mental Illnesses*. Cambridge, MA: Harvard University Press, 1998.
——. *The Social Construction of What?* Cambridge, MA: Harvard University Press, 2000.
Hafferty, F. W. and J. B. McKinley (eds). *The Changing Medical Profession: An International Perspective*. Oxford: Oxford University Press, 1993.
Handlbauer, Bernhard. *The Freud-Adler Controversy*. Translated by Laurie Cohen. Oxford: One World, 1998.
Harrington, Ralph. "The Railway Journey and the Neuroses of Modernity." In *Pathologies of Travel*, edited by Richard Wrigley and George Revill, 229–60. Amsterdam: Rodopi, 2000.
Healy, David. *The Antidepressant Era*. Cambridge, MA: Harvard University Press, 1998.
——. *The Creation of Psychopharmacology*. Cambridge, MA: Harvard University Press, 2002.
——. *Let Them Eat Prozac*. New York: New York University Press, 2004.

Heidenheimer, Arnold J. "Conflict and Compromises between Professional and Bureaucratic Health Interests 1947–72." In *The Shaping of the Swedish Health System*, edited by Heidenheimer and Elvander, 119–42.

Heidenheimer, Arnold J. and Nils Elvander (eds), *The Shaping of the Swedish Health System*. London: Croom Helm, 1980.

Henningsen, Bernd. "Jante eller den skandinaviska medelmåttans lag. Om ett inslag i välfärdsstatsidentiteten." In *Den svenska framgångssagan?*, edited by Almqvist and Glans, 181–96.

Herf, Jeffrey. *Reactionary Modernism*. Cambridge: Cambridge University Press, 1984.

Hirdman, Yvonne. "Crisis: The Road to Happiness?" In *Culture and Crisis*, edited by Witoszek and Trägårdh, 155–69.

Hirschman, Albert. *The Rhetoric of Reaction*. Cambridge, MA: The Belknap Press of Harvard University Press, 1991.

Hirschmüller, Albrecht. "The Development of Psychiatry and Neurology in the Nineteenth Century." *HP* 10 (1999): 395–423.

Johannisson, Karin. "Bot för en nervtrött generation: Ett läkemedel i idéhistorisk belysning." In *Vetenskap och läkemedel: Ett historiskt perspektiv*, edited by Tore Frängsmyr, 74–112. Stockholm: Almqvist & Wiksell, 1987.

———. *Den mörka kontinenten. Kvinnan, medicinen och fin-de-siècle*. Stockholm: Norstedts, 1994.

———. "Folkhälsa: Det svenska projektet från 1900 till 2:a världskriget." *Lychnos* 1991, 139–96.

———. *Kroppens tunna skal: Sex essäer om kropp, historia och kultur*. Stockholm: Norstedts, 1997.

———. *Medicinens öga*. Stockholm: Norstedts, 1990.

———. *Tecknen: Läkaren och konsten att läsa kroppar*. Stockholm: Norstedts, 2004.

Johansson, Per Magnus. *Freuds psykoanalys*. Band 2: *Arvtagare i Sverige*. Göteborg: Daidalos, 1999.

———. *Freuds psykoanalys*. Band 3: *Arvtagare i Sverige del 2*. Göteborg: Daidalos, 2003.

———. "Sweden and Psychoanalysis." *Journal of European Psychoanalysis* Nr. 17 (2003): 123–38.

Jönsson, Lars-Eric. *Det terapeutiska rummet*. Stockholm: Carlsson, 1998.

Kagan, Jerome. *Three Seductive Ideas*. Cambridge, MA: Harvard University Press, 2000.

Kandel, Eric R. "Biology and the Future of Psychoanalysis: A New Intellectual Framework for Psychiatry Revisited." *The American Journal of Psychiatry* 156 (1999): 505–24.

———. "A New Intellectual Framework for Psychiatry." *The American Journal of Psychiatry* 155 (1998): 457–69.

Kevles, Daniel. *In the Name of Eugenics*. New York: Kopf, 1985.

Killen, Andreas. *Berlin Electropolis. Shock, Nerves, and German Modernity*. Berkeley: University of California Press, 2006.

Kivivuori, Janne. *Psykokirkko*. Helsinki: Gaudeamus, 1999 [In English: 'Psychochurch'].

Kleinman, Arthur. *The Illness Narratives: Suffering, Healing and the Human Condition.* New York: Basic Books, 1988.

Koselleck, Reinhart. *Futures Past: On the Semantics of Historical Time*. Translated by Keith Tribe. Cambridge, MA: The MIT Press 1985.

———. "Some Questions Concerning the Conceptual History of 'Crisis'." In *Culture and Crisis*, edited by Witoszek and Trägårdh, 12–23.

Kutchins, Herb and Stuart A. Kirk. *Making Us Crazy: DSM: The Psychiatric Bible and the Creation of Mental Disorders*. London: Constable, 1999.

Lagerspetz, Kirsti. *Naisten aggressio.* Helsinki: Tammi 1998 [in English: 'Female Aggression'].

Lagerspetz, Kirsti, Kaj Björkqvist and Tarja Peltonen. "Is Indirect Aggression Typical of Females? Gender Differences in Aggressiveness in 11- to 12-year Old Children." *Aggressive Behaviour* 14 (1988): 403–14.

Lagerspetz, Kirsti and Kaj Björkvist. "Indirect Aggression in Girls and Boys." In *Aggressive Behaviour: Current Perspective*, edited by L. Rowell Huesmann, 131–50. New York: Plenum Press, 1994.

Laqueur, Thomas W. *Solitary Sex: A Cultural History of Masturbation*. New York: Zone Books, 2003.
Larson, Magali Sarfatti. *The Rise of Professionalism*. Berkeley: University of California Press, 1977.
Larsson, Hans Albin (ed.). *Boken om Sveriges historia*. Stockholm: Forum, 2001.
Lennerhed, Lena. *Sex i Folkhemmet: RFSUs tidiga historia*. Uppsala: Gidlunds förlag, 2002.
Lerner, Paul. "From Traumatic Neurosis to Male Hysteria: The Decline and Fall of Hermann Oppenheim, 1889–1919." In *Traumatic* Pasts, edited by Micale and Lerner, 140–71.
———. *Hysterical Men: War, Psychiatry, and the Politics of Trauma in Germany, 1890–1930*. Cornell: Cornell University Press, 2003.
Lindbeck, Asser. *Swedish Economic Policy*. Berkeley: University of California Press, 1974.
Ling, Sofia. *Kärringmedicin och vetenskap*. Studia Historica Upsaliensia. Uppsala: Uppsala University Press, 2004.
Longum, Leif. "Psykoanalysen og kulturradikalismen: Freud og Reich i skandinavisk kulturkamp 1920–1940." In *Kulturradikalismen*, edited by Bertil Nolin, 23–62. Stockholm: Brutus Östlings bokförlag Symposion, 1993.
López Piñero, Jose. *Historical Origins of the Concept of Neurosis*. Cambridge: Cambridge University Press, 1983.
Luft, Rolf. "Sektionen för endocrinologi." In *Svenska Läkaresällskapet 175 år*, edited by Stephan Rössner, 37–42.
Lundgren, Frans. *Den isolerade medborgaren: Liberalt styre och uppkomsten av det sociala vid 1800-talets mitt*. Hedemora: Gidlunds Förlag, 2003.
Lundin, Georg and Arvid Myrgård. "Hälsovården och socialmedicinen i det moderna samhället." In *Medicinalväsendet i Sverige 1813–1962*, edited by Wolfram Kock, 281–328.
Lundquist Wanneberg, Pia. *Kroppens medborgarfostran*. Stockholm: Stockholms universitet, 2004.
Luttenberger, Franz. "Hypnotisörernas tid: Hypnotismen i svensk medicin 1880–1900." *Lychnos* 1983, 91–119.
Luttenberger, Frans. *Freud i Sverige. Psykoanalysens mottagande i svensk medicin och idédebatt 1900–1924*. Stockholm: Carlssons, 1989.
———. "Striden mellan David och Goliat—Psykoanalytiska och psykodynamiska synsätt i svensk medicin." In *Psykiatrins marginaler*, edited by Qvarsell and Eriksson, 15–46.
Mäkinen, Ilkka. *On Suicide in European Countries.* Stockholm: Almqvist & Wiksell International, 1997.
Mansén, Elisabeth. *Ett paradis på jorden: Om den svenska kurortskulturen 1680–1880*. Stockholm: Atlantis, 2001.
Marmot, Michael. *Status Syndrome*. London: Bloomsbury, 2004.
Mattila, Markku. *Kansamme parhaaksi. Rotuhygienia Suomessa vuoden 1935 sterilointilakiin asti*. Helsinki: Suomen Historiallinen Seura, 1999 [In English: 'In Our Nation's Best Interest—Eugenics in Finland until the Promulgation of the Sterilization Law of 1935'].
Mayou, R. A. "Psychological Factors and the Course of Illness." In *Oxford Textbook of Medicine*, edited by D. J. Weatherall et al., 24.31–34. Oxford: Oxford University Press, 1984.
Mazlish, Bruce. *The Uncertain Sciences*. New Haven: Yale University Press, 1998.
Micale, Mark S. *Approaching Hysteria: Disease and Its Interpretations*. Princeton: Princeton University Press, 1995.
———. "Discourses of Hysteria in Fin-de-Siècle France." In *The Mind of Modernism: Medicine, Psychology, and the Cultural Arts in Europe and America, 1880–194*, edited by Mark S. Micale, 71–92. Stanford: Stanford University Press, 2004.
———. "Jean-Martin Charcot and les névroses traumatiques: From Medicine to Culture in French Trauma Theory of the Late Nineteenth Century." In *Traumatic Pasts*, edited by Micale and Lerner, 115–39.

——. "The Psychiatric Body." In *Medicine in the Twentieth Century*, edited by Cooter and Pickstone, 323–46.
Micale, Mark S. and Paul Lerner (eds.). *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870–1930*. Cambridge: Cambridge University Press, 2001.
Moscucci, Ornella. *The Science of Woman: Gynaecology and Gender in England, 1800–1929.* Cambridge: Cambridge University Press, 1990.
Mosse, George. *The Image of Man: The Creation of Modern Masculinity*. Oxford: Oxford University Press, 1996.
Moynihan, Ray, Iona Heath and David Henry. "Selling Sickness: The Pharmaceutical Industry and Disease Mongering." *British Medical Journal* 324, April 13 (2002): 886–90.
Moynihan, Ray and Alan Cassels. *Selling Sickness: How the World's Biggest Pharmaceutical Companies Are Turning Us All into Patients*. New York: Nation Books, 2005.
Neumärker, Klaus-Jürgen and Andreas Joachim Bartsch. "Karl Kleist (1879–1960)—A Pioneer of Neuropsychiatry." *HP* 14:4 (2003): 411–58.
Nilsson, Ingemar. "Sydney Alrutz och nervstrålningens problem." *Lychnos* 1977–78, 10–53.
——. "Lennmalm, Frithiof." In *Svenskt Biografiskt Lexicon*, Vol. 22, 561–3. Stockholm: Norstedts, 1979.
Nilsson, Torbjörn. "Scandinavian Liberalism—Prophets Instead of Profits." In *The Cultural Construction of Norden*, edited by Sørensen and Stråth, 206–30.
Nilsson, Ulrika. *Kampen om kvinnan: Professionalisering och konstruktioner av kön i svensk gynekologi 1860–1925*. Uppsala: Uppsala University, 2003.
Nordberg, Karin. *Folkhemmets röst: Radion som folkbildare 1925–1950*. Eslöv: B. Östlings förlag, 1998.
Nordenfelt, Lennart. "What is Health?" In *Philosophy Meets Medicine*, edited by Pekka Louhiala and Svante Stenman, 15–22. Helsinki: Helsinki University Press, 2000.
Nye, Robert. *Crime, Madness and Politics in Modern France*. Princeton: Princeton University Press, 1984.
——. "Degeneration, Neurasthenia and the Culture of Sport." *Journal of Contemporary History* 17:1 (1982): 51–68.
Öberg, Lars. "Marcus, Henry Isaac." In *Svenskt Biografiskt Lexicon*, Vol. 25, 126–29. Stockholm: Norstedts, 1987.
Ohlander, Ann-Sofie. "Kvinnor, barn och arbete i Sverige 1850–1993." Stockholm, *SOU*: 38/1994.
Oosterhuis, Harry. *Stepchildren of Nature: Krafft-Ebing, Psychiatry, and the Making of Sexual Identity*. Chicago: The University of Chicago Press, 2000.
Oppenheim, Janet. *'Shattered Nerves': Doctors, Patients, and Depression in Victorian England*. Oxford: Oxford University Press, 1991.
Österberg, Carin. *Natur och Kultur. En förlagskrönika*. Stockholm: Natur och Kultur, 1987.
Ottosson, Jan-Otto. *Psykiatrin i Sverige*. Stockholm: Natur och Kultur, 2003.
Palmblad, Eva. *Medicinen som samhällslära*. Göteborg: Daidalos, 1990.
Palmborg, Stina. *Ernst Westerlund—en läkekonstens storman*. Stockholm: Natur och Kultur, 1939.
Pick, Daniel. *Faces of Degeneration: A European Disorder, c. 1848–c. 1918*. Cambridge: Cambridge University Press, 1989.
Pietikainen, Petteri. "Dynamic Psychology, Utopia, and Escape from History: The Case of C. G. Jung." *Utopian Studies* 12:1 (2001): 41–55.
——. "'The Sage Knows You Better Than You Know Yourself': Psychological Utopianism in Erich Fromm's Work." *History of Political Thought* 24:1 (2004): 86–115.
——. "Utopianism in Psychology: The Case of Wilhelm Reich." *JHBS* 38:2 (2002), 157–75.
—— (ed.). *Modernity and Its Discontents: Sceptical Essays on the Psychomedical Management of Malaise*. Stockholm: Ax:son Johnson Foundation, 2005.

Pinker, Steven. *The Blank Slate: The Modern Denial of Human Nature*. New York: Viking, 2002.
Porter, Roy. "The Body and the Mind, the Doctor and the Patient: Negotiating Hysteria." In Gilman, Sander L. et al., *Hysteria beyond Freud*, 225–85.
———. "Diseases of Civilization." In *Companion Encyclopedia of the History of Medicine*, edited by Bynum and Porter, 584–99.
———. "The Patient's View: Doing Medical History from Below." *Theory and Society* 14:2 (1985): 175–98.
———. "Religion and Medicine." In *Companion Encyclopedia of the History of Medicine*, edited by Bynum and Porter, 1449–68.
Prestjan, Anna. "Kultursjukdomar i Örebro 1860–1910—exempel på sjukdomsbegreppets relativitet." *Svensk Medicinhistorisk Tidskrift* 2:1 (1998): 49–78.
Qvarsell, Roger. "Från vanart till psykopati. Om barnpsykiatrins framväxt i Sverige under mellankrigstiden." *Lychnos* 1985, 167–88.
———. "Locked Up or Put to Bed: Psychiatry and the Treatment of the Mentally Ill in Sweden 1800 to 1920." In *The Anatomy of Madness*, edited by Bynum and Porter, 86–97.
———. *Ordning och behandling: Psykiatri och sinnessjukvård i Sverige under 1800-talets första hälft*. Umeå: Umeå Universitet, 1982.
———. "Socialmedicinen och den sociala ingenjörskonsten." *Nordisk Medicinhistorisk Årsbok* 1995, 125–48.
———. "Tora Sandström och psykoterapins historia." *Lychnos* 1995, 115–44.
———. *Vårdens idéhistoria*. Stockholm: Carlssons, 1991.
Qvarsell, Roger and Eriksson, Bengt-Erik (eds). *Psykiatrins marginaler*. Linköping: Linköpings universitet, 1997.
Rabinbach, Anson. *The Human Motor: Energy, Fatigue, and the Origins of Modernity*. New York: Basic Books, 1990.
Radkau, Joachim. *Das Zeitalter der Nervosität: Deutschland zwischen Bismarck und Hitler*. München: Carl Hanser, 1998.
———. "The Neurasthenic Experience in Imperial Germany." In *Cultures of Neurasthenia from Beard to the First World War*, edited by Gijswijt-Hofstra and Porter, 199–217.
Reichardt, Rolf, Eberhard Schmitt and Brigitte Schieben-Lange (eds). *Handbuch politisch-sozialer Grundbegriffe in Frankreich 1680–1820*, Vols. I–II. Oldenbourg: München, 1985.
Rieff, Philip. *The Triumph of the Therapeutic: Uses of Faith after Freud*. New York: Harper & Row, 1966.
Rigné, E. M. "Discontent and the Rise of Psychology." In *Modernity and Its Discontents*, edited by Pietikainen, 85–101.
———. *Profession, Science and State—Psychology in Sweden 1968–1990*. Göteborg: Göteborg University, 2002.
Ringmar, Erik. "The Institutionalization of Modernity: Shocks and Crises in Germany and Sweden." In *Culture and Crisis*, edited by Witoszek and Trägårdh, 24–47.
Risse, Guenter B. and John Harley Warner. "Reconstructing Clinical Activities: Patient Records in Medical History." *Social History of Medicine* 5:2 (1992): 183–205.
Rönnbäck, Josefin. *Politikens genusgränser. Den kvinnliga rösträttrörelsen och kampen för kvinnors politiska medborgarskap 1902–1921*. Stockholm: Atlas, 2004.
Rose, Joanna. "Läkemedlen som söker sina sjukdomar." *Forskning & Framsteg* No. 1 (2004): 48–9.
Rose, Nikolas. *Governing the Soul: The Shaping of the Private Self*. 1st edition 1989. London: Free Association Books, 1999.
———. *Inventing Our Selves*. Cambridge: Cambridge University Press, 1996.
Rössel, James. *Kvinnorna och kvinnorörelsen i Sverige 1850–1950*. Stockholm: YFS:s Förlag, 1950.

Rössner, Stephan (ed.). *Svenska Läkaresällskapet 175 år. Svenska Läkaresällskapets Handlingar*, *Hygiea* 92 (1983).
Runcis, Maija. *Steriliseringar i folkhemmet*. Stockholm: Ordfront, 1998.
Rydström, Jens. *Sinners and Citizens: Bestiality and Homosexuality in Sweden 1880–1950*. Stockholm: Stockholm University, 2001.
Sandström, Birgitta. *Den välplanerade sexualiteten*. Stockholm: HLS Förlag, 2001.
Sapolsky, Robert. "Sick of Poverty." *Scientific American*, December (2005): 92–9.
———. *Why Zebras Don't Get Ulcers: A Guide to Stress, Stress-Related Diseases and Coping*. New York: Henry Holt and Co., 2004.
Sassoon, Donald. *One Hundred Years of Socialism: The West European Left in the Twentieth Century*. London: I. B. Tauris, 1996.
Schäffner, Wolfgang. "Event, Series, Trauma: The Probabilistic Revolution of the Mind in the Late Nineteenth Century and Early Twentieth Centuries." In *Traumatic Pasts*, edited by Micale and Lerner, 81–91.
Schiller, Francis. *The Möbius Strip: Fin-de-siècle Neuropsychiatry and Paul Möbius*. Berkeley: University of California Press, 1982.
Sennett, Richard. *The Fall of Public Man*. New York: Vintage Books, 1978.
Shamdasani, Sonu. "'Psychotherapy': The Invention of a Word." *History of the Human Sciences* 18:1 (2005): 1–22.
Shephard, Ben. *A War of Nerves: Soldiers and Psychiatrists 1914–1994*. London: Pimlico, 2002.
Shorter, Edward. *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era*. New York: The Free Press, 1992.
———. "The History of the Doctor-Patient Relationship." In *Companion Encyclopedia of the History of Medicine*, edited by Bynum and Porter, 783–800.
———. "Private Clinics in Central Europe 1850–1933." *Social History of Medicine* 3:2 (1990): 159–95.
———. "Somatoform Disorders: Social Section." In *A History of Clinical Psychiatry*, edited by Berrios and Porter, 476–89.
Showalter, Elaine. "Hysteria, Feminism, and Gender." In Sander L. Gilman et al., *Hysteria beyond Freud*, 286–344.
Sjöström, Bengt. *Den galna vården. Svensk psykiatri 1960–2000*. Lund: Bokbox Förlag, 2000.
Skinner, Quentin. *Visions of Politics*. Vol. 1: *Regarding Method*. Cambridge: Cambridge University Press, 2002.
Søland, Birgitte. *Becoming Modern: Young Women and the Reconstruction of Womanhood in the 1920s*. Princeton: Princeton University Press, 2000.
Sørensen, Øystein and Bo Stråth (eds). *The Cultural Construction of Norden*. Oslo: Scandinavian University Press, 1997.
Spektorowski, Alberto and Elisabet Mizrachi. "Eugenics and the Welfare State in Sweden: The Politics of Social Margins and the Idea of a Productive Society." *Journal of Contemporary History* 39:3 (2004): 333–52.
Stein, Marvin. "The Establishment of the Department of Psychiatry in the Mount Sinai Hospital: A Conflict between Neurology and Psychiatry." *JHBS* 40 (2004): 285–309.
Stenius, Henrik. "The Good Life is a Life of Conformity: The Impact of Lutheran Tradition on Nordic Political Culture." In *The Cultural Construction of Norden*, edited by Sørensen and Stråth, 161–71.
Stolt, Carl-Magnus. "'När man är förfärligt ledsen söker man—tror Ni inte det?—människan?' Patienter skriver till doktor Poul Bjerre." *Svensk Medicinhistorisk Tidskrift* 5 (2001): 153–69.
———. "Varför fick Freud aldrig Nobelpriset?" *Svensk Medicinhistorisk Tidskrift* 4 (2000): 75–114.
Stråth, Bo. *Folkhemmet mot Europa*. Stockholm: Tiden, 1993.
Sulloway, Frank J. *Freud, Biologist of the Mind*. 1st edition 1979. Cambridge, MA: Harvard University Press, 1992.

Svartz, Nanna. "Holmgren, Israel." In *Svenskt Biografiskt Lexicon*, Vol. 19, 264–8. Stockholm: Norstedts, 1973.
Svenska Psykiatriska Föreningen—en återblick. Svenska Psykiatriska Föreningen: Stockholm, 1980.
Thullberg, Per. "Myrdal, Alva." In *Svenskt Biografiskt Lexicon*, Vol. 26, 161–72. Stockholm: Norstedts, 1989.
Tjeder, David. "One Hundred Years of Uncertainty: Changing Conceptions of the Ideal Man, 1800–1900." In *Only Human: Studies in the History of Conceptions of Man*, edited by Arne Jarrick, 153–90. Stockholm: Almqvist & Wiksell, 2000.
Trägårdh, Lars. "Crisis and the Politics of National Community." In *Culture and Crisis*, edited by Witoszek and Trägårdh, 75–109.
——. "Statist Individualism: On the Culturality of the Nordic Welfare State." In *The Cultural Construction of Norden*, edited by Sørensen and Stråth, 253–85.
Tully, James (ed.). *Meaning and Context: Quentin Skinner and His Critics*. Cambridge: Cambridge University Press, 1988.
Tydén, Mattias. *Från politik till praktik: De svenska steriliseringslagarna 1935–1975*. Stockholm: Acta Universitatis Stockholmiensis, 2002.
——. *Svensk antisemitism 1880–1930*. Uppsala: Centre for Multiethnic Research, 1986.
Uimonen, Minna. *Hermostumisen aikakausi: Neuroosit 1800-ja 1900-lukujen vaihteen suomalaisessa lääketieteessä*. Helsinki: Suomen Historiallinen Seura, 1999 [In English: 'The Age of Nervousness: The Neuroses in the Late Nineteenth and the Early Twentieth Century Finnish Medicine'].
Unestål, Lars-Eric. "Hypnos förr och nu." In *Hypnos i teori och i praktik*, edited by Lars-Eric Unestål. Örebro: Veje Förlag, 1982.
Valenstein, Elliot S. *Blaming the Brain*. New York: The Free Press, 1998.
Vinterhed, Kerstin. *Gustav Jonsson på Skå: En epok i svensk barnavård*. Stockholm: Tiden, 1977.
Watson, William. "Psychiatry as Craft." *HP* 9 (1998): 355–81.
Weingart, Peter, Jürgen Kroll and Kurt Bayertz. *Rasse, Blut und Gene. Geschichte der Eugenik und Rassenhygiene in Deutschland*. Frankfurt am Main: Suhrkamp, 1988.
Weiss, Sheila F. *Race Hygiene and National Efficiency: The Eugenics of Wilhelm Schallmayer*. Berkeley: University of California Press, 1987.
——. "The Race Hygiene Movement in Germany." *Osiris*, Second Series, 3 (1987).
Wessely, S., M. Hotopf and M. Sharpe. *Chronic Fatigue and Its Syndromes*. Oxford: Oxford University Press, 1999.
Whitaker, Robert. *Mad in America. Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. New York: Basic Books, 2002.
Wikström, Owe. *Stöd eller börda? Religionens roll i psykiatri och psykoterapi*. Uppsala: Verbum, 1980.
Wilkinson, Richard. *The Impact of Inequality: How to Make Sick Societies Healthier*. London: The New Press/Routledge, 2005.
——. *Mind the Gap: Hierarchies, Health and Human Evolution*. London: Weidenfeld and Nicolson, 2000.
Witoszek, Nina. "Moral Community and the Crisis of Enlightenment." In *Culture and Crisis*, edited by Witoszek and Trägårdh, 48–74.
Witoszek, Nina and Lars Trägårdh (eds). *Culture and Crisis: The Case of Germany and Sweden*. New York: Berghahn Books, 2002.
Wretmark, Gerdt. "Svenska Psykiatriska Föreningen 75 år." In *Svenska Psykiatriska Föreningen—en återblick*, 7–17. Stockholm: Svenska Psykiatriska Föreningen, 1980.
Young, Allan. *The Harmony of Illusions: Inventing Post-traumatic Stress Disorder*. Princeton: Princeton University Press, 1995.
Zaremba, Maciej. *De rena och de andra*. Stockholm: Bokförlaget DN, 1999.
"20 år med Westerlundsällskapet." *Uppsala Nya Tidning*, April 19, 2004.

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