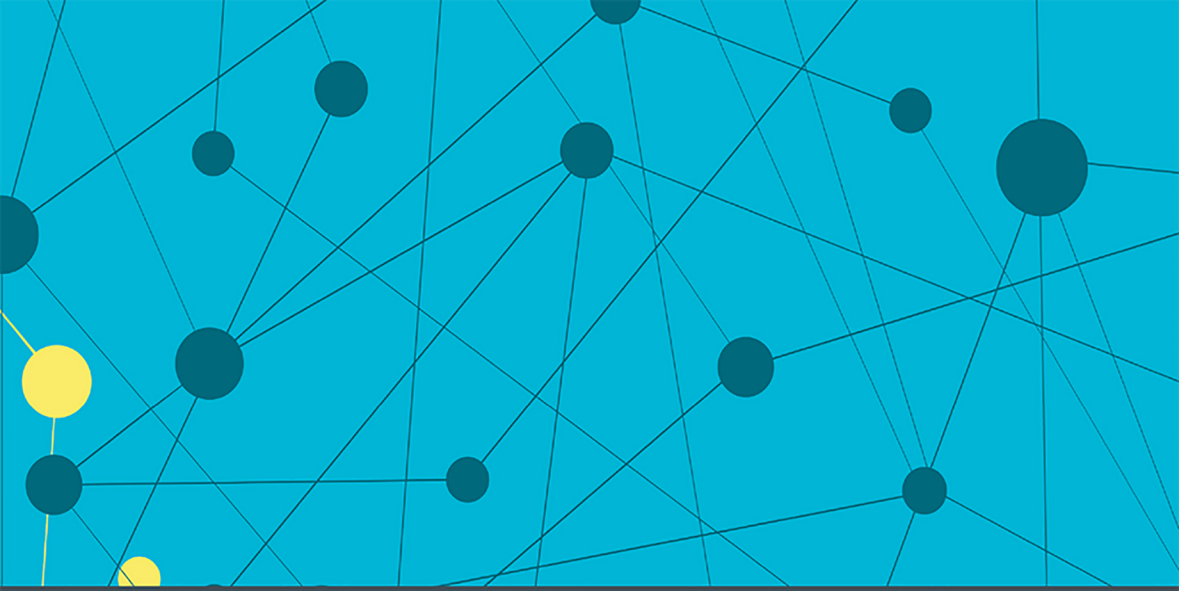

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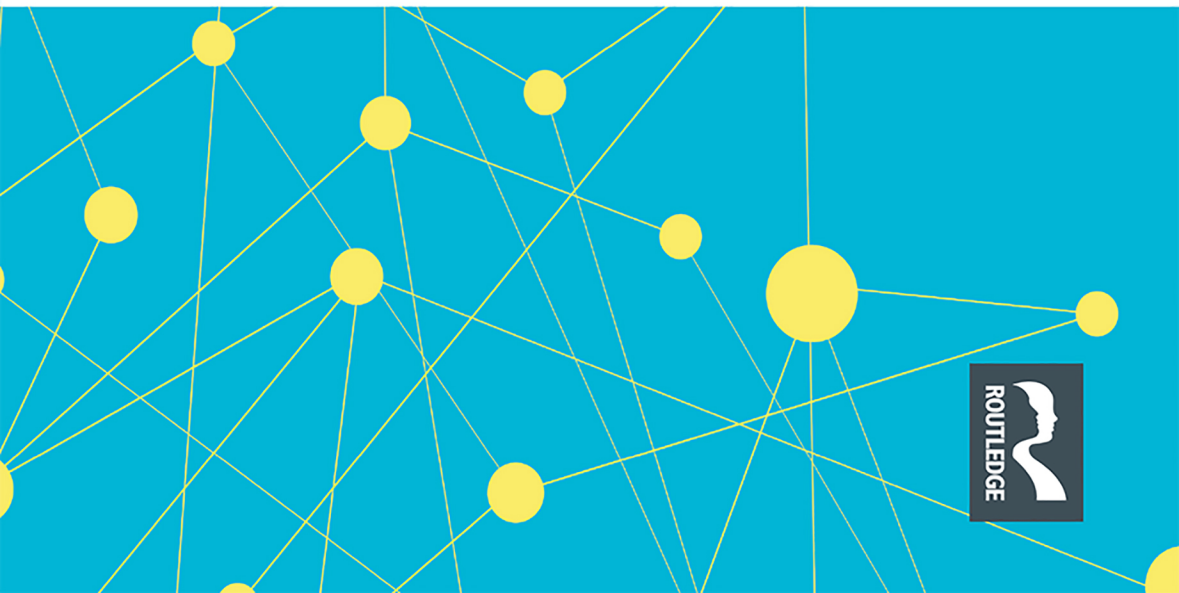
SOCIAL CLASS AND MENTAL ILLNESS IN NORTHERN EUROPE

Edited by Petteri Pietikäinen and
Jesper Vaczy Kragh



Social Class and Mental Illness in Northern Europe

This book examines the relationship between social class and mental illness in Northern Europe during the 20th century. Contributors explore the socioeconomic status of mental patients, the possible influence of social class on the diagnoses and treatment they received in psychiatric institutions, and how social class affected the ways in which the problems of minorities, children, and various 'deviants' and 'misfits' were evaluated and managed by mental health professionals. The basic message of the book is that, even in developing welfare states founded on social equality, social class has been a significant factor that has affected mental health in many different ways – and still does.

Petteri Pietikäinen is Professor of the History of Science and Ideas at the University of Oulu, Finland.

Jesper Vaczy Kragh is principle investigator at Psychiatry Region Zealand and a Fellow at CoRe, the University of Copenhagen, Denmark.

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Petteri Pietikäinen and
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Introduction

Petteri Pietikäinen and Jesper Vaczy Kragh

It is by now a well-established fact that the lower socioeconomic classes are at a greater risk of falling ill and having a shorter life span than those better off in society.[1] Research on health inequalities has suggested that each step down the socioeconomic ladder correlates with poorer health. Some researchers have argued that the psychosocial consequences of being poor, especially *feeling* poor, activate stress responses that then increase the probability of stress-sensitive illnesses and disease – such as depression, hypertension, and cardiovascular disease. The much-discussed research by social epidemiologists Richard Wilkinson, Michael Marmot, and Kate Pickett also suggests that an increased disparity in income between rich and poor predicts poorer health for both.[2] Social class thus appears to be a significant variable that needs to be effectively taken into account when examining and explaining the prevalence of mental disorders in a society.

This book examines the relationship between social class and mental disorders in Northern Europe between the late 19th and late 20th centuries. During this period the number of patients confined in mental hospitals increased to the point where they were often overcrowded and understaffed by the outbreak of World War II. After this point, the numbers confined began to go down as a large-scale process of deinstitutionalisation began. If the period between the end of the 19th century up until the middle of the 20th century was seen as the era of 'great confinement', then the second half of the 20th century clearly witnessed the era of 'great deinstitutionalisation'.[3] In this volume, both these eras are covered, although the majority of chapters deal with the early and mid-20th century. The contributors to this volume explore the socioeconomic status of patients with mental disorders, the possible influence that social class had on the diagnoses and treatment they might have received in psychiatric institutions, and the ways in which mental health professionals were affected by the social class of the criminals, 'deviants', or 'misfits' that they needed to evaluate and manage. The basic message of this book is that, even in developing welfare societies that aim to provide certain public services for all, class has remained a significant factor affecting the way mental health care is delivered.[4] This is at least partly

because, in spite of high hopes and universalistic social support, welfare societies have been unable to eradicate health inequalities.[5]

The impetus for writing this book came from the rather surprising observation that we could barely find any historical studies about Northern Europe that have made the issue of social class and mental illness their *main focus*. While the topic may often have been acknowledged in previous histories of madness and mental health, social class has not been the primary subject of more recent studies. Historical research on the correlations between social class and mental illness started in the late 1930s with the now classic 'ecological' study of mental disorders in urban Chicago.[6] Robert Faris and Warren Dunham, authors of this study, looked at the residential areas of mental patients and noticed that there were clear correlations between these areas and the quantity and quality of mental disorders. Applying the theory of social disorganisation developed by the Chicago School of Sociology, they concluded that people living in inner city zones that were assumed to be 'naturally disorganised' were at the highest risk of suffering from schizophrenia. They also argued that social isolation, poor communication among residents, an increased concentration of immigrants, and a high turnover of residents (i.e. those moving in and out of the area) had detrimental effects on the mental health of residents in the area. Faris and Dunham's study made a lasting contribution to social psychiatry by providing an impetus for research into the relationship between mental illness and social environments on the one hand, and mental illness and social class on the other.

In the 1950s and the 1960s, mental health studies on the American population confirmed this thesis that the prevalence of mental illness is to some extent dependent on the socioeconomic status of individuals. An especially important study was August B. Hollingshead and Fredrick C. Redlich's *Social Class and Mental Illness* (1958), in which the authors reported on variations in social class corresponding not only with the prevalence and incidence of mental illness, but also with the different kinds of mental health treatments available to those classes.[7] Nevertheless, to this day, we still lack general population studies that provide more robust information about the correspondence between mental health and social inequalities across European countries. For now, what we do have, is more limited research that examines the links between socioeconomic status and mental health within a number of European countries.[8] This research is usually made up of several national cross-sectional studies, which together reveal the situation over a relatively short period of time, but there are usually only rather vague references to potential long-term changes, and any follow-up studies have usually focused on relatively small national samples.

Of the few historical studies on mental health that do focus on social class, there is Frantz Fanon's *The Wretched of the Earth* (1961), Michel Foucault's *History of Madness* (1961), and Klaus Doerner's *Madmen and the Bourgeoisie* (1969), all of which forcefully argued that mental illness and psychiatry

functioned as an extension of broader social struggles over race, colonial control, and the social dominance of bourgeois values. Some form of class analysis has been visible in this stream of scholarship which exemplifies the 'sociological' turn that took place in the 1960s and 1970s.[9] During more recent decades, a number of publications have addressed the issue of social class and mental illness across a range of contexts such as nationality, ethnicity, and gender.[10] Compared to the so-called revisionist literature of the 1960s and 1970s, however, these recent studies have tended to focus on the history of a single asylum, rather than on wider sociocultural and economic changes and developments.[11] In addition, most of this work has focused specifically on the Anglo-American world. From the perspective of social class, there are also relevant studies on mental illness and social exclusion, migration, and deinstitutionalisation.[12]

These publications indicate that historians are increasingly interested in the social, political and cultural aspects of mental health. None of these books, however, examine the issue of social class at length. As the historian and sociologist Andrew Scull wrote in 2006, '[g]ender has been far the more popular area of scholarly research in the past two decades in the history of psychiatry, with class often addressed only in passing, if at all.'[13] Additionally, those previous studies which *do* specifically address social class and mental health, are usually looking at psychiatry and mental hospitals in the 18th and 19th centuries. Our book, in contrast, focuses on the 20th century.

To fill this research gap, we (the editors), together with our colleagues, organised two workshops in Finland and Denmark (2016–2017) on the issue of social class and mental health in Northern Europe, to be discussed from a historical perspective. In our discussions, we were very aware of the fact that there is now a wide consensus in the international research community about the relevance of studies examining mental health in social, cultural, and political contexts.[14] Thus, this volume contributes not only to international historical and social scientific research, but also to psychiatric and epidemiological research on mental health.[15] An important aim of this book is also to draw attention to the history of psychiatry in Northern Europe in general, and to Nordic countries in particular. So far, only a small number of books in English have been published on mental health care in the Nordic countries.[16] By combining studies from countries such as Norway, Finland, Sweden, and Denmark on social class and mental health, this volume goes some way to filling this gap, while also providing international access to aspects of the history of psychiatry that may be less well known.

In presenting a variety of perspectives, sources, and methodologies, this volume affords researchers an opportunity to consider how they themselves might take up the topic in their future studies. Contributors not only examine histories of class structure in asylum populations, but also analyse interpretations of class given by mental health professionals in this period which also betray the doctors' tacit class assumptions about patients and themselves. Contributors have paid particular attention to a wide range of

sources, which include hospital and patient records, government papers, published medical literature, and memoirs – making this book useful for both scholars and students alike.

Above all, the research described in this volume draws on robust empirical data contained in patient records and institutional archives – sources which have previously been only rarely used in historical studies of psychiatry and mental illness in the 20th century. Indeed, seven of the ten chapters in this book make extensive use of such patient records, as the state and hospital archives in Nordic countries are in an excellent condition, and their in-depth study could significantly contribute to research on mental illness and its history at the international level. Unlike many other countries, where psychiatric patient records have either been destroyed, or where confidentiality and privacy concerns obstruct their use, Nordic hospital records are generally very well preserved and accessible to researchers, and as primary sources they will draw attention to new aspects of social class and mental illness. As a consequence, this volume offers important insights into how patient records can be employed in historical scholarship.[17]

First and foremost, the records reveal how patients were evaluated, diagnosed and treated by staff in the institutions. Secondly, they usually provide valuable information about the life history of the patients, including their family and social environment, upbringing, education (if any), work, the onset of illness and the specific circumstances surrounding the patient when the first symptoms emerged and developed. Thirdly, in several cases there are unsent letters, notes, and sometimes drawings or poems by the patients themselves contained in the records. These provide a more concrete basis for assessing the patients' own perspectives and their mental state – their fears, hopes, delusions, hallucinations, and sometimes their own awareness and understanding of their condition.[18] Fourthly, together with the annual reports of the hospital and other official documents, the patient records allow us to get an overall view of both the everyday functioning of these institutions (treatments, daily routines, social programmes, forms of recreation) and the behaviour of patients – in response to their treatment and towards other people. This behaviour would sometimes, for instance, manifest itself in violence, escape, or attempted suicide.[19]

The regular collection of vital statistics on a national level from the mid-18th century onwards (including statistics on healthcare) has provided Nordic researchers with very valuable quantitative material for historical research on mortality and sickness. Our volume also pays careful attention to specific aspects of mental health policy and practice that have, until now, received relatively little academic attention – such as forensic psychiatry, school psychiatry, and family-based care.

Finally, there is so far relatively little on Nordic practices among English-language publications in the field. At the same time, although the geographical scope of the volume is restricted to 'Northern Europe'[20] (including Britain and Germany), the mental health-care practices discussed, by and

large, strongly resemble those of other European countries and the west. In this respect, a historical study of this region yields valuable insights into the nature of mental health care in general, and the suffering and life histories of mental patients in the western cultural sphere in particular. In the case of our volume, the readers from outside Northern Europe will gain knowledge about the 'management of madness' in this region and be able to make comparisons with their own culture. Our aim is to encourage readers to also consider the issue of social class, both in their own cultural sphere and globally, when examining or discussing mental disorders.

Objectives

This volume starts with two related issues that are examined from the historical perspective. First, we discuss the fundamental thesis that mental illness is related to social class; but how is it related? This deceptively simple issue is approached by studying mental patients who received institutional treatment in the Nordic countries, Germany, and the UK. Making full use of the patient records, we seek answers to the following questions: how social class influenced diagnoses made, treatments carried out, and both the medical and non-medical characteristics attributed to patients in mental hospitals; how criminals, psychopaths, and other 'deviants' were evaluated and managed by mental health experts in Northern European societies; and finally whether the construction of the welfare state changed not only the perception of class in mental health care, but also the perception of deviance – and if so, why?

Second, emphasising the difference between historical and psychiatric studies, the contributors analyse how mental health professionals took social class into account in their work and research. Whereas psychiatric researchers, such as epidemiologists, test for the incidence of prevalence within particular set categories, historians look at how these categories themselves were formed. We thus look at the historical processes within which psychiatric expertise is situated and examine the psychiatrists' apparently transparent groupings, as well the historical contexts of the conclusions they have drawn regarding correlations between social class and mental illness. We approach class, ethnicity, gender, health, deviance, and other variables as context-dependent categories, which are not a sociocultural necessity, but rather a product of historical processes.

Third, the contributors ask how mental health professionals made the connection between social class and mental illness. What kind of markers did they use, and how did these markers change with time? 'Occupational social class', for instance, has been a term frequently used in British studies, but how was this constructed? How have markers such as education, occupation, and gender been evaluated in these studies? With these questions in mind, the chapters in this book look at how society's prevailing assumptions and cultural values are reflected in the psychiatric discussion of mental

illness. Were the patients from a disadvantaged class more likely to be used as a labour force in mental hospitals than middle-class patients? How much did a doctor's awareness of a patient's social background predispose the doctor to a certain diagnosis and choice of treatment? Earlier research has suggested that elements of social construction vary among illnesses; and clearly it seems that some symptoms and syndromes have been more prone to cultural-cognitive variability than others.[21]

When we look at the history of mental health care in Northern Europe, we can find one fundamental fact in it that highlights its class-based character: among the patients treated in public mental hospitals, the majority were working-class. In late 19th- and early 20th-century Nordic countries, the working class consisted of landless rural workers, tenant farmers, and domestic servants, as well as industrial workers. This was because industrialisation in the area started almost a hundred years later than in Britain. Among the Nordic countries, Denmark and Sweden industrialised ahead of Norway and Finland, and within each of these countries there were clear differences between the urban-industrial centres and rural-agricultural peripheries. To understand the peculiar characteristics of mental health care in the northernmost parts of Europe, it is necessary to grasp this unevenness in development both between and within each of these countries.

In this volume, Northern Europe is represented not only by the Nordic countries, but also by Britain and Germany. Unlike the Nordic Countries at this time, Britain was already heavily industrialised by the mid-19th century and the majority of people earned their livelihood in primary production. After its unification in 1871, Germany quickly caught up with Britain, too, and became one of the great powers of Europe and the world, thanks to rapid industrialisation, militarisation, and colonisation of parts of Africa. In this respect, Britain and Germany represent European 'centres' in this volume, while the Nordic countries are on the 'periphery'.[22] What this means in the mental health care context, is that medical authorities in these peripheral Nordic countries were strongly influenced by developments at the centre (i.e. in Germany, Britain, and France). In their efforts to establish institutional health care, Nordic countries wanted to follow the examples set in the centre, and in so doing become civilised and modern. For this reason, the mental asylums established in Nordic countries between the late 19th and mid-20th centuries, had distinct resemblances to those in Germany and Britain, if we discount the Nazi era in Germany (1933–1945), which was clearly far from 'civilised', as Maike Rotzoll's chapter makes clear here.

To better understand the assumptions, theories, and therapies of mental health professionals in Northern Europe, we need to first take into account the different explanatory frameworks that were used when mental health issues were addressed during the late 19th and mid-20th centuries. The first was based on genetics or 'racial hygiene', in which mental conditions were seen to be determined solely by inherited traits that were more or less immune to environmental influences. The second was based on psychology

(or depth psychology), in which patients' suffering was attributed to problems assumed to come from the family, or from other authorities that had an influence on the children. In the psychoanalytic framework, especially, causal links were made between alleged childhood traumas and neuroses with mental afflictions that manifested themselves in adulthood. The third framework was environmental or sociological, which determined that socioeconomic, cultural, and even political conditions should, at least in some respect, be taken into account when discussing mental health problems.

In Nordic countries, it was the first of these frameworks – the genetic – that prevailed in mental hospitals until the post-war era; and it was not until 1945 that the other two frameworks came to the fore. One could argue that today's 'biopsychosocial model' was already in use by the early 20th century, but did not feature so much in asylum psychiatry as in private practices, consultation rooms, child guidance clinics, and private sanatoria – the latter catering for the middle classes suffering from diagnoses such as neurasthenia and 'weak nerves'. In Nordic psychiatry, hereditary factors were clearly seen as the primary factors, while social conditions and family environments were usually seen as the triggers that catalysed the hereditary predisposition to manifest itself.[23] This is actually not so far removed from today's biopsychosocial model in psychiatry, where 'bio' appears to provide the most fundamental explanation for mental problems, and 'psycho' and 'social' (especially the latter) describe the settings in which these problems are likely to manifest themselves.[24]

Structure and themes

This volume is divided into two parts that look at the relations between social class and mental illness from two distinct perspectives. Part I ("Psychiatry, Mental Hospitals and Social Class") focuses on the close link between the socioeconomic status of mental patients and the health care provided for them in public institutions. The chapters in Part I thus examine the various ways in which social class made itself visible, not only on the wards of mental hospitals, but also in the establishment of the very institutions themselves. In Nordic countries, where 'public' referred to both state mental hospitals and publicly funded municipal hospitals, most hospitals were indeed public institutions, and the large majority of mental patients were from the most disadvantaged classes of society. In Britain and Germany, however, where the middle class was much larger and stronger than in Nordic countries, there were also privately run hospitals, clinics and sanatoria. Nevertheless, in both Britain and Germany, public mental hospitals were the backbone of their respective mental health care systems.[25] Thus, while the middle classes may have been overrepresented in the private institutions, in the public hospitals the class proportions by and large reflected the overall class proportions of society as a whole, even if the more privileged patients had access to private care too.

Part I starts with *Petteri Pietikäinen*'s chapter on the early development of psychiatric mental health care in Finland. Like in most European countries, access to health care in Finland was very much dependent on one's wealth in the 19th and early 20th centuries. And as the majority of people in this predominantly agrarian country were poor at this time, the mentally disordered typically lived within the local community, either with their own family, or in receipt of a rudimentary form of municipal poor relief. Pietikäinen's main argument is that the management of mental illness in Finland was very tightly linked to social class. Rather than being just one factor among other significant determinants shaping mental health care in Finland, it was actually intrinsic to the very establishment of public mental health care itself. What this meant in practice was that, until the mid-20th century, most mental patients were from the disadvantaged classes. Why this was the case is the principal question that Pietikäinen addresses in his chapter.

With *Åshild Fause*'s chapter we move from Finland to Northern Norway, and from institutional care to family care. By the early 20th century, a publicly supported family-care system had become the most common form of mental health care in Norway. This household-based care was provided by private individuals, usually farming families, who received compensation from the state for having the mentally ill live in their homes. It was a small-scale, decentralised system that was an informal care system, deeply rooted in the local community and in a tradition that already went back a long way in Northern Norway. Fause examines the socioeconomic status of the mentally ill in Northern Norway between 1900 and 1940 and makes use of case records to shed light on whether medical practitioners in Northern Norway took socioeconomic status into account when they diagnosed their mental patients. Finally, she discusses the ramifications of the fact that the caregivers in this family care system were usually from the same class as the patient they were assigned to look after.

In the chapter by *Vicky Long*, the focus is on class and mental health in post-war Britain. In her analysis, the developments made in 20th-century mental health care would seem to indicate a progressive move to treat all equally and restore citizenship to those suffering from mental disorders; yet on closer inspection, psychiatric hospitals continued to remain underfunded compared to other parts of the National Health Service. Matters worsened as psychiatric deinstitutionalisation gathered pace, fuelling reluctance to invest in resources which were now earmarked for closure. Long argues that deinstitutionalisation failed to provide service users with the same socioeconomic opportunities as everyone else, as psychiatric services remained underfunded and disconnected from social services. While the discourse around deinstitutionalisation promised social inclusion, government failure to assign the necessary resources or leadership to shift care delivery to community-based settings in practice pauperised and excluded many service users in Britain.

Moving to post-war Germany, *Maike Rotzoll* discusses a project in which she and her colleagues studied four mental hospitals in each of the Allied occupation zones directly after the end of World War II. During the war, these hospitals had been converted into centres for killing 'useless mouths' by the Nazi government. Rotzoll examines the dire situation found in these asylums by the Allies when they arrived to occupy Germany, and how it changed over the following years. She points out, first of all, that starvation was still common in the immediate post-war years. Secondly, new forms of treatment, such as electroconvulsive therapy, psychotropic drugs and psychotherapy were gradually being adopted. Third, although patients diagnosed with 'schizophrenia' in its various forms still made up the largest patient group in the asylums, their numbers declined while the number of patients with psychiatric diseases related to old age increased in three of the four asylums under study. Fourth, the changes in the patient groups did not lead to major changes in the distribution of social classes across the asylums' patient populations – class distribution was more or less the same as it was in the general population. This is understandable in the light of the National Socialist era, when diagnosis rather than social class had been a criterion for the selection of mental patients to be murdered. Rotzoll concludes that, by the early 1950s, changes in the four asylums reflected the ways in which they were trying to lose the stigma of having once been killing centres under the National Socialist rule.

Part I concludes with a discussion by *Tuomas Laine-Frigren* about the fate of nearly 80,000 Finnish children transferred to families in Sweden, Denmark, and Norway during the course of World War II. The great majority of these 'war children' travelled back to Finland in the years directly after the war. Laine-Frigren analyses the psychiatric responses to the question of war children, focusing on the period after their homecoming. He pays close attention to the relationship between migration, mental health, and social class as manifested in the efforts of mental health professionals to explain the social maladjustment of war children. He argues that when the profession eventually acknowledged war children as a special group, this came to challenge the more socially prejudiced and/or biology-based explanations of mental illness and health. The way psychiatrists evaluated and assessed many of these children's cases reveals a continuity of older ideas, and many sources show varying degrees of socioeconomic bias. Laine-Frigren shows how the supposedly 'scientific' objectivity of the experts in fact often betrayed a certain social prejudice, lack of understanding, and in some cases simply repulsion, as they described the situation from their own perspective which was very far from the grim reality that the parents of war children often had to face.

Part II ("Psychiatry, Crime and Deviance") looks at specific social groups that had either committed crimes or were socially disadvantaged and thus marginalised in terms of their socioeconomic status and political rights. Some groups were subjected to forensic psychiatric examination due to

criminality, vagrancy, prostitution and other indications of what educated elites and experts saw as 'social maladjustment'. The diagnosis of psychopathy conveniently incorporated much that was regarded as socially harmful, and psychopaths – at least those held in institutions – typically represented the lower echelons of society. Furthermore, to be woman was in itself a disadvantage, and it was doubly so if you were a lower-class woman with a record or reputation of being maladjusted or morally insane. Thus, the question of gender and its relations with class is also addressed in Part II.

In his chapter on social class and drug addiction in European psychiatry, *Jesper Vaczy Kragh* shows that in the late 19th century, drug addiction (opiate abuse) was associated neither with young people of a lower socioeconomic status, nor with schizophrenia, as it is today. Rather, opiate addiction was seen as the disease of middle aged, affluent people, who were not psychotic. His chapter explores the emergence of drug addiction, especially morphinism, in German, French, and Danish psychiatry. A change in diagnostic procedures occurred in the early 20th century, as more drug abuse patients of a lower social status began to be admitted to psychiatric clinics and hospitals, and social class issues clearly played a significant role in psychiatric diagnoses during this era. Psychopathy was often associated with drug addicts of a lower socioeconomic status, but hardly ever with those addicts who were themselves doctors. Drug abuse was also controlled in different ways depending on the addicts' social status. In recent decades, the drug problem has reappeared in psychiatry, but when compared to the early 20th century, the social profile and diagnosis of patients are quite different today.

In the following chapter, the focus moves from drug addict mental patients to those diagnosed as psychopaths and 'querulants' in Sweden. *Annika Berg* examines the use of these two diagnoses in Swedish psychiatry during the 1930s and 1940s. In these decades, the concept of psychopathy was employed to specify a number of constitutional 'abnormalities' that hovered somewhere on the borderline between sanity and insanity. The diagnosis for querulants – *paranoia querulans* – on the other hand, was used to explain an excessive urge to challenge authorities, file lawsuits, or litigate that was thought to no longer be a sign of normal anger, but of mental illness. Her study shows that the very nebulousness of these diagnoses made it difficult for patients categorised as psychopaths or querulants to be permanently released, and nigh on impossible for them to be declared sane. This was especially true of psychopaths, as the basis for their diagnosis was thought to be constitutional, and so they were not expected to get better. For working-class women diagnosed as psychopaths, notions of gender and class would often prove to be a toxic combination that would work against them in their appeals.

The next two chapters discuss forensic psychiatry. In the first, Jesper Vaczy Kragh and Petteri Pietikäinen focus on criminal patients and forensic psychiatry in Denmark and Finland in the early decades of the 20th century. Kragh and Pietikäinen explore the crimes that were committed in

these social contexts by examining patient records from a Danish high security unit and Finnish mental hospital, paying special attention not only to the psychiatric assessments of the patients in these two institutions, but also their social class. The first conclusion they arrive at is that forensic psychiatry in both these Nordic countries was predominantly concerned with crimes committed by the lower classes; the second is that the socioeconomic and cultural contexts of crimes committed by persons of unsound mind were, due to their complexity, open to quite different interpretations regarding guilt and responsibility. Contextualising these crimes helps better understand the ways in which desperation, deprivation, and lack of social and psychological support led to acts which, although clearly against the law from the legislative perspective, were less clear and more ambiguous when seen from the moral.

In the next chapter, *Maria Antonie Sæther* examines the history of Norwegian forensic psychiatry. Her analysis focuses first on the forensic psychiatric assessments of female patients at Østmarka Asylum from the late 1930s through to the late 1960s. She looks in particular at the ways in which psychiatrists portrayed their socioeconomic status by taking into account the patient's educational background, occupation, as well as their parents' occupations. She then compares these factors to the social backgrounds of male patients at the Norwegian Criminal Asylum in Trondheim. Sæther remarks how the psychiatrists' understanding of female mental health seemed to be related to the notion of gender- specific 'respectability'. The sexual behaviour of female patients was prioritised and scrutinised even when their crimes were non-sexual. In particular, open displays of female sexuality were clearly perceived as somehow being violations of the norms of feminine respectability. The forensic assessment processes at Østmarka represent cross-class encounters in which a male psychiatrist's conception of a normal woman was most likely influenced by the (or at least his) middle-class ideal of femininity. Her chapter contributes to the research on how psychiatry used information relating to social class in the forensic psychiatric assessment process – in this case middle-class respectability.

In the final chapter of the volume, the tone changes as we move from forensic psychiatry to a new, reformist, and radical approach to the control of deviants in the 1960s. In their analysis of a Finnish SMO – the 'November Movement' (ML) – *Mikko Myllykangas* and *Katariina Parhi* have conducted a case study of a group of radical intellectuals that aimed to change the ways society treats deviant individuals in a developing welfare state. Defining 'deviant individuals', such as mental hospital patients, children in reform schools, prisoners, sexual minorities, and the homeless, as their target group, the ML argued that the Finnish politics of control in place at the time was irrational and inhumane. As the majority of these deviant individuals belonged to the most disadvantaged classes, the ML viewed established psychiatric practices and control policies as a means of consolidating the status quo. Through public actions, press campaigns, and statements, the

ML significantly influenced the ways in which deviance was discussed and managed in Finnish society. Consequently, social class became an essential factor in explaining a wide range of mental disorders and other conditions in Finland. Furthermore, by presenting data about Finnish society and by disseminating international literature on the correlation between socially disadvantaged groups, deviance, and mental health problems, the ML paved the way for others to campaign for societal changes to come in the future.

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To sum up, *Social Class and Mental Illness in Northern Europe* presents a rich variety of empirical material as well as methodological and theoretical approaches to the topic. At the same time, it never loses its focus on social class as a key factor that must be taken into account when mental illness is examined and explained, both in a historical context and now. This volume aims to fill a historiographical gap and to serve as an inspiration and example for future researchers studying other regions in Europe and beyond.

Notes

1 See the World Health Organisation's position: www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/
2 Wilkinson & Marmot 2003; Marmot 2004; Wilkinson & Pickett 2010; Wilkinson & Pickett 2018.
3 de Haan & Kennedy 2005, 428. See also Kritsotaki, Long & Smith 2016.
4 Dahl & Birkelund 1997.
5 Perhaps the most striking testimony to health inequality prevailing in a welfare society was revealed when the so-called Black Report was published in the UK in 1980. This document demonstrated that, despite the overall improvement of health across the country with the introduction of the National Health Service after World War II, health inequalities remained widespread, and the main cause for this was seen to be economic inequality. What was most alarming for authorities and experts was not just that the mortality rate for men of a certain age in the lowest social class was twice as high as the rate for those of the same age in the highest, but also that the gap between these two socioeconomic groups was not getting smaller as had been expected; instead it was actually getting bigger. *Inequalities in Health* 1992.
6 Faris & Dunham 1939.
7 Hollingshead & Redlich 1958. See also Leighton 1959; Srole, Langner, Michael, Opler & Rennie 1962; Langner & Michael 1963; Myers & Bean 1968.
8 Pinto-Meza 2013.
9 On the historiography of psychiatry see Micale & Porter 1994.
10 Andrews & Digby, 2004; Metzl 2009; Gründler 2013; Raz 2013; Hide 2014. In comparison with our volume, Hide's book has a different approach with its analysis of only two London County asylums. The period after World War II and transnational perspectives are not explored in her study. Gründler's study on the relations between poverty and madness in the practices of social welfare in the late 19th and early 20th-century Scotland is highly relevant for our volume.
11 Andrews & Digby 2004, 13.

12 Hubert 2001 is a study of social and physical exclusion from society from a multidisciplinary perspective, including archaeology, anthropology, disability studies and psychiatry. On deinstitutionalisation, see Kritsotaki, Long & Smith 2016; on migration and mental health, see Harper 2016.
13 Scull 2006, 377–379.
14 Engstrom 2008; Hess & Majerus 2011, 141–142. See also Laine-Frigren, Eilola & Hokkanen 2019.
15 On the status of current psychiatric epidemiology, see *International Journal of Epidemiology*, Volume 43, Issue 2, April 2014; Susser, Schwartz, Morabia & Bromer 2006.
16 Pietikäinen 2007; Laine-Frigren, Eilola & Hokkanen 2019.
17 The use of patient records as a source for historians is usually dated back to Erwin Ackerknecht article A Plea for a 'Behaviourist' Approach in Writing the History of Medicine (Ackerknecht 1967). Since then, a substantial amount of literature on medical history and patient records has been produced, e.g., Risse & Warner 1992; Noll 1994; Edwards 1998.
18 For more on the patient's perspective, see Porter 1985; Condrau 2007; Bacoppoulus-Viau & Fauvel 2016.
19 For a thorough discussion on the benefits and pitfalls of using psychiatric patient records, see Edwards 1998.
20 Northern Europe usually includes the Netherlands too; for historical perspectives on the Dutch mental health system, see Gijswijt-Hofstra & Porter 1998; Boschma 2003; Gijswijt-Hofstra, Oosterhuis, Vijselaar & Freeman 2005.
21 Pietikäinen 2007; Bringedal & Tufte 2012.
22 On international perspectives on centre-periphery relations in psychiatry, see Müller 2017.
23 This becomes clear when one leafs through the volumes of the journal *Acta Psychiatrica & Neurologica Scandinavica* (founded in 1927).
24 Boyle 2011; Pilgrim 2015.
25 Berrios & Freeman 1991; Engstrom 2004; Schott & Tölle 2006.

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