Erotic Insanity
Sex and psychiatry at Vadstena asylum, Sweden 1849-1878

Imelda Helena Ek

Academic dissertation for the Degree of Doctor of Philosophy in History of Ideas at Stockholm University to be publicly defended on Friday 24 November 2017 at 13.00 in Auditoriet, Humanistvillan, Frescativägen 24.

Abstract
The early nineteenth century saw the emergence of institutional psychiatry across Europe. Aware that Sweden had fallen behind in this development, Parliament decreed in 1823 that a number of specialised institutions for the care of the insane were to be established. The Vadstena asylum, opened in 1826, was the first such institution in Sweden.

The aim of this study is to examine medical interpretation of and responses to erotic behaviour in psychiatric practice at the Vadstena asylum in the period 1849-1878.

The book places the theme of the erotic, a topical subject in nineteenth-century public debate, in the context of psychiatry as an emerging specialty in Sweden. The book explores how erotic behaviour was conceptualised as disease, and the nature of therapeutic intervention in erotic cases, in order to present a more nuanced image of nineteenth-century medical attitudes to sexuality. By highlighting the superintendency of physician Ludvig Magnus Hjertstedt, and linking his account of an 1845 study tour through Europe to medical practice at Vadstena, the study situates responses to erotic patients in a period when psychiatry claims authority over human sexuality.

In methodological terms, the study applies critical questions inspired by revisionist scholarship to a body of empirical source material. Focusing on a single institution, and conducting in-depth readings of case notes – with regard to language, form, and function – allows the study to highlight the everyday practice of the asylum physician in his encounters with male and female erotic patients, including the use, importance and diagnostic integrity of the concepts nymphomania, erotomania and masturbation. Hjertstedt’s travel journal provides insight into the physician’s medical philosophy, informing the analysis of diagnostic and interpretive procedures, while connecting medical practice at Vadstena to its European paragons.

The results indicate that while the use of specific diagnostic terms to describe erotic behaviour was infrequent, therapeutic and managerial intervention shows that sexual acts and expressions of desire were considered disturbing and dangerous symptoms in both male and female patients. The analysis thus makes visible a gap between psychiatric theory and asylum practice, emphasising uncertainties and complexities inherent in the latter. While erotic behaviour could be considered indicative of illness, it might also be interpreted as a lack of character or a result of insufficient moral instruction. The asylum’s regime of work and moral instruction was designed to restore health as well as sound values and appropriate behaviour in its patients, indicating a medical culture at Vadstena which was both curative and normalising.

Keywords: history of psychiatry, history of medicine, asylums, moral treatment, medicine and society, history of sexuality, nineteenth century, Vadstena, Ludvig Magnus Hjertstedt, Georg Enгрström, Gustaf Göthlin.

Stockholm 2017
http://urn.kb.se/resolve?urn=urn:nbn:se:diva-146255


Department of Culture and Aesthetics
Stockholm University, 106 91 Stockholm
EROTIC INSANITY
Imelda Helena Ek
Erotic Insanity
Sex and psychiatry at Vadstena asylum, Sweden 1849–1878
Imelda Helena Ek
To Isobel, light of my life.
Contents

Acknowledgements 3

Introduction 5
  Aim and research questions 6
  Methodology and sources 6
  Theoretical concepts: Power, discipline and medicalisation 10
  Previous scholarship 16
  Outline 21

Prologue: Swedish lunacy reform and the European context 23

1. The Physician-Traveller 32
  Doctors abroad 35
  Public and private institutions 39
  Hjertstedt, John Conolly and the non-restraint movement 42
  Beauty, order and comfort 48
  Conclusion 52

2. The Aetiology of Erotic Insanity 54
  Erotic and sexual causes 54
  Disappointed love 60
  Anger, pride and lust 62
  Social causes 63
  Heredity 66
  Harmful stimuli 68
  Conclusion 71

3. Nymphomania 73
  Labelling the Erotic: Describing Nymphomania and Satyriasis 74
  The Origin and Seat of Nymphomania 82
  The boundaries of decency 86
  Cases of nymphomania 90
    Hildegard C, admitted in first class, August 28th, 1859 90
    Anna J, admitted in third class, 18th February, 1870 93
  Conclusion 103

4. Masturbation 106
  “Suspected onanist”: Descriptions of masturbating patients 109
  Diagnosis and prognosis 111
  Masturbation as moral and medical issue 117
  Female masturbation 122
  Cases of Masturbation 127
    Carl P, a farmer, admitted in 3rd class, August 3rd 1868 127
    Karl W, admitted in 3rd class, 26th of June, 1888 129
  Conclusion 131

5. Erotomania 134
  Love as source of joy and cause of disease 135
  Erotic symptoms 141
  Silences and omissions 145
  “Fancies” – erotic and religious symptoms 146
  Irregular sexuality 150
Case of Love Madness 153
Fredrika S, admitted in 1st class, 29th of January, 1892 153
Conclusion 156

6. Treatment and management 158
Psychological treatment: Building the curative asylum 159
Work as treatment 164
Mechanical restraint 168
Somatic treatment 174
The role of the physician 180
Patients on treatment 183
Conclusion 185
Table A. Medicinal treatments used at Vadstena asylum in the period 1826-1890 188

Results and concluding analysis 191
Coda 202
Summary in Swedish 203
Works Cited 210
Index 230
Acknowledgements

On my first day at Northumbria University back in 2003, I decided that I was going to try and stay at university for as long as possible. There was something about the environment, about the sense of possibility, about realising just how much there was to learn that made me dizzy with excitement. Fourteen years later, I still feel that way.

My time as a PhD candidate has been spent in the Department of Culture and Aesthetics at Stockholm University. It has been a privilege to work, learn and grow in such a stimulating environment, and with so many inspiring scholars around.

First of all, my heartfelt thanks go to both my supervisors. As my main supervisor, Professor Elisabeth Mansén has applied her wide-ranging knowledge and experience and her keen eye to countless chapter drafts with admirable patience. Her genuine enthusiasm for the subject matter of my thesis has opened up new avenues of inquiry, and encouraged me to trust my instincts and skills. My second supervisor Karin Dirke has an uncanny ability to identify the weakness in any argument, and the fluff in any text. Her constructive and perceptive readings have helped me to structure, formulate and present my ideas, while providing much-needed encouragement and support. I would also like to thank all past and present participants at the research seminar in The History of Ideas at Stockholm University, for providing their insight to my texts at various stages throughout the process.

Working on a doctorate can be a lonely and somewhat bewildering experience, and it would have been even more so without my fellow PhD candidates in the department. Thank you to Emma Hagström Molin, Matts Lindström, Johan Fredrikzon, Isabelle Ståhl, Lydia Wistisen and Hilda Jakobsson for taking the time to read drafts of my work and provide insightful feedback, as well as sharing advice and encouragement along the way. Some colleagues become more than just associates, and some of the best, most interesting, challenging and hilarious conversations and exchanges during the last five years have been had at the lunch table, in the hallways and over pints at the pub. Linn Holmberg, Annika Berg, Staffan Bergwik and Daniel Strand are the coolest friends anyone could wish for.

Thank you to the administrative staff at Humanistvillan, and especially to Polly Hsu, Mia Åkestam and Magdalena Hernow who have always been on hand to help out with the administrative and practical side of work. You have saved my sanity on many occasions.

Furthermore, I would like to thank Cecilia Riving for her insightful and meticulous reading of the first full draft of my thesis. Recieving detailed advice from another historian of psychiatry at that crucial point in time was absolutely essential. Staff at the Regional Archives in Vadstena, the Swedish National Archives at Marieberg and the Stockholm City archives have taken an interest in my research and been enormously...
generous with their expertise in acquiring and deciphering a wealth of writing by
nineteenth-century doctors. Thanks to Mathias Liebing, who gave me permission to
use his beautiful and evocative photograph for the front cover, and to Andy Redfern
for your meticulous proofreading of my final manuscript. A special thanks also to Jim
Löfgren at Östergötlands museum who provided images for this book at the eleventh
hour, and to Sverker Högborg, for telling me the story of his grandfather, attendant at
the Vadstena asylum around the turn of the last century, and for providing me with
additional sources. Finally, the thesis support team at the Stockholm University
Library have contributed their technical expertise to the layout and formatting of this
book, and I couldn’t have done it without them.

Curiously, my life seems dotted with men whose names start with J, and three of
them deserve a special mention for their part in making this book happen. Thank you
Jesper, for convincing me to apply for a PhD position when I was convinced I didn’t
have a chance of getting it. You believed in me when I could not, and that made all the
difference. Thank you John, my constant office-companion for the past five years, for
your constructive feedback on my work, our chats about life, parenting and politics,
and most of all for your unfailing kindness. And thank you Jens, shekh ma shieraki
anni, for all your help and (tech-) support. Your love has strengthened me in ways you
don’t even know. A final thanks goes to my friends, who lit the way on stormy seas,
and provided tea, laughter and musical entertainment when my morale was failing.
You know who you are.

Look Isobel, mummy’s book is finished! Maybe some day when you’re older you
will care that I dedicated it to you. I love you more than ice cream and rainbows.

Imelda Helena Ek
Stockholm in July 2017
Introduction

Erotic Insanity is a project concerned with the earliest beginnings of psychiatry in Sweden, highlighting the central and problematic position of sexuality in nineteenth-century society. It is a study of doctors, their interpretation of irregular behaviour and the growth of a medical specialty. It is also, however, a study of words, stories and language. Finally, it is concerned with men and women who became patients; individuals whose conduct was perceived as being “erotic” as well as “mad”. When the first seeds of Swedish psychiatry were sown in the form of a government act in 1823, physical institutions were the first to materialise. At the time, Sweden had no legislation regulating the admission of insane persons into care and treatment, no official classification system of the various types of mental illness, no instruction in the contemporary doctrines of psychiatry within medical education in universities, and as a result no doctors specialised in the field. However, in 1826, the Vadstena county asylum for the insane was established as the first institution devoted exclusively to the care of the unsound of mind. The position was advertised three times and received no applicants before the physician to the venereal hospital at Vadstena, Georg Engström, was personally approached by the Board of Directors. Engström agreed – somewhat reluctantly – to become superintendent. Thus, the first Swedish asylum came into being. Psychiatry, in the sense of an established medical discipline devoted to the study, diagnosis, treatment and prevention of mental disorders, was yet to develop. Ludvig Magnus Hjertstedt, whose period of service coincided with the establishment of practical psychiatry in Sweden, was appointed to the post of assistant medical officer at Vadstena in June 1840. He succeeded Engström as superintendent in 1849, and would remain at Vadstena until his death in 1878.

Erotic Insanity deals with a period during which what we perceive as psychiatry was very much in its nascent phase: its doctrines of knowledge, its experience of practice, its treatments and prognoses. It is the period during which psychiatry comes to address and claim authority over the dominion of the erotic, seeking, as part of its self-defining process, to define in medical terms the boundaries of male and female normative sexuality, and in doing so giving rise to a new category of patient. Aware of their lack of experience, the Swedish Board of Health sent physicians abroad to study renowned asylums and practitioners, and to return home with proposals, ideas and recommendations for the amelioration of the emerging Swedish asylum system. What follows is a micro-study of eroticism as it was interpreted in one asylum, and its role in the creation of psychiatric knowledge through practice.
Aim and research questions

The aim of the study is to examine the interpretation of, and responses to erotic behaviour in medical practice at the Vadstena asylum during the period 1849-1878. The statement of intent may be broken down into the following main research questions: How do interpretations of, and responses to, erotic behaviour at Vadstena relate to contemporary European psychiatry in theory and practice? How is erotic behaviour explained in aetiological terms? How, and to what extent, was erotic behaviour framed and treated as disease in the case records from Vadstena?

Methodology and sources

The first fifty years following the 1823 act were crucially formative ones. They mark the beginning of Swedish institutional psychiatry, as well as the historical period where medicine began to make sex its business. The asylum at Vadstena was the first of its kind, and would remain the largest in terms of patient numbers until 1885. 1 The choice of Vadstena as an object of study is also based on the quality and quantity of records; its patient files are the first to follow official directives for case-keeping and admission procedures. The only such institution in Sweden at the time, its patient records are available, preserved in good condition and adequately organised, from the asylum’s establishment in 1826. A number of patient letters were previously archived among the Vadstena documents, but regrettably appear to have been removed by archivists.

The period upon which this study is based encompasses the superintendency of Ludvig Magnus Hjertstedt, who began his career at Vadstena in 1840, and served as head medical officer of the asylum for almost thirty years, from 1849 to 1878. The cases featured in this study have been selected from the asylum’s admission records, now held at the regional archives in Vadstena, a stone’s throw from the former site of the asylum itself. Hjertstedt’s journey through Europe and consecutive reforms of the daily management of the asylum make his working years a fascinating and previously unexplored period for study. A full survey of patient admissions to Vadstena during the period has been conducted, identifying cases

- where the cause of illness was believed to be masturbation, sexual excess or love.
- where symptoms were of an explicitly erotic or sexual nature.
- where the terms nymphomania, satyriasis, erotomania or masturbatory insanity were used as a diagnostic labels.

1 Bidrag till Sveriges officiella statistik, K) Helso- och sjukvården II, Underdämnig berättelse för år 1885, 1, 17.
To indicate patterns of change or consistency over time, one sample of patient files from Georg Engström’s superintendency (patients admitted in the years 1830-1835), as well as one from Hjertstedt’s successor Gustaf Wilhelm Göthlin (patients admitted in the years 1890-1895) have been included in the material.

The conceptualisation of erotic behaviour as pathological, and the labelling of such behaviour with specific diagnostic terms originated in the medical literature of the first half of the nineteenth century. Academic medical texts, treatises on sickness and health for domestic use, medico-moral pamphlets and books on etiquette all contain advice on how to engage in physical relations without causing harm to one’s health, but it is in the pages of psychiatric journals and textbooks, as well as in asylum practice that these new disease categories are created. The concept of nymphomania has been described as a way of interpreting and labelling female insanity intimately connected with the widespread ideal of nineteenth-century femininity. The male form of the same condition, satyriasis, is noted in early psychiatric treatises, but is even there regarded as very rare, and appears not to have been used in practice. The true male equivalent to nymphomania as a concept both moral and medical was masturbatory insanity. Both diagnoses had a limited life span in psychiatric theory, and had largely been abandoned as diagnoses by the end of our period. Scholarly works on concepts such as nymphomania, satyriasis, masturbation and erotomania have typically not engaged with asylum records to explore their use in medical practice. Based on the assumption that the creation of psychiatric knowledge was a two-way process – medical theory influenced practice, and practice contributed to new theoretical knowledge – _Erotic Insanity_ seeks to elucidate medical interpretations of erotic behaviour. The wide-ranging term “erotic behaviour” is used in order to include a range of symptoms perceived, by patients’ families and people in their immediate surroundings, to warrant committal to an asylum, and to ensure the inclusion of both male and female patients.

Prior to analysis and discussion regarding the function of the case record, it seems prudent to first clarify what the case record is; that is, dwell for a moment on its form and its different components. These components will be presented in two groups: those that were composed prior to admission, and those that were authored within the asylum walls. The reason for this being that each group shares a common function, and furthermore these documents are archived in this manner; admission documents together by year in boxes, and patient histories in casebooks by date of admission and patient number. It is worth noting that not all certifying letters were written on the official form, but where this is not the case, the certifying officials have nevertheless

---

provided answers to the prescribed questions, often in the specified order, suggesting that a form was used as a template. For each patient included in this study, the following documents exist:

Pre-asylum, “admission” documents:

- Medical certificate, Litt. A
- Clerical certificate, Litt. B

Although their authorship is diverse – even more so if we consider the providers of information as co-authors – these documents all communicate the express wish that a person considered insane be admitted into a medical facility. The minister’s letter is above all a source for family testimony of the patient’s illness, and provides an insight into the attitudes of the patient’s community toward them. It is unusual for ministers to add personal information not related by the family, even when the patient is someone well known to them (which is often the case with patients from rural areas). Any behaviour perceived as deviant will be recorded here; from violence and threats to singing, undressing and running away from home.

The second group consists of the internal asylum documentation, the case note, containing:

- Patient’s details.
- Diagnosis.
- Summary of information provided in admission documents.
- Continuous updates on the patient’s condition.

While much more uniform in authorship (written by doctors, for doctors), the case note is somewhat ambiguous in its purpose. On an everyday basis, the casebook – that is, the bound volume in which each patient’s case note was composed – would have served as a medical officer’s almost diary-like record of a patient’s progress or decline. At least that appears to have been the intention. The keeping of a casebook was required by the 1828 Act on the care of lunatics and written into the official instruction for the physician’s post.\(^3\) Although the form of the case note was not officially stipulated until 1859, the Vadstena case notes are consistent in form and appearance throughout the period, making comparison possible on a number of points and over time. What was, to the doctor, a continuous charting of an individual’s progress or decline and the record of treatment and behaviour within the asylum is to the historian a valuable record of the interpretation of symptoms, of medical ideas at work, and of the continuous production of medical knowledge. Although rarely articulated, the physician’s ideas and attitudes can be interpreted between the lines of the case note, in the spaces and silences as well as in his selections and interpretations.

\(^3\) CA FIII:1 Instruktion för Hospitals-Läkaren i Wadstena, 15/6 1826.
In this thesis, the admission documents are studied concurrently, although in less depth than the case notes, in order to identify acts of selection and interpretation on the part of the asylum physician.

The discovery of an additional primary source, the travel account of Vadstena physician Hjertstedt, has added another dimension to the study. In 1845 Hjertstedt received funding from the Board of Health to conduct what amounted to a study trip: a journey through England, France, Germany, Italy, and Belgium with the express instruction to visit asylums and compile a report of his observations. The finished report, in a bound volume comprising roughly 300 pages, contains detailed information of the history of the asylum system, its legislation and development in the early nineteenth century for each of the countries visited, and ends with a brief afterword in which Hjertstedt outlines his suggestions for asylum reform in Sweden, based on his observations. England was the first destination on Hjertstedt’s itinerary, and the section recording his visit there is both longer and more detailed than the ones that follow. Due to Hjertstedt’s personal bias in favour of the English system, this section of the travel account will be emphasised in the following study. The express intention of Swedish medical authorities to reform psychiatry in accordance with European models warrants the inclusion of such a document, which will allow for an examination of how medical ideas were received and used in practice. Hjertstedt’s own ideas on matters of medical practice, and his personal standpoint in contemporary psychiatric debates are discernible in his descriptions of medical practice abroad, making the travel journal a useful supplementary source.

The sources employ a set of terms and expressions with reference to psychiatric patients, which may appear provocative to the twenty-first century reader. These include both general terms such as “insanity”, or “the insane”, and diagnostic terms such as “dullness”, “idiocy” and “imbecility” or *imbecillitas*. The language and definitions of the past are integral parts of the context in which they were used. By making use of such terms in this thesis I wish to acknowledge the categorisation made in the source material from Vadstena, and the implications that said categorisation

---

4 As Risse and Warner have observed: “Converting complex clinical perceptions of illness into written narratives involves both selection and interpretation; and although intended to lay bare the course of illness and therapy, much else is often revealed.” Guenter B. Risse and John Harley Warner, “Reconstructing Clinical Activities: Patient Records in Medical History”, *Social History of Medicine* 5 (2), 1992, 183-205, 189.
5 Sw. Sundhetscollegium.
6 Sw. Vansinne, dårskap.
7 Sw. De vansinniga, därarna.
8 Sw. Slöhet.
9 In these cases, the Swedish sources use the Latin terms *idiotia* and *imbecillitas*, as well as the more vernacular Swedish *svagsinthet* and *fånighet*. 
would have had for the doctors, the patients and their immediate environment.\(^{10}\) The title of my thesis – *Erotic Insanity* – is not a diagnostic term taken from the Vadstena case histories, but rather an umbrella concept used in Swedish and British theoretical psychiatry. I will be employing it to refer to a group of patients described by the Vadstena physicians as “erotic”, “lewd”, “indecent”, or as suffering from “romantic delusions”.\(^{11}\)

**Theoretical concepts: Power, discipline and medicalisation**

This study takes as its standpoint what has been called a post-revisionist stance.\(^{12}\) It emphasises the perspective of a single institution during a limited time period, placing the records of medical practice at the heart of the project. The research questions are inspired by a significant body of critical scholarship on power, discipline and medicalisation, the so-called revisionist tradition, which has dominated the field of psychiatric history since the 1960s. Applying such questions to case records from Vadstena will permit me to connect far-reaching discourses on power, discipline and medicalisation to the everyday medical practice of the asylum.

By definition, illness of any kind is an “other” state; outside of and deviant from an assumed healthy ideal which we call normality. Such a definition presupposes some form of power; something or someone that determines the boundaries of the normal, thereby also defining the abnormal and pathological, confining it to the area of medicine. Thus, the theme of power necessarily permeates the history of psychiatry, and this thesis.

In 1981, historian Michael MacDonald stated that anyone writing about the history of insanity in Early Modern Europe “must travel in the spreading wake of Michel

---


\(^{11}\) Sw. Erotisk, lederlig, oanständig, kärleksgriller.

Foucault’s famous book, *Madness and Civilization*. More than 35 years later, the lasting impact of Foucault and the revisionist school on the discipline has been such that any attempt to write about the history of insanity or psychiatry in any era must necessarily declare its position in relation to that tradition. Published in 1961, *Madness and Civilization* has been viewed as the starting point of modern psychiatric history. Abandoning the tradition of celebratory narratives of progress, great physicians and institutions, Foucault instead conducted an analysis of psychiatry as an instrument of discipline and control, delivering a searing critique of early psychiatric institutions and practitioners. Rejecting enlightenment and humanism as well as medical progress as driving forces behind the emerging asylum system at the end of the eighteenth century, Foucault emphasised the expulsion and incarceration of madness as a means of maintaining order. He viewed the asylum as an instrument of both physical and moral discipline, under the authority and strict surveillance of the physician. The revisionist tradition emphasised the power of the physician or alienist within the institution. In his early works *Madness and Civilization, The Birth of the Clinic* and *Discipline and Punish* Foucault describes power as residing within the institutions themselves, rather than with individuals which run them. Simultaneously, the image of the asylum physician as a figure of absolute paternal authority is prevalent in *Madness and Civilization*. For Foucault, the asylum, the clinic and the prison all embodied a disciplinary power that used surveillance as a corrective tool for deviant bodies. In the words of David Armstrong:

> Instead of the King’s power being used to brutalize the body of the offender, the new power sought to appraise and transform the body in its charge. In the prison and the hospital, bodies were observed and analysed with the purpose of effecting a passive and malleable body, but at the same time establishing those bodies as individual and discrete.

Foucault’s concept of power is notoriously elusive; he himself remarked that the only thing that could be said about power in general terms was that it is a flexible, more or less coordinated “cluster of relations”. Emphasising the limitations of general theo-

---

ries of power, his work focused more on analysing how power worked in different settings. Hence, disciplinary power, which is a central theme in *Madness and Civilisation* and *The Birth of the Clinic*, should not be read as a simple top-down power relationship. In *The History of Sexuality*, Foucault explains:

> Power’s condition of possibility [...] must not be sought in the primary existence of a central point, in a unique source of sovereignty from which secondary and descendent forms would emanate: it is the moving substrate of force relations which, by virtue of their inequality, constantly engender states of power, but the latter are always local and unstable.17

In this study, I view the asylum as an essentially disciplinary institution, recognising its mechanisms as being designed to internalise control, making the patient responsible for self-discipline. Foucault’s philosophy of power in psychiatry was developed in his lectures at the Collège de France in 1973-74, where he dwelled on the formation of psychiatry as a medical specialty. He points out that early psychiatry was more a moral than a medical practice, and that its formation as a field, and the asylum as an institution, was linked to the needs of nineteenth-century society.18 The discrepancy between psychiatric theory and practice highlighted in those lectures further inspired this project. Unlike Foucault and the revisionists, I have sought to write a history of medical practice at Vadstena where the humanitarian ideas of the medical profession and authorities are taken into account. Power and humanism, care and control are not seen as contradictory concepts, rather the assumption is that the tension between them was a defining aspect of nineteenth-century asylum practice.19

Foucault was not alone in challenging historical optimism. The first two years of the 1960s saw the publication of three academic works which offered similar perspectives on psychiatry: Erving Goffman’s *Asylums*, R.D. Laing’s *The Divided Self* and Thomas Szasz’s *The Myth of Mental Illness* further challenged the status of psychiatry as a science, and emphasized its hegemonic status and oppressive practices.20 Although different in intellectual style and origin, these four works have been described as the foundation of revisionist history of psychiatry. During the course of the 1960s the analyses of Goffman, Laing, Szasz and Foucault would combine with Marxist psycho-

---

logies, critiques of psychoanalysis, critical feminist theory and the psychiatric patients’ liberation movement to form an influential anti-psychiatry movement21, as well as inspiring a wealth of subsequent scholarship from various academic disciplines. Proponents of the anti-psychiatric movement claimed that mental illness itself was a myth, constructed to legitimise control of deviant elements in society. Such radical denunciations have largely disappeared from modern scholarship, and the constructivist current, which has remained strong in psychiatric history in the last two decades, is largely influenced by the more reflective work of philosopher of science Ian Hacking.22 The work of sociologists such as N D Jewson undermined the assumption that medical knowledge was discovered, arguing instead that the emergence of pathological medicine was not due to discovery but creation.23

The constructivist approach which often accompanied revisionist histories questioned categories which had previously been viewed as objective and static, re-examining medicine, gender, race and madness itself. Psychiatric illness differs from its somatic counterpart in that it is inherently social: it is made visible in the behaviours and communication of the sufferer.24 As such, it is both a medical and a social issue, and the parameters for what constitutes irregular or deviant behaviour shift and alter over time. The constructivist assertion that psychiatric illness is partially cultural in its construction does not necessarily deny the experience of the individual sufferer, but rather the aim is to understand how symptoms, behaviours and interpretation vary in accordance with the ideas prevalent in contemporary society.

Building on the constructivist idea, feminist historians of psychiatry went on to show how, like gender, madness is a culturally formed category, establishing a vibrant and productive research field in its own right since the 1970s.25 Following Foucault, feminist historians of psychiatry criticised the tradition of associating femininity with

21 Ibid., 8.
unreason, and emphasised the repressive nature of psychiatry in pathologising the female body and mind. Later feminist histories have largely abandoned the emancipatory agenda in favour of a gender analysis which takes into account the experience of both male and female patients.

The analyses of feminist historians of the relationship between gender and madness have proved influential in informing my research, especially with regard to the study of nineteenth-century gender norms and how they permeated medical understanding of health and illness. Cultural perceptions of masculinity and femininity determine what is considered deviant and other, manifesting as expectations of behaviour. This has been especially important as the patients featured in this project are defined as erotic, implying a deviance from sexual morality, in a period where sexuality has been identified as an area of special interest to medical science.26

Since the 1990s a new current has been discernible in the history of psychiatry, which may be viewed as a reaction against the revisionist school. The contributors to what has been termed the post-revisionist tradition have taken issue with the theories and outright political agenda of the revisionists.27 Writing in 1994, Roy Porter and Mark Micale argued that such scholarship tended to be unreflective regarding its own political mindset, and that ‘its demystifications of Whig idealizations have often only generated “heroic” neo-Marxist and Foucauldian remystifications’. 28 Critiques of Madness and Civilization have to a great extent focused on Foucault’s lack of empirical thoroughness, with Porter, a self-confessed admirer of Foucault, stating that: “Foucault’s revisionism cannot, however, be more than partially accepted, for it does not fit the facts, at least not for England.”29 The recent (primarily Anglo-Saxon) post-revisionist tradition has sought to free itself from the anti-psychiatric legacy of the discipline, and temper what has been viewed as an overly ideologised approach. By undertaking detailed empirical studies that remained close to the primary material, historians endeavoured to nuance the image of alienists and institutions, and to place

their practice in a broader socio-political context. Driven by an interest in the role played by family in the care of the mentally ill, as well as by a scepticism of the authority previously ascribed to the alienist, many post-revisionist historians have in recent years moved away from the asylum as the primary object of study, focusing instead on the role of families and communities in caring for the insane.

The nineteenth century sees the birth of what Foucault calls “the science of sexuality”, and in his later work, most notably the first part of History of Sexuality, Foucault stresses that power is not simply oppressive, but also “a condition of possibility”. This dual concept of power in the work of its most influential scholar – on the one hand disciplinary and on the other relative, diffuse and dynamic in nature – has not prevented revisionist accounts of psychiatry from at times portraying asylum power structures in a somewhat unambiguous manner. As sociologist Andrew Scull has pointed out, the lingering influence of anti-psychiatry in the history of madness and asylums has meant that “power” has come to mean oppression, and that as a result psychiatric intervention has often been viewed as inherently “malevolent and ill conceived”. The post-revisionist tradition has balanced this view through its focus on the role of the family and community, and the ways in which agents outside the asylum exerted influence on the definition and construction of madness and deviance. While acknowledging the disciplinary role of the asylum, this study seeks to temper the image of an oppressive institution under a tyrannical superintendent, and highlight how practical asylum discipline was designed to impart values and norms of nineteenth-century Swedish society.

Medicalisation is a reoccurring concept in the historiography on sexuality. As defined by Thomas Szasz, it rests on the assumption that some phenomena belong in the domain of medicine, and some do not. Historians have identified an increasing

32 Foucault, The History of Sexuality, 12.
33 Ibid., 93.
tendency in nineteenth- and twentieth-century society to assign to the areas of medicine and psychiatry various forms of deviant behaviours: most notably alcoholism, theft, vagrancy and various other forms of antisocial conduct, as well as life events such as puberty, childbirth and menopause. This development has been explained in terms of the growing authority of medicine in society, and as a response to the fundamental social upheaval of nineteenth-century European society, which brought about a new form of social policy. Such policy provided greater freedom and more equal opportunities to maintain good health, but to achieve this, the authorities must interfere more in the private sphere of its citizens. Sociologist Bryan S. Turner has summarised the reasoning in what he calls the **Foucault paradox**:

> Citizenship is broadly considered as a series of individual rights and entitlements; therefore, the paradox is that the provision of citizenship, of which health is an aspect, entails greater surveillance and social regulation by quasi-governmental organisations and agencies.

In her 2008 thesis, historian Cecilia Riving points out that medicalisation as an analytical tool can be used in two ways in an analysis of asylum care. Firstly, it emphasises the increasing influence of medicine in society since the nineteenth century; secondly, it draws attention to the fact that the medical interpretation is one of several possible explicating models when it comes to deviant behaviour, and highlights the fact that the demarcation between the sick, the healthy and the criminal is never obvious or unproblematic. In this thesis, medicalisation is not viewed simply as a means of social control, but as a more complex process involving the patient, the certifying officers, the asylum and the psychiatric profession.

**Previous scholarship**

The history of psychiatry and asylums has been described as an “academic minefield”. Historically, accounts of psychiatric history were authored by professionals active in

---


41 Riving, *Icke som en annan människa*.

42 Riving, *Icke som en annan människa*, 32.
the field, or by their supporters. Often celebratory in nature, these accounts charted the “progress” of psychiatry, neglecting difficulties within the profession or inconsistencies in medical thinking. Following its publication in 1961, Foucault’s *Madness and Civilisation* overturned the assumptions made by traditional psychiatric history. The birth of psychiatry, Foucault argued, was not a source of progress, but rather a means of estrangement, the banishment of madness and the mad to the fringes of society. The impact of Foucault’s contributions to the debate has been acknowledged; his view of madness as variable social construct, as opposed to an ahistorical given, and his insistence that the history of madness is a crucial part of the history of reason, are now generally accepted by historians of psychiatry. Although on the level of specific historical facts and interpretations, particularly his theory of a ‘great confinement’ and the absence of discussions regarding asylum location and reform, his work has been found wanting. The legacy of Foucault and the revisionist school of psychiatric history can scarcely be underestimated in the Swedish academic literature on early psychiatry, which since that period has focused to a great extent on exploring the corrective and disciplining functions of the asylum.

Roger Qvarsell’s 1982 thesis *Ordning och behandling*, an exhaustive empirical study of the Vadstena asylum under its first superintendent Georg Engström, has been extensively referenced in Swedish scholarship since its publication. Although not the first work on Swedish psychiatry, physician Gösta Harding’s book on the first three Swedish professors of psychiatry predates it by seven years, Qvarsell’s work remains the only book-length study of a single Swedish asylum based on archival material. Like Harding’s text, Qvarsell continues to be cited in works of medical history, the history of ideas and sociology when addressing questions regarding the creation of medical knowledge in Sweden, nineteenth-century medical and social policy, and the history of discipline and incarceration, to name but a few. As an authoritative presence in Swedish medical history since the early 1990s, Karin Johannisson’s prolific


scholarship has arguably opened the door for a new generation of medical historians in Sweden. Her histories of melancholia, the female body in turn-of-the-century medicine, and the medical encounter draw on a wide range of medical and literary sources and conduct important Foucault-inspired analyses of the ideas, techniques and assumptions of medical science.\textsuperscript{46} Perhaps most widely known for her work on the medical construction of female biology as inherently problematic, Johannisson’s illumination of medical models of female pathology in nineteenth-century psychiatry have directly influenced the choice of focus for this study.\textsuperscript{47}

Institutionalised Swedish psychiatric practice has emerged more prominently as a topic for academic research since the turn of the millennium. Ethnologist Mikael Eivergård’s 2003 doctoral thesis analysed asylum practice in the period 1850-1970 as a modern disciplinary project, using annual reports and case records from six different institutions.\textsuperscript{48} Eivergård’s thematic focus on medicine in practice and the techniques applied to control patient sexuality has informed the approach to the primary material in this study. While Johannisson and Eivergård primarily cite material from the years surrounding the turn of the century, their findings regarding the disciplinary nature of medical intervention has inspired the direction of this study, which seeks to determine whether the same tendencies are visible in earlier asylum material. Considering the weight of the combined scholarship on the subject, it has become the dominant view that nineteenth-century psychiatry was essentially disciplinary in its nature. Following Foucault and the revisionists, previous scholarship has generally examined eroticism and erotic patients as targets of medicine’s disciplinary power and the body and sexuality of psychiatric patients viewed as sites of control, power and resistance.\textsuperscript{49}

Moreover, due to the growing trend of feminist scholarship in medical history, studies of the medicalisation of erotic behaviour have focused on female patients and the conceptualisation of mental illness as essentially linked with femininity. Based on Finnish archival sources, sociologist Jutta Ahlbeck-Rehn’s Swedish-language thesis \textit{Diagnosticering och disciplinering}, published in 2006, analyses constructions of female insanity from a feminist perspective; identifying and highlighting the micro-


\textsuperscript{49} Eivergård, \textit{Frihetens milda disciplin}. 

18
structures of power at work within the asylum. Although not exclusively concerned with psychiatry, historian Jenny Björkman’s thesis on the debate surrounding compulsory care in Sweden 1850-1970 presents a sophisticated analysis of the tensions between care and control in institutional settings. Björkman does not view “humanity” and “social control” as dichotomous, since coercion, control, normalisation and discipline were not historically seen as contradictory to good and humane care. In her thesis, discipline and humanism are inextricably intertwined; they are two sides of the same process, one always accompanying the other. Björkman accepts the Foucauldian view that the reformed and, to our eyes, improved care of the insane relies on the internalisation of behaviour rather than external disciplinary measures.

Medical historian Cecilia Riving employs admission documents and casebooks from three Swedish asylums in a comparative study of the interaction between psychiatry and the local community in the second half of the nineteenth century. Focusing on the definition of insanity by medical professionals, and the impact of lay perceptions of madness on psychiatry, Riving’s work is inspired by the post-revisionist school of psychiatric history, emphasising the small-scale interactions between local authorities, families of patients and the asylum. Similarly, in his 2012 thesis, historian Lars Garpenhag focuses on the treatment of the criminally insane from the mid-nineteenth century, with an overall perspective of analysing insanity and the treatment of the insane as a social and cultural phenomenon. The book emphasises the institutional practice in separating criminally insane patients from other asylum inmates, as well as from offenders deemed to be of sound mind, as well as the variability of symptoms over time.

This study seeks to supplement the existing scholarship on Swedish psychiatry by conducting a rigorous empirical investigation that highlights the medical interpretation and responses to erotic behaviour in asylum practice. It thus aims to join a relatively recent trend in Swedish psychiatric history by focusing on the day-to-day workings of the institution. By allowing head physician Hjertstedt’s ideas and the experience gained on his journey to feature in the text, the project wishes to acknowledge the therapeutic intentions and optimism of early psychiatric practitioners and medical authorities with respect to insanity. Furthermore, Hjertstedt’s travel account is used to connect the Vadstena practice with the larger national project of turning to European institutions as models for the Swedish asylum system.

50 Ahlbeck-Rehn, Diagnosticering och disciplinering.
51 Björkman, Vård för samhällets bästa.
52 Ibid., 25.
53 Björkman, Vård för samhällets bästa, 23.
54 See also Suzuki, Madness at Home.
55 Garpenhag, Kriminaldärar, 28.
56 Ibid., 29.
The history of psychiatry has a considerably longer history as an academic discipline in the English-speaking world than it does in Sweden. The range and scope of scholarship on the history of asylums and psychiatry and related themes is such that only a brief overview will be possible here. In terms of influence, few works published in the last thirty years can compete with literary critic Elaine Showalter’s *The Female Malady*, originally published in 1987, and often credited with writing women back into a discipline which until that point had been centred around male physicians. Showalter carries out an analysis of statistics of asylum confinements and cultural representations of female insanity to illustrate how cultural conceptions of “proper” femininity shaped the classification and treatment of female patients in nineteenth-century psychiatry. Her work highlights how patients and sufferers were sexualised in medical, artistic and literary depictions of female madness, identifying a tradition of intertextuality between art and medicine on the subject. Showalter’s text, and sociologist and psychologist Joan Busfield’s critique of it, have had an instrumental role in the shaping of this thesis. Busfield criticised Showalter for exclusively focusing on female madness, arguing that such an approach produced a distorted view of history. In her own work, Busfield included both male and female patients to conduct an analysis of the complex interplay between gender and madness. While questions regarding the relationship between madness and gender permeate this study, the issues raised in these works regarding the interplay between medicine and culture have been especially valuable to me. Specifically, they have informed my analysis of the source material by providing an understanding of madness as transgression of gender norms, and an awareness of the intertextuality of medicine and fiction. The historical association of gender, eroticism and mental disorder has proved a rich area of interdisciplinary study in the wake of Showalter’s book.

For the understanding of the medical concept of nymphomania, *Erotic Insanity* is indebted to the work of Ann Goldberg, whose work on eroticism and religious madness in a German asylum examines closely the creation of a medical diagnosis in

---

asylum practice. Out of the significant literature on masturbation as a subject of medical, moral and religious concern, Thomas Laqueur’s encyclopaedic *Solitary Sex* and the more recent thesis of Diane Mason have provided necessary context for masturbatory insanity as a medical concept.

The introduction of Foucauldian themes into psychiatric history laid the foundations for the controversial work of Andrew Scull, who placed the growth of institutionalised psychiatry in England in the context of urbanisation and the resulting breakdown of traditional familial and community structures. Critical of “micro” approaches to psychiatry for being too particular and isolated, Scull emphasised the need for research to connect with broader themes. Scull’s work has not gone unchallenged, and in the past twenty years historians have produced richly varied work on individual institutions, which highlight the disparities of asylum practice, and contribute to a more nuanced perception of nineteenth-century practical psychiatry. Examples of such studies include those of Charlotte MacKenzie and Anne Digby, the former on Ticehurst Asylum in Sussex and the latter on the York Retreat, both private establishments who catered mainly to paying patients. Covering the other end of the social spectrum, the work of John Walton on pauper lunatic admissions and discharges, like that of David Wright on the Buckinghamshire County asylum, emphasised the relevance of family and community relationships in the processes of asylum admission and discharge. Such institutional histories drawing on archival material in order to contextualise practice and patients, while challenging assumptions regarding the nature of the nineteenth-century asylum have served as the main inspirations for the current project.

**Outline**

The prologue for this study provides the legislative framework for nineteenth-century asylum reform in Sweden, and describes the inception of Vadstena County asylum as

---

60 Goldberg, *Sex, Religion, and the Making of Modern Madness.*
62 Andrew Scull, *Social order/mental disorder.*
the country’s first institution exclusively devoted to the care of the insane. A brief introduction to European psychiatry in the early part of the century is provided, including key concepts and figures essential to the following chapters. Furthermore, the medical officers in residence at Vadstena throughout the period are described. Chapter one follows Ludvig Magnus Hjertstedt on his journey to England in 1845, starting at Vadstena County asylum where he served as assistant medical officer under Georg Engström. Through Hjertstedt’s account of English psychiatry we glimpse the model that Swedish medical authorities sought to emulate in their development of the Swedish asylum system. Chapter two introduces erotic insanity as a medical and social concept through the medical attribution of insanity to erotic and sexual causes. Concerned with the question of how important a factor erotic behaviour was in the developing aetiology of insanity, the text is based on admission and case records as well as official statistical tables regarding causes from the Swedish Board of Asylums. Chapters three (“Nymphomania”), four (“Masturbation”) and five (“Erotomania”) examine how and to what extent erotic behaviour was framed as disease in medical practice at Vadstena. The use, construction and status of diagnostic and descriptive terms in the interpretation and labelling of erotic behaviour are explored here. Chapter six (“Treatment and Management”) is concerned with medical intervention in erotic cases at Vadstena, and explores the treatment documented in case notes, and its recorded effects. Including medicinal and moral treatment as well as restraint and punishment, the chapter questions the goal of treatment, and juxtaposes the therapeutic reality at Vadstena with the ideal of the curative asylum. The concluding chapter presents the study’s findings, and discusses the results in relation to its aims and research questions. Finally, a summary in Swedish concludes the thesis.
Prologue: Swedish lunacy reform and the European context

Vadstena County Asylum, the scene for what follows herein, was established in 1826, in accordance with an act passed in 1823, as the first decisive step in centralising care of the insane into a small number of specialised institutions. As we shall see, the formulation of psychiatry as a separate medical specialty occurred somewhat later in Sweden than elsewhere in Europe.

At the time of Vadstena’s inception, the great reform movements in Britain and France were already well underway. Reform was championed in France by the man often hailed in the nineteenth century as the father of psychiatry, Philippe Pinel (1745–1826), and in England by William Tuke (1732–1822), founder and proprietor of the famous York Retreat. Hospitals for the care and treatment of the mentally afflicted were not new; Pinel himself had been physician to both the capital’s great hospitals: the Bicêtre, founded in 1642 was simultaneously a prison, an asylum and a hospital with beds for four thousand male patients. The Salpêtrière, established in 1656, was at the turn of the century the largest hospital facility in Europe, housing around eight thousand elderly, impoverished and insane women. Though never exclusively dedicated to the care and treatment of lunatics, both institutions had separate wards for the insane from the 1790s. Similarly, the most famous madhouse in Europe, London’s Bethlem Royal Hospital, or Bethlem, had been caring for the poor, destitute and insane since the mid-thirteenth century. The precise date of Bethlem’s transition to being a purely psychiatric facility has proved difficult to determine; the first definitive evidence of insane patients being held there can be found in the details of a visitation by the Charity Commissioners in 1403. Although nowhere near as vast in size as its French counterparts (the complete patient population in 1800 was just 266) Bethlem’s long history and the well-publicised accounts of abuses and

---

66 Building on the ideas of Pinel, and in line with their beliefs as Quakers, the Tukes rejected all form of restraint and coercion and stressed instead the importance of fresh air, diet and exercise, and above all firm but kind treatment of lunatics in a family environment, aiming to restore the patient’s moral character, self-restraint and compassion; a “moral regimen”. See Samuel Tuke, A Description of the Retreat, an Institution near York, for Insane Persons of the Society of Friends. York: W. Alexander, 1813, 131-139.
inhumane treatment discovered there in the early nineteenth century has made the popular designation of its name – Bedlam – synonymous with madness and chaos in the English language. Outside of the capital, in spite of the County Asylums Act being passed in 1808, only six public asylums pre-dated 1820: Manchester Royal, Norfolk, Bedfordshire, Gloucestershire, Cornwall, and West Riding County Pauper Asylums.\footnote{Andrew Roberts, \textit{Index of English and Welsh Lunatic Asylums and Mental Hospitals}. http://studymore.org.uk/4_13_ta.htm Retrieved 22nd Sept 2014.} Lunacy Law in England was not to be consolidated until the inception of the Lunacy and County Asylums Acts of 1845.

A desire to emulate the systems in place in other European states is evident in the surviving pamphlets and publications of those Swedish physicians who travelled abroad and witnessed such specialised care in person\footnote{Georg Engström, \textit{Berättelse afgifven till Kongl. Seraphimer-ordens-gillet angående åtskilliga utländska hospitals-inrättningar och vansinnige personers behandling därstädes}. Stockholm, 1835, Bengt Erik Eriksson, \textit{Vägen till centralhospitalet: två studier om den anstaltsbundna sinnessjukvårdens förhistoria i Sverige}, Göteborg: Daidalos, 1989, 237-241.}, and in the willingness of the Guild to contribute financially to such research expeditions.\footnote{Johan Fredrik Sacklén, \textit{Sveriges läkare-historia}. Stockholm: Beckman, 1853, 113, 167.} It appears that practical illustrations from foreign hospitals, administrative-economic aspects and an influx of medical ideas regarding the curability of insanity together became the basis for asylum reform.\footnote{Eriksson, \textit{Vägen till centralhospitalet}, 237-241.}

Like their French and English equivalents, early Swedish hospitals were charitable institutions which cared for the needy. The first mentions of sanctuaries\footnote{Sw. Helgeandshus.} in medieval Sweden are found in sources dating from the late thirteenth and early fourteenth centuries.\footnote{Ragnar Engeström, \textit{Visby: Historisk bakgrund, arkeologiska dokumentationer}. Stockholm: Riksantikvarieämbetet, 1988, 130.} The town of Vadstena had a sanctuary for the poor, sick and elderly as early as the fifteenth century, and an infirmary was founded in 1520.\footnote{Sven Bergman, \textit{Seklernas Vadstena}. Vadstena: Vadstena affärstryck, 1955, 386.} The two facilities were merged in 1532, and like other such institutions, the hospital continued to care for a diverse group of patients; lepers, epileptics, the frail and infirm shared the space with orphans and the insane. Few institutions had separate lodgings for insane individuals prior to the nineteenth century. One example was the infamous Danviken.

\begin{footnotesize}
\begin{enumerate}
\item Sw. Helgeandshus.
\item Sven Bergman, \textit{Seklernas Vadstena}, Vadstena: Vadstena affärstryck, 1955, 386. The meaning of the Swedish word hospital has shifted over time, as new institutions formed; in the Middle Ages a hospital was a leprosarium, dedicated to the isolation and care of lepers and usually situated outside of towns. Following the Reformation, the word became used for a type of mixed care facility which admitted both sick, old and disabled individuals. With the institution of the county asylums in the early nineteenth century, hospital came to mean asylum, and it still has this meaning in modern Swedish.
\end{enumerate}
\end{footnotesize}
hospital in Stockholm, which had received and housed such patients since the 1740s.\textsuperscript{78} Originally founded in the mid-sixteenth century by King Gustav Vasa, the institution and its buildings were already antiquated by the beginning of the nineteenth century.\textsuperscript{79} With the decision to centralise care of the insane, and the establishment of Vadstena as Sweden’s first county asylum, Danviken appears to have been left behind as the interest of the Guild and the Collegium Medicum focused on shaping a more effective and modern institution.\textsuperscript{80} Although housed separately, the insane at Danviken received no specialised treatment; and the overcrowding and appalling living conditions that resulted became the target of fierce criticism from contemporary doctors as well as historians from the nineteenth century to the present day.\textsuperscript{81} Prior to the 1830s, Swedish authorities had housed mentally disturbed patients in county hospitals alongside those suffering from bodily ailments, and in poorhouses and workhouses alongside the destitute and frail.\textsuperscript{82} An 1813 missive from the Guild indicates that such institutions were intended to keep potentially dangerous individuals away from society, rather than for treatment.

Those who have reached the degree of feeblemindedness that they, in order to not harm themselves and others, must be kept under constant surveillance, or are burdened with such incurable illnesses and infirmities and affections that they must be separated from society.\textsuperscript{83} Since 1787, the kingdom’s hospitals had been under the direction of the Guild of the Royal Order of the Seraphim.\textsuperscript{84} In a missive of October 20\textsuperscript{th} 1822, addressed to His Majesty Charles XIV John, the Guild lamented that the costs of running the county

\textsuperscript{78} Gustaf Näsström, 400 år på Danviken, Stockholm: H. Geber, 1951.
\textsuperscript{80} Eriksson, Vägen till centralhospitalen, 243.
\textsuperscript{82} Mikael Söderström, “Svängstolen vid Vadstena hospital”, Hygiea 98 (16), 1936, 545. See also Eriksson, Vägen till centralhospitalen, 213-220.
\textsuperscript{83} Sw. “De som uppnått den grad af sinnessvaghet att de, för att ej skada sig sjelfve och andra, måste hållas under ständig bevakning, eller äro behäftade med sådana obotliga sjukdomar samt kroppssluten och åkommor, att de från samhälls-lefnaden måste afskiljas.” “Serafimerordens circolär d. 18 Nov 1813 ang. (s.k. profkur för sinnessjuke, eller) en närmare pröfnin och undersökning om de personers tillstånd, som hädanefer anmälas till vård och underhåll på lånshospitalerna” in Alfred H. Wistrand, Författningar angående medicinal-väsendet i Sverige 1667-1859. Stockholm 1860-1861, 443f.
\textsuperscript{84} Hereafter referred to as “the Guild”.
hospitals had become so onerous that the Guild found itself unable to carry out the planned and highly necessary improvements to the care of insane patients. The letter was invoked by the estates of the realm in another communiqué to the regent the following year. In it, the estates professed to have found the county hospitals much in need of improvement; and as the funds would not allow the necessary measures to be taken for all institutions, a suggestion was put forward that a smaller number of county hospitals be instated. These would be able to care for a greater number of patients, and specialised treatment would be provided. The consolidation of the smaller hospitals into bigger institutions would mean greater financial efficiency, argued the estates, and suggested that the new county asylums were to be established where suitable buildings were already available. Alongside the first institution at Vadstena, county asylums were planned for the towns of Stockholm, Göteborg, Malmö, Nyköping, Växjö and Uppsala.

In 1826, the county hospital at Vadstena officially became Vadstena county asylum. The first of its kind in Sweden, it was to be devoted exclusively to the treatment of the insane. The institution was established in the grounds and buildings of the former county hospital, originally a convent, which had been seized by the state during the Reformation. Georg Engström (1795–1855) was employed as physician, and a chaplain was hired to care for the spiritual needs of the patients. A Board of Directors made up of the town mayor, the town vicar and an army major was assembled and placed in charge of the new institution. Notably, no medical representative was included. The medical superintendent was to be responsible for the patients’ treatment and care, and undertake weekly rounds of the wards. In all other matters the physician was to be instructed by the Board of Directors, and guided in his practice by the instruction – the official directive issued by the Guild. Patients were to be admitted after having undergone a trial period in a county hospital (originally this was regulated to one month, but from 1832 the Guild decreed that trial periods could be extended to two months or at the individual doctor’s discretion). Efforts were made to separate the calm from the raving and violent, and the curable from the chronic. As per the 1826 missive by the Guild, admission to an asylum no longer automatically indicated an incurable state of insanity, representing a significant change in attitude.

87 “Serafimerordensgillets instruction, d. 25 okt. 1826, För hospitals-läkaren i Wadstena”, Wistrand, Författningar, 264.
88 Sw. Provkur.
90 Qvarsell, Ordning och behandling, 191.
91 Eriksson, Vägen till centralhospitalet, 254.
The trial period would eventually be abolished with the 1858 Act for Regulation of the Care of the Insane, with the argument that it delayed “proper” asylum treatment. From 1836 Vadstena offered separate accommodation for first class patients.\textsuperscript{92} In return for a higher fee, patients of the “better” classes enjoyed larger and more cheerful accommodation, better quality food, and were permitted to wear their own clothes. The general wards mixed second-class patients who paid for their own care, and third class, or pauper patients, whose small fees were paid by their local parish. Furthermore, patients were divided by degree of manageability; those who were considered clean, calm and able to work were housed together, and separate form the violent and filthy.

When Hjertstedt was made medical superintendent in 1849, Vadstena had been in operation as a specialised institution for the insane for twenty years. The case records from this period indicate no special provision, treatment or indeed classification of patients whose illness involved symptoms of an erotic or sexual nature. The cases are found in first, second and third class, they are male and female, and diagnosed with various forms of mania, melancholia, dementia and dullness, as well as nymphomania. A number of non-medical terms are used to describe their behaviour, and the supposed cause of their condition. Among these, “romantic whims”\textsuperscript{93}, “disappointed love”\textsuperscript{94}, “lewdness” and “obscenity” occur most frequently.

As part of this prologue, a brief introduction is warranted of the men who will play a major role in our analysis: the physicians of the Vadstena asylum. Together, their years of service spanned nearly the entire nineteenth century, and the first seventy-five years of the asylum’s existence. Though often referred to as psychiatrists or alienists in historical and biographical texts, none of these physicians had specialised training in psychiatry, and they all held positions at other medical institutions throughout their careers.\textsuperscript{95} In regard to published material and participation in contemporary medical debate, these three appear to have played a modest role in nineteenth century Swedish medicine. As somewhat anonymous contributors to the development of Swedish psychiatric knowledge, the case notes they kept are perhaps the most revealing evidence of their thought and practice.

\textsuperscript{92} Qvarsell, \textit{Ordning och behandling}, 75.
\textsuperscript{93} Sw. \textit{Kärleksgriller}.
\textsuperscript{94} Sw. \textit{Olycklig kärlek}.
Georg Engström (1795-1855)

Trained at the Karolinska Institute in Stockholm, Engström received the degree of Master of Surgery in 1821. He was employed as physician to the venereal hospital in Västervik in 1823, and to the County asylum at Västerås three years later. The fact that the position of asylum physician was advertised indicates that Engström, who was resident in Västervik and would have been well known to the Board of Directors, did not express an interest in the position. His biographer Roger Qvarseel calls Engström Sweden’s first full-time psychiatrist, in practice if not by training. Due to his weak health Engström officially retired from his position at the asylum in 1850, but the archival evidence suggests that assistant medical officer Hjertstedt had largely managed the work of the medical superintendent for at least five years prior to this.

His only published work was the account of his travels in Europe provided to the Guild in 1835, but Engström appears to have been more active as a translator. In the period 1829-1839 he translated German volumes on apoplexy and the treatment of piles, as well as a small pamphlet in Danish on how to clean and care for teeth. His most substantial translation work appears to have been a 600-page volume by Johannes Baptista Friedrich on forensic psychology, for which Engström also provided a foreword and a number of critical footnotes.

In his twenty years as head medical officer, Georg Engström used the diagnostic term “nymphomania” only twice in the casebook, though the phrase “signs/symptoms of nymphomania” was used more frequently to describe a patient’s behaviour. Six cases of male insanity are attributed to masturbation.

---

95 Qvarseel, Ordnings och behandling, 95.
96 Engström, Berättelse.
99 Johannes Baptista Friedrich, Systematisk handbok i juridiska psykologin för läkare och jurister. Örebro: Lindh, 1839.
in this period\textsuperscript{101}, and of these cases two continued the practice after having been admitted to the asylum. Mechanical restraint is recorded as having been used in one case to prevent a patient masturbating.\textsuperscript{102} In his work on Vadstena under Engström, Roger Qvarsell observes that: “The treatment records contain relatively few notes about forcible measures, and if these paint a true picture of life in the asylum, such techniques were not part of the day-to-day treatment of patients, but were applied with a measure of caution.”\textsuperscript{103}

\textsuperscript{101} FIIc:1 No 227, FIIc:3, No.404, FIIb:3 No.273, FIIc:5 No. 760, FIIc:5 No. 827, FIIc:5 No.884.
\textsuperscript{102} FIIc:5 No. 760.
\textsuperscript{103} Qvarsell, \textit{Ordning och behandling}, 150.
Ludvig Magnus Hjertstedt (1810-1878)

Hjertstedt began his studies at Lund University in 1828, gained his MD from Uppsala University in 1837\textsuperscript{104}, and his Master of Surgery from the same institution in 1839. Having completed his studies, Hjertstedt served as ship's doctor on-board a corvette (Näfjorden) for an expedition to the Americas and the Canary Islands, and kept a diary of his observations.\textsuperscript{105} From 1840 onwards Hjertstedt was based in Vadstena, serving as town physician from 1840 to 1849, physician in charge at the venereal hospital from 1846 to 1868, and as assistant medical officer to Engström at the asylum from 1840, before succeeding him as medical superintendent in 1849.\textsuperscript{106} In addition, he served as superintendent of the spa at Medevi Brunn from 1842 to 1846. According to a somewhat biased biographer, the mid-nineteenth century Vadstena physician P.E. Sellberg, Hjertstedt’s travels were to greatly influence his work as medical head of Vadstena. The biographer portrays Hjertstedt as an energetic and stubborn campaigner (presumably with the Board of Directors, as well as the Board of Health) for improvements to the asylum. Sellberg highlights the improvements made at Vadstena under Hjertstedt, including the complete separation of male and female patients, as well as separate wards for calm and unruly patients. Sellberg also credits Hjertstedt as the driving force between the complete refurbishment and extension of the asylum which was completed in the early 1860s.\textsuperscript{107}

His publications consist of his MD thesis, on the whooping cough, supervised by Uppsala’s renowned professor of medicine Israel Hwasser (1790-1860), and a version of

\textsuperscript{104} Israel Hwasser, *Om kihosta: Academic Afhandling för Medicinska Graden erhålende avgifven of Ludvig Magnus Hjertstedt, Smådöningen. Ät medic. auditorium den 26 april 1837. p. v. t. e. m. I delen., Diss. Uppsala: Lefler & Sedell, 1837.
\textsuperscript{105} Ludvig Magnus Hjertstedt, *Dog-bok under en resa kring Sveriges kuster, samt till N. Canarisk öarna, West-indien, södra och norra Amerika, 1829 och 1840*. Unpublished manuscript, Lund University Library.
\textsuperscript{106} Sacklen, *Sveriges läkare-historia*, 157.
\textsuperscript{107} Sellberg, “Bingittas sjukhus i Vadstena”, 202-203.
the annual report for 1850. The superintendent at Västena was required to deliver such a report to the Guild for each year; the reason why this particular one was published has not been determined. Very little of Hjertstedt’s personal communication has been preserved in archives, but a single letter dated 1860 implies that he occasionally provided medical advice via correspondence, when requested to do so.

Gustaf Wilhelm Göthlin (1839-1895)

The most anonymous of the Västena physicians, Med. Lic. Gustaf Göthlin received his degree from Uppsala University in 1872. Göthlin served as town physician in Västena from 1872 to 1878, and during the same period served as assistant medical officer under Hjertstedt at the asylum. He succeeded as medical superintendent in 1878, and remained at Västena until his death in 1895.

Assistant medical officers at Västena during the period studied here were Wilhelm Öhrström (1871-1891), later superintendent of Konradsberg asylum in Stockholm and professor of psychiatry, Carl Anjou (1823-1883), later superintendent of the Gothenburg asylum, and Gustaf Knös (1836-1899).

Figure 3. Gustaf Göthlin. Image from Albin Hildebrand, Svenskt porträttgalleri XVIII, Läkarekåren. Stockholm: Tullbergs, 1911, 197.

1. The Physician-Traveller

In the annual report from Vadstena asylum for the year 1849, the institution’s newly appointed head physician, Ludvig Magnus Hjertstedt, commented on the use of physical restraint within the asylum:

Restraint is rarely used at Vadstena, and consists only of the so-called straitjacket and the chair. /…/ Showers and isolation in a dark cell are also used with the utmost care. Without agreeing with Dr Conolly’s views that physical restraint should be completely abandoned, I have however found that it can be immensely restricted, this institution is remarkable proof of that.110

At the point of writing, Hjertstedt had served as assistant medical officer at Vadstena for nine years, working alongside its first superintendent Georg Engström, as the latter’s health declined.111 During that period, Hjertstedt travelled extensively in Europe – generously funded by Sundhetscollegium – visiting a total of 21 specialised psychiatric institutions, and writing reports of his observations.112 This, alongside his previous journey to the Americas meant that even by nineteenth-century standards, Hjertstedt was a well-travelled man.

Hjertstedt’s first annual report as head medical officer speaks in the confident voice of someone well acquainted with the day-to-day operations of Vadstena, as well as with prevalent European psychiatric ideas and practice. While partly an advertisement for the modern, humane asylum – some pride can be detected in the description of Vadstena – the report contains a powerful self-introduction on the part of the new head physician. Hjertstedt demonstrates familiarity with one of the most celebrated psychiatric reformers of his day, Dr John Conolly (1794-1866), and adapts the idea of non-restraint to his own institutional practice and experience. Also, the quote alludes to an established medical philosophy; a code of care which differs from that advocated by Conolly: a Vadstena way of doing things. During his 23 years as chief medical officer of Vadstena, Georg Engström had combined his own learning and experience with that gained from abroad through books and his own travels, and created the environment in which the young Hjertstedt gained his earliest experience of psychiatric practice.

110 Sw. Tvångsmedel är vid Vadstena Hospital sällan använda, och bestå endast av så kallad tvängströja eller tvängstol. /…/ Douche och isolering i mörk cell begagnas även med yttersta varsamhet. Utan att ingå på Dr Conollys åsikt att kroppsliga tvångsmedel helt och hållet behöva umbäras, så har jag dock funnit, att de kunna ofantligt inskränkas, hvarpå härvarande Hospital lemnar märkvärdiga bevis. Årsberättelser 1842-1862, Sjukhuschefens arkiv BII:1.

111 The position was combined with that of town physician (Sw. stadsläkare) to Vadstena.

112 Ludvig Magnus Hjertstedt, Reseberättelse, RA, Sundhetscollegiums arkiv.
In undertaking his journey through Europe; making stops in England, France, Germany, Belgium, Holland and Italy, Hjertstedt made himself part of a tradition of Swedish doctors travelling abroad with the aim of forwarding psychiatric knowledge and asylum management at home. The National Archives in Stockholm contain over a hundred letters and reports of varying length from doctors in the period 1833-1879. Physicians travelled to visit institutions and famous colleagues, to attend lectures and surgeries and bring back the latest and greatest ideas and innovations in their respective fields. Hjertstedt’s predecessor Georg Engström, the first full-time asylum physician in the country, was among the first to undertake such a journey. In the summer of 1833, the Board of Directors at Vadstena supported an application for leave by Engström, in order for him to undertake a trip, funded by Sundhetscollegium, to visit asylums in Denmark and Germany. The Directors believed that the resulting account of Engström’s observations abroad would be “greatly beneficial for the suffering population”\(^\text{113}\), and he was asked to contribute his ideas for the amelioration of asylum care in Sweden as part of his report. In the same year, another physician whose name was to be intimately associated with the care and cause of the insane in Sweden set out on a similar journey; Carl Ulrik Sondén (1802-1875) was then assistant physician of Stockholm’s Danviken asylum, and like Engström was granted financial support to visit a number of psychiatric institutions in Denmark, Holland, Germany and France.\(^\text{114}\) His reports were of more organised and effective systems of care than any that the author had witnessed in Sweden.\(^\text{115}\) While Swedish doctors had travelled abroad before, the journeys of Engström and Sondén were the first to be funded by Sundhetscollegium with the express intention of collecting psychiatric knowledge from abroad.\(^\text{116}\) The 1823 Parliament had consolidated care of insane patients into eight county asylums (Sw. Centralhospital), a reform which indicates a desire to provide institutions for specialised, humane care of the disordered of mind in a similar form to those already in place elsewhere in Europe. Historian Mikael Eivergård has argued that the manner in which a society cared for its weakest and most vulnerable citizens

\(^{113}\) Qvarsell, Ordning och behandling, 98. Sw. Af oberäknelig fördel för den lidande menskligheten.


\(^{115}\) Carl Ulric Sondén, “Meddelande om ett sinnessjukhus i Bordeaux”, Journalen, 100, May 2nd 1834.

\(^{116}\) In 1819, surgeon Carl-Johan Ekström (later knighted Ekströmmer) (1793-1860), wrote of his self-funded visit to Berlin’s Charité hospital that the psychiatric ward therein was the most remarkable in the entire establishment, and a paragon for the care of the insane elsewhere. See Aina Ekströmmer, Livmedicus Carl Johan Ekströmer: kirurg och nydane 1893-1860. Köpingsvik: for the author, 2007.
was increasingly viewed as an indicator of the humane, scientific and cultural advancement of that society, and in this respect, Sweden appeared hopelessly left behind.\(^{117}\) The work, placement and design of the new county asylums, as well as the institution at Danviken in Stockholm, would repeatedly come under criticism from doctors and social reformers throughout the nineteenth century, as the Swedish institutions were measured against their English, French and German counterparts, and generally found lacking.\(^{118}\) Following his own extensive asylum tour through France, Germany, Belgium and Switzerland in 1853, Professor Magnus Huss (1807-1890) of the Karolinska Institute expressed a feeling of embarrassment when required to describe the Swedish asylum system to foreign colleagues.\(^{119}\)

Although little evidence exists of their interactions with each other, Sweden’s earliest alienists appear to have been familiar with, and to a certain degree involved in, each other’s work. In his pamphlet on the amelioration of Danviken asylum, Carl Ulrik Sondén cites Hjertstedt’s expert opinion on a suggested new site for the Stockholm institution, calling the latter “an excellent psychical physician”.\(^{120}\) The fierce criticisms of Magnus Huss toward the living conditions at Danviken appeared only after Sondén had called attention to the matter in a pamphlet of his own, and in his later role as head of the Board of Asylums, Huss was to inspect both Vadstena and Danviken on behalf of the crown. The pioneers of Swedish psychiatry all travelled in Europe, visited the same countries – Denmark, Germany, France and England – and all shared the view that a cure for the disordered mind could only be achieved within the walls of an asylum.

This chapter will follow Hjertstedt on his journey through England, viewing the English system of care through his eyes, and focusing on the points of asylum practice which are emphasised in his travel account. The section on the English asylum system is the longest out of the six parts of his travelogue, and as he holds the English system as a model, it is warranted to dwell on it as a main source of inspiration. The points that Hjertstedt takes time to highlight in his account will form the basis of analysis of his own practice in the following chapters.

The main primary source used is Hjertstedt’s own account of his journey, written for Sundhetscollegium upon his return to Sweden: a 300-page volume, which records the physician’s observations on his visits. As we have seen, seeking out and learning from the knowledge and experience of psychiatric institutions and practitioners abroad had been an objective since the establishment of the County asylum system in Sweden,


\(^{118}\) Huss, *Kan eller bör hufvudstaden längre undvara en välordnad kuranstalt för sinnessjuka?*, “Om anstalter för sinnessjukes vård och behandling”, *Svensk Tidskrift* 148, 1853.


\(^{120}\) Sondén, *Danviks dårhus*, 85-6.
and thus since Vadstena’s earliest inception. Georg Engström’s travel journal pales in comparison with that of his successor, but is mentioned here to highlight the role of foreign examples in developing psychiatric practice at Vadstena. Hjertstedt’s more extensive account chronicles his observations in detail, providing historical and legal context for asylum care in each of the countries he visits. By focusing primarily on Hjertstedt’s impressions and ideas as found in his travel journals as well as the archive material from the asylum, we may glimpse the process whereby modern ideas were brought to Vadstena and to what extent they were incorporated, modified or rejected in Hjertstedt’s own practice.

**Doctors abroad**

In 1833, The Guild of the Royal Order of the Seraphim contributed 300 riksdaler toward the cost of a study trip for Georg Engström, in order to advance the knowledge of asylum science in the country.¹²¹ He set off in the summer of that year, and the first destination was the Saint Hans Hospital outside Roskilde in Denmark, established in 1816. Though not exclusively an asylum at the time – elderly and sickly pauper individuals were also cared for – St Hans was the largest institution caring for the insane in the country. Engström’s comments on the asylum are brief; he was impressed by the pastoral beauty of its surroundings, its clean air and large parks.¹²² The favourable description indicates familiarity with the early nineteenth-century ideal therapeutic environment, championed by the Tukes of the York Retreat among others, as one where the hospital surroundings served to employ patients with outdoor work, as well as restore and distract suffering souls and minds by its tranquillity and beauty.¹²³

The second stop on Engström’s journey, the Schleswig asylum in the Danish duchy of the same name, does not appear to have impressed him, in spite of its new and

---

¹²¹ Qvarsell, *Ordning och behandling*, 98.
¹²³ Though not mentioned in his account, it appears likely that Engström was aware of the recent history of St Hans. The asylum had been the site of a highly publicised controversy surrounding its first medical superintendent, chief surgeon Johannes Henrik Seidelin (1786-1855), in its first years of operation. Seidelin believed that insanity was caused by moral failings and had implicated a regime of strict discipline. In the summer of 1829, a judicial complaint was lodged by a former patient, law student Wilhelm Frydendahl, claiming that he had suffered beatings, whippings and psychological punishment at Seidelin’s hands. The resulting 1830 commission investigation found support for Frydendahl’s claims among testimonies of the hospital staff; the Board of Directors was reprimanded, and Seidelin was dismissed by royal decree in 1831. At the time of Georg Engström’s visit, Adolph Göricle (1898-1885) had replaced Seidelin as superintendent.
expensive purpose-built architecture. His brief description does note that patients were separated according to type of illness, and that a number of measures had been introduced for the leisure and occupation of patients. Engström would, on his return to Sweden, remark in a quarterly report to the Guild that suitable leisure activities might raise the spirits of the melancholy, focus the confused mind and keep the disordered imagination in check. It is possible that it was the leisure facilities at Schleswig that inspired Engström to suggest to the Board of Directors in 1839 that a skittles alley be built in the asylum grounds. The majority of Engström’s account is taken up by the description of his final destination, the famous Sonnenstein asylum at Pirna, in Saxony. The institution’s international reputation, which was substantial at the time of Engström’s visit, had been enhanced by the lengthy description of its methods authored and published in 1829 by the head of the Board of Directors, Count Gottlob Adolf Ernst von Nostitz und Jäckendorf (1765-1836). Engström had a copy of the text in his library, but it is not known whether he acquired it before, after or during his visit. In the summer of 1833, the head physician of that institution was Ernst Pienitz (1777-1853), a disciple of Pinel who had trained at the Salpêtrière alongside Esquirol. Influenced by his instructor’s novel approach to the treatment of insanity, Pienitz had tried to implement his ideas in Saxony, and created what appeared to Engström to be the very pinnacle of a modern asylum. Following a thorough description of the asylum’s day-to-day operations, including meals, occupations of patients as well as Pienitz’s moral treatment, Engström calls Sonnenstein “a perfect institution”. When making suggestions for future asylums in Sweden, and recommendations for their construction and management at the end of his account, Engström used Sonnenstein as a model in all aspects.

Directly or by extension, Engström came into contact with many of the most influential ideas in contemporary psychiatry on his journey; he knew to seek out the most famous asylum in Germany, and became personally acquainted with highly specialised psychiatrists. Furthermore, records of the contents of Engström’s personal library indicate a genuine effort on his part to familiarise himself with the field. The collection contained upwards of 95 volumes, the majority of which were works of early Ger-

---

125 Engström, Berättelse, 33 and 41f.
126 Qvarsell, Ordning och behandling, 146.
127 DA, E1:10, Engström to the Board of Directors, February 16th, 1839. The plan would never be realised, and no record of any further discussions on the matter has been found.
129 Sw. En fullkomlig sjuk-inrättning, Engström, Berättelse, 46.
130 Qvarsell, Ordning och behandling, 105-112, 226-232.
man psychiatrists, though French and English physicians are represented, the latter in German translation. The book collection is to be considered very extensive indeed given the relatively new status of psychiatry as a medical specialty and the relatively small number of specialised practitioners. That Engström, based as he was in a rural area, and seemingly constantly struggling with financial constraints, succeeded in accumulating such a collection signifies a level of dedication to his task. Presuming that he read the works, they would have afforded a substantial orientation in the psychiatric literature of his time. Engström’s suggestions for improvements and the expansion of asylum care in Sweden imply a commitment to the reformist ideas of his European contemporaries. Mildness on the part of the physician, a commitment to moral treatment, and above all an orderly therapeutic environment are stressed as key factors in the model asylum. There is no evidence that Engström ever ventured abroad on official business again. Presumably his duties as superintendent did not permit extensive travelling, especially since Engström was the only physician at the asylum until 1840. Furthermore, Engström was sickly, and requested leave from his post on several occasions in order to tend to his health. Following his appointment as assistant medical officer, Hjertstedt continued and expanded on the work that Engström had started; moving further abroad and visiting more institutions with the intent of importing ever more knowledge of asylum organisation and practice.

Hjertstedt’s travel account covers his European trips of 1845, and is dated December 9th 1846, after his return to Sweden. Written for Sundhetscollegium, the aim of the report was to document asylum care, and provide suggestions for the furthering and improvement of the system of care for the mentally ill in Sweden. As such,

---


133 *Ibid*., 96.
the account is thorough, rich in detail, and decidedly diplomatic – even when addressing issues that were of great interest to the physician-author himself. Debates, disagreements and controversies are reported in a measured and tactful manner, and Hjertstedt takes care to not colour such reports with his own personal opinions. However, he freely expresses his admiration (and occasionally, his disapproval) for the quality and condition of the institutions and the provisions made for their patients.

The travel account begins with descriptions of his official visits to English asylums in 1845. Prior to the record of his own observations, he spends eighteen pages summarising the legislative framework for asylum care in England, as stipulated by the “Act for the Regulation of the Care and Treatment of Lunatics” which was passed in the year of his visit. Having clearly spent some time familiarising himself with the history of psychiatric provision, and the recent reforms carried out for its improvement, Hjertstedt expresses his approval for the measures taken. He mentions by name the philanthropist and social reformer Anthony Ashley-Cooper, 7th Earl of Shaftesbury (1801-1885), sponsor of the two 1845 Lunacy Acts, and head of the Lunacy Commission, calling him “a zealous and noble defendant of the depressed”. In typical diplomatic fashion, the Swedish physician does not venture to assess the particulars of the English legislative measures. He writes:

Without attempting to criticise these laws and their possible faults, which the future will most effectively reveal, I cannot but express my greatest admiration for the zeal with which the English nation has addressed this important issue, which sadly has not been given the attention it deserves in many civilised countries.

The organisation and work of The Metropolitan Commissioners in Lunacy, the public body established by the 1828 Act to oversee asylums, is described in some detail, and Hjertstedt relies heavily on their official reports, sometimes translating them verbatim, in describing the state of English asylums. Although no such suggestion is explicitly made, a comment on the lack of state control over private institutions in Sweden in his afterword suggests that Hjertstedt saw the need for such an inspectorate to be established. The lack of comments on, or criticism of the Commissioners’ reports indicates that Hjertstedt did not have a supplementary source of information, apart from his own observations.

134 Hjertstedt, Berättelse, 5.
135 Under the 1845 Act, the Metropolitan Commissioners in Lunacy became simply The Commissioners in Lunacy, thus indicating more clearly their jurisdiction which had, in 1842, been extended from London to the whole of England.
136 Hjertstedt, Berättelse, afterword.
Public and private institutions

While institutions for the unsound of mind in Sweden were almost exclusively public, private establishments for the unsound of mind were already in operation in England in the Elizabethan period\textsuperscript{137}, and by the eighteenth century what has often been called the “trade in lunacy” saw the peak of its success. Private madhouses were set up by individuals or families, of which some, though far from all, had some degree of medical training. By the end of the eighteenth century, around 45 private madhouses were recorded in England and Wales, but the total is likely to have been much higher\textsuperscript{138}. Many of these were highly specialised; as boarding houses for “idiots”, elderly patients, or insane women of the upper classes, or, as in the case of Drayton Parslow Asylum in Buckinghamshire, catering primarily for insane Oxford undergraduates\textsuperscript{139}.

Hjertstedt spends a considerable amount of ink relaying the rise and regulation of the private mad trade; describing the different types of asylums and their intended patient groups. The six different institutions visited by him during his stay together represent the different types of institutions for the insane available in England in 1845. The ancient Royal Bethlehem Hospital (hereafter referred to as Bethlem) cared for London’s pauper lunatics, while St Luke’s Hospital for Lunatics catered mainly to the middle class and was funded on a subscription basis\textsuperscript{140}, the Middlesex County asylum at Hanwell and the Surrey County asylum represent the large-scale county institutions made mandatory by the 1845 Lunatics Act, and London’s Whitmore House and Bethnal Green asylums represent private-run establishments for paying and pauper patients respectively. Citing the 1844 report of the Commissioners in Lunacy\textsuperscript{141}, Hjertstedt records that in the year in question, there were 17 county asylums in England and Wales, and 136 private asylums, of which 92 were for paying patients and 44 for paupers. Continuing to cite the Metropolitan Commissioners, Hjertstedt states that these asylums vary a great deal in comfort and quality; some are grand and provide patients with all desirable comfort and occupation, and are set in very suitable


\textsuperscript{138} Marland, “Introduction: The Trade in Lunacy”.


\textsuperscript{140} Subscription hospitals had their income from charitable societies, organisations and individuals. Patients would pay a fee covering most or all of the cost of their room, board and treatment. See further Leonard Smith, \textit{Care, Comfort and Safe Custody: Public Lunatic Asylums in Early Nineteenth-Century England}, London: Leicester University Press, 1999, 53f.

\textsuperscript{141} Published as Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor, London: Bradbury and Evans, 1844.
surroundings, while some are cramped, situated in cities with no access to fresh air, and are “generally lacking”.

In contemporary England, private madhouses were often viewed with suspicion as mere moneymaking schemes for immoral entrepreneurs, and convenient dumping-grounds for difficult family members and relatives. The prospect of financial gain undoubtedly attracted profit-minded individuals (after all, all that was needed in order to run a facility for the insane was a small, safe house and a few servants), and reports of terrible living conditions and outright abuses proliferated in the late eighteenth and early nineteenth centuries. As early as 1728, the novelist Daniel Defoe had claimed that husbands used private madhouses to dispose of unwanted wives, and called for the suppression of such institutions, or at least their placement under effective regulation and regular inspection. Defoe was never to see this goal achieved: it was to be 46 years from the writing of his broadside until the passing of the first Madhouses Act, in 1774. Previously unregulated, proprietors of private establishments for the mad were now required to have a license, issued by a committee of the Royal College of Physicians. The license holder was allowed to operate a single house, and would have to re-apply for his license each year. Madhouses were subject to annual inspection by the committee, and a register would be kept of all confined lunatics in London. Also, the Act required, for paying patients being admitted to private madhouses, the completion of a certificate of insanity by a physician, surgeon or apothecary. No legislation existed which required certification for pauper lunatics on admission to a public institution.

Alongside the accusations and reports of abuse, evidence does exist which indicate that some private asylums were run by persons with genuine concern for the mentally disturbed, or by doctors devoted to the furthering of knowledge about the care and treatment of insanity. One such character was Nathaniel  

---

142 Sw. Bristfällige på alla sätt.  
Cotton (1707-1788), poet, physician and proprietor of the Collegium Insanorum at St. Albans, who treated the poet William Cowper, and gained his patient’s gratitude and respect.

It is difficult to determine to what degree Hjertstedt was aware of public opinion of private madhouses, but he notes in his account that cases of wrongful confinement do occur, and gives an example that alludes to the fears expressed by Defoe more than a hundred years earlier.

People have been unlawfully incarcerated in such institutions, and in the year 1842 the Metropolitan Committee found a completely sane woman interred as insane in a private facility (Derby), as a result of her husband’s desire to be the sole beneficiary of her fortune.

By his own admission, Hjertstedt was not well acquainted with private care for insane patients in Sweden, and little evidence remains to trace the extent of such practice. From the royal instruction to erect county asylums for the care and treatment of insanity in 1826, these institutions housed the great majority of the kingdom’s suffering individuals. At the time of Hjertstedt’s journey, Sweden had nine county asylums for the care and treatment of insane patients, all of which were supervised by the Guild of the Royal Order of the Seraphim. In the afterword to his travel account, Hjertstedt mentions private asylums in Sweden, as well as the fact that anyone may receive disturbed persons for care, and calls for the regulation of such activity. While some physicians were known to see patients with psychological problems and symptoms in their private practice, no licences were required for the establishment of private madhouses.

---

149 Cowper wrote of his experience in a letter: “I reckon it one instance of providence /.../ that I was not delivered into the hands of some London physician, but was carried to Dr. Cotton. I was not only treated by him with the greatest tenderness while I was ill, and attended with the utmost diligence, but when my reason was restored to me, and I had so much need of a religious friend to converse with, to whom I could open my mind upon the subject without reserve, I could hardly have found a better person for the purpose.” Thomas Taylor, The Life of William Cowper. London: Smith Elder & Co., 1833, 41.
150 Sw. “Exempel saknas ej, att personer blifvit olagligen insperrade i dylika sjukinrättningar, och år 1842 fann metropolitan-committeén ett fullkomligt klokt frunntimmer insatt i en privat anstalt (Derby) såsom wansinnig, till följe af mannens begär; att ensam få ätnjuta dess förmögenhet.” Hjertstedt, Berättelse, 17. The report of the Metropolitan Commissioners states that the asylum was Green Hill House, Derby, and that the female patient was released by the Commissioners on their visit in October 1844, having been confined without certificates since May of that year. Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor, 56-57.
151 Qvarsell, Ordning och behandling, 53.
The work of Elisabeth Mansén on Swedish spas has established that individuals suffering from milder forms of psychiatric distress had the option of taking treatment at health spas across the country. 152 Like the health spas, Swedish county asylums admitted patients (at spas referred to as “guests”) in first, second and third class, according to the rate the patient’s family or guardians were able or willing to pay. Non-paying guests could have their stay paid for by a designated fund, and pauper asylum patients would have their treatment funded by their home parish. Like public asylums, hospitals and provincial doctors, proprietors of spas were obliged to provide annual reports to the National Medical Board, and some of these were published in the annual official reports. Private asylums or institutions for individuals with learning difficulties did not have the same obligations, and none such are mentioned in the official reports of the National Medical Board before 1870. 153 Hjertstedt does not appear to be categorically opposed to the idea of private asylums, only careful to stress the need for their proper supervision.

Hjertstedt, John Conolly and the non-restraint movement

The asylum at Hanwell /…/A temple sacred to benevolence, a monument and memorial of the philanthropy of our times. 154

The previously-mentioned Dr Conolly was the alienist usually credited with making non-restraint the prevailing orthodoxy in nineteenth-century British psychiatry. 155 A Professor of Medicine at the University of London, and founder of the British Medical Association, Conolly was resident physician of the Middlesex County Asylum at Hanwell from 1839 to 1845, and was responsible for the abolition of physical restraint there. Although not the first to take such action – similar agendas had been pursued by the Tukes at the York Retreat, and more recently by another physician, Robert Gardiner Hill, at the Lincoln asylum – Conolly’s radical implementation of the system in a large metropolitan asylum was a powerful statement. 156 Although not universally admired, the resulting publicity made Conolly a national celebrity, and among his

153 Öfverstyrelsen öfver Hospitalens Underdåniga berättelse för år 1870.
155 Scull, Social Order/Mental Disorder, 163.
156 At the time of Conolly’s appointment the institution had around 800 patients, at the time of his visit, Hjertstedt estimates the number to about 1000.
vocal supporters were men of great influence: Samuel Tuke, Lord Shaftesbury, and founder and editor of The Lancet Thomas Wakley to name a few. To contemporaries, the institution seemed inspirational, and Conolly’s work was lauded by Shaftesbury as the “greatest triumph of skill and humanity” that the world had ever known. It is likely that Conolly’s fame and his reforms at Hanwell was at least in part the reason for Hjertstedt’s visit there.

Hjertstedt begins by providing a sober description of the non-restraint system: in place of mechanical devices, manual force and seclusion are the only means employed to calm raving or violent patients.

They do not believe it should be called coercion when a patient’s violent outbursts and fury must be quelled with the physical strength of the staff, or when he is secluded in a cell.

The quote indicates a level of distance, a subtle indication that Hjertstedt himself is not convinced by the definition of what constitutes restraint or coercion. Even so, he dutifully reports the arguments set forth by Conolly and his followers in favour of non-restraint: that it is more humane, and has a calming effect on patients, that it allows the patient to develop his own self-control, that mechanical restraint morally degrades patients, that patients under restraint are easily abused by asylum staff, and that control and order may just as easily be maintained with careful classification of illness, and a large body of staff.

The somewhat sceptical tone returns as the Swedish physician records that superintendents of non-restraint asylums report no inconvenience as result of the new system, but rather that order and comfort is much improved within the asylum. Relying once again on the annual reports of the Metropolitan Commissioners,

157 Quaker philanthropist and mental health reformer Samuel Tuke (1784-1857) was the grandson of William Tuke, founder of the York Retreat, and the author of the Description of the Retreat, which made the institution famous across Europe.
159 Ibid., 164.
160 Sw. De anse det ej böra kallas tvångsmedel, då patientens utbrott af våldsamhet och raseri måste kufvas af betjöningens armstyrka, eller då han innestängas på cell.
161 Hjertstedt, Berättelse, 41.
Hjertstedt relays some of the objections against Hanwell raised by that body following their inspections of 1843 and 1844.  

The inspections revealed in-asylum incidents where patients had been injured, and in one case even murdered, by fellow patients in a maniacal, raving state, incidents where members of asylum staff were injured by patients, and reported of complete disorder in communal rooms and walking courts. In addition to the Committee report, the former resident surgeon at Hanwell, Dr George Peacock Button, reports in The Lancet in 1841 a long list of injuries done by patients to staff during his time at the asylum. Furthermore, he argues that the Hanwell practice of excluding ranting or violent patients in a cell, sometimes without light, is more detrimental to the spirit and moral wellbeing of patients than partial mechanical restraint.

The incidents are the same as those highlighted by one of Conolly’s fiercest critics: former Hanwell asylum chaplain Francis Tebbutt. Tebbutt had lost his position in 1840, and proceeded to criticise Conolly and the non-restraint system fiercely throughout the legal proceedings in which he sought to vindicate himself. Hjertstedt alludes to the hostilities between Conolly and Tebbutt (mentioning the latter by name), suggesting that he may have taken part of Tebbutt’s criticisms, most likely in the medical journals’ correspondence sections. In his critique he joins the likes of Hanwell’s visiting physician Sir Alexander Morison, and both its assistant medical officers in condemning what he calls “Conolly’s high-handed approach”. However, ever the pragmatic, Hjertstedt explains the “extreme” of total non-restraint as a reaction against the previous regime in which excessive restraint was commonplace, and credits Conolly for raising awareness of the many abuses in the application of mechanical restraint. The vitriolic accounts of Tebbutt concerning Conolly’s character seem not to have influenced Hjertstedt’s personal impression of his colleague, as he repeatedly refers to Conolly’s “philanthropy” and “good intentions”.

With regard to the country in general, Hjertstedt reports that “some” private and public asylums have done away with mechanical restraint altogether, that others make cautious use of gloves, belts and chairs to restrain patients on rare occasions, and that only “the worse ones” still used manacles and chains until recently. Displaying again his faith in the Metropolitan Commissioners, Hjertstedt believes that such have been

---

162 Hjertstedt, Berättelse, 39.
164 See Francis Tebbutt, Letter to the Magistrates of the County of Middlesex from the Rev. Francis Tebbutt, Printed for the magistrates only, London, 1841.
165 Sw. Conollys egenmäktiga förfarande.
altogether disposed of as a result of “the committee’s thorough inspections”.

He concludes that the majority of alienists in the country believe that there are cases in which restraint is necessary for the safety of the patient. The only dangerous behaviour highlighted here is violence to others, but a survey of medical periodicals in the early 1840s reveals wider concerns.

Among those who write in favour of a system in which restraint is permitted (all agree that it must be mild, short-term and never applied except on the orders of the superintendent), behaviours classified as “obscene” are often highlighted as requiring such action. This appears to include masturbation and sexual assault, as well as more general indecency (doctors often use terms such as “practical indecencies”, and in one case “unheard-of, preposterous obscenities”). Masturbation, that “odious sexual habit, as invincible as it is humiliating and degrading” was notoriously difficult to control in patients so inclined, and advocates of restraint claimed that the straitjacket was the only means to prevent them indulging at night. “To be secured in the night, and never to be allowed to pass out of the sight of the guardian during the day – not even to go to the water-closet – are both and equally necessary” writes one physician. Masturbation was believed to be harmful for patients in several ways; many letters to The Lancet describe it as though it were a form of self-harm, a tenacious habit which gradually weakens both physical and moral health.

166 Sw. Blott i de nämre woro jernkedjor, handklofwar m.m. för några år sedan ännu allt för mycket i bruk, men som genom Metropolitan committeens noggranna inspectioner nu troligen äro afskaffade.

167 Hjertstedt, Berättelse, 41.

168 The list of negative consequences of the non-restraint system held up by critics is long, and includes examples of terrible events within asylums which could not be prevented without restraints; patients who commit the most horrifying acts of self-harm, patients who eat their faeces, and patients who are allowed to starve themselves to death, as forced feeding is no longer permitted. “Sir John Scott Lillie on the Restraint of Lunatics at Hanwell”, The Lancet, 35 (912), 20 February 1841, 759-760. In financial terms the system also had some unforeseen consequences, the report of the meeting of the Middlesex magistrates in 1840 bemoaned the cost of replacing broken glass in the asylum windows, which had dramatically risen with the introduction of Dr Conolly’s regime. “Middlesex Magistrates and Lunatic Asylums”, The Lancet, 35 (897), 7 November 1840, 238-241.


171 Philalethes, 537.

172 Anon., “Cases of Insanity in which Bodily Restraint is Imperative”, The Lancet, 57 (959), January 1842, 544-545.
masturbation were believed to be in a sense infectious. Applying restraint to prevent such practices from occurring would thus be beneficial both to the individual patient, and to the health of the patient population as a whole. Hjertstedt appears to have spent some time considering the issue of non-restraint, and reports that he has consulted with “the most skilled physicians of the soul in other countries on the subject. He claims that they all oppose the single-minded application of the non-restraint system, and that all consider mechanical restraint necessary in some cases. Interestingly, he returns to England’s brutal asylum past, appearing to make an excuse for non-restraint by viewing it as a backlash to the brutality of past asylums. While visiting Bethlem, he recalls comments on its infamous past, and notes that non-restraint is now the prevailing system within its walls. The debate appears to have continued among Hjertstedt’s Swedish colleagues in the 1860s; former assistant physician at Vadstena Wilhelm Öhrström (1821-1891) distinguishes himself in an 1866 article as another prominent voice in favour of mild restraint. Reacting against an article of the previous year, where the author claims that all coercion constitutes abuse, and echoing the arguments of the English alienists who opposed Conolly, Öhrström maintains that restraint is necessary and in fact more humane than the absence thereof. His examples do not, however, include masturbation, but rather the necessity of forced feeding to prevent patients starving themselves, and of the straitjacket to stop raving patients from aggravating their wounds and eating excrement.

---

174 Sw. *De skickligaste själsläkare*.
175 De skickligaste själsläkare jag rådfrågat i andra länder i detta ämne hafwa alla ogillat det ensidiga användandet af non-coercion systemet och påstå att, ehuru mycket man än må inskränka bruket af mekaniska tvångsmedel, gifwas dock tillfällen, der de äro både nödvändiga och nyttiga. Det öfwerdrifna bruket af hårda och swåra tvångsmedel såsom kedjor, jernblockar och andra för brotstlingar begagnade plågoredskap som förr begagnades inom många hospital i England, hafwa utan tvifvel gifwit anledning till ytterlighet å andra sidan.
Figure 4. The Middlesex County Asylum at Hanwell, 1875, with the chapel at the centre. The panopticon tower of the male ward is visible in the distance. Printed in Edward Walford, *Greater London: A Narrative of Its History, Its People and Its Places*. London: Cassell & Co., 1883.

At all the English asylums visited on his journey, Hjerstvedt found that male and female patients were carefully separated. The larger institutions like Bethlem and St Luke’s had entirely separate wings for each sex, with their own walking grounds, day rooms, entertainments and workshops. Hjerstvedt or the English superintendent: give no rationale for the strict division of the sexes; but in the context of Victorian morality such an explanation would be superfluous. The asylum itself was, from the early nineteenth-century, considered to be a powerful therapeutic tool; it was to be an environment that isolated the patient from harmful influences, and emulated all the aspects of a healthy, productive and moral life. Maintaining propriety and decency was of the uttermost concern to superintendents, and any failure to do so brought on negative publicity and was severely reprimanded by the inspectors. Under Georg Engström, efforts had been made to separate male and female patients at Vadstena, but
patients remained in close proximity to each other, and outdoor areas were often shared.178

**Beauty, order and comfort**

Comments made about the outdoor spaces available to patients in the various English asylums reveal the importance attached to fresh air and outdoor occupation by early nineteenth-century psychiatry, both in Sweden and on the continent. The appearance of buildings and their surroundings is noted for each asylum visited, and not only their practicality or suitability as spaces of care for the insane; “beauty”, “cheer” and “comfort”179 are reoccurring terms, signalling a belief in the calming and curative effect of attractive surroundings on the disordered mind. The palatial exteriors of Bethlem and Hanwell, criticised by some English contemporaries for allegedly influencing experts and public alike to look upon the increasing numbers of committals favourably,180, are admired in Hjertstedt’s account. Upon his arrival at Hanwell, the physician is struck by the grandeur of its main building, which “competes with royal palaces in splendid appearance”181, and considers the surrounding park one of the most beautiful he has ever seen.182 Hanwell’s rural setting and substantial acres of farmland meant that patients could be set to work outdoors in the summer months, and Hjertstedt notes this with approval, adding that all the foremost alienists in England agree that “useful occupation and leisure” are powerful therapeutics in psychiatric practice.183 In comparison with the large and purpose-built county asylums of England, Vadstena might seem a diverse and difficult-to-manage little collection of buildings. Concerns about the many separate houses that were taken into use for the housing of patients during Vadstena’s expansion in the 1830s and 40s and the fact that none of them was built as a hospital returns repeatedly during Hjertstedt’s superintendency, both in his own annual reports, and in those of inspectors.184 The first purpose-built

178 Qvarsell, *Ordning och behandling*, 71f.
179 Sw. *Trefnad*.
180 “The very imposing appearance of these establishments acts as an advertisement to draw patients towards them. If we make a convenient lumber-room, we all know how speedily it becomes filled up with lumber. The county asylum is the mental lumber room of the surrounding district, friends are only too willing, in their poverty, to place away the human encumbrance of the family in a palatial building at county expense.” Andrew Wynter, “Non-Restraint in the Treatment of the Insane”, *Edinburgh Review*, 131, 1870, 221.
181 Sw. *Täflar med furstliga palatser i storartadt utseende*.
183 Hjertstedt, *Berättelse*, 68.
184 For a full description of the Vadstena asylum’s different buildings and wings as they were at the beginning of Hjertstedt’s superintendency, see Qvarsell, *Ordning och behandling*, 70-75.
asylum in Sweden, Konradsberg in Stockholm, was opened in 1861. The palatial building met with some of the same concerns as the English county asylums, and was commonly known as “the castle of fools”.

Figure 5. The asylum at Vadstena viewed from the east. Image from Öfverstyrelsen öfver hospitalen underdåniga berättelse för år 1861.

Wilhelm Ohlström, “Beskrifning öfver Byggnaderne vid Stockholms Hospital Conradsberg”, Öfverstyrelsen öfver Hospitalen Underdåniga Berättelse för år 1861, appendix B. VII.
The term “useful occupation” is recurrent in Hjertstedt’s account, as well as in psychiatric treatises of the early nineteenth century. Industriousness was a chief virtue both in Sweden and Victorian England, and while work played a central role in the curative regime of the asylum, physicians also sought to fill patients’ non-working hours with activities which served to calm the mind and distract patients from harmful thoughts. Hjertstedt notes with approval that Bethlem possesses a well-stocked library with books and magazines, a billiards hall (for male patients), a skittle-alley, and a pianoforte, as well as many board games including chess, whist and backgammon, for the amusement of patients. He notes that among the calm female patients dances are arranged and that this is much appreciated among the ladies. At the time of Hjertstedt’s visit there was no teaching of patients at Bethlem, however he reports that plans are being made to establish a school, and expresses his approval. A measure of intellectual work, alongside the physical is often beneficial, he asserts, “in awakening powers of the soul that have long slumbered.”

If the initial, long account of English asylum legislation and inspection gives the impression of a man who has set out to suggest reform on a legal and administrative level (but who also displays some caution in doing so) Hjertstedt’s notes from asylum visits indicate a great interest in the day-to-day operations of institutions. As someone whose asylum work has up to this point been that of the assistant medical officer, his interest in practical solutions to ensure the safety and well-being of patients is evident, and the text indicates a greater confidence in suggesting reform at this level. Hjertstedt expresses great interest in the Bethlem system of using night-clocks, or “tell-tales” to detect any neglect on the part of the night attendant to perform his rounds at the correct times. Having never seen such clocks elsewhere, he thinks the “excellent” device deserves to be implemented in each asylum. Also at Bethlem, Hjertstedt notices the use of a special, very strong fabric to make clothes for patients who have a propensity to tear them. In a rare mention of his own practice, he recognises a need for such a solution at Vadstena. Stronger clothing would eliminate the need for the strait-waistcoat in cases where destruction is the only violent behaviour, Hjertstedt reasons, adding that the waistcoat is humiliating and tends to agitate such patients further.

---

186 Sw. Nyttig sysselsättning.
187 Hjertstedt, Berättelse, 62.
188 Hjertstedt, Berättelse, 62.
189 Andrews, et al., The History of Bethlem, 453.
190 Hjertstedt, Berättelse, 60.
191 Sw. Äfven hos oss är högeligen af behofwet påkalladt, att kläder af något så beskaffadt starkt tyg må användas för dylike patienter /.../, och som nu i brist af dylik stark beklädnad, måste fängelas med tvängströja, ett medel som ofta ännu mera uppreter och förödmjukar den sjuke, och vilket, längre til användt, slutar med att förstöra patientens physiska helsa. Hjertstedt, Berättelse, 60.
On his travels, Hjertstedt encountered a number of the most prominent psychiatric physicians of his time and found many of them worthy of admiration, if not above criticism. As we have seen, he admired the philanthropy and zeal of John Conolly, but believed that the latter’s complete abolition of restraint was excessive. At Bethlem and St Luke’s Hjertstedt noted that the relatively small role played by the visiting physicians meant that the apothecary appeared to be the “actual doctor”, as he was the only medical officer to be resident on the premises and visited the patients daily. For this reason, he reports, Bethlem has not developed to the same level of perfection as the newer German asylums, where the doctor “like the father of a family fends for his patients’ happiness”. The image of the physician as a father figure returns in Hjertstedt’s account of his visit to the Salpêtrière, where the impressive figure of Jean-Pierre Falret (1794-1870) receives a special mention.

Falret’s way with the ill is remarkable”, writes Hjertstedt, “With only a look, an expression or a few words he often expresses his contentment or disappointment, and seems to entirely control his patients in this manner. These are treated with fastidiousness and kindness, and he gives, out of his own pocket, small rewards to those who are most deserving. The patients appear to love him as a father and seem to do anything to acquire a kindly look or a few genial and encouraging words. The “psychic”, moral methods of treating the insane emphasised by English reformers such as the Tukes of the York Retreat and John Conolly of Hanwell appears to Hjertstedt to be most successfully practiced in France, and he adds that mechanical restraint seems to be made largely redundant by such treatment. At no point in his travel journal does Hjertstedt reflect in more detail upon the role of the physician and his relationship with his patients. The image that emerges of the Vadstena physician is that of a thoroughly practical man, with a keen eye for details, and a profound interest in the everyday workings of the successful asylum, with rather less of the philanthropist set upon grand humanist reforms.

192 In 1845, Sir Alexander Morison (1779–1866) and Dr Edward Thomas Monro (1789–1856).
Conclusion

In the brief afterword to his account, Hjertstedt acknowledges his “duty to report the noteworthy differences” between Swedish asylum care and that in other countries, in accordance with his instruction. It is surprising to find that this seemingly key point of his account is so brief and perfunctory, making up only two-and-a-half pages. The suggested reforms are listed as follows: first and foremost the kingdom requires a specific legislation, like those of England and France, regarding the asylum system and the care and treatment of the insane. Hjertstedt writes that it is his firm belief that the existing Swedish legislation could be improved upon to a great degree. He suggests that by using the English and French examples as models for such improvements, the process of producing new legislation would not necessarily be expensive or time-consuming. Secondly, he calls for the regulation of private asylums or homes for the care of the insane, stressing that above all; the insane must be protected from violence and “arbitrary treatment”. No specific measures of how this is to be achieved are suggested in the afterword. Rather, Hjertstedt’s suggestions are presented in a more convoluted way, in the long accounts of his visited asylums, where he praises and criticises the psychiatric practice he has witnessed. Primarily, he is fiercely pro-asylum, arguing throughout for highly specialised care of the insane, and dismissing families “whose supervision and care is often the most unfit and unsatisfactory of all”. This comment is to be read as a call for political action; as we have seen official statistics for Sweden at mid-century recorded that only a quarter of the nation’s citizens deemed insane were cared for in institutions. Hjertstedt favours the English system above all, for the energy spent on reforming psychiatry, the means set aside to build and run county asylums, and to ensure government inspection and supervision of those institutions. His admiration for what he appears to view as a particular regime of structure specific to that nation shines through in several places, for example the kitchens at Bethlem are characterised by a cleanliness and order, which “can scarcely
be possible outside of England”. 197 His travels never take him outside the southeast of England, and (most likely relying on the reports of the Metropolitan Commissioners), he is content to report that in the other parts of the British Isles, the state of the insane is deplorable.198

Although an ambitious document, the travel account reads as cautious and pragmatic, both in tone and in the suggestions it makes for improvements to the Swedish asylum system. Though Hjertstedt will go on to make a name for himself as a diligent and admirable superintendent of Vadstena – some have even hailed him as reformer and benefactor of the insane199 – at the point of writing he is young and has relatively little experience in his field. However, the attention paid to the daily operations of the asylums visited, the living conditions of patients, and especially to the application of restraint and the availability of useful occupation, signals a profound interest in his profession, and an acute eye for practical solutions. It is also indicative of Hjertstedt’s own experience up to that point: as assistant medical officer under Engström his chief concern would have been the day-to-day practice of psychiatric care. Schooled in a medical culture which bore the mark of Engström’s philosophy – a firm belief in the inherent curative power of the asylum, a minimum of restraint applied, and an emphasis on reinstating order and healthy habits into the lives of patients – Hjertstedt appears to have approached English psychiatry with a curious, but measured gaze. In the following chapters, we return to Vadstena and Hjertstedt’s own practice to try and discern if, and in that case how, his impressions from abroad impacted on the medical culture at Vadstena, and especially on the interpretation and treatment of erotic insanity.

197 Sw. I souterainen är köket och de öfrige till hushållningen hörrande rum belägne, utmärkande sig för en snygghet och ordentlighet, som utom England väl knappt är möjlig.
198 Hjertstedt, Berättelse, 45.
199 Söderström, “Svängstolen vid Vadstena Hospital”.
2. The Aetiology of Erotic Insanity

Madness is categorised in the Vadstena case records as an act of transgression. It is described as a pathological inability to adhere to, participate in and reproduce societal norms of behaviour. Patients are defined against an unseen ideal, an unspoken model of respectable nineteenth-century citizenship that exists in the asylum sources only as the invisible example against which their own actions are measured. “Shows no inclination for work.”200 “Has displayed great incontinence.”201 “Great thirst for spirits.”202 “Has disordered ideas about religion.”203 “Tears their clothing and destroys objects.”204 “Goes about naked, showing no shame.”205 These statements are reoccurring in Vadstena casebooks as descriptions of illness symptoms. Similar descriptions are also found in admission records, where certifying ministers and physicians attempt to provide explanations for the outbreak of illness. In the eyes of medical men, idleness, drunkenness, vagrancy, violence (domestic or otherwise), an immodest life, and too much brooding on religious matters could be depicted as symptoms indicating a disordered mind, but also as causes of mental suffering.

Erotic and sexual causes

From 1861, the annual reports of the Swedish Board of Asylums contain tables recording the presumed cause of insanity among patients committed to Swedish asylums for that year; reporting how many patients had been admitted in the current year, and how many had remained from the previous year. Prior to this, no such statistics are available for Sweden as a whole, though cause of insanity was recorded in registers of individual asylums, and given in annual reports to the Sundhetscollegium. In the years following 1861 (until 1895 when this study ends), the tables of causes contain between 35 and 40 cause categories, presented under seven headlines: moral causes, intellectual causes, sensual causes, organic causes, external causes, predisposing causes. The seventh – and often the largest category – appears last in the tables, the disparaging cause unknown. (See figure 6.) It is noteworthy that the cause categories are not fixed; the tables simply represent the presumed causes of patients currently in asylum care as given by asylum doctors. A single case of illness attributed to, for example, head trauma, means that that cause is included in the table for that year. Thus, certain cause categories disappear and reappear throughout the period.

200 Sw. Visar ingen lust till arbete.
201 Sw. Har visat stor lidelighet.
202 Sw. Starkt begär efter spirituosa.
203 Sw. Har förryckta idéer om religionen.
204 Sw. Sönderstiller sina kläder och sönderställer föremål.
205 Sw. Går omkring naken, visar ingen blygsel.
without this necessarily indicating any shift in medical thinking regarding aetiology. However, the terminology used in the tables warrants some attention. Masturbation occurs in the tables throughout the period (under the heading “sensual causes”), and so does “love” (under the heading “moral causes”). From 1861-1875 “masturbation” is its own cause category, and appears alongside “exaggeration in fulfilment of sexual desire”. From 1876, “masturbation” becomes “masturbation and nymphomania”, and the previous “exaggeration in fulfilment of sexual desire” has been left out. In the 1885 report, nymphomania has disappeared, but masturbation remains, albeit under a different name; previously always referred to as masturbation\(^{206}\) it is now in the table as self-abuse\(^{207}\). The significance of these changes is difficult to assess; excess in gratifying one’s sexual desire (with another person) remains in some form until the report of 1885, but as the term “nymphomania” indicates female patients only, its use suggests that lewdness is only, or mainly, pathogenic for women. Also, the fact that nymphomania is listed here as cause of insanity demonstrates the fluid nature of the term; here it is separated from the illness itself, elsewhere it is the label attached to a specific set of symptoms and behaviours, and at times even a diagnosis. The re-labelling of masturbation as sjelfbefläckelse (self-abuse) appears to the modern reader to be a more morally charged term, but may simply be a return to a Swedish word of German origin used in older works following a period where medical language on the subject was influenced by French and English treatises, which both used onanie/onanism.

\(^{206}\) Sw. Onani.
\(^{207}\) Sw. Sjelfbefläckelse.
<table>
<thead>
<tr>
<th>Årsrapport</th>
<th>Svavelämnen</th>
<th>Svavelämnen med m.</th>
<th>Svavelämnen med f.</th>
<th>Svavelämnen med b.</th>
<th>Svavelämnen med l.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1923</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>39</td>
<td>11</td>
</tr>
<tr>
<td>1924</td>
<td>123</td>
<td>50</td>
<td>10</td>
<td>31</td>
<td>13</td>
</tr>
<tr>
<td>1925</td>
<td>130</td>
<td>50</td>
<td>15</td>
<td>37</td>
<td>14</td>
</tr>
<tr>
<td>1926</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>38</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Årsrapport</th>
<th>Svavelämnen</th>
<th>Svavelämnen med m.</th>
<th>Svavelämnen med f.</th>
<th>Svavelämnen med b.</th>
<th>Svavelämnen med l.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1927</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>39</td>
<td>11</td>
</tr>
<tr>
<td>1928</td>
<td>123</td>
<td>50</td>
<td>10</td>
<td>31</td>
<td>13</td>
</tr>
<tr>
<td>1929</td>
<td>130</td>
<td>50</td>
<td>15</td>
<td>37</td>
<td>14</td>
</tr>
<tr>
<td>1930</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>38</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Årsrapport</th>
<th>Svavelämnen</th>
<th>Svavelämnen med m.</th>
<th>Svavelämnen med f.</th>
<th>Svavelämnen med b.</th>
<th>Svavelämnen med l.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1931</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>39</td>
<td>11</td>
</tr>
<tr>
<td>1932</td>
<td>123</td>
<td>50</td>
<td>10</td>
<td>31</td>
<td>13</td>
</tr>
<tr>
<td>1933</td>
<td>130</td>
<td>50</td>
<td>15</td>
<td>37</td>
<td>14</td>
</tr>
<tr>
<td>1934</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>38</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Årsrapport</th>
<th>Svavelämnen</th>
<th>Svavelämnen med m.</th>
<th>Svavelämnen med f.</th>
<th>Svavelämnen med b.</th>
<th>Svavelämnen med l.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1935</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>39</td>
<td>11</td>
</tr>
<tr>
<td>1936</td>
<td>123</td>
<td>50</td>
<td>10</td>
<td>31</td>
<td>13</td>
</tr>
<tr>
<td>1937</td>
<td>130</td>
<td>50</td>
<td>15</td>
<td>37</td>
<td>14</td>
</tr>
<tr>
<td>1938</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>38</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Årsrapport</th>
<th>Svavelämnen</th>
<th>Svavelämnen med m.</th>
<th>Svavelämnen med f.</th>
<th>Svavelämnen med b.</th>
<th>Svavelämnen med l.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1939</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>39</td>
<td>11</td>
</tr>
<tr>
<td>1940</td>
<td>123</td>
<td>50</td>
<td>10</td>
<td>31</td>
<td>13</td>
</tr>
<tr>
<td>1941</td>
<td>130</td>
<td>50</td>
<td>15</td>
<td>37</td>
<td>14</td>
</tr>
<tr>
<td>1942</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>38</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Årsrapport</th>
<th>Svavelämnen</th>
<th>Svavelämnen med m.</th>
<th>Svavelämnen med f.</th>
<th>Svavelämnen med b.</th>
<th>Svavelämnen med l.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1943</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>39</td>
<td>11</td>
</tr>
<tr>
<td>1944</td>
<td>123</td>
<td>50</td>
<td>10</td>
<td>31</td>
<td>13</td>
</tr>
<tr>
<td>1945</td>
<td>130</td>
<td>50</td>
<td>15</td>
<td>37</td>
<td>14</td>
</tr>
<tr>
<td>1946</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>38</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Årsrapport</th>
<th>Svavelämnen</th>
<th>Svavelämnen med m.</th>
<th>Svavelämnen med f.</th>
<th>Svavelämnen med b.</th>
<th>Svavelämnen med l.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1947</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>39</td>
<td>11</td>
</tr>
<tr>
<td>1948</td>
<td>123</td>
<td>50</td>
<td>10</td>
<td>31</td>
<td>13</td>
</tr>
<tr>
<td>1949</td>
<td>130</td>
<td>50</td>
<td>15</td>
<td>37</td>
<td>14</td>
</tr>
<tr>
<td>1950</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>38</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Årsrapport</th>
<th>Svavelämnen</th>
<th>Svavelämnen med m.</th>
<th>Svavelämnen med f.</th>
<th>Svavelämnen med b.</th>
<th>Svavelämnen med l.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1951</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>39</td>
<td>11</td>
</tr>
<tr>
<td>1952</td>
<td>123</td>
<td>50</td>
<td>10</td>
<td>31</td>
<td>13</td>
</tr>
<tr>
<td>1953</td>
<td>130</td>
<td>50</td>
<td>15</td>
<td>37</td>
<td>14</td>
</tr>
<tr>
<td>1954</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>38</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Årsrapport</th>
<th>Svavelämnen</th>
<th>Svavelämnen med m.</th>
<th>Svavelämnen med f.</th>
<th>Svavelämnen med b.</th>
<th>Svavelämnen med l.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1955</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>39</td>
<td>11</td>
</tr>
<tr>
<td>1956</td>
<td>123</td>
<td>50</td>
<td>10</td>
<td>31</td>
<td>13</td>
</tr>
<tr>
<td>1957</td>
<td>130</td>
<td>50</td>
<td>15</td>
<td>37</td>
<td>14</td>
</tr>
<tr>
<td>1958</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>38</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Årsrapport</th>
<th>Svavelämnen</th>
<th>Svavelämnen med m.</th>
<th>Svavelämnen med f.</th>
<th>Svavelämnen med b.</th>
<th>Svavelämnen med l.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1959</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>39</td>
<td>11</td>
</tr>
<tr>
<td>1960</td>
<td>123</td>
<td>50</td>
<td>10</td>
<td>31</td>
<td>13</td>
</tr>
<tr>
<td>1961</td>
<td>130</td>
<td>50</td>
<td>15</td>
<td>37</td>
<td>14</td>
</tr>
<tr>
<td>1962</td>
<td>135</td>
<td>54</td>
<td>15</td>
<td>38</td>
<td>13</td>
</tr>
</tbody>
</table>

Figure 6. Table of the presumed causes of illness for the patients admitted to Swedish asylums during 1861. Översynsvisa efter Hospitals Underlämna Berättelse för år 1861, § 10, 36.
The cause tables are often followed by a brief comment on the development in the given year, and the difficulty in determining the aetiology of insanity is repeatedly emphasised. The Vadstena material illustrates further the complexity of the aetiological investigation in individual cases; where masturbation or manifestly erotic or sexual behaviour is classed as part of a patient’s symptoms, the cause is most often associated with love or masturbation. However, the majority of patients have several possible causes listed in their admission documents, and these illustrate just how great a range of experiences, injuries and vices were perceived as potential origins of insanity. In the case of Pehr S, a minister, admitted in 1835, the clergyman’s letter reads:

Painful memories of disordered youth, guilt over harsh and immoral treatment of his brothers and sisters, unsatisfied claims on his parents and for distinction, and probably masturbation, are considered the main causes of his insanity.208

The search for causes in the archive material from Vadstena involves the identification of many separate voices in the material, most of whom provide only fragmentary evidence, and cannot be identified. In the case of Pehr S, the certifying minister (who was required to sign the letter personally) is clearly reporting information communicated to him from another source. Phrases such as “it is said that”, “Pehr S is said to have” are recurrent in the account, but nowhere does the minister state who provided the information. In cases where the certifying clergyman was personally acquainted with the sick individual, direct remarks regarding their previous life and character may occur, but most often admission documents have all the markers of reported testimony. In some cases, a note by the clergyman indicates that information was left by the sufferer’s parents or relatives.209 Admission record accounts predictably suggest previous illness and injury, family history of insanity, as well as social and economic circumstances as possible causes for the outbreak of mental disorder. A comparison of the suggested causes in admission documents from Vadstena with the official tables of causes in the Board of Asylum’s annual reports reveals no great disparity between the types of incidents which were suggested as triggers in lay and medical testimonies. However, clergymen as well as physicians had official questionnaires to guide their interviews with family members and relatives, and thus testimony would be partially dictated by the questions therein. The Vadstena material does contain examples of cases in which the cause suggested in admission documents is entirely disregarded by the asylum physician. Brita J210 was admitted in 1854, and the minister’s letter states

208 FIic:3 No. 404.
209 FIId:2 No. 2967, FI:26 No. 2927, FI:19 No. 2192, FI:19 No. 2164. For a comprehensive study of the role of the family in the shaping of psychiatric knowledge and care, see Suzuki, *Madness at Home*, and Riving, *Icke som en annan människa*.
210 FIia:8 No. 599.
that her illness was caused by harsh treatment at the hands of her husband, and “some irregularity” in connection with the onset of menstruation (the imprecise wording is typical of non-medical statements regarding the female reproductive system in the Vadstena sources). In the Vadstena register, the cause of Brita J’s condition is recorded as “unknown”, suggesting that Hjertstedt dismissed the causes indicated by the minister as invalid or not relevant.

“Madness may occur due to and in contexture with all the aberrations of emotional life,” wrote Swedish physician Otto Manderup Witt in his treatise on the pathology of the soul in 1864. The Vadstena records display an increasing amount of cases resulting from excessive emotion throughout our period. Nowhere, it seems, is the lingering belief in the balance of the organism through strict morality more prevalent than on the subject of love. From the first report in 1861 until the end of the nineteenth century, “love” features as cause under the heading “Moral causes” in the annual reports of the Board of Asylums. The tables (for Sweden as a whole) illustrate that love and “religious melancholy” were by far the most numerous in terms of cases among the moral causes. The Vadstena records examined for this study are not representative of the country as a whole in this respect; confused ideas about religious matters features as contributing cause in only seven cases. However, religion is often mentioned in admission documents and casebook entries even when it is not a cause or symptom. “No religious brooding”, may seem an unhelpful comment by a certifying physician, but most likely served to eliminate what was perceived as a frequent cause of mental unrest. Love and religion were connected in the sense that both were capable of stirring the soul to such a degree that reason may be affected; confused ideas in one area might to lead to similar confusion regarding the other. Both causes also feature prominently in the Vadstena admission documents and casebooks. Vadstena patients with love as cause of insanity are primarily, but not exclusively, female, and the term “love” covers a range of incidents and circumstances.

Cases of insanity where masturbation is recorded as the likely cause occur in the Vadstena case records from the inception of the asylum, but become more numerous throughout the period. Under Georg Engström’s period as medical superintendent, six male patients have been found in the asylum records that match this description. 26

212 From 1861–1881 the term “Love anxiety, jealousy” (Sw. Kärleksgrubbel, svartsjuka) is used, from 1882–1895 it is simply “love”.
213 Sw. Religionsgrubbel.
214 FIIc:5 No. 832, Dla:13 No.1520, Dla: 13 No.1399, Dla: 13 No.1284, FIIc:9 No1218, FIIId:1 No.2524, FI:30 No 3280.
215 Sw. Inget religionsgrubbel har förekommit. FI:26 No. 2927, FIIId:2 No. 2907, FI:17 No. 1904, FI:17 No. 1849.
patients were diagnosed with insanity caused by masturbation under Hjertstedt’s superintendency, another three (all female), had masturbation recorded as a symptom but not as a cause. Under his successor Gustaf Wilhelm Göthlin, who was head medical officer at Vadstena from 1878 until his death, the number of patients whose illness was believed to result from masturbation was 34. Only six cases of female patients where masturbation is explicitly recorded in the casebook have been located and in all these cases onanism coincides with some form of erotic mania. In female patients, onanism is rarely seen as the cause of insanity, but rather a symptom indicative of the advanced stage of illness. The increase in admissions in the 1880s of female patients with masturbation as cause of illness that medical historian Karin Johannisson has identified should be viewed as part of a move towards a more stern approach to all masturbation in the decades following our period. To support the tentative finding that more cases of insanity were attributed to masturbation in the last decades of the nineteenth century, a small survey was carried out for Sweden as a whole. A survey of the annual reports from the National Board of Asylums from 1861-1871 reveals that the amount of cases attributed to masturbation in those years ranges between 1.2 and 3.6% of the total admissions for all of Sweden’s asylums. The same calculation for the period 1885-1895 shows a range of 2.1–4.8%. This indicates a rise in the amount of insanity cases attributed to masturbation in Sweden, in the last decades of the nineteenth century.

Unlike most other causes, doctors did not rely entirely on report from patients’ families and communities when it came to detecting masturbation. Characteristic in its

---

216 Dla:13, Patientrulla 1858-1879, Dla:14, Patientrulla 1879-1895.
217 FIIc:5 No. 885, FIIa:7 No. 571, FIIc:10 No. 1298, FIIid:2 No.3241, FI:26 No. 2914, FIIid:1 No. 2586.
219 1861 was the first year that the annual reports of the Board of Asylums contained statistics for all Swedish asylums, not only of admissions but of presumed cases of illness.
effect upon the body, many believed that a discerning eye could detect telltale signs of the solitary vice.

Regarding the detection of masturbation in a patient, Charles William Ellis wrote in 1838: “Cases of insanity arising from masturbation are most easily distinguishable from the appearance of the countenance, to those thoroughly conversant with the disease; yet any attempt to describe the particular symptoms would be more likely to mislead than to be of any practical utility.” According to Ellis, only the qualified medical gaze could reveal the shameful cause of illness in these cases, and the above quote suggests a willingness on Ellis’ part to keep it that way. Similarly, in Sweden Israel Hwasser (echoing Esquirol), emphasised the importance of the trained gaze in detecting the hidden cause of illness.

It [the vice] occurs not so seldom as one might think, and it cannot be unfamiliar to physicians who have owned the full confidence of their patients, or even without it, have had a sharp enough gaze to see through to the real causation of multiple nervous disorders, that not even otherwise respected persons, which seem above such suspicion, are always unencumbered in this matter.

Among the Vadstena cases in which masturbation was believed to be the cause, many had their propensity for self-abuse recorded in their admission letters, often by family members who had supposedly witnessed it. In these cases, the physician accepted masturbation as a, if not always the, cause of illness, and entered it into a special register of illness causes. Fewer cases occur where no mention of masturbation is found in the minister and physician’s letters, but where Hjertstedt appears to have drawn the conclusion himself.

Disappointed love

Witt neatly summarised mid-nineteenth century medical ideas about love in his 1864 treatise:

---


223 See for example FIIc:5 No. 827, FIIa:6 No. 908, FI:12 No. 671, FI:17 No. 1834, FI:17 No. 1849, FI:19 No. 2136.

224 FI:19 No. 2160, FI:19 No. 2192, FIIc:1 No. 2436, FIIc:5 No. 884.
“Love is the highest and noblest of all feelings, the most beneficial and the most elevating to the person himself, when it is pure, tempered and reciprocated.”

“Disappointed love” is the term used in the Vadstena sources for patients who have either been betrayed by a lover or betrothed, or who have been unable to pursue a relationship with their chosen one – victims of unreciprocated love. For female patients, the situation is often complicated by the birth of an illegitimate child. In the case of Catharina J, admitted in 1835, a frivolous life is documented in the minister’s letter. She is said to have been “somewhat lecherous”, and had several lovers. To the provincial court, Catharina J named “the one she liked most” as the father of her child, but as witness testimonies claimed that he was not her only lover, the man was acquitted. The letter reads:

Thus she was left without a father to the yet living child. It is thus unfulfilled expectations and disappointed love which have caused her madness.

Interestingly, the minister does not attribute the outbreak of madness to Catharina J’s frivolous lifestyle: it is the emotional trauma of not having her child’s father recognised that is seen as the triggering factor, rather than the somewhat erotic character of the patient. Similarly, the illegitimate children of both Anna A, admitted in 1848, and Christina O, admitted in 1870, are noted in the admission documents, but appear to be aetiologically insignificant. On the single occasion where Hjertstedt has been found to comment on the many patients who have birthed illegitimate children, it is with regret: “Some have, according to received information, been lain with after the outbreak of illness, not even idiots have been exempt.” Thus, no blame is attached to the women, but rather to the men who would take advantage of the sick and disabled.

Anna P, admitted in 1837, was reported in the certifying doctor’s letter to have fallen ill following a disappointed love, “she had been betrayed by a farmhand.” In the case of Lovisa Å, admitted in 1854, the effects of “a disappointed adolescent

225 Witt, Själen i normalt och sjukligt tillstånd, 152.
226 Sw. Olycklig kärlek.
227 FIIc:3 No. 253.
228 Sw. Så fick hon ingen fader till det ännu levande barnet. Det är således felslagna förhoppningar och olycklig kärlek som vållat henne vansinnighet.
229 FIIc:6 No. 913.
230 FIIc:18 No. 1916.
231 Underdånig berättelse för år 1861, XLIII.
232 FIIc:3 No. 516.
233 Sw. Hon har blifvit sviken af en dräng.
234 Fl:11 No. 576.
"love" were recorded as the primary cause of illness, possibly in combination with a previous bout of cholera. The three male patients at Vadstena whose illness was completely or partly attributed to love have similar histories. The provincial doctor who filled out the information about Jonas P, admitted to Vadstena in 1837, recorded that the sufferer had always been of a melancholy disposition, but that the illness was triggered by the patient hearing about the wedding of a farmer’s daughter in the parish. Although the provincial doctor records no testimony communicated to him that develops or further explains the connection between said farmer’s daughter and Jonas P, his conclusion is that the violent mania occurred as a result of a disappointed love. The circumstances of the love considered responsible for the illness of Per P were also unknown. The admission documents state only that disappointed love was the cause, but following his admission to Vadstena, asylum physician Göthlin identified an additional cause, stating drily: “By all appearances he is an onanist.” In an interesting comment in the case history of Pehr S, the certifying physician dismissed love as cause. “He has certainly had love affairs, but has treated them much too thoughtlessly for them to be considered as cause of insanity.” The implication appears to be that while the ideal love was ardent and true, such love might also, when disappointed or thwarted, cause madness.

Anger, pride and lust

The influence of the passions on mental and physical health was a strong and reoccurring theme in eighteenth- and nineteenth century medicine. Physicians agreed that emotions must be tempered to prevent them taking too strong a hold on the individual who would then run the risk of a disordered mind. Restraint must be learnt and exercised from an early age. In the case of the previously mentioned Anna A, Hjertstedt attributes her love-madness to inadequate parenting. "A less than prudent upbringing has rendered the patient unable to contain her passions, which have been chiefly anger and love," writes Hjertstedt, although we cannot be certain as to whether the conclusion is his own, or has been reported to him from some source better acquainted with the patient’s family. “Violent passions”, more specifically love and pride, is recorded as cause of illness for Eva A, admitted in 1835, and student
Pehr M\textsuperscript{241}, admitted in the following year. In the admission document for Albertina N\textsuperscript{242}, love and vanity are believed to have caused her mania. Pride, anger, and lust – it is tempting to make the association with the seven cardinal sins, when even the language of the admission document and the medical casebook used alludes to the Christian doctrine of ethics. These “moral” causes illustrate the strong presence of religious ideas in early psychiatric doctrine, and the belief that undesirable personal characteristics were not only morally objectionable, but also literally harmful to the individual. “Pride is the most deep-rooted and dangerous of all mankind’s faults,” wrote Witt in 1864\textsuperscript{243}, adding “vanity is ambition writ small”\textsuperscript{244}. The healthy life was the virtuous life, and any excess in emotion, or indulgence of one’s desires could prove a slippery slope to a disordered mind.

Psychiatry, even in its earliest forms, reflected the concerns and current issues of the society in which it developed. In 1858, the Conventicle Act\textsuperscript{245} was repealed. A royal ordinance in effect since 1726, it had safeguarded the dogmatic position of the Church of Sweden by outlawing any religious gathering, except family worship, without a minister of the Church present.\textsuperscript{246} Following the abolishment, free churches were able to preach and spread their doctrines without fear of legal consequences.\textsuperscript{247} This major transformation, occurring in the middle of Hjertstedt’s superintendency, was a controversial political and social subject, and would remain so throughout the nineteenth century. The unorthodox forms of worship and preaching now permitted were a potential source of excitement and confusion in individuals with a predisposition to unsoundness of mind, doctors argued. The case records from Vadstena contain ample evidence of Hjertstedt’s misgivings regarding non-conformist religion and its effect on the human emotions in the years following the repeal of the Act.\textsuperscript{248} Furthermore, the first half of the nineteenth century saw the growth of the Swedish temperance movement, and in 1837 the first official temperance society was formed.\textsuperscript{249} Concern regarding alcohol consumption, especially of the rural working classes, is evident in

\textsuperscript{241} FI:3 No. 273. 
\textsuperscript{242} DIa:13 No. 1636. 
\textsuperscript{243} Witt, Själen i normalt och sjukligt tillstånd, 81. 
\textsuperscript{244} Ibid., 85. 
\textsuperscript{245} Sw. Konventikelplakatet. 
\textsuperscript{248} See p. 124f. 
medical works as well as religious and moral texts during this period. The casebooks and admission documents from Vadstena carefully note excessive alcohol consumption from their earliest beginnings and throughout the period. Brita T, admitted in 1854 had an “irresistible urge for spirits” as well as exhibiting strong nymphomaniacal tendencies, Petter N, admitted in 1868 for his unmanageable bestiality was also prone to drunkenness, although neither case note explicitly states that excessive alcohol consumption caused the patients’ illness (diagnosed as “mania” and “idiitia” respectively). The material indicates that drunkenness was primarily one of several factors contributing to what doctors call “disordered life” or “sinful living”, alongside lewdness, violence and vagrancy, and as such the details rarely make it into the casebook summary of the patient’s history. Johan L, Johan J, Fredrika W and Karl J were all described as having led such disordered lives, and drunkenness was believed to have played a part in causing insanity in all cases. Per K was admitted in 1887, and diagnosed with dementia. The minister’s letter gives alcohol abuse as the cause of insanity, while the certifying town physician in Linköping is more careful (“possibly alcohol abuse”). The casebook record for Per K makes no mention of his drinking whatsoever, but dwells on his outbursts of violence and his increased sexual instinct. Such an omission may also be explained in terms of the original purpose of the sources; the admission documents state why a person is unfit or unable to live amongst others, while the casebook is intended for in-asylum use; hence the emphasis therein is on recording symptoms which may need intervention while the patient is admitted. In describing masturbation and drinking, notions of excess, compulsion, or a morbid appetite appears to be at the heart of the medical interpretation, as well as the sufferer’s inability to exercise control over their own passions, and, thus, conduct themselves in accordance with social morality. The term “moral insanity” is used by the certifying physician to describe Per K’s illness,

251 FII:8 No. 574.
252 Sw. Oemotståndligt begär på brännvin.
253 Fl:17 No. 1860.
254 Sw. Begiven på fylleri.
255 Sw. Oordentliga lefnadsförhållanden.
256 Sw. Lastful lefnad.
257 Dla:13 No.1444.
258 Dla:13 No.2373.
259 FIIId:2 No. 279
260 FIIId:2 No. 2986.
261 FIIId:2 No. 2907.
and indicates the influence of renowned English mad doctor James Cowles Prichard, whose famous 1835 text introduced that concept. Prichard classified masturbation as a moral insanity, and his definition of his new diagnostic label illustrates elegantly how medicine and morality blended to form new disease concepts: “The individual is found to be incapable /.../ of conducting himself with decency and propriety in the business of life.”  

Powerful and volatile, the sexual desire must be carefully managed, doctors argued, but some medical texts speculated that complete sexual abstinence in the healthy adult might also cause illness. In a German sexual advice text translated into Swedish in 1840, a Dr Friedrich Richter (a pseudonym for Karl Westphal) warned that a complete lack of sexual enjoyment could bring the entire organism into disarray, causing melancholia and impaired reason. Dr Eduard Winkler, whose Amor and Hymen, or, The Secrets of Love and Marriage Revealed went through nineteen Swedish editions following its publication in 1846, warned that for women, abstinence could be more harmful than indulgence, causing inflammation of the reproductive parts resulting in nymphomania, insanity, and occasionally, death. At Vadstena, two cases have been identified where physicians record abstinence as possible cause of illness. Demoiselle Lovisa L was admitted in 1848, and servant Maria P in 1864, both diagnosed with mania. In the case of Lovisa L, the certifying physician speculates that an inability to satisfy her desire may have caused the patient’s illness, without giving any further information regarding the circumstances. Hjertstedt does not comment, but transfers the reported cause into the casebook, suggesting that he did not dismiss it. Alongside the attributed cause, “religious brooding”, in Maria P’s case note, a scrawl in Hjertstedt’s hand suggests “unsatisfied desire?” The two cases indicate that Hjertstedt did not consider a presence of desire as abnormal in itself.

Social causes

In his account of asylums in England, Hjertstedt noted that “household troubles” were among the most common causes of insanity, according to the asylum doctors and sur-

---

263 Hjalmar Limström, Svenskt Boklexikon 1830-1865, II, Uppsala: Bokgillets Förlag, 1884, 302.
266 FIIc:6 No. 919.
267 Dia:13 No. 1520.
geons that he consulted on his journey.\footnote{Hjertstedt, Berättelse, 27-28.} It is nowhere specified what was meant by the expression, but the category is also found in the Swedish Board of Asylums’ tables, under “moral causes”. Without stretching the imagination too far we may presume that the case of Anna E\footnote{FIIa:2 No. 109.} would fall into this category. Admitted in 1835, speechless and violent, Anna E was said to have always lived in hatred and resentment of her husband, whom she had been forced to marry by her mother. The admission documents make no reference to physical abuse in this case, and on arrival at Vadstena Georg Engström attributes Anna E’s illness to a “bad marriage”. In the case of Brita J\footnote{FII:11 No. 599.} the certifying minister speculated that her illness may have derived from the patient’s “much too harsh treatment at the hands of her husband”, while Hjertstedt disregarded this theory entirely and recorded the cause as unknown. Domestic violence and marital discord appears to have been an acknowledged cause of ill health during our period. In a comment on the causes table for 1861, the anonymous writer establishes that women are more likely to suffer insanity due to household difficulties, adding:

\begin{quote}
The man is most often the cause of unrest in the domestic life of the lesser classes; the woman is unable to bear it, she is driven to despair, and despair generates madness.\footnote{Underdålig berättelse 1861, § 10, 37.}
\end{quote}

However, there is no rule without exception, and in the admission document of Brita T\footnote{FIIa:8 No. 574.} the opposite can be discerned. The “highly immoral” life of the wife, consisting of drunkenness and fornication, is reported to have forced her husband to leave their home. The certifying doctor adds to the image of a tragic situation by describing how Brita T sold off all the worldly possessions of their home in order to fund her “unquenchable thirst for spirits”. It seems a marriage did not need to be violent or plagued with alcohol abuse for it to be a possible cause of insanity; among the contributing factors to the illness of Karl O\footnote{FIIId:1 No. 2486.} the physician lists “regretted marriage” alongside masturbation, hereditary predisposition, and fear of losing employment.

\textbf{Heredity}

In an account of Vadstena in the annual report of 1865, Hjertstedt states hereditary predisposition as being \textit{the} most common cause of insanity.\footnote{Underdålig berättelse 1865, 45.} The occurrence of
mental instability or illness in the patient’s family is carefully noted in admission documentation and casebooks throughout the period. Heredity was seen as one of the main causes of insanity in England at the time of Hjertstedt’s journey there, and became increasingly prominent as an explanatory model in Sweden in the 1880s and 90s. Previous scholarship on Swedish psychiatry has highlighted how heredity was reconceived in official statistics on mental diseases in the 1880s: from having been part of the aetiological scheme as a direct cause, to achieving a wider function as an underlying predisposition. The focus on heredity within late-nineteenth-century Swedish psychiatry is to be seen as part of a wider European context connected to the theories of Morel on degeneration, which were first published in the 1850s, and subsequently developed and expanded in the following decades by physicians of a social-darwinistic persuasion. The influential works of British psychiatrist Henry Maudsley (1835–1918)\textsuperscript{276}, Italian criminologist and physician Cesare Lombroso (1835–1909)\textsuperscript{277} and German psychiatrist Richard von Krafft-Ebing (1840–1902)\textsuperscript{278} all built on Morel’s idea of degeneration as a gradual downward spiral of moral and physical decay by the spread of defective genes.

Vadstena case histories confirm the assumption that a propensity for erotic behaviour and overexcitation was partially attributed to heredity, especially in the last two decades of the period. However, while always noting the presence of insanity in a patient’s family, physicians rarely discuss or expand on the matter. Most often, as in the case of Maja D,\textsuperscript{279} admitted in 1843, a note in the casebook margin states simply, “hereditary predisposition”.\textsuperscript{280} In Maja D’s case, the cause of illness is believed to be disappointed love, and no indication is given that the physician connected the direct cause with the patient’s family history of illness. Rebecka P\textsuperscript{281}, and Carolina C\textsuperscript{282}, both admitted in 1869, are recorded as having had family members admitted to asylums for treatment. Rebecka P’s sister was treated and discharged recovered from Växjö regional asylum a few years prior, and Carolina C’s father was insane at the time of his death. Both patients are diagnosed with mania; in Rebecka P’s case the cause is believed to be childbirth, but for Carolina C no cause is given. The description of her reoccurring insanity is lengthy and specific, recording several illness outbreaks of

\textsuperscript{275} Riving, Icke som en annan människa, 96-98.
\textsuperscript{279} FIlc: 5 No. 726.
\textsuperscript{280} Sw. Ärftligt anlag.
\textsuperscript{281} FIlc:18 No. 1867.
\textsuperscript{282} FIlc:18 No. 1878.
illness over a period of eight years, but nowhere in the case history does the asylum physician make an explicit connection between the family history and the patient’s present condition. The evidence from Vadstena suggests that heredity is more likely to be given as a cause, but rarely on its own, in the 1880s and 90s. Clara L, admitted in 1881, is described as having always been “somewhat simple” and the asylum physician notes that her parents are much the same. This however is a description of the patient’s normal state; at 41 years old, Clara L has always been able to work and look after herself, until the present outbreak of mania, supposedly caused by a disappointed love connection. Thus, heredity is the explanation for her congenital stupidity, but not for her present maniacal state. In the case history of Edla A is a rare glimpse of the physician’s own part in the process of determining causation. The certifying physician attributes Edla A’s outbreak of mania to childbirth, and a melancholy predisposition. The information is transferred to the casebook, where a small undated note in the margin in Hjertstedt’s hand wonders: “Why not also hereditary predisposition?” The appearance of the note does not offer any clues as to when it was made, and no additional information is given to explain why Hjertstedt would make this suggestion.

Harmful stimuli

It appears to have been widely accepted in medical theory that even the most virtuous and morally sound might lapse into insanity if subjected to certain kinds of external stimulus. Music and theatre were seen as potentially harmful for the effect they had on the imagination, especially in women, who were considered naturally more frail and nervous. In The Female Guide, an 1844 treatise cautioning women against the horrifying effects of masturbation, physician and medical lecturer Calvin Cutter (1807-1873) wrote:

> If a young person gives unequivocal signs of excessive sensibility, all books depicting exaggerated sentiments must be withheld. The reading of fashionable novels is sure to falsify the judgement of the young by the most absurd exaggerations, to render their duties distasteful and even to predispose to disease. Even the study of the fine arts may render the imagination too active. Of these, drawing is the least objectionable; and

---

283 Sw. Något mindre vetande.
284 FIIc:18 No. 1865.
285 FIIc:18 No. 1865.
286 Sw. Hvarför ej äfven ärftliga anlag?
music, being the language of passion, is the most dangerous, especially music of the most impassioned and voluptuous nature.288

The quote illustrates the twofold danger of reading as it existed in nineteenth-century medical imagination: on one hand, consumption of fiction was associated with laziness and an unproductive life, on the other, doctors believed that the resulting excitation resulted in physical and mental illness.289 Indications of a similar understanding are discernible in the Swedish material also. The 1885 report of the Board of Asylums contains a new and unexpected addition to the list of causes; one patient is recorded as having fallen sick due to “reading Strindberg’s Getting Married”.290 No further details are given as to the patient or their illness.

The pathogenic work in question was a volume of short stories published in 1884, in which August Strindberg (1849-1912) made his contribution to a contemporary literary debate on sexual morality in the Nordic countries.291 A section on the sacrament of communion led to the author’s prosecution for blasphemy, but the book’s notoriety appears to have stemmed to a great degree from its candour in sexual matters. Physician Seved Ribbing (1845-1921) in particular was critical of Strindberg’s depiction of a young man’s illness and death as a result of abstinence in Getting Married, and included the author on a list of writers regarded as dangerous.292 Writing in 1889, Ribbing cautioned readers against indulging in suggestive literature, and named the authors he considered the primary offenders of his generation (the list includes, alongside Strindberg, Émile Zola, and Norwegian novelist Arne Garborg).

“I will not suggest” writes Ribbing, “that any of these authors produced their work in the interest of vice, but they display little knowledge of human nature indeed if they do not realise that these books will prove to be seducers of young people”.293

Two cases have been located within the Vadstena sources where reading is specifically recorded in the case history. Both occur toward the end of the period, under Hjertstedt’s successor as medical superintendent, Gustaf Göthlin. Karl W, admitted in 1888294, and Selma Å, who entered the asylum in 1891295, are both said to have become ill as a result of reading novels, and are both reported to have engaged in masturbation. In the case of Karl W, as is common for male patients, masturbation is

288 Calvin Cutter, The Female Guide. West Brookfield, Mass.; Charles A. Mirick, 1844, 43.
290 Sw. Läsning af Strindbergs bok ‘Giftas’.
291 Sw. Sedlighetsdebatten.
294 FIId:2 No. 2967.
295 FIId:2 No. 3241.
the cause seized upon and followed up on throughout the case history. The mentions of reading novels are in the admission documents: one by the patient’s local clergyman, with information provided by his mother, and one from a hospital physician in nearby Linköping. At Vadstena, Göthlin amends the cause in his own case note, attributing it simply to masturbation and heredity, both words being underlined in the casebook. Such a disparity suggests a re-evaluation of the cause of illness on the part of the physician, and a dismissal of family testimony. Although Karl W exhibits evidence of a greatly disordered imagination as well as symptoms of physical decay (seen as characteristic of the long-suffering onanist), the asylum physician’s emphasis is clearly on the act of masturbation. As a contrast, Selma Å is also reported in the minister’s letter to have “given herself over to self-abuse”, and the hospital physician enforces this with the sober comment “suspicions of masturbation confirmed”, yet no further elaboration on this is provided in the asylum case history. We are left to wonder, for example, whether her reading habits are viewed as having brought on the sexual excitement which led her to practise masturbation.

By the time Ludvig Magnus Hjertstedt became head physician of Vadstena in 1849 the link between masturbation and insanity was well established. “All psychiatrists bear witness to the many cases where psychic illness is by this vice either caused or upheld” wrote physician J L Dahlberg. “It has occurred in almost all forms of insanity and is often, though not always, of aetiological significance.”

Erotic symptoms appear to manifest in patients of all ages, apart from the very young and the elderly; the youngest patient to feature in the material is David F, aged just fifteen when he was admitted in 1844. The oldest is Per K, who was 66 years old on his admission in 1887. Both men were believed to have fallen ill as a result of their masturbatory habit. Based on the cases examined here, age does not appear to have been a factor in explaining patients’ symptoms, as none of the medical concepts used to explain them seem to have been associated in practice with a specific stage in life.

---

296 “Visual and auditory hallucinations…ever transient ideas, with no rhyme or reason”.
297 Johan Leonard Dahlberg (1817–1898) gained his medical degree from Uppsala University in 1858 and served as district physician in Skinnskatteberg 1858–1890.
299 FIIc:5 No. 760.
300 FIId:2 No. 2907.
Conclusion

The sample of patients examined here can in no way be said to represent the total patient population of Sweden in our period, in terms of aetiology. Where erotic and explicitly sexual behaviour presented as symptoms, the cause of the illness appears to have been sought in such circumstances. While erotic symptoms and nymphomania could be classed as a result of organic disease, trauma or hereditary predisposition, it appears to have been most frequently associated with social, “moral” causes; disappointed love, disordered life and harmful influence of various kinds. Masturbation has a somewhat different status, figuring mainly as cause in the Vadstena material. While several patients continue to masturbate during their time in the asylum, surprisingly little attention is given to masturbation as a symptom, and even less to the business of preventing it, as we shall see in the following chapter.

Love is more than twice as common as masturbation in the cause tables in any given year in the Annual Reports, which suggests that although very much present in medical literature and in the mind of asylum physicians, masturbation was not, in fact, the cause of a great proportion of insanity cases during Hjertstedt’s superintendency. It should also be stressed that Hjertstedt himself appears in his writings to be a very practical physician; his notes from his journeys are concerned with all the minutiae of the day-to-day running of the asylum, and with the safe, humane and effective care of the insane. His travel account makes only passing comments on the causes of insanity in England, and even then he only reports what English alienists have communicated to him, without further comment. It appears that to Hjertstedt, as to his Swedish contemporaries, the area of psychiatric aetiology was to a great extent unknown territory; asylum physicians appear to have been content to ascertain that a great number of factors may cause insanity (and asylum records often give multiple possible causes for each patient), and that separating and identifying them in each individual case could only be done with the greatest difficulty. The largest post in the official tables drawn up by the Board of Asylums each year is “unknown causes”. (See Figure 6.) The tables indicate that “irregular life” was responsible for a large number of cases, but also include indications that regular life events may cause the mind to become disordered. The categories “domestic troubles” and “accidents and adversity” suggest grief and bereavement, trauma and violence as contributing factors. Financial difficulty features as contributory cause in the Vadstena records, and in a passing comment in his travel account, Hjertstedt gives poverty and pauperism as main causes of insanity in England as a whole. An awareness of want, worry and what we might today call stress as result of difficult living and financial conditions is noticeable in the

301 Sw. Hustiga bekymmer.
302 Sw. Olyckor och motgångar.
medical understanding of what might cause insanity. For Hjertstedt, the faith in the curative power of the asylum itself lay partly in medical intervention, but mainly in the removal of such factors from patients’ lives, and in providing an environment characterised by order, calm, cleanliness and safety.
3. Nymphomania

On the 28th of August 1859, the young Hildegard C arrived at Vadstena, having travelled some 144 km from her home in the parish of Nora. Upon arrival, she was examined by Hjertstedt, who entered his observations in the casebook, on a new page headed with her name, date of birth and date of admission. With the patient were delivered the two certificates required for admission to an asylum, a letter from her minister, and one from a local physician, each providing information about her earlier life and the symptoms which required medical intervention. Of their first meeting, Hjertstedt wrote in the casebook that “the patient is calm and compliant”, and that her answers to questions were lucid and coherent.303 Described as very chatty, merry and lively, Hildegard displayed no sadness at having been removed to an asylum. Hjertstedt notes the patient’s “favourable appearance”, describing her as fattish, plump and neatly dressed, and concludes, “aside from her extraordinary joyousness, nothing appears abnormal with regard to her mental state”.304 The impression of Hildegard’s blithesome nature is enhanced by the reported conversation (“She speaks of pleasures and amusements”305) and the fact that she is recorded as having “a propensity for tawdriness in dress”306.

We will return to Hildegard’s case below. This first examination, together with the testimonies of the minister and the certifying physician, form the basis for Hjertstedt’s classification of her illness. Starting here, his expertise guides the classification, treatment and care of Hildegard until that same expertise deems her healthy enough to be returned to society. How then, is the interpretation of symptoms made? “To arrive at a diagnosis”, writes psychiatrist and medical historian Vernon A. Rosario, “a physician extracts a patient’s history and tries to match it with a recognized ‘natural history’ of a disease”.307 Writing in 1858, physician J L Dahlberg explains how the standardised admission questionnaire of 1835 aids in the diagnostic process. Dahlberg describes the formulation of questions as effective in establishing whether the patient is suffering from mental disorder. He adds that, when thorough answers are provided, the learned physician can, by comparing the described circumstances with the symptoms of the illness, come to a conclusion regarding the “true” cause of the condition, and design treatment accordingly.308

This chapter seeks to explore the crucial components in the interpretation process: the patient history, the ‘natural history’ of erotic diagnoses in nineteenth-century

303 FIIc:10 No. 1298.
304 Sw. Utom hennes ytterliga glättighet synes intet abnormt i psychiskt hänseende.
305 Sw. Hon talar om nöjen och förströelser.
306 Sw. Synes ha benägenhet för präl i klädsel.
307 Rosario, The Erotic Imagination, 8.
308 Dahlberg, Bidrag till den psychiska aetologien, 2.
psychiatry, and the sexual morality of nineteenth-century Sweden. The case note is the place where these three come together, and thus the only record available to us of a physician’s thought process. Although they cannot account for the entire train of reasoning that led to a specific diagnosis or treatment, they allow the historian insight into a selection process (which symptoms are considered significant, which facts regarding the patient’s previous life and circumstances), which in itself is indicative of medico-moral ideas.

**Labelling the Erotic: Describing Nymphomania and Satyriasis**

Nymphomania and satyriasis are described in medical textbooks as states of pathological sexual excitement, occurring in females and males respectively. The first book-length study of nymphomania was published in 1771, and the concept of nymphomania featured in medical literature well into the twentieth century. In his 1771 treatise, the French physician D.T. De Bienville (pseudonym for Jean Baptiste Louis de Thesacq, 1726–1813) described the condition as characterised by an insatiable desire for sexual intercourse, accompanied by delirium. Consequent descriptions of the condition in prominent medical texts throughout the nineteenth century echo de Bienville’s description. They describe a state of constant overexcitement with amorous desires and fantasies, sufferers who actively seek male company and exhibit violent outbursts against those who seek to prevent the gratification of desire. Patients in the final stage of illness are said to fall victim to masturbation and “shamelessly obscene” speech and conduct. However, the exact cause and classification of nymphomania appears to have been a subject of some debate. In the early decades of the nineteenth century, it was classified as a physical disorder, rather than a psychological one.

---

311 De Bienville, *Nymphomania*, 64.
indicating the genitals as the seat of illness, though not necessarily the site of origin.

Early nineteenth century psychiatry did not have a single, established model to explain erotic symptoms, but rather a number of possible explanations and diagnostic labels. Additionally, Swedish psychiatry lacked a formal classification system of mental diseases in this period. The physician, and later medical superintendent of Uppsala asylum, Gustaf Kjellberg’s 1863 doctoral thesis was the first attempt at creating one, but it does not appear to have been universally accepted.

Although medical writers were not in agreement as to what the exact relationship was between pathological sexual desire and insanity, from the 1860’s nymphomania occurs as a separate diagnosis in European and Swedish medical texts. It replaced the earlier term uterine fury to describe “a pathological over excitation of the sexual instinct“. “A woman suffering thus, can completely lose all modesty, demanding with veritable fury to have her senseless passion gratified” wrote obstetrician Georg Kress. Nineteenth-century medical writers alternate between describing women as virtually asexual, and as naturally more prone to excess in desire than men.

Esquirol, whose influence on the emerging Swedish psychiatric field was considerable, classified nymphomania as a monomania and carefully defined it in relation to erotomania and love melancholy. Unlike the latter two, nymphomania (and satyriasis), he claimed, originated in the reproductive organs, causing an irritation there that acted upon the brain. Dahlberg, echoing Esquirol, uses the same word when accounting for patients’ propensity for masturbation, intercourse and state of maniacal excitement. While always accompanied with unsoundness of mind in some form, nymphomania itself was not necessarily viewed as a form of madness. Swedish physician Sven A. Hedin (1750-1821) attributed the outbreak of nymphomania and satyriasis to extreme abstinence from physical pleasure in the young and strong. His

---

German contemporary C W Consbruch defined nymphomania (which he also referred to as “amorousness”) as a particular inclination for intercourse, which “if unsatisfied may develop into insanity, convulsions &c”. While the exaggerated desire is certainly viewed as abnormal in these treatises, it is not described as a disease in itself. The cause of the increased sexual desire is given as an excess of blood in the genitals and the use of “stimulating substances”. Like his famous Scottish contemporary, the marvellously named John Batty Tuke, Hjertstedt appears to have seen nymphomania as a feature which might occur in many forms of insanity. For Hjertstedt in his practice, madness was an established fact by the time he encountered his patients, and therefore the case notes cannot tell us whether he considered excessive desire to always be a sign of illness. In the unsound of mind, it was primarily a disturbing symptom, a side effect of illness, rather than an illness in itself.

Nymphomania appears to have had a special connection with asylum practice at Vadstena. In a study comparing archive material from three Swedish asylums, historian Cecilia Riving has found that, with the exception of a few isolated cases, nymphomania only exists in case notes from Vadstena during Hjertstedt’s superintendency. Challenging this finding would require a much more extensive investigation than the one conducted here, but we may add to Riving’s finding that Hjertstedt’s predecessor Georg Engström also made use of the concept. This then raises the question why nymphomania seemingly occurs only at Vadstena, and during a limited time period.

The Vadstena practitioners were influenced by the classification systems of prominent foreign works, with Georg Engström sketching and using his own unofficial system. The result was a psychiatric practice that acknowledged and employed a great variety of diagnostic concepts, accepting a certain level of fluidity between them. Interestingly, Engström appears to have concerned himself with classification of illness to a much greater extent than his successor, suggesting a level of enthusiasm for his new professional area. The fact that he made use of a relatively specific diagnostic term like nymphomania supports this interpretation. Engström’s understanding and use of nymphomania as a diagnosis may be traced to his reading in the field of psychiatry: his personal library contained works by German physician Johann Christian Reil (1757-1813) and psychiatrist Johann Christian August Heinroth (1773-1843) both of

322 John Batty Tuke, “A Pathological Classification of Mental Disease”, *The Journal of Mental Science*, Jul 1870, 16 (74) 195-210, 204.
324 Qvarsell, *Ordning och behandling*, 134f.
which based their understanding of nymphomania on the Brunonian theory of excitement.\textsuperscript{325}  

Hjertstedt only uses nymphomania as a formal diagnosis in a single case, preferring to use the term to describe a set of behaviours, which are often unspecified. However, tracing Hjertstedt’s understanding of nymphomania is made difficult by the fact that he left no personal library behind, and rarely discusses psychiatric theory in writing. The only source found is an annual report from 1850. In a short paragraph on the subject of sexuality, Hjertstedt writes:

> In some the heightened sexual instinct appears at the outbreak of insanity, and the accompanying nymphomania or satyriasis is then to be regarded as symptom rather than cause.\textsuperscript{326}

Hjertstedt appears, from the case notes, to be more interested in nymphomania, but his use of the term indicates a focus on its moral implications, rather than its actual medical nature. As an asylum physician, his primary concern is to prevent disturbing symptoms and behaviours, rather than ascertain the seat and origin of the condition.

Twenty cases in which the term nymphomania is explicitly used, as a diagnostic label, or as part of a descriptive statement (“symptoms of nymphomania”, “signs of nymphomania”) have been located in the Vadstena archive sources, of which sixteen were admitted during Hjertstedt’s time as superintendent.\textsuperscript{327} The patients come from various social backgrounds, are admitted in first, second or third class, and vary in age from 19 to 65. Their common denominator, aside from being female, is that the term nymphomania is used in some form to describe their illness or their symptoms. The concept of nymphomania is not defined or described in the case notes, and thus the investigation includes the challenge of piecing together a picture of what exactly the term entailed for Hjertstedt and his colleagues. Satyriasis features in Swedish medical texts, but is described as the male form of nymphomania and does not appear to warrant its own definition. The use of the term in Swedish medical practice has yet to be researched, but the Vadstena records contain no cases of satyriasis, or indeed any other form of male hypersexuality. Only a single case of bestiality has been located in

\textsuperscript{325} Scottish physician John Brown (1735-1788) created the Brunonian system of medicine, which imagined disease as caused by an imbalance between stimulus from the outside world and the excitability of the body. See William F. Bynum and Roy Porter (eds.), \textit{Brunonianism in Britain and Europe}. London: Wellcome Institute for the History of Medicine, 1988.

\textsuperscript{326} Ludvig Magnus Hjertstedt, \textit{Berättelse om Wadstena Central-Hospital}.

\textsuperscript{327} FlIc:5 No. 832, FlIc:5 No. 851, FlIc:5 No. 885, FlIa:7 No. 571, FlIc:7 No. 1093, FlIa:8 No. 574, FlIa:8 No. 576, FlIa:8 No. 599, FlIa:8 No. 615, FlIc:8 No. 652, FlIa:8 No. 668, FlIc:10 No. 1298, FlIc:10 No. 1284, FlIc:18 No. 1913, FlIc:19, No. 1960. The remaining four cases (FlIc:1 No. 139, FlIb:1 No. 204, FlIb:1 No. 309, FlIb:4 No. 539) were admitted and diagnosed during Georg Engström’s time as head physician.
the Vadstena material. In cases of what was considered disordered or pathological male sexuality, masturbation itself appears to have been the main concern of physicians.

In the casebooks, a diagnosis is entered at the very beginning of the record at the top of the page, just below the patient’s name and date of admission. This indicates that at least a preliminary diagnosis was given following the doctor’s first examination of the patient. However, many of the case notes examined have two or even three diagnoses seemingly added to the top of the case record at different times, indicating that diagnoses were often changed or modified. Five patients have been located where nymphomania is entered as a diagnosis in the casebook. Only a single one was admitted by Hjertstedt, Johanna S, and her diagnosis is recorded as “dullness with nymphomania”. Among the remaining patients, the diagnoses vary a great deal. Like Johanna S, patients Brita J, Emilia S and Hilda B all displayed “symptoms of nymphomania”, but were diagnosed with dullness. Their case histories indicate that they were all periodically confined to their beds, and uncommunicative. The dullness diagnosis seems to describe the patients’ ability to reason and interpret their surroundings, but is not synonymous with complete apathy. Both Brita J and Emilia S suffered violent outbursts, and Hjertstedt noted that they displayed “fair physical strength”. Gustava J and Wilhelmina A were both diagnosed with general confusion, and showed “signs of nymphomania”. The case records note that both patients worked and conducted themselves properly in between shorter periods of mental disarray, highlighting the intermittent nature of their symptoms. For Märtha L, admitted in 1859, the diagnosis given was melancholia religiosa, although both certifying and asylum physician noted her erotic behaviour. In the detailed case record, Hjertstedt mentions her propensity to undress as though in passing, and devotes more ink to describing her religious hallucinations. Märtha L heard voices telling her that she was the greatest sinner on earth, the doctor reported, and she was convinced that her children would be punished for her transgressions. Hjertstedt’s description indicates that her symptoms were dramatic, and contain a measure of sympathy for the patient’s desperate suffering:

She is ever complaining and always very frightened. At times bursts into convulsive crying, often lying on her knees for those around her, begging for forgiveness. Neither myself nor the Chaplain are able to calm her.

---

328 FIIc:18 No. 1860.
329 Cases occur in the Vadstena material where the patient appears to have been diagnosed based on admission documents only, in spite of the asylum physician being unable to find any signs of illness. An example of such a case is that of Lena N, discussed in chapter 5. Roger Qvarsell made the same observation of Georg Engström’s diagnostic practices, see Qvarsell, *Ordning och behandling*, 129.
330 Sw. Slöhet.
Other patients, like Clara L, were described as “lively”; speaking animatedly, laughing, whispering and sometimes screaming and singing. Some, like Christina O and Kristina E were said to be constantly tearing their clothes off and spending their days in various states of undress. Terms like “whimsical” or “erratic” are used to describe their behaviour and movement. Female patients with melancholic symptoms are generally described in somewhat romanticised terms, with a measure of pity clearly discernible between the lines. In *Love’s Madness*, Helen Small argues that, contrary to widespread assumption, sentimental and romanticised descriptions of female asylum patients were not the product of clinical observation. Rather, they were a means for physicians to demonstrate gentlemanly sensibility and a gentle heart, both of which were desirable qualities in a nineteenth-century doctor. Small uses the writing of John Conolly as an example, and a similar tendency to express pity for female patients is discernible in Hjertstedt’s case notes. Having expressed his admiration for the English gentlemen reformers in his travel journal, Hjertstedt may have been influenced by their philanthropic image and the culture of sensibility which accompanied it. However, the superintendent’s expressions of compassion appear to be reserved for patients who were not explicitly sexual in their behaviour; as seen in the example of Hildegard C below, overt flirtation was met with suspicion and distaste. Although rare, the occasional example of a male patient being described in terms of their appearance does exist. The physician’s letter for Pehr M describes him as being

> In a state of excitement of body and soul, facial features animated, moving, as were his eyes, facial colour red, pulse full and sudden. The patient’s entire physiognomy expresses excitability and violent passions, though without depth and durability.

Clearly, the idea that a patient’s excited state of mind and heightened passions can be visible in the facial expressions and physical manners could be valid for male patients also, but Pehr M is the only patient in the Vadstena material to be described in this way. In Hjertstedt’s case notes, such descriptions are reserved for female patients.

It is not clear from the Vadstena case records exactly what made a patient a nymphomaniac in the eyes of the physicians, or what separated them from patients labelled simply “erotic” or “lewd”. The phrases “signs of nymphomania” or “symp-
toms of nymphomania” are more commonly used than the diagnostic term itself, but there are few clues as to what signs are intended. One rare description of symptoms is found in the case note of Wilhelmina A\textsuperscript{337}, who is described as exhibiting “symptoms of nymphomania”. In the case note, Hjertstedt explains what this entails: “manifests in a desire to kiss”. We are left to imagine whether fellow patients or asylum staff were the intended objects of this desire. Masturbation would seem an obvious symptom of pathological desire, but only six female patients have been found where masturbation is recorded in the case history, and not all are diagnosed with nymphomania.\textsuperscript{338} Thus, not all nymphomaniacs had masturbation as a symptom. The sources indicate that any signs of desire that were seen as exceeding the boundaries of propriety might be described as symptoms of nymphomania.

The majority of nineteenth-century medical texts characterise nymphomania as a state of overexcitation, associated with fervour, restlessness and violent emotion. While the cases from Vadstena are primarily described in similar terms, nymphomania also occurs in cases of melancholia and fatuity. Brita J\textsuperscript{339}, admitted in 1854 and diagnosed with dullness spent her six years at Vadstena completely bedridden, and is described as exhibiting “all the symptoms of nymphomania” throughout her stay. The quiet and uncommunicative Lovisa Elisabeth Å\textsuperscript{340}, admitted in 1865 and described as stupiditas – another term for dullness – which Hjertstedt attributes to “organic brain damage”, also exhibited symptoms of nymphomania. The fact that the case notes feature nymphomania as descriptor in both excited and depressive cases, suggests that it might occur as a feature in various types of insanity, and that Hjertstedt did not consider it a diagnostic term. The example of Hildegard C further supports this conclusion; in spite of earlier testimony regarding her erotic tendencies, the patient was diagnosed simply with mania, with the added determiner “Ecstasis” referring to a state in which the mind is fixed on a single idea.\textsuperscript{341} A comparison between the cases described by Hjertstedt as showing “signs of nymphomania” and those diagnosed as such by Engström does not reveal any clues as to why Engström was more inclined to use nymphomania as diagnosis. Additionally, as a descriptive term nymphomania seems to have reached the peak of its use under Hjertstedt, and then virtually disappeared from case notes during the second half of his period as superintendent. His successor Gustaf Göthlin did not use the concept at all in his notes, preferring to describe patients with similar symptoms in a variety of ways. Augusta N, admitted in 1892, was reported to have repeatedly attacked men and tried to kiss them, and

\textsuperscript{337} FIIa:8 No. 668.  
\textsuperscript{338} FIIc:5 No. 885, FIIa:7 No. 571, FIIc:10 No. 1298, FIId:2 No. 3241, FI:26 No. 2914, FIId:1 No. 2586.  
\textsuperscript{339} FIIa:8 No. 599.  
\textsuperscript{340} FIIc:16 No. 1562.  
\textsuperscript{341} Consbruch, Klinisk handbok, 287.
Göthlin interprets her symptoms as indicative of “increased sexual instinct”\textsuperscript{342}. However, the use of the seemingly clinical term is not necessarily indicative of shift toward more medicalised language in descriptions of patients, as Göthlin continues to use older terminology as well. Female patients like Fredrika W and Emma S, who undress and tear their clothes in the asylum, are simply referred to as “unchaste” and “indecent”, and very few details are given as to what their behaviour actually entailed.\textsuperscript{343} This suggests that by the 1880s the term had fallen out of use, or outlasted its usefulness.

\textsuperscript{342} FI:31 No. 3343. The same description is given of Johan L, FI:30 No. 3250, admitted in 1891, and Andreas C, FI:35 No. 3762, admitted in 1895.

\textsuperscript{343} FIId:2 No. 3069.
The Origin and Seat of Nymphomania

While nineteenth-century physicians described nymphomania in similar terms, the exact nature of the illness appears to have been a subject of some debate. Admission documents from Vadstena illustrate that some certifying doctors prescribed to the view that nymphomania was seated in the genitals, though they did not necessarily believe that the condition originated there. Emilia S, admitted in 1847, had undergone a trial period in a hospital in Filipstad.344 While there she was treated for her nymphomania with camphor and cold wraps to the genitals; both common cooling therapies, indicating that her physician identified her condition as physical and seated in the reproductive organs. Following her admission to Vadstena, Hjertstedt records no treatment at all aside from the occasional use of the straitjacket to prevent her violent episodes. In a similar case, Gustava J, admitted in 1853 and described by Hjertstedt as showing signs of nymphomania, had received similar cooling treatment while in hospital.345 The certifying physician, who was also responsible for administering said treatment, attributed her illness to “an excess of blood in the reproductive parts”. Interestingly, the casebook record shows that Hjertstedt prescribed medication “to act on the genitals”, but in his summary of the case in the second case note, he attributes the illness to “domestic problems”, rejecting the somatic explanation given by the certifying physician. Nymphomania is thus both a modifier, used to describe the nature of illness and treatable symptom in this case.

Mid-and late-nineteenth-century Swedish medical texts appear to be influenced by Esquirol’s emphasis on moral causes, as well as the concept of moral insanity, coined in 1835 by English alienist James Cowles Prichard (1786-1848), and some follow Prichard in classifying nymphomania as a form of moral insanity.346 According to Prichard’s definition, moral insanity was partial, affecting only a portion of the patients’ mind, and leaving the remaining mental faculties intact. “In individuals where the moral sense had not been cultivated to perfection, sexual desire, strongest among the natural instincts, may become exceedingly violent”, wrote Björnström in 1883.347 The differences in interpretation of pathological desire appear to have been part of a greater discussion in medical circles regarding the seat of the passions, and the role of the brain in their operations. In a discussion held in the Swedish Society of Physicians in 1842, renowned physician Magnus Huss (1807–1890) argued that the

344 FIIc:5 No. 885.
345 FIIc:7 No. 1093.
346 Kjellberg, Om sinnessjukdomarnas stadier, 51, Björnström, Sinnessjukdomar, 58.
347 “Deras drifter, som icke tyglas av någon sedlig känsla, blifva särdeles väldsamma, i synnerhet könsdriften.” Björnström, Sinnessjukdomar, 52. See also Nyström, Om sinnesrubbing, 37.
cerebellum did not have the assumed power over the genitals, based on clinical findings. Obstetrician Pehr Gustaf Cederschiöld (1782-1848) did not only agree but went so far as to say that the brain had nothing at all to do with the actual passions. Cederschiöld cited language for support; figures of speech placed the understanding in the head, but emotions and passions in the body. Thus, the function of the brain was rather to control the passions.

Similarly, discussions regarding the relationship between the brain and the sexual parts were being held in the pages of England’s medical journals during the same period. Nymphomaniac patients were anatomised so that physicians could search the tissues of their brains for anomalies, and asylum practitioners treated cases of pathological sexual desire with cooling treatments to the head, as well as to the genitals. Some British medical sources argued for the possibility of an entirely somatic origin of nymphomania. Writing in 1866, Scottish alienist W.C. McIntosh, superintendent of the Perthshire County Asylum, mused: “The sexual instinct is a remarkable one, and in itself may be quite independent of cerebral influence, since it may be excited as a nerve action by external impressions only.” The same idea of local irritation as original cause was put forward by English alienist and private madhouse proprietor George Man Burrows (1771-1846), who warned against “laxity of morals”, but added: “local irritation will excite wanton feelings in either sex, however naturally virtuous and chaste”. These somatic explanations for a condition which appeared so abhorrent and threatening to respectable nineteenth-century society freed the sufferer from blame, describing nymphomania as any other type of insanity.

In 1858, Dahlberg considered the argument over psychical and somatic causes settled, stating that it had been established within psychiatry that both were capable of

351 Burrows, Commentaries, 276.
352 See also John Charles Bucknill and Daniel Hack Tuke, A Manual of Psychological Medicine. London: Churchill 1879 (4th ed.), 282-284. The view of nymphomania as being somatic in origin was shared by Bucknill and Hack Tuke, although the difficulty in determining, in practice, where the condition had originated was acknowledged in their text. “The two may exist together, and patients may completely exceed the limits of propriety, without having any evidence that the primary disease is in the degenerative organs”. Perhaps, the writers suggested, a more comprehensive use of the term erotomania was to be preferred; one that included nymphomania and satyriasis as varieties of essentially the same disorder.
causing insanity, and that in most cases psychical and somatic causes were both present, and so intertwined that a single cause could not be agreed upon. The observation was correct in the sense that no major debate between a psychical and somatic school is discernible in Swedish psychiatry in the latter half of the nineteenth century. The Vadstena material consistently includes physical, moral and psychological causes of insanity throughout the period. The nymphomania cases all share a history of disappointed love, which indicates a tendency to associate the concept with emotional distress. While medical texts associated nymphomania with the female reproductive system, often making ambiguous statements about the dangers inherent in puberty, menstruation, childbirth and menopause, the Vadstena physicians generally do not emphasise female biology in their case notes. Hjertstedt does note the regularity (or lack thereof) of the menstrual cycle in a number of nymphomania cases, but this appears to have been standard for all female patients, irrespective of symptoms and diagnosis. As menstrual regularity is noted in association with other observations made during the initial physical examination, and rarely occurs again later in the case notes, it appears to be a comment on general physical health, and not necessarily indicative of some disorder of the reproductive organs.

While Hjertstedt notes a presumed cause of illness in each case, there is no speculation or elaboration on causation of any kind in the casebooks. Often the physician-writer never returns to the cause of illness in the record. We may presume that it was not considered relevant, as the patient, by their very admission to the asylum, was believed to have been removed from the harmful influences attributed as cause of their insanity.

It is noteworthy that while heredity features more prominently as a cause of insanity in case notes from Göthlin’s period, he does not associate erotic behaviour with degeneration in the case notes examined here. Göthlin’s period as superintendent coincides with the last decade of the nineteenth century when nymphomania was classified by Krafft-Ebing, in his influential Psychopathia Sexualis, as a psychopathology, and combined with the idea that such disorders were inheritable. Furthermore, the idea that the nymphomaniac would be so plagued by her condition that she would employ any means to satisfy it meant that she became, in the minds of physicians, a threat to public morality. Echoing Cesare Lombroso, the psychiatrist and

---

353 "Striden om huruvida psychiska sjukdomar hafva en ursprungligen psychisk eller somatisk grund kan väl nu anses utkämpad och afgjord, sedan det torde vara allmänt erkändt, att sådana sjukdomar kunna uppstå uteslutande ur den ena, såväl som ur den andra inflytelsen, om än i de allra flesta sådana sjukdomsfäller psykiska och somatiska orsaker visar sig så sammanvända, att någon prioritet dem emellan omöjlig kan upptäckas." Dahlberg, Bidrag till den psychiska aetiologien, 4.
354 FIIC:5 No. 832, FIIa:7 No. 571, FI:11 No. 599, FIIC:10 No. 1298, FI:17, No. 1912.
355 Krafft-Ebing, Psychopathia Sexualis, 403f.
medical superintendent of the Konradsberg asylum Bror Gadelius wrote in 1914: “Often the nymphomaniacs yields to prostitution, and for reasons of humanity it is necessary to intern her to an asylum”. The case of Kajsa N, admitted to Vadstena in 1859, illustrates how the connection between nymphomania and prostitution was made in medical practice long before Krafft-Ebing and Lombroso published their theories. In her admission document, the certifying physician describes Kajsa N as suffering from “drinking mania”, and outlines the consequences of her desperate addiction. Aside from being violent toward her husband and children, Kajsa N completely neglected her home and her own physical appearance, even going so far as selling sexual favours for alcohol. The admission document reads: “Often, and quite publicly, she offers herself to the vilest scum, to receive payment in spirits.” The certifying physician’s assessment of the case illustrates his disgust: “Must be admitted to an asylum, as she lacks all decency and propriety, and is repugnant to society.” Upon her admission to Vadstena, Hjertstedt describes Kajsa N’s condition as dipsomania with nymphomania – thereby translating the account into psychiatric terminology. This case is an example of the word nymphomania being used as merely a descriptive term; the symptoms of the patient’s illness are of a sexual nature.

In spite of their disagreement regarding the origin and seat of nymphomania, medical writers and asylum practitioners appear to have shared an image of the condition; a set of characteristics which were identifiable by the trained gaze of the physician. Nymphomaniacs were described as consumed by a perpetual excitement; the image of a fire burning inside them is recurrent, as are mentions of reddened faces and glowing eyes. The irresistible desire for sexual contact would make patients seek male company, and strive to attract their attention. The two nymphomania cases below share many of the characteristics commonly associated with nymphomania in medical textbooks. They are typical in the sense that both include various transgressions of acceptable nineteenth-century femininity, in terms of speech, conduct and appearance. The descriptions echo literary tropes of female insanity when physicians describe shining or glittering eyes, flushed cheeks and wild, flowing hair. Hjertstedt writes of Rebecka P: “her entire being, looks and manners express a highly excited

357 FI:13 No. 1306.
358 “German Psychiatrie: An Introductory Lecture, read at the opening of the Psychiatric Clinique, in Zürich (Summer Session, 1863)“ The Journal of Mental Science, Jan 1864, 9 (48) 531-547, 534.
359 De Bienville, Nymphomania, 33f., Dahlberg, Bidrag till den psychiska aetologien, 4, 26f, FI:10 No. 1298, FI:9 No. 1218, FI:1 No. 2586.
360 Showalter, The Female Malady, 90f.
imagination and excitation”. The previously mentioned Kajsa N was described as having “eyes glittering with crude sensuality”. In the case of Sophia B, admitted in first class in 1851, Hjertstedt goes so far as to note an assessment of her looks in the casebook, finding her “of slim build and favourable appearance”. The same remark is made of Hildegard C, but unlike the latter, Sophia B made no attempt to charm the physician on her arrival. She is described as angry, violent and utterly confused, and it is noteworthy that Hjertstedt made a positive comment on the appearance of a patient admitted in such a state. Both patients who were objects of the physician’s admiration in the casebook were admitted in first class, suggesting that such comments were reserved for ladies of some social status.

The boundaries of decency

Nineteenth-century morality is often associated with a prudish attitude to sexuality, the term “Victorian” being used, even in Sweden, to describe an atmosphere of primmness, repression and censorship, especially so with regard to female desire. French physicians such as Alexandre Mayer (1814–1896) and Auguste Debay (1802–1890), and their infamous English colleague William Acton (1813–1875) are cited to illustrate the belief that the female was naturally devoid of sexual feeling, and that therefore any evidence of desire was in itself pathognomonic. “O wives! Follow this advice”, entreated Debay in his popular marriage manual, “Submit to your husband’s needs/…/ Force yourself to satisfy him, put on an act and simulate the spasm of pleasure; this innocent deception is permitted when it is a question of keeping a husband.” While Swedish physicians Erik Wilhelm Wretlind (1838–1905) and Henrik Berg (1858–1936) prescribed to similar views, other Swedish medical writers throughout the period appear to have been somewhat more temperate in their views of female sexuality. Seved Ribbing (1845–1921) and Fredrik Johan Björnström (1833–1889) allowed for a presence of desire in women, and praised the inherent virtue.

362 Sw. Hela hennes väsen, blick och åthäfvor uttrycka en högt uppjagad fantasi och exaltation. FI:18 No. 1867.
363 Sw. Ögon gnistrande af rå sinnlighet. FI:13 No. 1306.
364 Sw. Af smart wäxt och fördelagtigt utseende. FI:7 No. 571.
superior to that of the male, which allowed them to contain it. Swedish obstetrician Pehr Gustaf Cederschiöld (1782–1848) believed that sexual desire was stronger in the female than in the male, and that sexual frustration might cause various pathological conditions, including nervousness, nymphomania and hysteria. At Vadstena, Hjertstedt recorded “unsatisfied sexual appetite” as a contributing factor in causing the mania of Lovisa L, admitted in 1851, and that of Maria P, admitted in 1864, signalling a view of female sexuality similar to that of Ribbing and Björnström. Although perceived as natural, sexual feeling was potentially dangerous both when unsatisfied and when acted on, wherefore it must always be placed under the strictest self-control. The language used in descriptions of nymphomaniac patients signals the social and moral importance of tempering desire; the term “immodest”, used to describe Kristina E, Anna J and Maria N seems to refer primarily to their propensity to undress and tear their clothes. In the case note of Anna E, Hjertstedt reports from her admission document that she has always been “desirous of games and dancing, less concerned with decency and propriety”. Such examples provide clues as to the duality of the evaluation taking place during the medical examination; while examining the patient’s body and recording her actions, Hjertstedt carried out a moral appraisal. For the physician, immorality was connected with insanity, whether as a cause or a symptom, and posed specific problems. As we have seen, erotic women made for problematic patients as their perceived lack of decorum put them in danger of being seduced or otherwise exploited within the asylum.

Thus, Hjertstedt’s concerns regarding indecency in female patients were social and moral, as well as medical and practical in nature, setting these patients apart from lewd and masturbating males. While men were also, if to a lesser extent, subject to prevailing norms of sexual morality, they were able to act on their desire without potentially endangering their health and their future. Karin Johannisson has described the change in attitude to female sexuality in Sweden between the late-eighteenth and late-nineteenth centuries. From having been described in open and positive terms, joyously and in detail by Linnaeus to being the subject of science, Johannisson notes how all mention of the female orgasm vanishes from medical discourse in the first decades of the nineteenth century. However, as Johannisson points out, the idea of female sexuality as boundless and connected with nature, animal desire and chaos was not new in the nineteenth century, but commonly occurring already in eighteenth-

367 Ribbing, Om den sexuela hygienen.
368 Cederschiöld, Lärobok i vården om qvinnans slägtlif, 138.
369 FIIc:6 No. 919.
370 Dla:13 No. 1520.
371 FIlA:2 No. 190.
372 Carl von Linné, Om sättet at tilhopa gå, reprint from an original from c. 1740, 4th ed.
century literature. In the *Bourgeois experience* series, American historian Peter Gay discusses the image of the sexually frustrated bourgeois woman. Gay argues, like Johannisson, that the asexual stereotype, “the angel in the home”, was created by doctors through the view of woman as constitutionally frail, but also in fear of women as sexual beings.373

Inability or unwillingness to carry out duties associated with marriage and motherhood are reoccurring themes in nymphomania case notes. The example of Märtha L, admitted in 1859, illustrates the connection between erotic behaviour and a perceived selfishness. Widowed at the time of her admission, the 48-year-old patient was described by both minister and certifying physician as having been lazy, disgruntled, and “incompetent at managing the duties of a wife and mother”. Her recorded enthusiasm for Evangelicalism following her husband’s death and her “significant recklessness” adds to the list of improper behaviours, and the patient’s history ends with the conclusion that “indecent thoughts” and religious brooding have caused her nymphomania. Hjertstedt’s account of Märtha L contains no comment on her previous life, and no further signs of nymphomania are recorded in her case note. Instead, the physician noted her anxiousness and her desperate concern for her children, relating with some pity her conviction that she was an irredeemable sinner. Her initial erratic behaviour and “capricious” nature are described in passing, and as signs of motherly affection. When the patient stayed up all night to write letters to her friends and relatives, and “ran from one room to another, hanging up handkerchiefs in windows to send messages to them”, Hjertstedt connected this behaviour with her desire to get back home to her children. Although she refused all medication, there is no indication in the case note that any treatment was forced upon her. After eight days in the asylum, Märtha L was described as significantly calmer. Three months later, she was discharged “calm and lucid, working diligently”, with the added comment “had an ardent longing to return home to her children”. While the certifying minister and physician found ample evidence in Märtha L’s previous life for their classification of her condition as nymphomania, Hjertstedt appears not to have seen any such indication during her stay at Vadstena. Her display of concern for her family appears to have coloured Hjertstedt’s impression of her in a favourable way. Furthermore, the case reads like an advertisement for the curative institution which Hjertstedt sought to create: freed from the harmful influences of non-conformist religion and any opportunity for reckless behaviour, Märtha L soon recovered her soundness of mind and sense of propriety. The presence of maternal feeling and responsibility, however erratically expressed, was noted with approval as a sign of healthy femininity. The case note is open to the interpretation that, following a period of initial confusion,

Märtha L quickly perceived what was required of her within the asylum, and that she adapted to its rules with the understanding that this would allow her to return home.

While the pathologisation of erotic behaviour is the focus of interest here, it is necessary to point out that not all erotic or indecent behaviour appears to have been perceived as illness. Two cases have been located from Engström’s superintendency in which patients are described as “lewd”, and where the physician has added the words “not insane”. These two patients, both men, were admitted in the earliest years of the asylum at Vadstena, and the fact that they were admitted shows that their behaviour was sufficiently disturbing to their immediate surroundings that they needed to be removed from their homes. We cannot know whether their actions actually made them appear insane to their families, friends and neighbours, or whether the asylum was a last resort when nothing else seemed to help. However, the case notes tell us that in Engström’s professional opinion, these men were not ill. Lewdness was rather a choice, a vice which together with drunkenness, petty crime and vagrancy made up the idea of “disorderly life”, a phrase often used in admission documents and casebooks to describe patients’ circumstances. No examples have been found of female patients where erotic behaviour is dismissed in this way, however cases do occur of female patients who have, prior to their admission, given birth to illegitimate children. Where such information is available, both Hjertstedt and Engström include it in admission and case records, but it appears to have little weight on determining the patient’s cause of illness and diagnosis. The material from Hjertstedt’s period as superintendent suggests that erotic symptoms in both male and female patients are considered potentially significant. Hjertstedt does not elaborate on the meaning or impact of erotic behaviour, but he does not dismiss it either. In the cases discussed here erotic behaviour might be cause, symptom or syndrome, but it is always part of the illness picture.

The following two case histories are chosen partly for their length and quality of detail, but also because the two histories share two common authors; the patients were certified by the same hospital physician, a Dr Stjernström of Norrköping, and treated by the same medical superintendent at Vadstena (although more than ten years apart). In addition, the two patients concerned represent an unexpected discovery; that spectacular cases of nymphomania, of the type described in contemporary European medical texts, exist within the asylum sources from Vadstena. The cases are those of Hildegard C, a 25-year old woman of unknown occupation who was admitted to Vadstena in August 1859, and that of maidservant Anna J, admitted in February 1823.  

374 DIIa:1 No. 13 and No. 49, Lars S, admitted 28/6 1810, and Carl Gustaf H, admitted 27/9 1823.
375 See for example FI:3 No. 253, FIIa:6 No. 361, FIIa:8 No. 574.
1870 at the age of 24. Both exhibited symptoms of nymphomania, both spent a relatively short period of time in the asylum, ten and seven months respectively, and were discharged having recovered. Both their initially violent symptoms and their speedy recovery and discharge set them apart from the great majority of asylum patients at Vadstena in the mid-nineteenth century, where the discharge rate remained at a steady 3-5% per year.

Cases of nymphomania

Hildegard C, admitted in first class, August 28th, 1859

The minister’s document for Hildegard is in the form of a letter but does appear to follow the general structure of the official certification form. This is not uncommon in asylum records, it appears that especially clergymen tended to have a copy of the form as a template, and fashioned their letters based on it.

Her admission into first class tells us that Hildegard was a young woman of the better classes, and the minister names her father as a military officer of local renown. She is reported as having been previously healthy, and to have a cheerful, calm and compliant temperament. The minister notes that “unsuccessful love” is the assumed cause of her illness, but does not provide any details of the precise circumstances. A volatile mental state (“now cheerful, now downcast”) is given as the main symptom of insanity. The letter also reports that Hildegard’s “menses” had been interrupted for a period in the previous winter, but that the monthly flow has now been restored to normality. No indication is given as to where this information has come from, but as requests for admission to the asylum were generally made on behalf of a patient’s family, we are left to assume that this information has come to the minister’s attention during an interview with someone close to Hildegard. It is not impossible that the patient has provided the information herself, although patients’ own testimony tends to be clearly indicated by phrases such as “the patient states”, “the patient complains of…”. No such indication is given here. The official form asks specifically whether there has been any interruption or disturbance in “blood flow”, but as there is no such form here, we cannot know for certain whether the minister is simply filling out answers or making an observation based on his own experience and medical insight.

Like all would-be asylum patients in the first half of our period, Hildegard underwent a trial period in a hospital where it was determined that she was in need of specialist care in the asylum. Such trial periods had been introduced in 1786 (and

377 FI:17 No. 1912.
378 DA EIIa:1.
379 FI:16, No. 1298.
380 Sw. Provkur.
regulated in more detail by the Guild in 1813) in order to establish the asylum’s status as a curative institution for the insane (and not as a storage facility for the old, sick and infirm). The person suspected of insanity was subjected to various treatments (purging, bleeding, blistering, cold baths and showers) for a period of no more than three months. It was the task of the hospital physician to evaluate, based on the response to treatment, whether a patient was in need of asylum treatment or not. Roger Qvarsell has suggested that the decision by the Board of Health to maintain the trial period in use (in spite of considerable criticism) for such a long period indicates a resistance toward viewing psychiatry as a separate specialty. The belief that any physician could evaluate the condition of an insane person, and make a first diagnosis, would have undermined the authority of the alienist. In the two examples studied here, Hjertstedt the specialist noted the diagnoses and observations arrived at by the hospital physician, but did not comment, and in the case of Anna J, made a different diagnosis. Nothing in the material suggests animosity on Hjertstedt’s part toward general practitioners. Trial periods were officially abolished in 1858\(^{381}\), but the evidence in Hildegard’s case suggests that the practice had not disappeared entirely one year later.

The physician’s letter on Hildegard C consists almost exclusively of reported information (again, from an unidentified source). It is likely that the symptoms and observations recorded here come from hospital staff better acquainted with the patient, as well as from her family. Like the minister, the physician dates the point of origin of Hildegard’s illness to the previous winter, stating that she began exhibiting symptoms of “mental suffering” around that time. The current state of confusion is said to have erupted around Midsummer, as a result of “a change in circumstances”. No details are given of what this signifies (such wording becomes common in the later part of the period when referring to male patients who have found themselves in financial difficulty, but such an explanation seems unlikely here).

The reported symptoms are excessive joy, garrulousness, a desire for male company, flamboyance in dress, and delusions of wealth. She has also been caught masturbating. Hildegard herself is also recorded as complaining of a headache and of a general feeling of anxiety. The inclusion of the patient’s own complaints here suggests that she was still to some degree reliable as a source, and communicative. The only observation in this document that appears to be that of the writing physician himself is that digitalis has been administered to great effect, and that the patient was quiet and decent at the time of examination. It seems likely that Hjertstedt’s interest in Hildegard contributed, together with a special interest in nymphomania, to the production of a case record which is unusually rich and detailed.

The first case note is undated, and mostly concerned with Hildegard’s manageability. She is described as “quarrelsome”, and “difficult to please”, ever complaining

\(^{381}\) Qvarsell, *Ordning och behandling*, 53.
about something. This is likely the voice of a nurse or orderly in the ward, reporting to
the superintendent, judging from the focus on conduct rather than medical signs. Hildegard’s
difficult personality did not affect everyone it seems, as the casebook notes that “she often claims to be sick when the doctor is coming”, and that when in
his presence “her eyes and gestures betray lust”.

In October, Hjertstedt reports no change in Hildegard’s condition. Her menstruation
is in order, but for its duration her behaviour has been excited, anxious and indicative
of sensuality, and she has exhibited “unmistakeable signs of nymphomania”.

A case note from the early days of November describes Hildegard as once again
deteriorating with the onset of menstruation. In a section clearly provided by staff, Hjertstedt records that the patient now tears her clothes and throws them in the
chamber pot, shows anger toward the staff and fellow patients, and hallucinates about
men visiting her at night. Although not explicitly stated, it appears the Superintendent
paid his patient a visit during this time, as the following passage begins with the
words: “Towards the doctor she is exceptionally kind and loving”. Observations made
of her pulse (“heavy, loud and rapid”), expression (“the eyes are alight with an unusual
glow”), and demeanour (“all gestures convey lust”) further support this assumption.
The statement that Hildegard is not ashamed to practice “self-abuse” in front of others
may indicate that she has even masturbated while in the presence of her physician. A
measure of pity can be traced as Hjertstedt describes her as “tortured” by halluci-
inations of men pursuing her and “wanting to take her away”, and being unable to
sleep because of them. In what appears to be an extra note concerning the period of the
9th to the 14th of November 1859 the patient is so violent, “filthy” and unruly, that she
must be removed to the disruptive ward. The straitjacket has had to be employed in
order to prevent her tearing her clothes and masturbating. Alternately screaming and
singing, she is unable to rest even at night.

The last paragraph in the casebook contains in it the very short narrative of
Hildegard’s last seven months in the asylum. On November 26th, she is reported as
being calm enough to once again be moved to her private room, although the
straitjacket is at times still required to prevent her from tearing her clothes. The
following lines are undated, and simply state: “During the months of March and April,
complete convalescence gradually occurred; the patient is still, orderly and hard-
working. In the month of June the patient became completely restored and was
returned home”.

Considering the length of the text describing the first three months, August until
November, this final paragraph describing Hildegard’s return to health seems oddly
disjointed. We have witnessed evidence of Hjertstedt’s initial interest in her case, and
if we are correct in making that assumption, why is Hildegard, a first-class patient,
allowed to spend such a period under his care without a single comment being made
on her progress? A partial explanation may be the workload of the Superintendent,
who in the second half of 1859 received no less than 35 new patients into the asylum\textsuperscript{382}, and was without an assisting physician for the majority of that time.

*Anna J, admitted in third class, 18\textsuperscript{th} February, 1870*

The clergyman’s letter for Anna J\textsuperscript{383} is written on the standardised form, and the minister adds of the patient’s family history that her mother supposedly suffered a period of mental derangement while pregnant. Previous illness in the family is specifically enquired after in the form, and hereditary factors are recognised as a contributing cause throughout our period. The cause of Anna’s madness is nevertheless said to be disappointed love, but no details are provided regarding the incident in question. The minister claims no knowledge of lewd behaviour; the question is answered simply with the word “No”. If we assume that the minister has entered all the information known to him, the individuals supplying information about Anna have clearly made an omission here. British studies of asylum admissions have found that concealment of information was often due to domestic discord surrounding an admission, or fear of bringing scandal onto the family name.\textsuperscript{384} The minister’s narrative clearly indicates that he has no personal knowledge of the case, statements are framed in such a way that we are made aware he is simply reporting information provided by others, and the patient is not referred to by name. She is described as having been in good bodily health and of a cheerful temperament prior to her illness.

The physician’s letter indicates that Anna spent some time under his observation in a hospital prior to her arrival at Vadstena. As no bodily illness is recorded, we are left to assume that she was brought there by family members due to her unsoundness of mind, and remained for a period of time. As we have seen, the trial period previously employed in insanity cases had been abolished by the time Anna was admitted, but families appear to have continued to first seek advice in conventional hospitals, especially if the nearest asylum required a long journey. The letter is not dated, and the physician does not specify how long Anna remained in hospital, but remarks regarding her behaviour and treatment indicate a period long enough for several medicines to be tried and rejected.

As well as having had some time to observe his patient, the certifying physician appears to have been more successful in obtaining information from Anna’s family, making his account significantly richer than that of the minister. He reports that she has lead a “salacious life” in later years, the knowledge of which can only have come from someone close to the patient. Either the informants have been more forthcoming

---

\textsuperscript{382} DA EIIa:1, *Inspections-Journal 1859-1883*, 20.

\textsuperscript{383} FI:17 No. 1912.

with information of this kind than in their contact with the minister, or the physician has asked more specific questions regarding the patient’s morality. We know for certain that the physician has had contact with Anna, meaning that in theory she could have provided the information herself. However, the following account of her behaviour and nonsensical speech makes such an assumption implausible. The minister’s observation of the supposed cause is repeated, that Anna has “presumably gone mad following the promises made by a man”. No speculation or alternative causes are provided, suggesting that the physician accepts the explanation as credible.

What follows is the physician’s own observation of Anna. She is unusually cheerful and lively and cannot be made to sit still. She speaks “incessantly” and incoherently, and has a habit of screaming and singing. A volatile mental state is evidenced, as her dominant mood is said to be “cheerful”, but prone to seemingly random acts of violence. Having struck the doctor, a nurse and other hospital patients, it is concluded that she is “a danger to others”. Furthermore, the physician observes “a passion for lewdness” which is evidenced by Anna’s indecent attack on a nurse and her behaviour towards a male patient in the same ward. The records state: “She has been found standing by a cage in which a man is kept, making obscene signs”. Such language is typical of the period; it is very rare that a physician explicitly describes the obscene behaviour witnessed, but we may assume that either speech, flashing or inappropriate touching is implied. The observation that Anna’s thoughts “appear to be concerned with love affairs” could only be ascertained from the patient’s speech, but none of her communications are included in the record.

Anna’s tendency to “always run around naked, with only a sheet thrown over her shoulders” seems to add to the doctor’s observations of lewdness, but a significant detail is added here. The record states, “In the last few days, she has taken to attaching an old cloth to the sheet, as a train”. Two interpretations are possible here; Anna herself may have stated what the purpose of the cloth was (in which case it is notable that her doctor reports hallucinations directly), or the physician had interpreted her behaviour in the context of contemporary tropes of madness. Irrespective of the actual background, this seemingly trivial comment in an otherwise relatively sparse record displays amusement and a taste for the scandalous on the physician’s part.

The treatments administered, “morphine for the night” and “camphor with phosphoric acid” have had no effect on the patient’s condition. Based on the above infor-

---

385 No comment is made on the fact that Anna has behaved indecently towards a person of her own sex, suggesting that homosexual behaviour fell under the category of pathological sexuality.

386 The image of the madman as dressing himself in fantastical costumes and believing himself to be a king, emperor or pope had been a well-established trope of insanity since the mid-eighteenth century, see for example William Hogarth, “The Rake in Bedlam”, The Rake’s Progress, 1735.
information, although he is not required to do so by the official form, Dr Stjernström makes his diagnosis; nymphomania.

In the transference of previous information into the casebook record, Hjertstedt summarises Anna’s symptoms simply as “symptoms of nymphomania”\(^{387}\), and notes that she has been increasingly “wild”. Only her violence towards others is mentioned specifically, indicating that her indecent behaviour in the hospital is understood as typical of a nymphomaniac. The initial diagnosis is quoted here, but Hjertstedt himself names Anna’s condition as simply “mania”.

On arrival to the asylum, Anna is described as “very confused and disrupted”. No reference is made to lewd behaviour in the record of her initial medical exam. Hjertstedt reports that she cannot answer questions put to her; making the interpretation that she in fact does not even seem to understand them, and describes her as uncooperative.

Her behaviour is excessively lively and excited; she is “always moving around”, screaming and making noise. The cryptic sentence “attaches herself to the clothes”\(^{388}\), would appear to refer not to the patient’s own clothes, but to those of someone else present. No further information is given here, and it appears likely that had the patient clung to the physician’s clothes this would have been stated more explicitly. With Anna’s history of attacking hospital staff in mind, we may guess that the object of her attention here is a nurse or orderly present at the examination. The physician notes that in spite of her thinness and small stature, Anna “appears to possess sound strength”, indicating a difficulty in containing her outbursts. In a later case note references are made to Anna’s “previously documented violent behaviour”, but as no other specific incidents are recorded, the patient’s behaviour on admission may have been disruptive enough for this conclusion to be drawn. The only comments on Anna’s appearance record her pallor, and the “burning, excited and confused” look in her eyes.

The following casebook note is undated, but appears to contain information about the patient’s first weeks at Vadstena. Following her admission, Anna is immediately placed in the “disruptive” ward of the asylum; the decision is motivated by “her destructive and violent behaviour”. There she continues to run about naked “without the slightest sense of shame”, screaming and chattering without end. She is reported to be “restless” at night, “filthy”, but displaying a good appetite. These comments are concerned mainly with order, and the level of care and surveillance required in this case. The lack of medical observations and language suggests that the information, although recorded by Hjertstedt, was communicated to him by someone working in the ward. The prescribed medications are provided in list form only: “Digitalis. Potassium bromide. Tepid baths.” No information is provided as to the dosage or frequency of

\(^{387}\) FIIc:18 No. 1913.

\(^{388}\) Sw. Hänger sig fast i kläderna.
administration of these measures, but clearly one of them, or the combination of all, proved effective, as the following case note, dated April 1870, reports an improvement in Anna’s condition.

In April Anna “begins to show signs of returning sense and lucidity”, but remains restless and easily moved to anger. Hjertstedt notes that she is beginning to “take an interest in work and orderliness”. In the next note, written in May, we are informed that Anna has now been moved to the quiet ward. Although still prone to irritability, she is “compliant”, hard-working and orderly. A remark that her menstruation has not returned seems oddly out of place, as no information about such a disruption has been recorded elsewhere in the case history. Nevertheless, Hjertstedt considers her “bodily health much improved”.

The return of such medical observations in the case history, previously preoccupied with the patient’s manageability, may imply that on this occasion the Medical Superintendent has actually seen or examined the patient himself. It is possible that on arrival Anna was classed as a hopeless case, and placed among incurable and particularly difficult patients, which were of little interest to the physician, and so received few visits. This would account for the two case notes in which little medical information is recorded, save the prescription of drugs. When signs of improvement occur, the physician again visits and proclaims the patient much improved. We are left to imagine that Anna’s last months in the asylum continued without further incident, as the next and final note states simply: “Discharged improved, August 6th, 1870.”

There is considerable overlap in the descriptions of behaviour in these two case histories. Together, these symptoms form a picture of abnormal femaleness, and by describing the symptoms that indicate erotic insanity the physicians are providing us with an image that is the polar opposite of acceptable, desirable femininity. Both Anna and Hildegard have reportedly become insane as a result of a disappointed love, and their interest in men is documented early on in their case histories. Hildegard is said to “desire male company” and appears to develop an attachment to the asylum physician. In fact, considering classic symptoms of lewdness in the medical literature, Hildegard’s conduct during her first medical exam hints at such a conclusion although Hjertstedt does not consider it pathological. It does not require too much of a stretch of the imagination to conclude that the good doctor, somewhat flattered by the attention, chooses to interpret Hildegard’s interest in him as non-pathological. Only later, when other symptoms have manifested themselves does his mentioning that she is “exceedingly kindly and tender” in her dealings with him suggest a slightly inappropriate level of affection. Anna’s obscene behaviour toward a nurse and a male patient in the hospital is indicative of an aggressive sexuality which was not believed to be natural in women, and her “shamelessness” and nudity are repeatedly mentioned in her
case history.\textsuperscript{389} The wanton displays of desire, active pursuit of male company, masturba
tion and unabashed nudity of these women, as well as their language, is occasionally considered so obscene that the physician-writer does not even wish to record it.

A certain level of tolerance in regard to immoral behaviour is apparent in asylum records; infidelity or illegitimate children are routinely noted for female patients, but little importance is attached to such incidents if no other evidence of lewdness exists. Masturbation, so hotly debated and carefully cautioned against towards the end of the century, and so frequently occurring in male asylum records, is very rarely seen in medical textbooks as a symptom for women. Since it barely exists in medical literature, based on the asexual nature of women, a greater amount of attention would be expected from the physicians when faced with masturbating patients. The matter-of-fact fashion in which such incidents are reported for both Hildegard and Anna suggests that female masturbation was in no way as rare as some contemporary medical texts would have it. Mostly described without euphemism (unlike elsewhere in Europe\textsuperscript{390}), and mentioned without the use of morally charged adjectives, masturbation appears to have the status of any other symptom in the asylum records. Nevertheless, measures were occasionally taken to prevent female patients masturbating, as we have seen in Hildegard’s case history, not only for reasons of propriety, but because masturbation was believed to cause excessive lust as well as being the ultimate expression of overpowering sexual desire.\textsuperscript{391} Thus, it was believed that a patient who was able to continue the practice would prevent their own recovery.

A description recording the patient’s temperament, personality and behaviour prior to the onset of illness is given in the minister’s and the physician’s letters of admission. A limited number of words are reoccurring in describing healthy behaviour, especially when female patients are concerned; “calm”, “docile”, “compliant” and “content” being among the most commonly used.\textsuperscript{392} The adjective \textit{livlig}, meaning spirited, active or gay, appears to have a double function: it is often used in admission records as a favourable description of previous temperament, but also


\textsuperscript{390} Ekenstam, \textit{Kroppens idéhistoria}, 136.


\textsuperscript{392} Sw. \textit{Stilla, foglig, medgörlig, färnöjd}.
occurs, as we have seen in both Anna’s and Hildegard’s case histories, in descriptions of symptoms. We are to understand from this that it is the degree of spiritedness that determines whether it is a sign of health or not; Anna’s fervent activity and inability to remain still is viewed as unnatural, while Hildegard’s spiritedness in conversation with her physician is noted with approval.

Propriety in attire as well as and conduct was required for women, and both patients discussed here transgress the social norms. Anna does not only undress and run around naked in the wards, but fashions herself a costume with a train out of cloth. The trope of madness referred to in Anna’s case history section served both as a caricature of the mad person and also as a reminder of the danger inherent in madness. The physician hints at amusement in describing a maidservant who makes herself an elegant, regal dress to go with her delusions of grandeur, but the fear of chaos and a social order turned upside down is implicit. Hildegard, being of the better classes, is not ridiculed for dressing above her station, but it is nevertheless noted that her dress sense is gaudy. Both patients exhibit “mad” behaviour; by attempting to dress above their station, both are breaking the rules of acceptable female conduct. As her condition improves, Hjertstedt notes in the casebook that Anna is “neat” and “tidy” in her appearance, signalling the return of her sense of propriety. Such signs of improvement noted in the casebook record also indicate what is considered healthy, and one of the most commonly occurring signs of recovery is a willingness to employ oneself in the various forms of work available in the asylum. For both men and women idleness is considered a sign of an unsound mind, and providing work and “meaningful” employment is among the most important forms of therapy in the earliest decades of psychiatric practice. This is especially the case for patients of the lower classes, where the survival of any family was dependent on the ability of all its members to contribute, but women from wealthier backgrounds are also employed with less arduous tasks. Failing to fulfil the demands and expectations of their environment, both in terms of conduct, appearance and labour, was a worrying sign for a woman and one that might indicate insanity. Feminist historians of psychiatry have highlighted how when reversed, descriptions given in asylum records portray the ideal mother and wife; docile, passive, asexual and devoted to her family.393

Interrupted or otherwise disturbed menstruation has been associated with ill health since ancient times, and an understanding of the human body based on the idea of the four humours appears to have held sway in the minds of medical and non-medical

---

thinkers alike until well into the nineteenth century. Thus, it is fair to assume that the clergyman responsible for requesting a place in the asylum for Hildegard would have asked specifically about her menstrual history, being somewhat acquainted with popular medical theory. Menstruation was believed to have a dual function; it symbolised the purification of the body (and mind), and also served to drain the body of excess blood, which would result in too much heat. The source material from Vadstena illustrates the preoccupation with the monthly flow of female patients; whether sparse, rich or normal, delayed or absent, the state of the menses is always noted with concern.

Hildegard’s decline following admission is intimately linked with her menstrual periods in the casebook record, all incidents are mentioned as happening during or just before menstruation, thus indicating a connection between the two although that connection is never explicitly explained or explored. The idea of episodes of female insanity or hysteria as associated with menstruation is present in the medical literature also, but the precise relationship between the two appears to have been shrouded in mystery even to prominent medical minds. It is notable here that a number of possible contributing factors are reported; disappointed love and a change in circumstances related by the clerical official and the initial medical contact, but no importance seems to be ascribed to these by the asylum physician. In fact, there is no discussion of a cause at all, no discussion of the reported information and nothing inferred from his own observations. The physician seizes instead on the physical symptom of the menses and this is the line of inquiry followed throughout the record. In Anna’s case, her menstruation is mentioned only once, at the end of her stay at Vadstena when she is said to be improving. From this comment, that her menses have not yet returned, we understand that the disruption has lasted some time, but the absence of such a symptom in the previous record is a puzzling oversight. As Anna is on the road to recovery, and appears in good bodily health, no further attention is given to the absence of menstrual flow.

Imagery associated with fire is present in both case histories. Anna’s eyes are described as “burning”, and Hildegard’s are “alight with an unusual glow”. The symbolic

---

394 It is relatively common that doctors describe their patients according to the humoral system as being of “sanguine”, “phlegmatic” or “choleric” temperament. See for example FIIa:7 No. 576.
395 The Swedish word used to describe patient’s menstruation, reningen, literally means “the cleansing”.
396 William Acton, who proclaimed the asexual nature of women in general, was willing to concede that a small part of women would experience sexual desire “to a limited degree” around the time of their menstrual period. He was careful to ensure his readers that this was a rare and transient phenomenon, which would soon “cease entirely” until the next menstrual period. William Acton, The Functions and Disorders of the Reproductive Organs (2nd American ed. From the 4th London ed.). Philadelphia: Lindsay and Blakiston, 1867, 145.
use of fire to describe nymphomania goes back to de Bienville, who in his 1771 treatise used such imagery to connect the condition with the passions. De Bienville speaks of “the fire that devours them”, the “burning heat” that they experience, and describes a sufferer’s eyes as “full of fire”. The association between fire and female sexuality more generally was widespread, and as such we cannot infer that Hjertstedt was familiar with de Bienville’s treatise from this evidence alone. What seems highly likely, in light of his description of Hildegard, is that he was however familiar with other writing on the subject of nymphomania. As the only medical superintendent at Vadstena to use the term with any regularity, it is safe to assume that Hjertstedt had some reason to see the condition where his predecessor and successors did not.

The actual diagnostic label attached to these cases presents some interesting questions. In spite of displaying many of the symptoms recorded in the medical literature as typical of a nymphomaniac, the patients are diagnosed simply with “mania”. It is noted in Hildegard’s casebook record that she exhibits “unmistakeable symptoms of nymphomania”, but the explicit diagnosis is never made. In Anna’s case the hospital physician has labelled her illness as nymphomania, and Hjertstedt repeats this without valuing or commenting on it. If we accept that the style and length of Anna’s case record is indicative of weariness and growing pessimism on the part of the physician, the broad diagnostic concept “mania” is a convenient one. Like all narrative, the case history is concerned with time and causality, and the time aspect may offer an explanation in this case. As patients were entered into the casebook, their name, occupation, age and date of admission were added to the top of the page. The patient’s diagnosis appears directly below, suggesting that a classification of the case had been made before the case record had even begun. This would suggest that a diagnosis was made based on family and community testimony as well as the initial medical examination upon arriving to the asylum. A speedy diagnosis would be important from an administrative point of view, as the Medical Superintendent was required to provide annual tables of the inmates of the asylum that included both cause and diagnosis. This is not to say that the diagnosis could not change; there are many examples in the casebooks of patients that have several diagnoses recorded at the top of their casebook record, and occasionally one word will be crossed out and replaced by another. We may not be able to determine at exactly what point a diagnosis was

398 Out of the twelve patients identified as nymphomaniacs, nine are admitted and diagnosed during Hjertstedt’s time as superintendent.
399 In fact, out of all the case histories of patients exhibiting symptoms of a sexual nature that have been examined at this stage, only one is diagnosed with nymphomania in the casebook. FIIc:1 No. 139.
entered into the casebook, but the time aspect raises important questions with regard to the diagnosis of nymphomania.

In the case histories examined here, nymphomania is clearly a concept which acts as a reference point, but its precise status has yet to be determined; whether a diagnosis, a symptom, or a more general state of being associated with a number of signs and symptoms.

The lack of a shared system is obvious in the large amount of diagnostic labels in use in the Vadstena records, which is made even larger by the common practice of labelling patients with two conditions (“General confusion with dullness”401, “melancholia with fatuity”402). In the case of Hildegard, her violent outbursts certainly seem to indicate the classic conception of mania and the later occurrences of lewd behaviour and speech would not necessarily negate this diagnosis. Physician Otto Manderup Witt commented in his 1864 text on mental illnesses on the transient nature of insanity: “Complications between, and transitions to different types of illness are relatively common. The monomania changes its form or turns into dementia. In some types of nymphomania pure attacks of mania occur.”403 In the light of Hildegard C’s case we can then assume that the opposite is also possible; that symptoms of nymphomania can be present in a manic patient without it altering the diagnosis.

The contrast between the records of the initial medical exam for Hildegard C and Anna J is worthy of attention. Not only the brevity and lack of detail in Anna’s case, but the very tone of the text; its short sentences, lack of pronouns and adjectives, suggests clinical detachment, even disinterest on the physician’s part. The text records only what is required with no elaboration, speculation or reference to previous documentation. It is assumed that Anna’s uncommunicative nature is partly responsible for this; clearly the physician has labelled her speech as nonsense and her behaviour as erratic and disruptive, and feels that no useful information can be obtained from her at this stage. If we recall Hildegard’s first casebook entry, in which she conversed, laughed and was perceived as attractive, Anna in contrast is not interested in making any kind of contact with her physician, is noisy, unpleasant and behaves in a way commonly associated with being “mad”. Hildegard displays (or mimics) desirable, sane female behaviour that arouses the physician’s interest. Paradoxically, Anna, who displays all the classic symptoms of insanity, appears less interesting to the alienist.

401 Sw. Allmän förvirring med slöhet.
402 Sw. Melankoli med fänighet.
403 “Kompilationer emellan, och övergångar till olika sjukdomsformer förekomma ganska ofta. Monomamien byter form eller övergår i demence. I vissa former af nymphomani förekommer rena anfall af mani.” Witt, Själens i normalt och sjukligt tillstånd, 261. “The term Raving Madness”, wrote Bucknill and Hack Tuke, “may be used with propriety as an English synonym for Mania”. As a broad term for a violent and excited condition of disordered emotions with many variations, mania is the most commonly occurring diagnosis for disruptive and violent patients.
It has been previously suggested that the nymphomania diagnosis was a special area of interest for Hjertstedt, especially during the brief period 1854-1859, but if that was the case, that interest appears to have waned in 1870.\textsuperscript{404} No references are made to lewd behaviour in Anna’s initial medical exam, no comments are made as to the previous nymphomania diagnosis, and none of the classic symptoms of early nymphomania are observed. For Hildegard, Hjertstedt diligently copies down all the symptoms and behaviours described in the physician’s letter into his casebook summary, along with information about what treatment has been employed. Eleven years later, when entering Anna into the casebook, he reports only that she has a history of lewdness, but provides no details whatsoever.

Hildegard’s case record is different from the majority of others that have been examined in that it includes both accounts of a patient’s hallucinations as well as actual reported speech. Such records of a patients’ speech are rare in case histories from Vadstena, and where they do exist, generally refer to the speech of first and second-class patients. When direct quotations are used we understand that the physician has attached at least some value to the patient’s own account of their illness. In case notes from the end of the nineteenth century, reported and direct speech has disappeared almost entirely. In striving for more detached and clinical language, late-nineteenth century physicians interpreted patients’ speech and labelled it before it was recorded, or paid little attention to it at all. It is tempting to the historian to attach a degree of importance to patients’ speech as recorded in the case history; however, the temptation to view such utterances as partial illness narratives must be resisted.\textsuperscript{405} Remains of patients’ speech were recorded in retrospect, by a physician with complete power to select what was deemed important and noteworthy. It would be vain to think that we can discern with any degree of certainty the patients’ own experience of their illness, as their insanity made them unreliable witnesses. Patients’ speech then, is interesting as a tool used by the physician-writer\textsuperscript{406}, and for its function within the case history.

The 1860s and 70s represent a period of small shifts in the tone and language of the case history, toward a more detached and scientific account, where the patient virtually disappears. Hjertstedt as physician-writer strives to be invisible in the text; he takes the role of the omniscient narrator and does not draw attention to the influence he exerts.

\textsuperscript{404} In her 2008 study, comprising material from three different asylums, Cecilia Riving found that the nymphomania diagnosis only occurs in the Vadstena records, and that it was mainly used during Hjertstedt’s superintendency. Riving, \textit{Icke som en annan människa}, 260.


\textsuperscript{406} Patient’s speech is usually reported to illustrate the gravity of their illness (hallucinations etc), or to highlight the quality of asylum care (patients who have expressed their gratitude toward the physician and/or his institution tend to be quoted verbatim).
on the content. Even when clearly involved in the events described, his ambition is to distance himself. As Hildegard in her deteriorating state shows him inappropriate affection, Hjertstedt refers to himself in the third person (“the doctor”), as though he was describing an incident involving someone else. The difference in tone between the first and last paragraphs of Hildegard’s casebook record is remarkable; the last note is clinical, detached, with pronouns eliminated and verbs in the passive. Toward the end of her case history, Hildegard is stripped of her “personhood”407, while Anna in hers is scarcely a person at all. It has been stated that in the nineteenth century the aim of the case becomes “to achieve the tone and distance of the autopsy report whilst the patient is still alive”.408 Although many more cases would need to be examined for this to be ascertained, Hildegard and Anna’s case histories would indicate that the process developed considerably in the eleven years that separate them.

**Conclusion**

In his 1771 treatise, de Bienville described nymphomania sufferers as “monsters in human form”; with their sense of decency stripped away, victims would relentlessly seek satisfaction by any means necessary until the condition claimed their lives.409 The illness described in de Bienville’s text, and in subsequent medical treatises which drew on it, has not been found in the records from Vadstena. The rare use of the term as a diagnosis suggests that Hjertstedt did not consider nymphomania to be a specific form of illness in itself. Furthermore, no patients described as suffering from signs or symptoms of nymphomania descend into complete delirium and die, in fact, the majority recover, and are discharged to their homes. The preference for using nymphomania as a descriptive rather than a diagnostic term should not, however, be interpreted as disinterest in female sexuality. In his 1982 study of the Vadstena asylum under Georg Engström, Roger Qvarsell found that sexuality was not an area of special interest to the superintendent. However, as this study shows, Engström did use nymphomania as a diagnostic term, and to a greater extent than Hjertstedt. The latter’s use of the term shows a measure of continuity in practice between the two superintendents, suggesting that Hjertstedt was influenced by his older colleague’s methods and approaches while serving as assistant medical officer. If, as Cecilia Riving has found, Hjertstedt used the term nymphomania at a time where his Swedish colleagues were not inclined to, we may entertain the idea that his familiarity with the concept

---

may also derive from his travels in England and his contact with influential British alienists.

Hjertstedt’s case histories of nymphomaniac patients are longer and more detailed than those authored by Engström, suggesting a level of interest, although the precise nature of that interest is difficult to ascertain. On the one hand, descriptions of shamelessness and obscenity are strongly disapproving and excitability and excessive merriment is noted with suspicion, on the other hand cases occur where the physician seems somewhat intrigued by the patient. Hjertstedt’s ideal of healthy femininity can be glimpsed in his descriptions of recovering patients, where signs of improvement are listed. These include being lucid, but also decent, calm, pliant, and hardworking. A concern on the patient’s part with the well-being of her family is also noted with approval. Nymphomania appears in the Vadstena records of practice as a transgression of all the characteristics of acceptable femininity, including a wanton, selfish pursuit of pleasure and a disregard for one’s family. Several patients exhibit symptoms that are interpreted as pride, or as a desire to appear above their station. Symptoms then take the form of rebellion, against the constraints of social and cultural gender norms, and the rigid discipline of the asylum.

The word nymphomania is used as a description in itself, indicating that its connotations were well known to Hjertstedt, and to other physicians, making explicit descriptions of speech and actions superfluous in the casebook. Cases have been found where illness is attributed to a lack of fulfilment of desire, indicating that some sexual feeling was considered natural in females. It is rather the expressions of that desire in speech and actions which are viewed as indicative of illness. The fact that Hjertstedt does not explicitly attribute nymphomania to the reproductive parts, and does not apply treatment directly to patients’ bodies, suggests that he interpreted symptoms as originating in the mind. Thus, treatment consisted of work and other occupation to distract the mind, and calming medicines to eliminate the symptoms on a short-term basis.

At the turn of the nineteenth century, Swedish physician Henrik Berg neatly summarised the medical association of physical health with virtue: “It is entirely impossible to live an immoral life and remain healthy.” 410 Hjertstedt, practicing psychiatry at mid-century, appears somewhat more uncertain. To him, even when a history of perceived immorality was reported, it was not necessarily identified as the cause of disease. The Vadstena casebooks suggest that lewdness was not interpreted as a common cause of illness. While love certainly could be, lewdness appeared as a result of the faculties of reason being compromised. The records from Vadstena illustrate the coexistence of medical and moral symptoms, causes and judgements in early Swedish psychiatry. The language used to the describe patients is moralising in

the sense that Hjertstedt measures behaviour against normative ideas about femininity. His agenda in dwelling on erotic female patients seems to be concerned with the maintenance of such norms – virtue was considered an essential part of femininity, and as a physician, he sought to restore decency and propriety in his patients. However, the fact that nymphomania was viewed as a symptom rather than a separate illness is significant; to Hjertstedt, a temporary lapse of decency was a symptom of insanity like any other.

Throughout the period, Hjertstedt dwells on the appearance of female patients, often describing them in appraising terms. Where descriptions of men occur, they are more concerned with the patient’s bodily functions, describing injuries and infirmities as well as movements, strength and control. Hjertstedt’s descriptions of female patients such as Hildegard C are eroticising and objectifying in a manner which does not occur in the case notes of male patients. Social class appears to also be a factor; while female patients admitted in third class accommodation may be described as clean and tidy, Hjertstedt’s favourable comments on attractiveness and manners are reserved for first-class female patients.

The fact that nymphomania virtually disappears from the Vadstena records after 1870 is puzzling and fascinating in equal measure. The use of the term in constructions like “signs of nymphomania” and “symptoms of nymphomania” indicate that it never had the status of a fixed diagnosis at Vadstena; rather it appears to have been a marker for a set of behaviours. As such, it may have served Hjertstedt for a time as a means of describing a certain type of erotic patient, and fallen into disuse as patient numbers grew at the asylum, the physician became more established in his role, and, perhaps, less specific in his classification. Furthermore we may presume that the term nymphomania had limited value as a means of communication with other physicians, as previous research has found that it was rarely used in practice at other Swedish asylums. Whether Hjertstedt’s use of nymphomania was due to the influence of his predecessor or that of foreign asylum practice, it may have indicated learning and up-to-date knowledge, for a limited period of time. The fact that nymphomania cannot be said to have had the status of a diagnosis at Vadstena makes its disappearance somewhat less significant – case records from Gustaf Göthlin’s period as superintendent illustrate that erotic behaviour continued to be of interest, although not described in the same terms.
4. Masturbation

On December 5th, 1861, the 24-year old Anton E was escorted to Vadstena by his parents from his home in the nearby town of Linköping. The casebook record of the first meeting between the patient and medical superintendent Hjertstedt indicates that it was a dramatic one. Enraged at finding himself at an asylum, Anton E declared himself to be the Prince of Wales, and threatened that if Hjertstedt did not immediately release him, he would summon the full might of the English navy against the asylum and the town of Vadstena. Admitting Anton E in second class, Hjertstedt diagnosed his illness as paranoia, and reported in the casebook that the presumed causes were a prolonged fever, concern for a fiancée who had been gravely ill, and masturbation. Interestingly, the summary record of admissions for that year lists Anton E’s case with masturbation as a single cause, suggesting that Hjertstedt favoured this explanation.

Cases of illness believed to be caused by, or complicated with masturbation feature in the Vadstena case records from the asylum’s establishment. During Engström’s sample period, six patients were admitted where masturbation was believed to be the cause of insanity. During Hjertstedt’s superintendency, the corresponding number is 26, although most of these cases, like that of Anton E, are recorded as having several possible causes. Although Hjertstedt appears to have been acting head medical officer in the last years of Engström’s superintendency due to the latter’s illness, cases admitted and treated in Hjertstedt’s official period as head of Vadstena are the focus in this thesis. The concept of nymphomania pathologised desire in the female, and medical texts give satyriasis as its male equivalent. Hjertstedt uses the term in the same way in one of his annual reports, however, it has not been found in any casebook or admission order from Vadstena. For male patients, the focus of the physicians’ attention is not on the presence of desire, but on its solitary fulfilment, and the harmful effects associated with that practice.

It is worth noting that Hjertstedt explicitly refers to masturbation at a time when medical texts often used euphemisms for the act of self-gratification. Even in books and articles aimed at medical men some behaviours were considered too delicate to mention, and thus doctors refer to “the solitary vice” or “this disgusting habit”. Many euphemisms were laden with negative connotations well known to lay and medical men of the period. The term “pollution” (from the Latin pollutio) occurs in Swedish, English and French texts on masturbation, as well as in the Vadstena material, and its triple meaning corresponds to the history of the concept. In the moral definition, pollution meant the effusion of seed outside the function of marriage. In the medical

---

411 FIIc:12 No. 1400.
412 Sw. Förryckhet.
sense, it was a term for a disease of involuntary ejaculation. In the jurisprudential sense, pollution meant defilement or desecration of a sacred place.\textsuperscript{414} The multiple meanings reflect attitudes toward masturbation throughout the centuries, from the moral-theological condemnation of the Middle Ages and Early Modern period which focused on masturbation as a sin against nature, citing God’s condemnation of the biblical Onan, to the medical concerns of humoural imbalance within the body as a result of seminal discharge.\textsuperscript{415} The anonymous publication of \textit{Onania} in 1710 dramatically reordered European cultural perceptions of masturbation, transforming it from one of many forms of seminal and excretory loss into a sexual practice potentially fatal to individuals and society alike.\textsuperscript{416} The work came about as part of an Enlightenment trend concerned with the secularisation and medicalisation of morality; while improper acts had previously been condemned as crimes against God and ecclesiastical doctrine, they were now portrayed as violations of social and familial rules as well as “natural law”. Although a counter-reaction among historians has served to temper the image of onanophobia somewhat, medical literature and clinical records illustrate physicians’ preoccupation with onanism throughout the nineteenth century.\textsuperscript{417}

Fear of masturbation gained true medical legitimacy with the publication of Tissot’s famous \textit{Onanism, or, A Treatise upon the Disorders Produced by Masturbation in

\textsuperscript{414} All definitions here are taken from Denis Diderot and Jean de Rond d’Alembert \textit{Encyclopédie} (1751-1772), 568-71, see also \textit{Encyclopaedia Britannica} (4th ed.) Edinburgh: Andrew Bell, 1810, 125.

\textsuperscript{415} Genesis 37:8-10.

\textsuperscript{416} Anon., \textit{Onania: The Heinous Sin of Self-Pollution, and All Its Frightful Consequences, in Both Sexes Considered, with Spiritual and Physical Advice to those Who Have Already Injured Themselves by this Abominable Practice.} (8th ed.) London: Thomas Crouch, 1723 [1710].

Tissot’s focus was on describing the resulting medical problems, rather than the crime of masturbation itself. He cited noted medical authorities on the subject of seminal loss, and explained the pathology of onanism by relying on theories of humoural physiology. Masturbation weakened the entire organism by depleting it of its most precious fluid, semen, leaving both body and mind feeble and withering. Tissot emphasised that masturbation was especially dangerous to pre-pubescent children, although he did not believe that the practice was widespread (“happily we find but few monsters of either sex who indulge in it before this period, still the number is too great”). For Tissot, the ills of masturbation included, nevertheless, most of the disorders listed in *Onania*. Adding the full weight of medical rhetoric to the established moral vocabulary, he sought the same end as the anonymous author of that earlier text: to portray physical relations within marriage as normative, and promoting the overall regulation of sexuality. Tissot’s influence on psychiatry is largely to be attributed to Jean-Étienne Dominique Esquirol, who followed Tissot closely in his descriptions of madness caused by masturbation. In the first edition of his *Maladies Mentales*, published in 1816, Esquirol claimed that “masturbation is recognized in all countries as a common cause of insanity”. To Esquirol, masturbation was not simply a vice, or a harmful habit; but associated with a perverted imagination. Causing a state of perpetual lust in the patient, sometimes with hallucinations of an erotic nature; the masturbatory disorder forced the sufferer to constantly seek gratification. Among his most prominent Swedish followers was physician Israel Hwasser, who paraphrases Esquirol in his own description of the symptoms of masturbatory insanity.

In his annual report of 1850, Hjertstedt lists masturbation under “excesses in satisfying the sexual desire”, and states that such indulgence either by means of “onanism or coitus” is a relatively common cause of insanity at Vadstena. The short passage, the only text found where Hjertstedt expresses his views on the subject, seems to indicate that he does not believe masturbation to be more dangerous than coitus – the emphasis is on excess as the harmful element. Nevertheless, a comparison

---

422 Hwasser, “Om äktenskapet”, 297.
of descriptions of masturbating patients in the Vadstena casebooks reveals a number of reoccurring themes which echo the image created by Tissot.

“Suspected onanist”: Descriptions of masturbating patients

While a few masturbating patients, like Anton E, are described as restless and violent, the majority displayed more quiet symptoms. University student Lars T, admitted in 1846, is reported to have been universally loved for his quiet and exemplary conduct prior to the outbreak of illness.424 On his admission he is found to be incoherent, with no sense of order, and displaying great timidity. In a casebook entry three years later Hjertstedt describes the patient’s condition as “profound dementia”. The fifteen-year-old David F was admitted in 1844 with “a peculiar listlessness” as his only symptom, and descended into profound dullness within a few years.425 Masturbation is the only cause recorded in this case. Similarly, Sven D, admitted in 1848 is described as listless and lethargic, with irregular outbursts of violence.426 The repeated use of adjectives such as “enervated” and “indolent” and descriptions of feeble muscles indicate a loss of mental and physical vigour, of deranged or apathetic minds in soft, limp bodies, which are often found by the physician to be small, thin and pale.427 In addition, Hjertstedt often comments on the withdrawn character of masturbating patients. Jan J, a farmhand admitted in 1874, is described as timid and skittish, and his admission document states as a symptom that he “never looks anyone in the face”.428 The aforementioned Lars T exhibited great diffidence, and Anton E shied away from old friends, preferring to isolate himself with his delusions. These descriptions reproduce the image of the masturbator which had been put forth by Tissot, and continued to feature in medical texts throughout the nineteenth century.

Describing the effects of masturbation in an 1868 psychology textbook, the Swedish physician Otto Manderup Witt wrote:

They include a general withered state, impotence, diseases of the spinal cord, etc. On the intellectual faculties it causes loss of memory, difficulty to comprehend and formulate ideas, and finally fatuitas and dementia. Few causes have so many victims in the asylums. In the spiritual sense, confusion, disordered thoughts and suicide follow.429

424 FIlc: 5 No. 827.
425 FIlc: 5 No. 760.
426 FIl:6 No. 908.
427 FIlc: 20 No. 2136, FIlc: 5 No. 827, FIlc: 5 No. 760, FIlc: 17 No. 1834.
428 FI: 19 No. 2164.
429 Witt, Själen i normalt och sjukligt tillstånd, 74.
Scottish physician David Skae provided a similar description in the same year, writing of “peculiar imbecility and shy habits”, suspicion, fear, dread and suicidal impulse. In older offenders where the practice had been lengthier, Skae saw feebleness, a frightened facial expression, and gradual descent into dementia. Hjertstedt’s case note for Carl P, admitted in 1868, describes a corresponding course of illness. Though withdrawn and passive in every sense, the patient could be made to answer questions and follow instructions upon his arrival to Vadstena, but deteriorated slowly. At the top of the casebook record for Carl P, diagnostic terms have been added, in differently coloured ink, apparently on different occasions: “Melancholia (paranoia). Stupiditas. Dementia.”

Descriptions of onanists have something vague and undefined about them. Alongside physical attributes and symptoms, they speak of feelings exhibited on the person of the onanist: fear, dread, suspicion, shame, and timidity. There is something “peculiar” about the patients’ imbecility in Skae’s description, and Witt speaks of a “general withered state”, without describing it further. Masturbation was carried out in secret; concealed, denied and condemned, and these circumstances appear to have affected the sufferers’ very person, and caused an insidious condition which only the highly skilled and discerning physician would be able to detect. When Jan J was admitted 1874, the medical certificate that accompanied him stated in two places that there were ample signs of the dangerous habit. “He is presumed to have practiced masturbation”, wrote the provincial doctor, “which, judging by several signs, is not unlikely.” Hjertstedt reiterates the information in the casebook, but does not elaborate on the nature of the “signs”. In a later note, he adds, drily: “Patient appears prone to masturbation here also.”

The case of Anton E, who believed himself to be the Prince of Wales, is not unique in the Vadstena material. Delusions of grandeur and hallucinations regarding one’s place and function in society are reoccurring in case records of male masturbating patients. Sune V, admitted in 1847, also believed himself to be a prince of the blood. His case note, chronicling his 39 years at Vadstena, describes his proclivity for destruction of anything he could get his hands on, especially glass, porcelain and clothing. Hjertstedt notes that the patient was not susceptible to reprimands: “When reproached for his behaviour, he excuses himself in a noble fashion by saying ‘I could not help it’”. Unlike Sune V, Anton E is described as being an especially difficult patient, his actions and demeanour characterised by pride and arrogance. Although never violent, he remained stubborn, angry and impudent to staff throughout his stay. In spite of repeated efforts, he could not be made to take part in what Hjertstedt calls

430 FIIc:17 No. 1834.
431 Sw. Han förmodas hafta öfvat onani, som att döma of åtskilliga tecken, icke är osannolikt.
432 See also Lars S, FIIc: 21 No. 2192.
433 FIIc:5 No. 884.
“useful occupation”, and refused any medication. His time was spent writing letters to the people of England, commanding them to send “hussar regiments, steam frigates etc.” to free him from captivity. The amount of detail provided in the casebook suggests a significant frequency of interaction between the physician and his patient. Mentions of the patient being agitated and angry when contradicted suggest that Hjertstedt did not let his delusions pass without attempting to correct his confused ideas. An entry from January 1862 reads: “He pretends to know several languages, but is in all but his native tongue fairly weak.” The comment implies that Hjertstedt used his own considerable language skills – he frequently quotes from and comments on English, French and German medical texts and official documents in his travel journal – to assess the truth of the patient’s statement, and to effectively prove him wrong.

Another example is Alfred W, who professed himself a great scholar of many sciences, especially astronomy, and spoke much of purchasing property, for which, his family reported, he did not have the means. On his arrival at the asylum he believed himself to be a patron of an inn, and violently lashed out at staff when they did not wait on him. Hjertstedt’s disapproval of the patient’s behaviour is evident in the case history; Alfred W is described as “distinguishing himself by considerable stupidity and coxcombicality”. In appropriating the airs and graces of the better classes, and in the case of Anton E refusing to acknowledge his parents, these patients denied their place in society. For Hjertstedt, being satisfied with one’s station and circumstances was a sign of reason and health, and his descriptions of megalomaniac patients have an air of disapproval, as though pride and vanity were not only biblical sins but particularly disturbing medical symptoms.

Diagnosis and prognosis

In spite of widespread medical concern and a general acceptance of the idea that masturbation caused madness, it only appears as a specific type of insanity for a brief time. The diagnostic term “masturbatory insanity” originated in the texts of Scottish alienist David Skae (1814-1873), physician superintendent of the Royal Edinburgh Asylum at Morningside. His major work was the 1863 *Classification of the Various Forms of Insanity on a Rational and Practical Basis* in which he attempted to construct the nosological system that British psychiatry was still lacking. As was the case in Sweden, the individual asylum physician was free to make use of any of the numerous classification systems put forward in the great medical works of the early

434 FIIc:12 No. 1400.
435 FI:17 No. 1849.
436 Sw. Han utmärker sig för icke obetydlig enfald och narraktighet.
nineteenth century. 438 "There is no two asylum reports published in the empire in which the same rules and distinctions are rigidly observed in tabulating the forms of insanity under treatment", complained Skae, and went on to criticise the much-used taxonomies of Pinel and Esquirol for being classifications not of diseases, but of symptoms. 439 His own classification system, he claimed, was an aetiological one, based on the "natural history" of the condition. Skae received much criticism, but was generally respected for his valiant attempt to fill a significant gap in contemporary psychiatry. Skae presents masturbatory insanity as "scarcely requiring comment or illustration" 440 and his description of symptoms is similar to many previous ones published since the late eighteenth century. The diagnosis was only applied to male patients, and seems to have had little actual use outside Skae’s own practice. Although his name appears to have fallen into some disrepute among respectable alienists after the mid-nineteenth century, the idea of masturbation depleting the body of a precious fluid, and thereby weakening it, lingered.

The Vadstena material indicates that masturbation was viewed mainly as cause and symptom; the term masturbatory insanity is not used, and no evidence suggests that the physicians viewed the habit as part of any specific type of illness. In his annual report of 1850, Hjertstedt makes the general observation that the prognosis for a patient being admitted to Vadstena due to masturbation is not favourable, because in most cases the progress of disease is too great by the time they arrive at the asylum. The most common diagnostic concepts for masturbating patients at Vadstena, dullness and dementia, were considered incurable conditions, and often such a remark can be found relatively early in the casebook record. This is the case for the minister Pehr S, admitted to Vadstena in February 1835, who had fallen ill in adult life, and grew ever more weak and withdrawn following his admission. 441 Georg Engström remarks that his moments of clarity became fewer and shorter, until he finally became bedridden and unable (or unwilling) to communicate at all. The casebook is updated annually for

438 William Cullen, Nosology: or, A Systematic Arrangement of Diseases. Edinburgh: C. Stewart and Co., 1800 (1st Latin ed. 1769), Philippe Pinel, Nosographie philosophique ou La méthode de l’analyse appliquée a la médecine (6th ed.), Paris: J.A. Bousson, 1818, Esquirol, Mental Maladies. Though somewhat historiographically slighted in comparison with their French contemporaries, German medical writers were actively contributing to the nosology debates. Johann Christian Reil (1759-1813), first coined the term “psychiatry” and his Rhapsodien über die Anwendung der Psychischen Curmethode auf Geisteszerrüttungen (1803) alongside the work of Heinroth and Vering, helped to establish psychiatry as a modern discipline in Germany. They were all major influences on Georg Engström’s perception on the classification of insanity (see Qvarsell, Ordning och behandling, 105f.).


441 FIlc:3 No. 404.
fifteen years with the same reoccurring remark (“Patient’s condition unchanged”), interspersed with comments regarding the patient’s physical health, until his death from pneumonia in 1864.

However, incurable conditions did not automatically mean a lifetime in the asylum; the ambition to make the asylum a curative institution meant that physicians were obliged to try to prevent a build-up of chronic patients. A typical case is that of Johan R, admitted in 1856, and discharged eighteen months after his arrival. In the final casebook entry, Hjertstedt describes the patient as “calm, pliant and harmless”, adding that he is to be discharged into private care in the town of Vadstena. 442 The assessment here appears to be a double one; that Johan R could safely be cared for outside of the asylum, as he did not pose a threat to himself or anyone else, and that his illness was beyond any therapeutic intervention. Anders S, a farmhand, was admitted at the age of 21, and had previously spent time in an asylum for a spell of insanity caused by masturbation. 443 Following his discharge having improved Anders S was once again admitted, this time to Vadstena, in 1830. The cause of insanity was once again believed to be masturbation. Described as being “severely imbecile” and unable to care for himself in the slightest, he remained at the asylum, mostly bedridden, for 37 years. His discharge, having been described as incurable, in 1867 came at a time when the patient population was increasing steadily, and many calm patients were discharged in order to accommodate individuals who were curable, as well as dangerous and suicidal cases. Complete recoveries are rare among masturbating patients at Vadstena, the only example found being that of Emanuel O, admitted in July 1881 and diagnosed with mania. 444 In the first casebook entry, the patient is described as restless, excited and preoccupied with religious ideas “always walking back and forth, talking and preaching”. Superintendent Göthlin notes that the patient “speaks in a whining, half-singing fashion, anxiously and incoherently”, that he tears his clothes and clings violently to whoever enters the room. According to the casebook record, Emanuel O’s condition remained unchanged for six months, until a sudden drastic change materialised. The case note for 31st January 1882 reads:

The patient’s condition has been entirely unchanged from his admission until today, when he suddenly appeared completely composed, dressed himself and made inquiries as to where he was, how long he had been here etc. Was moved the same day to the quiet ward. Shows good appetite, but anaemic and his energy seems greatly diminished.

A few days later, Emanuel O began working in the asylum’s carpentry workshop, growing stronger and remaining calm and reasonable. The physician does not mention

442 FIIc:8 No. 1187.
443 FIIc:1, No. 227.
444 FIId:1 No. 2540.
whether masturbation continued, nor does he elaborate on what might have caused the patient’s sudden recovery. On March 11th 1882, eight months after his admission, Emanuel O was discharged “completely recovered” to his home. The cases above supports the impression that, in medical practice, masturbation could be attributed as a cause as well as symptom in any kind of insanity. However, descriptions of masturb- bating patients have certain reoccurring themes, illustrating that onanism was strongly associated with a number of characteristics, such as weakness, pallor, apathy and confusion.
Figure 7. Plate “representing the debilitated state of the body from the effects of Onanism or Self-pollution”. Image from R.J Brodie, The Secret Companion, a medical work on onanism or self-pollution, with the best mode of treatment in all cases of nervous and sexual debility, impotency, etc. London: For the author, 1845, Plate 1.
Figure 8. “Facial effects of masturbation” depicting various facial characteristics associated with onanism. Images from physician and Kabbalist Seth Pancoast’s (1823-1889) tantalisingly entitled *Startling Sexual Secrets! Boyhood’s Perils and Manhood’s Curse*. Philadelphia: For the author, 1858.
Masturbation as moral and medical issue

While the descriptions of masturbators are similar in Swedish and European medical literature, medical views on exactly how masturbation came about; that is, where in the body it originated, appear to have differed. Was the physical act of self-gratification, as Israel Hwasser argued, the result of a pathological imagination? Was it, in fact, a product of weak personal morality, perhaps from a neglected upbringing, which inspired lewd thoughts and actions in the individual? Or was some physical disorder, the “local irritation” often referred to, to blame for the solitary vice?

The crusade against masturbation was fought on two fronts, by medical men in the pages of journals and textbooks, as well as in asylum wards, and by moralists in advice books aimed at parents, teachers and the general public. Medical writers agreed that a good upbringing, with proper morals as its foundation, was the prerequisite for a healthy and sane adult life. This appears to be especially true for the prevention of lewdness, venereal excess and masturbation. In 1883 Fredrik Johan Björnström, then professor of Psychiatry at Karolinska Institutet, warned that “passions, unchecked by proper moral feeling, become violent, especially the sexual instinct”. A neglected or morally lax upbringing is also a reoccurring theme in the Vadstena case records, as Hjertstedt and his colleagues sought to chart the aetiology of the various forms of erotic insanity. The final entry in the casebook of Anton E is made following his final discharge into the custody of his family in December 1865, and suggests that Hjertstedt saw in his patient a spoiled young man whose illness had been partially caused by his parents’ tenderness.

Without doubt the patient could, if provided suitable occupation, and placed under careful and sensible supervision, regain his former haleness and force of spirit. But his home, where he appears to have been spoiled by a weak and indulgent mother, is not the right environment for his future health.

Such reflections are rare in Hjertstedt’s case notes, and this one seems somewhat out of place, being a subjective interpretation of the case, recorded after the patient’s discharge and departure. It appears that the physician meant to record his thoughts in

---

446 “Masturbation is not a disease, nor a disorder”, wrote William Acton in the definitive Victorian work on sexual functioning, first published in 1862. “It is rather an habitual incontinence eminently productive of disease”. Functions and Disorders of the Reproductive Organs, 83.
448 Björnström, Sinnessjukdomar, 52.
449 FIIc:12 No. 1400.
the event that Anton E returned once more to Vadstena. In addition, the note seems to provide Hjertstedt’s own explanation for an illness which had hitherto been unexplained.

However, like the medical literature, the Vadstena sources indicate that even the most virtuous individual might fall victim to masturbation as a result of unhealthy habits and external stimuli. Tissot had especially warned the rich and idle, men of letters and those who had no physical occupation, but were preoccupied with intellectual work.\textsuperscript{450} In an 1885 text, the German social democratic politician August Bebel (1840–1913), warned against stimuli which might cause unnaturally aggravated sexual desire; indecent images, novels, perfume, and an excess of poetry, music and theatre brought on “sexual irritation” in both men and women. His argument was first and foremost directed toward the middle and upper classes, but Bebel also targeted specific tasks: working by a sewing machine was especially likely to increase desire for sexual activity, as was working in warm rooms and at night.\textsuperscript{451} The physician Otto Manderup Witt agreed that lack of work, non-physical labour and suggestive reading were all contributing factors, and added that masturbation was especially common in students and scholars.\textsuperscript{452}

The connection between intellectual over-exertion and masturbation is also present in the Vadstena material. Student Sven D was admitted to Vadstena in 1848 and diagnosed with dementia, his admission record stating that “vigorous study, and masturbation” were the underlying causes of his illness.\textsuperscript{453} Similarly, Lars T is reported to have fallen ill after a period of intense theological study, during which he isolated himself in his room and refused to speak or socialise with his friends.\textsuperscript{454} Another student, Daniel G, admitted in first class in 1856, had his dullness and suicidal impulses attributed to a combination of vigorous study, religious melancholia and masturbation.\textsuperscript{455} In all three cases, masturbation is noted as cause in the asylum register. Hjertstedt does not comment on causes in the casebook, and thus his understanding of the connection between scholarly pursuits and masturbation are not

\textsuperscript{450} Rosario, \textit{The Erotic Imagination}, 20.
\textsuperscript{451} August Bebel, \textit{Woman in the Past, Present and Future}. San Francisco; Benham, 1897 (1\textsuperscript{st} ed. 1885), 66. Bebel states that sedentary employment causes blood to gather in the sexual organs, and that the pressure of such a position contributes to sexual excitement. Of the sewing machine, he adds: “Its effects on the nervous and sexual system are at the same time so exciting and so wearing that a working day of ten to twelve hours is sufficient to ruin the best constitution in a few years.” With no further explanation of what exactly made the sewing machine especially dangerous we are left to speculate as to whether its repetitive penetrating motion was the actual cause of concern.
\textsuperscript{452} Witt, \textit{Själen i normalt och sjukligt tillstånd}, 73-74.
\textsuperscript{453} FIIa:6 No. 908.
\textsuperscript{454} FIIc:5 No. 827.
\textsuperscript{455} FIIc:8 No. 671.
available to us; what is known is that the books available in the asylum library had to be approved by the superintendent and the chaplain, and were to be of a light-hearted and diverting character.\textsuperscript{456} While physical labour had an important role in Hjertstedt’s therapeutic regime (see chapter 6), intellectual efforts were seen as potentially harmful, and thus any literature considered too challenging or suggestive would not be permitted at the asylum.

Medical textbooks characterised onanism as a habit that quickly enslaved the sufferer. While he (the examples given are almost exclusively of male patients) had initially voluntarily indulged himself, the patient quickly lost the ability to control the practice. Masturbation is described as an \textit{addiction}, though the word is rarely used in nineteenth century texts, and coincides with a point in time when various forms of immoral and criminal behaviour are increasingly medicalised.\textsuperscript{457} These include alcoholism (\textit{dipsomania}), shoplifting (\textit{kleptomania})\textsuperscript{458} and the deliberate starting of fires (\textit{pyromania}).\textsuperscript{459} Although by the mid-nineteenth century masturbation had been discussed and condemned by doctors for almost a century, it formed part of a collection of undesirable behaviours which became increasingly framed as disease, and which were soon to be associated with degeneration and hereditary moral and physical weakness.

While Tissot had alluded to the influence of social forces on the organism as causing health and illness, nineteenth-century physicians came to distance themselves from this standpoint, and Swedish doctors were no exception. In 1878 physician Anton Nyström (1842–1931) proclaimed that those alienists who held civilisation as responsible for mental disorder were most gravely mistaken. Nyström instead blamed the “deformities” inherent in civilisation, the shortcomings and weaknesses inherent in human nature, and the “accidents” which accompany its “anarchical transitional phases”, meaning puberty, maturity, old age and possibly menopause.\textsuperscript{460} Although Nyström’s views, being somewhat radical, cannot be held as representative of his time, the critical stages in a person’s development that he identified were recognised as periods during which the individual was especially vulnerable to external influences. The transition from childhood to adult life was regarded as perilous to both men and women.

The idea that masturbation could be contagious, in the sense that one sufferer could inspire others to the same vice, had been put forward by Esquirol, and the idea appears

\textsuperscript{456} Qvarsell, \textit{Ordning och behandling}, 146.
\textsuperscript{457} See Tissot, \textit{Onanism}, 21, 61-69.
\textsuperscript{460} Nyström, \textit{Om sinnesrubnning}, 35.
to have spread among his followers.\footnote{Hwasser, “Om äktenskapet”, 298.} This further added to the sinister image of masturbation; a morally and physically subversive practice that could spread in secret, unless detected and checked wherever it was found. As a curative institution, designed to provide the treatment and instruction as well as the ideal environment for patients to recover, the asylum had to be morally irreproachable. In reality, preventing masturbation was problematic, and the case notes suggest that it was an ongoing concern at Vadstena. In his annual report of 1850, Hjertstedt wrote: “Even during their stay here there is great difficulty in preventing the unfortunate from indulging in the masturbatory habit.”\footnote{Hjertstedt, \textit{Berättelse om Wadstena centralhospital}, 23.} The case notes of patients Johan R, Gustaf Ö, Carl P and Jan J all explicitly state that the patients continued the habit while at the asylum, and none of the case notes mention any intervention to prevent such behaviour. In 1865, the year of his admission, Gustaf Ö is reported to “masturbate with prurienty when left unattended”, and the case note records that the habit continued until the patient’s death in 1890.\footnote{Sw. \textit{Bedriver onani med begärlighet då han lämnas obemärkt}. FIIc:7 No. 1096. FIIc:8 No. 1187.} In the case of the schoolteacher Johan R, Hjertstedt noted in the casebook that the patient’s strong urge to masturbate “seems [to be] the greatest obstacle to his recovery”.\footnote{Bidrag till Sveriges Officiella Statistik, K) Helso- och Sjukvården II, Underdånig berättelse för år 1885-1891. Writing in 1891, physician Wilhelm Wretlind claimed that the number for male patients was in fact 11% and for female ones 2%. Ekenstam, \textit{Kroppens idéhistoria}, 150.} The records indicate that restraint was not routinely used as a prevention technique for masturbating patients, and that while strict surveillance was most likely the preferred prevention technique, such measures were difficult to maintain in practice. The discussion regarding the prevention of masturbation at Vadstena is further developed in chapter 6.

A marked increase in the number of patients being admitted with masturbation as cause is discernible during the latter part of the nineteenth century. The sample period from the superintendency of Gustaf Göthlin, 1885-1891, contains 13 such cases, a seemingly large number in comparison with the 26 found during Hjertstedt’s 29-year service. An examination of the official reports from the Board of Asylums during the period 1885-1891 reveals that the number of patients admitted to Swedish asylums with masturbation as cause during those years was between 30 and 35 per year, or around 4.4% of the total admissions.\footnote{Bidrag till Sveriges Officiella Statistik, K) Helso- och Sjukvården II, Underdånig berättelse för år 1860-1869.} The corresponding number for the 1860s, the middle of Hjertstedt’s period as superintendent, was between 4 and 9 per year, or less than 2%.\footnote{The numbers for Sweden as a whole thus strengthen the impression gained from the Vadstena material, namely that masturbation becomes a more common
attributed cause at the end of the nineteenth century. In addition, two case notes have been found from 1891 where Göthlin describes masturbating patients as having “increased sexual instinct”. The wording indicates that Göthlin makes an assessment of desire in these cases and finds it exaggerated. In comparison, Hjertstedt and his predecessor Engström appear to focus on the act of masturbation itself and its presumed medical and moral effects, rather than the presence of desire. This finding, although minor, suggests a changing attitude toward masturbation at Vadstena in the 1890s. Furthermore, it appears to support the findings presented in Mikael Eivergård’s 2003 thesis; that excessive desire became a growing concern, and was increasingly pathologised, in psychiatry around the turn of the century.468

Doctors may have been unanimous in their condemnation of masturbation, but not of masturbators themselves. While acknowledging the difficulty in preventing patients from masturbating, Hjertstedt expresses no moral judgement as such of their behaviour in the casebooks. Where masturbation continued after admission, this is noted in a matter-of-fact fashion, and nothing in the language of the medical record indicates that self-gratification was viewed as any more deplorable or shameful than any other symptom. The Swedish literature on the subject contains examples of physicians and writers who stressed the need for pity and gentleness in dealing with masturbating patients. In an 1866 article, cleric and educator P.P. Waldenström (1838–1917) argued that the shame associated with masturbation might actually be more harmful than the practice itself.469 Physician Israel Hwasser also advocated pity and compassion for sufferers; in describing masturbation in terms of disease, he freed patients from blame:

\[
\text{The force which controls their soul, paralysing their moral powers, is terribly great, and between the condition in which they find themselves and one of the commonest forms of insanity, there is only one step. They are, in fact, in the first stage of the latter.470}
\]

However, as the nineteenth century wore on, the motivation for the crusade against masturbation appears to have been a concern with the collective body rather than the individual one. What emerges from the anti-masturbatory literature of the late nineteenth century is the perception of “deviant” individuals as viruses of the social body – polluting its national strength and purity. For Tissot, masturbation was especially deplorable in children, as it had a corruptive effect on their innocent, natural
bodies. By the time of the Restoration (1814-1830), the vector of contagion had been reversed: Réveillé-Parise and other hygienists were denouncing “masturopriomaniacs” as “the destroyers of civilized societies”.471 As insanity became increasingly associated with heredity and the degeneration theories of physicians like Benedict-Augustin Morel (1809-1873) and Richard von Krafft-Ebing in the second half of the nineteenth century, onanism was framed in terms of a moral threat to civilised societies. However, the anxiety regarding masturbation in childhood and youth remained, as children were associated with the future wealth and society of a nation.472

**Female masturbation**

Tissot had warned that onanism was equally harmful to both sexes, suggesting that the practice might in fact be more common among women473, although he offered no explanation for this, nor evidence to support his case. Esquirol claimed that it was more dangerous for men, and that female masturbation was just as common, but less noticed by physicians, as women were less prone to admit to it.474 German physician Jonathan Braun, whose thesis on sexuality was translated into Swedish in 1866, drew on the ancient theory of the female seed in his description of the perils of female masturbation.475 Texts attributed to Hippocrates, the Greek father of medicine, had argued that two types of seed were involved in conception; the fluid secreted by a woman during intercourse was also a type of semen, albeit a lesser one. The Hippocratic view appears to have lingered, as the two-seed theory is found in the work of Linnaeus476, and is even drawn upon in the nineteenth century. The example of Braun also illustrates the twofold physical danger associated with masturbation: physical weakness and nervous affection. Braun argued that as the female seed was less precious and vital to the organism than that of the male, women could endure seminal loss better. However, as the female nerves were finer and more delicate, the damage done to them by the solitary vice would be that much greater.477 The fact that the majority of Swedish-language advice books cautioning against the effects of self-abuse in the first half of the nineteenth century are addressed to young people of both sexes indicate that women were far from exempt from such indulgence in the minds of

472 Ibid., 40.
476 Linné, *Om sättet att tillhopa gå*, 45, 47.
moralists and physicians. It is important to note that not all responses to female masturbation were as sternly condemnatory as those of Tissot and his followers. Among those who believed in a somatic cause of masturbation was Swedish physical therapist Thure Brandt (1819-1895), who developed a system of treating disorders of the female reproductive parts through physical therapy and gymnastics. Brandt wrote briefly about nymphomania in his 1884 thesis on women’s illnesses, describing the suffering of nymphomaniac patients, and stressing that such individuals must be met with compassion and humanity in order for treatment to be successful. The historian of ideas Ulrika Nilsson has noted the difference between Brandt’s emotional, religiously influenced approach, and the coldly clinical gaze of specialists in the emerging field of gynaecology. While alienists and gynaecologists stressed the horrifying physical and mental effects of masturbation and attempted to prevent the practice with mechanical, pharmacological and, in extreme cases, surgical methods, Brandt’s methods were non-invasive and sought to remove the problem entirely.

In the few female case records from Vadstena which include onanism, it is rarely seen as the cause of insanity (in all cases cited here the cause was believed to be disappointed or unrequited love), but rather a symptom, indicative of the advanced stage of illness. In the case of Emilia S, admitted in 1847, the doctor’s certificate states that following the outbreak of insanity the frequency of masturbation has caused her vulva to become lacerated. Emilia S’s illness was attributed to an attack of the measles, and she was to remain in the asylum until her death in 1911. No mention of masturbation is made in the casebook throughout her long stay. Sophia B was admitted in 1851, and suffered periodic bouts of “masturbation with unmistakeable traces of nymphomania”. Having recorded a few of these outbreaks, Hjertstedt notes that they coincide with the patient’s menstruation, and in the intermittent periods she is calm, “if not completely lucid”. Aside from the implicit suggestion that Sophia B’s periodic confusion is in some way connected with her reproductive cycle, no cause of illness is recorded. Hildegard C, whose case is discussed in detail in chapter 3, is the only

479 Thure Brandt, Gymnastiken såsom botemedel mot svinliga underlivsjuksdomar: Jemte strödda anteckningar i allmän sjukgymnastik. Stockholm: Bonniers, 1884.
481 FIIc:5 No. 885.
482 Sw. Onani med omisskännliga spår af nymphomanie.
483 FIIa:7 No. 571.
female patient in the material to exhibit masturbation as a symptom after admission to Vadstena.\textsuperscript{484} Among her various symptoms indicating an erotic state of mind, the casebook reports that Hildegard C is not ashamed to indulge in self-abuse in the presence of others.\textsuperscript{485} Her illness is classified as mania, although frequent mentions are made of the symptoms of nymphomania present, and the clergymen’s certificate reports that the presumed cause is unsuccessful love. None of the casebook entries for these female masturbators contain any indication that measures were taken by the physician or by asylum staff to prevent masturbation. Interestingly, Emilia S, Sophia B, and Hildegard C were all admitted in first class. The idea that masturbation was primarily an affliction of the better classes was widespread\textsuperscript{486}, associated as it was with idleness and self-indulgence, but little can be made from such a small body of evidence.

The scarceness of female masturbation cases in the archive material reinforces the image of a vice mostly associated with males in the early and mid-nineteenth century. Medical texts discussing masturbation focused on the male perpetrator, and not until the late-nineteenth century did female masturbation become a subject of study in its own right.\textsuperscript{487} Images available of the effects of onanism almost exclusively portray men in pale, withered states, but few have been found of women (while portraits of women suffering from venereal disease are relatively common). The exception to the rule is Tissot’s portraits of Mademoiselle Ch from his \textit{Onanism}, where the young patient is shown as being wrinkled, aged and feeble in the late stages of masturbatory illness. The prevalence of male figures in images of masturbators indicates the lingering influence of the old humoural idea of depletion; women, naturally devoid of semen, suffered less dramatic physical effects from frequent self-abuse. Where female masturbation was discussed, it was as an afterthought, a subordinate issue to the more important one of managing the practice in males.

\textsuperscript{484} FIIc:10 No. 1298.
\textsuperscript{485} Sw. \textit{Hon blygs ej att i andras äsyn öfva sjelfbefläckelse.}
\textsuperscript{486} "Förhandlingar vid Svenska Läkare-Sällskapets sammankomster från oktober 1861 till och med september 1862", \textit{Hygiea} 23, 1862, 159.
Mme la Ch. âgée de 15 ans
(Suisse vaudoise)
Figures 9 and 10. Tissot’s drawings of Mademoiselle Ch** were intended to illustrate her physical decline and waning youth during her masturbatory illness. Portraying the patient in bed alludes to the inertia and shyness associated with the disorder, and suggests an enduring proclivity to the secret vice. Images from S.A.D. Tissot, *A Treatise on the Diseases Produced by Onanism* (1st French edition 1760). New York: Collins & Harnay, 1832.
It is worth noting that the medical literature describes the masturbating woman as taking on male traits; among other horrifying effects Tissot writes of the enlarged, sometimes grossly elongated clitoris of the female masturbator which at times could reach the dimensions of a small penis. Masturbation was said to have a detrimental influence on beard growth in men, but to encourage it in women.\textsuperscript{488} Similarly, male masturbators were described as deprived of strength and action, and masturbation was since the Middle Ages associated with the mortal sin of \textit{mollicies} (meaning softness or effeminacy).\textsuperscript{489} Female masturbation was frightening to nineteenth century physicians such as Isaac Baker Brown (1811–1873) because they believed it caused sterility, and because the notion of a female sexuality which did not have reproduction as its goal challenged the established role of the female as wife and mother.\textsuperscript{490} Masturbation then caused worrying signs of gender inversion in the individual. If we add to this the supposed effect of disinterest in “the lawful pleasures of marriage”, the motivation for seeking to eradicate self-abuse appears with some clarity. If we accept heterosexual marriage as one of the founding institutions upon which nineteenth-century bourgeois society was built, masturbation posed a serious political, as well as medical and economic, threat to that order.

\textbf{Cases of Masturbation}

\textit{Carl P, a farmer, admitted in 3\textsuperscript{rd} class, August 3\textsuperscript{rd} 1868}

The first information provided in the casebook is that Carl P had suffered a previous outbreak of insanity in the previous year, and had then been cared for in his home.\textsuperscript{491} Hjertstedt states that the cause was masturbation, and that the patient at that time had made a full recovery, but no indication is given as to which source provided this information. On arrival to the asylum, the patient was described as being in a near-catatonic state. He could not be persuaded to speak, and remained still “wherever he was placed”. He did not appear to pay any attention to his surroundings or what took place around him, and Hjertstedt draws the conclusion that Carl P is “indifferent to everything”. The physical description of the patient is brief, noting only his thin and pale physique, his “simple and dumb” eyes and his anxious facial expression. Interestingly, no mention is made of masturbation. The first casebook entry ends with the words “condition unchanged until year’s end”. This does not necessarily mean that

\begin{enumerate}
\item Bynum, “Onanism”, 1020.
\item Rosario, \textit{The Erotic Imagination}, 15-16.
\item FI:17 No. 1834.
\end{enumerate}
Carl P was not seen again by the physician for several months. However, it may be an indication that the physician has already identified in the patient an advanced stage of illness, for which the prognosis is bleak. The second case note, dated simply “1869”, reinforces this idea. Although Carl P is described as “somewhat more lively”, his prognosis is not improved. When the patient can be persuaded to speak, writes Hjertstedt, “his words betray severe dullness of all the mental faculties”. No details of the patient’s speech are given, only that he communicates many disordered ideas, and that he is anxious and wishes to return home. The case note is compiled in a list-like fashion, covering the standard information observed: the patient eats well and sleeps at night, is listless to any useful occupation and remains still where he is placed. Carl P is reported as continuing his masturbatory habits, but in spite of this the physician reports of a slight improvement “during the spring”; “The patient is less stupiditas, speaks now and then, but only nonsense”. At this point, Hjertstedt records an explicit prognostic assumption: the illness is “most likely incurable”.

The case note gives no clues as to whether the note dated “1869” was written all at once (it is all one paragraph), or if sentences were added here and there throughout the year. Thus, no clues are offered regarding the frequency of interaction between Carl P and his physician. What is clear is that the written attention given to patients considered incurable is decidedly less than in cases where there is hope of a cure. There is no record of any therapeutic measures whatsoever in Carl P’s case history; no medication is prescribed, no restraint applied, and no external therapies such as bathing, which may also indicate that Hjertstedt identifies the illness as incurable at an early stage. The initial diagnosis, entered at the top of the first page of the case history, is melancholia, but another diagnostic term, dementia, has been entered (with differently coloured ink) underneath. We cannot know when this addition was made, but it is likely that the change in diagnosis occurred at about the same time as Hjertstedt proclaimed Carl P incurable; as we have seen, the diagnostic term dementia had a permanent character.

Carl P remained in the asylum for nineteen years, but his case history is extremely brief following the note that assumes him incurable. A single line is recorded for each year of his stay, the notes reporting that the patient’s condition is unchanged, that he remains dull, enervated, “headstrong, but not violent”, and that he displays a “strong tendency for masturbation”. Twice, in 1877 and 1880, Carl P is reported to be working, which would appear to be an improvement on his previous condition, but nothing else is recorded about his mental condition. In 1888, Carl P is referred to as “troublesome”, a new symptom, but again, the physician does not elaborate as to what this means. The final note, dated 1889, is perhaps the most surprising. It reads simply, “In spite of his need for asylum care, the patient was discharged on June 27th.” No other case history has been found where a similar remark occurs; and we are left to speculate as to what actually happened to Carl P. Relatives of wealthy patients would
sometimes demand their discharge, or arrange for them to be cared for in the home, but such an arrangement seems unlikely for a farmer admitted in third class. Based on the information provided in the case history, and given the fact that Vadstena experienced a massive influx of patients from other asylums in the late 1880s and early 1890s, we may assume that harmless, incurable patients such as Carl P were discharged in order to accommodate the violent, dangerous and suicidal.

The description of this patient has much in common with the prohibitive portraits of onanists that were popular in early anti-masturbatory literature by medical and moral writers alike; the slow withering of body and mind, anxiety, weakness and bleak prognosis for recovery are all present. The case of Karl W shares some of these characteristics, but nevertheless provides a less simplistic image of the masturbator.

**Karl W, admitted in 3rd class, 26th of June, 1888**

The patient, whose father is reported in the clergyman’s letter to have died insane, is said to have suffered from weak bodily health for a period of seven years. In spite of a persistent and serious case of laryngitis, the minister reports that the patient had always displayed a mild and kindly disposition. The cause of the present outbreak of insanity is given as “masturbation and excessive novel-reading”. No source is provided for this information, but the certifying doctor repeats the statement and adds that the patient “has engaged in masturbation for many years”. The patient’s behaviour appears to have been unpredictable: after an initial outbreak of despair and anxiety, minister and certifying doctor both characterise his manner as “mostly violent, but now and then calling to God for help and anxiously asking about the possibility of redemption”. The certifying physician adds that Karl W’s awareness and comprehension are both compromised, and that his memory is “lost”. Furthermore, apparent visual and auditory hallucinations are said to be accompanied by a steady stream of “transient ideas”, communicated incoherently.

Although previously described as violent; kicking, hitting and being placed in a straitjacket to prevent destruction, the patient appears to have displayed no such tendencies on arrival at the asylum. The fact that Karl P was admitted to the quiet ward tells us that the doctor saw no reason to keep him restrained or isolated from other patients. Göthlin describes Karl W as being “dejected” with a shy and withdrawn face, and taking little interest in anything around him. Far from being incoherent, Karl W answered the doctor’s questions, and complained of “feeling ill”, suffering from a lack of sleep, and loss of appetite, and asked for help and medication. Although irritable


493 FIId:2 No. 2967.
and angry when contradicted, Karl W is described as “compliant” and followed instructions well. Such discrepancies between admission letters and the asylum physician’s notes on admission are not unusual; it appears that patients either sought to display their best behaviour on arrival to the asylum, perhaps in order to ensure their early dismissal, or that the receiving physician was skilled in managing restless and confused individuals. It is also possible that symptoms and signs were deliberately exaggerated (in the certifying letters) in order to ensure the sufferer’s admission to the asylum. Previous studies on asylum case records from the north of England have proved that certain phrases and symptoms acted as “buzz words”, that is, that the presence of them in the description of a patient dramatically increased the possibility of admission.494

There is no mention in the casebook of the patient masturbating while at the asylum, but Göthlin notes that when asked if he still practices onanism “he (the patient) becomes angry, and refuses to acknowledge ever having practiced the vice”.495 Karl W is unusual in this; the other patients who are asked this question by the physician admit their guilt.496 Göthlin does not comment on the patient’s denial, but the inclusion of it in the case history adds to the image of Karl W as short-tempered and cross when confronted. In the increasingly detached style typical of the 1890s, Göthlin records only what has passed between himself and the patient, and what he himself has observed. What is clear is that Karl W displays a number of symptoms associated with insanity caused by masturbation. His thinness, weakness and pallor, the incontinence that he complains about, the fact that he, following his arrival to the asylum, becomes bedridden, and remains that way for a whole year, are all textbook indicators of a masturbator. The introvert tendencies observed by Göthlin on arrival, as well as the shame and despair allegedly expressed by the patient in his earliest illness and described in the minister’s and physician’s letter, add to the image of secret self-abuse.

The treatment administered is equally typical of masturbatory insanity; the hospital physician and Göthlin both prescribe potassium bromide, a sedative, and choral hydrate, a sedative and hypnotic by-product of the chlorination of water (the other by-product of the same process being chloroform), presumably to help the patient sleep.

494 My master’s dissertation, a study carried out on the records of two public county asylums catering mainly for pauper patients, found that individuals described as prone to self-harm, suicide and homicidal impulses were always given priority admittance to the asylum. This was partly due to the fact that suicide and self-harm were seen as potentially epidemic. Imelda H. Löwenercorna, Making the Case: Form and function of the Patient Case History at the Newcastle upon Tyne Borough Lunatic Asylum, and the North and East Riding Lunatic Asylum 1847–1895. Unpublished Master’s Dissertation, Newcastle University, July 2009.

495 FIId:2 No. 2967.

496 FIId:1 No. 2436, FIId:2 No. 3210, FIle:10 No. 1295.

These two drugs were widely used in the asylum throughout the period, their calming properties serving to quieten the noisy, temper the raving and maintain order in the wards. While Karl W’s mental state appears to have improved – he is recorded as behaving decently and pleasantly, and feeling better five months after his admission – his bodily health deteriorated during his time at Vadstena. On New Year’s Eve 1888, Göthlin observed “a loose rustling” in the patient’s lungs, a violent cough and a lack of appetite. According to the following case history entries (which are very brief, consisting of only a few lines each), the patient’s cough persisted for many months, with the physician coolly observing that his state of mind is “somewhat depressed, but compliant”. In this particular case, given the patient’s pre-existing physical illness, the administration of drugs that kept him bedridden may have inadvertently caused his death from pneumonia in July 1889.

The physician draws the conclusion that Karl W’s illness is caused by masturbation and excessive novel-reading, he appears listless and lethargic, and shows no interest in his surroundings; the description illustrates the lingering impact of Tissot’s portrayal of the onanist.498

Conclusion

Masturbation is present in both case records and psychiatric discourse throughout the period, and in the latter changes in character and status: from sin to moral vice and pathogenic factor. The Vadstena case records illustrate the double nature of masturbation, it appears there as both medical and moral issue. Hjertstedt and his colleagues note both physical effects on the individual’s body, and the deterioration of reason and morality in their masturbating patients. The period studied here appears as a transitional stage where the mutual influence of morality and medicine characterise the physicians’ interpretation of patient behaviour and symptoms. Masturbation features in the Vadstena records as both cause and symptom of various forms of insanity, and no discernible effort is made to determine its status in the individual case. The presence of the habit is enough to cause concern. While Hjertstedt’s notes on masturbating patients do not indicate adherence to any specific school of interpretation or classificatory system, the established medical image of the male masturbator as exhibiting certain physical traits and behaviours is discernible in the records.

Little evidence exists in the casebooks to suggest a major influence from the supposedly infamously puritan Victorian medicine which Hjertstedt encountered on his travels in England. The Vadstena sources suggest that, in fact, the reproductive organs and sexual instincts of patients were not subject to special scrutiny under Hjertstedt. Roger Qvarsell has established that these themes were not especially important for his

498 Tissot, Onanism, 15-16, 100.
predecessor Georg Engström (disappointed love is a cause of 25 cases of insanity, but lewdness, masturbation and exaggerated desire account for only four cases of insanity in the periods 1828-1830, 1835-1837 and 1842-1844)\textsuperscript{499}. Like his predecessor, Hjertstedt acknowledges the potential role of excessive desire and masturbation in causing and exacerbating mental distress and disease. However, his relatively lenient attitude to preventing masturbation in the asylum suggests that it was not of prime importance. In the case notes, masturbation is associated with idleness, indecisiveness and inertia, creating a cluster of characteristics diametrically opposed to ideal nineteenth-century masculinity. In a 2016 article, historian Norman Aselmeyer has shown how reading was pathologised in Central European medical, social and pedagogical discourse, and as early as 1760, Tissot had argued that men who devoted themselves to intellectual work were particularly prone to masturbation.\textsuperscript{500} Masturbation was therefore a moral problem in the sense that it was unmanly, at a time when masculinity was intimately associated with, and defined by, characteristics such as industriousness and physical labour. The role of the asylum was to return patients not only to physical and mental health, but to instil and foster morality. The relative absence of physical restraint to prevent masturbation may be explained if we consider that the asylum environment was primarily designed to promote decency and strength of character through occupation and moral instruction – by leaving no opportunity for idleness the solitary vice would disappear. However, the evidence from Vadstena shows that in practice, such levels of instruction or surveillance were difficult to maintain.

Hjertstedt’s focus when describing erotic patients is on behaviour, on what the patient does and says, and he rarely makes assumptions based on patient history, cause and diagnosis. As we shall see, patient behaviour influences treatment and management, and for Hjertstedt, appearing in his travel journal as very much a practitioner rather than a medical theorist, observation is his foremost tool and technique. Academic works examining medical attitudes to female sexuality have often cited physicians active around the turn of the century; in Sweden these include Seved Ribbing, Henrik Berg and Erik Wilhelm Wretlind.\textsuperscript{501} The increasing presence of issues connected with female, and to a lesser degree male, sexuality in the medical literature at this time suggests an active debate on the subject. Furthermore, the amount of sex advice books for married couples also increase dramatically around this time.\textsuperscript{502} Hjertstedt’s period during the middle of the century sees less such conviction

\textsuperscript{499} Qvarsell, \textit{Ordning och behandling}, 137.
\textsuperscript{500} Norman Aselmeyer, “The Lazy Reader: Labor, Books and Disease in Nineteenth-Century Germany”, \textit{Literature and Medicine} 34 (2), 2016, 440-467.
\textsuperscript{501} See for example Johannisson, \textit{Den mörka kontinenten}, 23, 59, 73, 108.
\textsuperscript{502} See for example Hygien för det fysiska äktenskapet: Rådgivare för ogifta och gifta, Stockholm: Hemlandsvännens tryckeri, 1893, \textit{Helsovårdslära för äktenskapet och dess
regarding female sexuality, and his relatively relaxed attitude to female sexual behaviour, as well as the recognition of female desire, suggests a different point of view.

5. Erotomania

What constitutes an erotic patient? Previous chapters have shown how certain behaviours were associated with nymphomania and masturbation as causes and diagnostic concepts. This chapter is concerned with the medical interpretation of romantic and erotic behaviour, primarily what one late nineteenth-century advice text described as “a psychical and verbal obsession with erotic and romantic matters.”

On Monday the 8th of March 1869, Rebecka P, wife of a recently bankrupted tradesman in Oskarshamn, first set foot in the Vadstena asylum. Her local minister writes in his certifying letter of a tumultuous domestic situation. Rebecka P’s marriage had been characterised by “quarrelling and squabbling” and the patient was known for her harshness towards her four underage children. Somewhat pragmatically, the minister reports both sides of the conflict: “The husband accused her of slavery, the wife him of stinginess.” The minister’s letter reports that following a change in circumstances which left the husband penniless, he was admitted to the asylum at Växjö, where he was still being treated for insanity at the time of Rebecka P’s admittance to Vadstena. The clergyman describes Rebecka P as having a fearsome, erratic temper, and though never explicitly stated, the implication seems to be that the patient’s contentious nature at least contributed to her husband’s illness. However, the patient who Hjertstedt encounters at Vadstena on the day of admission does not fit the minister’s description. Rebecka P appears calm and reasonable, yet lively, conversing and answering questions without any sign of confusion. However, something in her appearance and manners attracts the attention of the physician. “Her aspect and movements express a highly excited imagination and exaltation,” writes Hjertstedt in the casebook, adding “shows herself affectionate toward men, and clings stubbornly to [the] clothes when one approaches her.”

What passed between Hjertstedt and Rebecka P on their first meeting is and remains a mystery, but the physician’s interpretation of her behaviour is clear; based on her appearance, her eyes, and her manners, Hjertstedt surmises that her imagination is abnormally excited. The man for whom Rebecka P had shown affection is most likely the physician himself; appearing to be flirtatious would be seen as a serious social and moral transgression in the context of a medical examination, in itself indicative of a lack of modesty and propriety.

---

504 Sw. Makarna lefde i kif och träta.
505 Sw. Mannen skyllde henne för slaferi, hustrun honom för snålhet.
506 Sw. Blick och åthäfvar uttrycka en högt upphägad fantasi och exaltation.
Love as source of joy and cause of disease

The idea that love, like anger, fear or jealousy, may cause madness was a recognised fact in early psychiatry. Mid-nineteenth-century psychiatry is often described as having two main strains of thought: the psychic and the somatic school of interpreting insanity. The somaticists who attributed madness to physiological processes in the brain sought to identify these by examining that organ, and focused their treatment on patients’ bodies. The more psychically oriented alienists believed that insanity resulted from the emotions and passions inherent in human beings. However, this division is somewhat simplistic; the physicians of the psychic school argued over the seat of the emotions, with many of them locating human passions and sentiments in the nervous system, and thus connected to the brain. Hjertstedt, like his predecessor Engström, appears to have favoured the psychic model; what the official reports term “moral causes” (see chapter 2) predominate his interpretations of illness. The emphasis in his practice on moral treatment, a well-ordered and regulated life and patients’ occupation further suggest that he believed the illness to be of the mind and soul, rather than of the brain.

The nineteenth-century medical term for love madness was erotomania, which featured prominently in French and British medical texts, but apparently less so in the relatively scarce Swedish material. In the case records from Vadstena, it is used only once, by Georg Engström in diagnosing Lena N, admitted in 1832, a case to which we will return below. Although erotomania appears to have been present in medical literature from its very beginning, what was covered by the term has varied over time. By the early nineteenth century alienists had abandoned the previously predominant humoural theories of erotomania, and come to view the condition as a form of monomania. Thus, the diagnosis was applied to those patients suffering from a

509 A detailed examination may be found in German E. Berrios, “Erotomania: A Conceptual History”, History of Psychiatry 3 (52), 2002. Medical historian Vernon Rosario argues that the concept of erotomania as it appeared in nineteenth-century psychiatry shaped our modern understanding of the erotic: “Nineteenth century erotomania described manic patients with “perverse” sexual sensations, obsessions, and compulsions but who confessed no particular amorous interests at all. In other words, a comotation of deviant sexuality (érotisme) was introduced into the diagnosis of erotomania in the nineteenth century and later withdrawn from it in the twentieth. The nineteenth century incarnation of erotomania is therefore central to the contemporary nation of the erotic: something ‘which is associated with physical love, which is of a sensual nature, sexual’, or artistic works which can incite the search for physical pleasure”. Rosario, The Erotic Imagination, 48.
focal mental pathology within an otherwise healthy mind. Esquirol clearly differentiates erotomania from nymphomania and satyriasis, stating that while “the nymphomaniac and the satyr are victims of a physical disorder, erotomaniacs are toys of the imagination”. It is however important to stress that unlike earlier physicians, Esquirol did not imagine erotomania as chaste, but characterised by an “excessive sexual passion”; the differentiating factor against nymphomania and satyriasis was then was merely the seat of origin within the body. With Esquirol, erotomania shifted from being a somatic/humoural disease to being a mental/nervous disorder predominantly due to moral causes. “It is a chronic cerebral disorder, characterised by excessive love, either for a known object, or for an imaginary object. In this disorder, only the imagination is troubled: there is no lesion of thought.” Although far from undisputed, Esquirol’s views were highly influential and echoed in subsequent texts throughout the century. In Sweden, even popular manuals of medicine for domestic use reiterated his definition, like that of provincial physician Carl Johan Hartman (1790-1849), published in 1828. More noteworthy is perhaps the fact that erotomania featured in such a work at all, which suggests that the concept was considered somewhat common. The concept of erotomania, whether as a separate condition, a set of transient symptoms, or one which subsumed nymphomania, is intrinsically connected with a wider medico-moral discourse on the necessity of tempering the passions. Otto Manderup Witt and Georg Engström placed both nympho- and erotomania under the subheading “monomania”, echoing Esquirol; while the superintendent at the Stockholm asylum, Fredrik Björnström, defined it as a subtype of hysteria. The term also features in nineteenth-century sex manuals, a growing genre of pseudo-medical advice books outlining the many regulations for maintaining a healthy love life. A similar description appears in Daniel Hack Tuke’s

510 Esquirol, Mental Maladies, 335-336.
511 Ibid., 32.
512 For the objections of Viennese psychiatrist Bénédict Morel, see “Dr B.A. Morel on Mental Disorders”, Journal of Psychological Medicine and Mental Pathology, 13, 1860, 237-239.
516 Witt, Själen i normalt och sjukligt tillstånd, 251, Qvarsell, Ordning och behandling, 127.
517 Björnström, Sinnessjukdomar, 45-53, 70.
518 For a thorough examination of this genre, see Pia Laskar, Ett bidrag till heterosexualiteten historia: Kön, sexualitet och njutningsformer i sexhandböcker 1800-1920, Stockholm: Modernista, 2005.
1892 *Dictionary of Psychological Medicine* where French alienist Gustave Bouchereau wrote of erotomania:

> It does not constitute a special form of mental disorder having its cause and its symptoms and development always in the same manner, but it is a pathological condition which presents itself in the course of various forms of mental disease as an intermediary stage of variable duration.\(^{519}\)

Due to the lack of written material authored by Hjertstedt and his Vadstena colleagues, any theories regarding their understanding of specific types of insanity gives the impression of conjecture, however, a view of love madness such as the one presented by Bouchereau and the sex manuals would explain the appearance of erotic symptoms in such a variety of cases. If physicians believed that erotic symptoms may appear at some stage in any form of insanity, and were not tied to the idea of erotomania or love madness as a specific type of disease, they would have been more prone to interpret behaviour as erotic.

The case of Lena N\(^{520}\), admitted in 1832, presents an interesting anomaly. Sent to the asylum at the initiative of her husband, Lena N spent four weeks in Engström’s care, and was then discharged. In the casebook, Engström provides a brief description of a quiet, reasonable and calm woman, and adds the exclamation: “Patient is not insane!” Lena N returns later the same year, and is once again discharged after six weeks, with the physician concluding that her mental state is unchanged; there is still nothing wrong with her. There appears to be evidence of traces of a domestic conflict. In the admission order, the husband insists his wife is erotic and indecent for reasons unknown to us, and having provided the appropriate documentation, the asylum physician is required to admit the patient for a trial period. Interestingly, Engström labels Lena N an erotomaniac even though he observes no signs of insanity or irrationality, suggesting that the diagnosis was made from the husband’s testimony, and entered into the casebook immediately following Lena N’s admission, before the physician had the opportunity to fully evaluate her condition.

Margareta C\(^{521}\), a widow from the town of Motala, was admitted to Vadstena on 1\(^{st}\) February 1859. Her case illustrates the extent to which medical interpretations of illness might differ, depending on reported evidence and the physician’s own observations. At 48 years old, Margareta C was a mother of six children, the eldest of which had been “feeble-minded” since birth, and had, according to the clergyman’s letter, been admitted to Vadstena and died there at the age of 15.\(^{522}\) All of the


\(^{520}\) FIIa:1 No. 7.

\(^{521}\) FIIc:10 No. 1271.

\(^{522}\) The admission document does not contain information as to when the child was admitted, making the identification difficult.
remaining children are reported as exhibiting “considerable weakness of the mental powers”. The certification document, signed by the town physician at Motala, does not specify where the information regarding the patient’s family was obtained. In spite of a family history of mental distress – the patient’s mother is also said to have been a patient at Vadstena – the admission documents attribute the outbreak of illness to “love, and unfulfilled expectations.” Disappointingly, no details regarding how this conclusion was arrived at are included, but we may suppose that both clergyman and town physician had access to some information which was not recorded. Margareta C is said to have been ill for around three years. The patient is described as having always been of a difficult temperament, “at home she has been careless, hot-tempered, cruel and surly”. The certifying physician adds: “Shows complete indifference for work and caring for her home and her loved ones, so that the children have been taken from her”. As the final symptom, the admission document records Margareta C’s erotic tendencies: “The carnal instincts appear powerful: she has a greedy appetite, and often suffers attacks of erotomania proper.” Again, no details are provided regarding when, or under which circumstances these attacks have manifested, and the observation appears oddly out of place. No source of the information is provided; no witnesses are present in the account, and there is no record of the patient having regular interactions with anyone, not even her children as they have been taken into care. The only specific incident included in the admission document is a report of a fire, apparently caused by the patient, where she “almost burned herself alive”, although whether deliberately or by neglect, the physician does not know.

Upon admission to Vadstena, Hjertstedt diagnosed Margareta C with “dullness”, stating in the casebook that she provided coherent and lucid answers to his questions, while also displaying stupidity and apathy. “She communicates no insane ideas or hallucinations, is compliant, but generally shows no spirit for work”, he added of her general condition. No observations of any erotic sentiment or behaviour are made, and Hjertstedt never alludes to any erotic aspect of the patient’s illness. In fact, on their first meeting, the physician seems to form the opinion that there is little he can do for the patient. A diagnosis of dullness indicates that he believed her illness to be chronic, and the first case note entry states somewhat enigmatically: “there is no indication for the use of curative measures”. Clearly an evaluation has already taken place, where Hjertstedt has identified the patient’s illness and judged her to be beyond

523 FI:13 No. 1271.
524 Ibid.
525 FI:13 No. 1271.
526 Sw. De simliga drifterna synes starkt utvecklade: hon har glupsk matlust, ej sällan anfall af verklig erotomania.
527 FIIc:10 No. 1271.
528 Sw. Någon indication för curativa åtgärders användande finnes icke.
the power of asylum treatment. The word “incurable” is not used in the first case note entry, but the fact that Hjertstedt goes on to suggest that the patient would, and indeed should, be just as well cared for in a workhouse “or elsewhere”, reveals that he sees no hope of improvement. Margareta C was reported for discharge on the 6th of April 1859, having spent only two months at Vadstena. However, due to a sudden outbreak of confusion and rage a few days later, which according to the casebook was to last all spring, “discharge was made impossible”. Hjertstedt calls the patient careless, and “without any self-control”, but no mention is made of any erotic symptoms. An attack of erysipelas, a skin infection, in May 1859 further exacerbated the patient’s dullness and confusion, and she is recorded as having gradually deteriorated until December 17th, when an apoplectic attack claimed her life. There is no record of any treatment being administered in Margareta C’s case, illustrating that even when her sudden deterioration made discharge impossible, Hjertstedt saw no hope of curing, or even ameliorating her illness. The erotic symptoms recorded by both clergyman and certifying physician appear not to have manifested themselves at all during the patient’s time at Vadstena, and Hjertstedt makes no reference to any erotic cause or symptom.

Margareta C was classified as erotic by her town physician, presumably based on evidence provided by persons in her immediate surroundings. While we cannot know the particulars of what made the physician use the expression “erotomania proper”, or what behaviour exactly it was used to signify, it appears that when moved into different circumstances – the asylum environment – those symptoms disappeared. Considering the information provided in the admission records, Margareta C seems to have been a social problem. A bad-tempered widow, lazy housewife, unfit mother, and apparently indecent, the town physician seems keen to have her removed to the asylum. Hjertstedt displays relatively little interest in Margareta C, because he interprets her condition as chronic. She is kept at Vadstena because her illness grows more serious, causing her to be a danger to others and herself, not because the physician has any hope of curing her.

The cases of Lena N and Margareta C illustrate how domestic and community conflict might lead to a woman being classified as an erotomaniac – interestingly Engström and Hjertstedt do not agree. The two cases demonstrate how appraisals of behaviour depend upon context, and how the use of diagnostic terms might vary between physicians.

Not only the term erotomania, but the traditional concept of love madness or melancholy as it appears in the medical literature is scarce in the Vadstena records. Furthermore, it is noteworthy that one of the few cases in which love is both cause and symptom of illness is that of a male patient. Jacob S, a mail clerk, was admitted in

---

529 Sw. Rosfeber.
1858, and diagnosed with dementia. Both his admission documents gave the cause of his illness as unrequited love, and Hjertstedt includes the information in the case note, suggesting that he accepted the explanation. Jacob S is described as calm and decent but uncommunicative, failing to answer any of the physician’s questions. Instead, Hjertstedt reports that the patient signals his assent with a slight, rueful smile and a nod. Subsequent casebook entries describe how Jacob S appeared “dreamy”, absent-minded and “unconcerned with his surroundings”, but remained calm and decent. While remaining taciturn, in the year after his admission, the patient took to writing letters. Hjertstedt reports of the contents that they exhibit “much confusion, especially on the subject of love”, adding, “patient is undoubtedly incurable”. The deduction appears based on the disordered ideas to which the physician now had access, but Hjertstedt offers no description of them. Did Jacob S, like Selma Å thirty years later, write love-letters to strangers? And if so, why was that information not included in the casebook? On a similar note, the account of the patient’s appearance is brief – we are told only that he is tall and pale – and in stark contrast to descriptions of erotic female patients like Rebecka P, which often find evidence of excitement or romantic sentiment in facial expressions and gazes. Although the patient’s unwillingness or inability to communicate certainly affected the contents of the medical record in this case, Hjertstedt does appear to record more details in his descriptions of female patients.

As we have seen in chapter 2, love featured as one of the most common causes of insanity in Sweden since the introduction of a national register of causes in 1861. While the majority of these patients were female in the 1860s and 70s, more male cases appear in the last decades of the nineteenth century. Due to the selection technique employed in this study, it is difficult to determine whether Vadstena experienced the same trend as the nation as a whole in terms of the increase in insanity cases attributed to love. What is clear is that the final decade of our sample period sees a greater amount of patients being admitted with erotic and sexual symptoms. The most readily discernible difference with regard to the Vadstena physicians’ ideas about sexuality and the erotic is their apparently increasing interest in such symptoms and diagnoses.

In spite of love featuring prominently as cause in Swedish asylum statistics in the latter part of the nineteenth century, the term love-madness, or a Swedish equivalent thereof does not occur in the Vadstena records. It appears no specific category of illness was associated with disappointed love as cause. Diagnoses reign from dullness to mania to the somewhat abstract but frequently used confusion. The phrase “erotic

---

530 FIIc:9 No. 1267.
531 FIIId:2 No. 3241.
532 Sw. Allmän förvirring.
"mania" is occasionally used in case histories to describe the nature of illness, but does not exist at all as a separate diagnosis. Similarly, the word kärleksgriller, which translates approximately to love fantasies or delusions, is used to describe some patients with confused ideas of a romantic persuasion, but never as a diagnostic term. Some patients where the cause is believed to be love never exhibit any romantic or erotic symptoms, like Margareta C above, and the maid servant Maria H, admitted in 1870. In the latter case, the presumed cause of unrequited love seems particularly at odds with the patient’s symptoms, which are described in the casebook as mania of persecution and spectacular hallucinations of demonic character. Believing her food to be poison, cat-meat or chalk, the patient refused to eat her own food, and instead stole from the portions of her fellow patients. Hjertstedt reports that Maria H was tremendously frightened and anxious, and while she “appeared to understand questions put to her, she was so controlled by her delusions that she did not take the time to answer”. The dramatic symptoms did not last long, however, as a casebook entry dated September 1870 – three months after her admission – states that Maria H’s condition was much improved. As though he was meeting her for the first time, Hjertstedt wrote: “The patient proves to have a simple, gullible disposition, reveals a variety of superstitions, and seems to have been very childish and babbling, even prior to her illness”. “Balanced, docile and neat”, Maria H was discharged on 1st June 1871, with a financial gift of 30 riksdaler from the Society for the Protection of the Insane “due to her severe poverty”. In neither case do the physicians record any erotic behaviour, nor is the presumed cause of illness ever referred or alluded to in the casebook text.

Erotic symptoms

As in the case of the previously mentioned Rebecka P and nymphomaniac Hildegard C, flirtatious behaviour directed at the physician appears to have been scandalous enough to warrant mentions in the casebook, but the behaviour of the majority of erotic female patients are described in more vague terms. Anna A frequently makes “utterances about love” and broods incessantly, Anna E is reported in her ad-
mission documents as having made sexual advances toward a member of household staff, and Johanna S539 shows “a strong appetite for the male sex”.

More often than actions, patients’ speech is given as evidence of their erotic nature, though physicians virtually never specify what has been said. As in the case of Christina B540, erotic patients are often described as noisy, speaking incessantly, “without order or context”. Aside from a general description (“now of an erotic character, now of a religious one”), no details of what Christina B actually says are included in the case note. There is “something erotic” about Clara L’s speech541, and Sophia P’s illness “shows itself in speech and actions of the most shameless nature”. Anders M543 voices “thoughts about love and lewd phrases”.544 Ida S545, admitted in 1887, became ill at fourteen, and her medical certificate states: “Her sexual instinct is lately increased, as is evidenced by her speech”546. The conclusion is repeated in the casebook, where Vadstena physician Göthlin writes; “As previously mentioned, the sex drive is increased, speaks of ‘wanting to get married’”.547 A conclusion of elevated sex drive based simply on an expressed wish for marriage seems rash and somewhat unfounded; we are left to imagine that the patient’s speech is omitted here, and what is recorded is simply the physician’s interpretation of said speech. It appears unlikely that this is an example of censorship; asylum case notes were intended exclusively for the use of medical men, primarily the institution’s own physicians, although they were made available to official inspectors on their visits. As such, there would be no need to censor lewd speech in order to protect the sensitive reader or public decency. Furthermore, the Vadstena case histories do not generally use euphemisms for sexually explicit behaviour; in all probability Ida S’s utterances are summarised in this way because the physician-author’s interpretation is already made, and thus her exact words are of little consequence. In the case history of Carolina C, admitted in 1869, Hjertstedt provides a rare insight into what he considers to be obscene speech, noting: “She speaks with fondness of the opposite sex, therewith indecent /.../ says she has had scores of men visiting her at night.”548 In this case, the implication appears to be that the patient imagines or hallucinates such encounters; this is supported by the admission document stating that her husband testifies that she is “man-crazy” but also

539 FIIc:5 No. 851.
540 FIId:1 No. 2586.
541 FIId:1 No. 2524.
542 FI:12 No. 654.
543 FI:26 No. 2927.
544 Sw. Kärleksfunderingar och otuktiga uttryck.
545 FI:26 No. 2914.
546 Sw. Könsdriften på sednare tid ökad, efter hvad af hennes tal framgått.
547 Sw. Könsdriften säsom nämnt ökad, talar om att ‘hon vill gifta sig’.
548 Sw. Talar med förkärlek om mankönet, dervid oanständig, säger sig haft tjogtals med karlar hos sig om nätterna. FIIc:18 No. 1878.
that no such encounters have actually taken place.\footnote{Sw. \textit{Karlgalen.}} Carolina C’s tendency to wander away from home was seen as perilous, and the chairman of the parochial board requested that she be admitted to the asylum “to prevent any debauchery” on her excursions. The case illustrates how erotic behaviour was viewed as problematic in the community; it is not her actions that are cited as the cause for admission, but the possibility of what might befall such a woman if she were allowed her freedom. Carolina C’s immodest remarks – she claimed that her husband had been unfaithful to her, and that she herself was pregnant by someone else – and wayward behaviour had made her a danger to family and community as well as a potential embarrassment to her husband. Upon meeting the patient, Hjertstedt diagnosed her with mania, but recorded no treatment in the casebook. Nevertheless, Carolina C appears to have recovered, and was fetched home by her husband six months after her admission.

The lack of details in casebook descriptions of erotic behaviour makes analysis difficult, but may be explained by the casebook’s intended function. Given that case notes were written by doctors for doctors, a certain degree of shared understanding may be presumed. Several Vadstena patients are described as being “amorous”, without any details whatsoever regarding what behaviour has led to that remark.\footnote{Dla:13 No. 1612, Dla:13 No. 1284, FIIc:19 No. 196, Dla:13 No. 1612.} While the historian may not, the assumption is that a nineteenth-century Swedish asylum physician would find the description sufficient, and that the term was more specific in its original context that it appears to the modern reader. Further, certain symptoms such as a desire to undress appear to have several possible meanings. Oskar J,\footnote{FII:25 No. 2811.} suffering from dullness believed to be caused by childhood masturbation, was admitted in 1878, discharged in 1885, and returned to Vadstena after only a few months. Described as dirty,\footnote{The Swedish term \textit{osnygg} is used to describe incontinent patients.} uncommunicative and disruptive due to his habit of screaming and singing at all times of the day, Oskar J also spent most of his time naked. The admission document records his “irresistible urge to tear his clothes, and anything else around him”, and reports that he “spends most of his time standing naked at the window, muttering to himself”. In the casebook, Oskar J’s nudity is explained with reference to his destructive behaviour; he is naked because when given clothes he persists in tearing them. The patient is not described as erotic, the diagnosis is simply “intermittent mania”, and the nudity does not appear to be interpreted as in any way sexual. Conversely, criminal patient Karl J,\footnote{FIId:2 No. 2986.} admitted in 1888, who exhibited the same urge to always tear his clothing as well as a propensity for lewd speech, is considered erotic in the casebook record, and in the case of Kristina E,\footnote{FIIc:19 No. 1960.} her
frequent nudity – the only symptom recorded which might be interpreted as erotic – was enough to diagnose her with “slight nymphomania”. In her study of eroticism and religious madness at a German asylum in the first half of the nineteenth century, historian Ann Goldberg found that nudity, as well as violent behaviour in raving mania, was often attributed to pathological sexuality in women, while male cases were not interpreted in such terms.555 The Vadstena records do not support such a conclusion in general; it appears to take more than violence for Hjertstedt and the other physicians to attribute behaviour to erotic and sexual causes in female patients. Undressing, such as in the case of Kristina E above, appears to have been associated with eroticism in female patients, but not necessarily for men. In the case of Karl J, the presence of lewd speech may have tipped the scales of interpretation in favour of an erotic classification. While men might also be considered erotic, the case notes suggest that such an interpretation was more likely to be made for female patients, illustrating the more problematic nature of female sexuality in the medical imagination.

In his 1838 essay on monomania, Esquirol added a second definition of the concept of erotomania: the delusional belief that one is loved by someone else. Selma Å, admitted in 1891, is the only patient in whom such a delusion is recorded. Described in the case note as a quiet, serious patient with a dreamy, romantic constitution, Selma Å’s main symptom was that she “imagined that people were in love with her, and wrote letters to them”.556 The admission letters add rich context for her letter writing; the report that ever since childhood, Selma Å had been fond of reading novels, “a habit which is considered to have had a harmful effect on her”. The admission letters add that she had been caught masturbating. When she speaks, it is only of “erotic matters”, prompting the certifying physician to conclude that her thoughts are preoccupied with such. In a style typical of 1890s case records, Göthlin provides some insight into the patients’ mind by referencing her speech more specifically: “she complains without reason that her family want to force her to marry against her will, and that she is always thinking of someone whom she cannot have”. The recipients of her erotic letters are identified only as “men she barely knows”. Although her case appears to fit the definition of the condition well, Selma Å is not diagnosed with erotomania, but instead with the generic and seemingly antiquated melancholia, and the word erotomania does not occur in the physician’s description of her.

While explicit sexual speech and conduct was, to asylum physicians, evidence of insanity which required treatment, detecting and containing lecherousness was also a matter of great practical importance within the asylum. In his contribution to the annual report of the Board of Asylums in 1861, Hjertstedt elaborates on this matter, and laments the fact that even given the greatest among of attention, unfortunate

555 Goldberg, Sex, Religion and the Making of Modern Madness, 91.
556 FIId:2 No. 3241.
consequences cannot always be avoided where great lecherousness is concerned. He recalls a case from his earliest time at Vadstena, where “a feebleminded male patient illicitly visited a young unmarried woman, with the unhappy consequence that she fell pregnant”. The female patient, who had been treated for erotic mania for over a year, has not been identified in the material. However, in spite of Hjertstedt’s assurance that the complete separation of the sexes within the asylum would prevent such tragic accidents, the case records contain evidence of a similar incident occurring in 1870. The case notes of Maria J describe a severely confused, excited and childlike young woman, prone to theft and violent outbursts, who had “displayed great lecherousness, and herself spoken thereof”. In a note written in her second year at Vadstena, the casebook reads:

In the autumn it was discovered that the patient was pregnant. The culprit could not be identified. It is likely that one of the contracted workers attending the repairs within the ward where she was kept, was responsible.

Aside from a note the following year that the patient was delivered of a boy, and remained in the same state of dullness, showing no affection for her child, no other mention of the incident has been found. Maria J’s case note does not reveal what happened to her child. For a man who so strongly advocated the virtues and therapeutic powers of the asylum, incidents such as these must have been deeply troubling and embarrassing for Hjertstedt.

Silences and omissions

As records of medical practice, the Vadstena case notes contain the information deemed important by the physician-author, and were not intended for an external reader to gain full understanding of individual cases. As such, they appear to us as fragmented narratives, where the impression is often that pieces of information are left out. Hjertstedt and his colleagues do not justify their diagnoses, or their courses of treatment, nor record their effectiveness. The frequency of casebook updates varies, but in most cases additional information is provided twice or three times a year, and then in the form of a general summary of the patient’s state since the last update. The great silences in between updates, and between the events considered significant, make the case notes problematic and puzzling sources for the historian. An example of such a case is that of Christina O, admitted by Hjertstedt in March 1870. Upon admission, Hjertstedt first names her condition, tumultuous general confusion, and

557 Underdånig berättelse 1861, XLIII.
558 FIIc:19 No. 1968.
559 FIIc:18 No. 1916.
goes on to mention her chief symptoms: incessant incoherent chatter, a failure to answer questions, tearing her clothes and acting “indecently”. “Due to her wildness, she is confined to the cell ward” Hjertstedt explains at the end of the first, and longest case note entry, taking up 8 lines. He prescribes potassium bromide, a sedative with anaphrodisiac properties, and opium. The following update is undated, and states simply: “During the spring months, the same confused screams. No peace at night.” The third and final entry, over two lines and dated June, records that Christina O contracted an infection of the lungs, and died on the 5 of that month, “very thin”. The short record of Christina O’s final months is upsetting in its brevity, and puzzling for its lack of detail. Given the drugs prescribed, and the decision to confine her to a cell, Christina O must have been a difficult patient, yet no details of her behaviour are recorded following her first meeting with Hjertstedt. It is as though, following that first interview where the initial assessment of her is made, the patient is largely forgotten about. Confined in a cell and medicated to prevent her from harming anyone, or disturbing the peace with her behaviour, she has been sufficiently dealt with. The case records from Vadstena suggest that two factors have an impact on the length and detail of the case note: prognosis and the patient’s social class and previous life. The structure of the case notes for the period suggests that a preliminary prognosis is formed in the physician’s mind almost immediately following admission; in cases where there is hope of a favourable prognosis, more time and effort is spent on charting the patient’s illness and progress. In cases where the patient appears in an advanced state of dullness or dementia, has been insane for a long period of time, or has a long history of a disordered or irregular life, Hjertstedt’s experience and all the psychiatric expertise available to him tells him that the illness is most likely incurable, and so the casebook contains only minimal information. Christina O is a day-labourer, the mother of five illegitimate children, and appears on arrival to Vadstena uncommunicative and disruptive. Though the gaps in her story are significant, the information provided suggests that her case was not one of interest to the physician. The treatment administered seems designed to contain her troublesome symptoms, rather than attempt a cure, and although Hjertstedt never uses the term incurable, such a conclusion upon admission would explain the lack of curative measures.

“Fancies” – erotic and religious symptoms

The combination of religious and erotic delusions or mania is a reoccurring one in the Vadstena case histories. The Swedish word griller is used to describe both and,  

560 Several of the previously discussed nymphomaniacs also exhibit religious delusions, or are “preoccupied with religious matters”. See for example FI:11 No. 576, FIIc:8, No. 1151, FIIa: 7 No. 571, FIIc:5 No. 832.
though difficult to translate, indicates confused fixed ideas on a subject.\textsuperscript{561} The admission document for the maidservant Albertina N, admitted in 1865, states that the cause of her illness was an unrequited love, as well as vanity.\textsuperscript{562} In his examination of the patient, Hjertstedt found no symptoms of an erotic or romantic nature, but noted that the patient claimed that she was soon to be married.\textsuperscript{563} The first entry in the casebook describes Albertina N upon her arrival as “excessively jovial and gay”, and records her telling the physician that as she was in excellent health, there was no need at all to admit her to the asylum. When told that she must remain there, the patient “displayed no real disinclination to do so”. Judging by the length of the first entry, a full page in the casebook, and the level of detail provided, we may infer that Albertina N was immensely communicative. Hjertstedt describes her as suffering from various insane notions, especially on religious matters. The patient claimed to have seen and heard angels speak to her, telling her that she was among “God’s chosen ones”, and an agent of His power and glory. Furthermore, she described meeting Jesus Christ himself and having “socialised with deceased relatives”. In the following entries Hjertstedt reports, somewhat wryly, that “due to her noble and holy status, the patient believes herself unfit for manual labour”. Albertina N was to remain at Vadstena until her death in 1905, and her long casebook record shows that her delusions persisted throughout her stay. Interestingly, Hjertstedt emphasises her vanity as much as her religious delusions. From their first meeting, he describes the patient as “very neat and coquettish about her attire”, and adds that her facial expression “displays a certain degree of excitation and a great deal of smugness”. In March 1866, the entry further describes her as headstrong and capricious, and according to the physician she “prances about with a certain superior expression and will not do anything useful.” No treatment or intervention of any kind is recorded in the casebook, but an 1867 entry states: “Insusceptible to convincing arguments and religious admonition”, suggesting that attempts to reason with the patient were made by the physician as well as the asylum minister, and that these had no effect on her behaviour. The repeated comments about Albertina N’s conceited behaviour, her preoccupation with her dress and appearance and the inclusion of her reasons for refusing work seem to the reader to be of little medical importance. Rather, Hjertstedt appears to be conducting a moral assessment of her character. The unrequited love given as cause in this case is never mentioned again, but the illness of Albertina N is similar to love madness in its form. Her mind is fixed on certain ideas, but she is described as otherwise lucid and

\textsuperscript{561} The Swedish expression is thought to be derived from the latin \textit{grillus} meaning grasshopper. Elof Hellquist, \textit{Svensk Etymologisk Ordbok}. Lund: Gleerups, 1922, 201. Other insects are used in various languages to describe a similar state of preoccupation or obsession with a notion or idea, as in the English expression “bee in one’s bonnet”.\textsuperscript{562} DLa:13 No. 1636.\textsuperscript{563} FIIc:16 No. 1636.
reasonable – Hjertstedt notes that she answers questions coherently, and that her memory and perception are unaffected. Also, her symptoms indicate to the physician the influence of the passions, manifesting as a morbid self-love. As in the case of Hildegard C (see chapter 3), Albertina N’s cheerful and blithesome demeanour on arrival is noted with concern, and later comments regarding her prancing and coquettish behaviour imply an element of flirtation. Proud, vain, idle, impetuous and completely impervious to correction, the patient crossed all the boundaries of proper feminine behaviour. The tone of the case note suggests that to Hjertstedt, this was a greater concern than her confused ideas about religion.

In the annual report of the Board of Asylums for 1865 Hjertstedt writes on the topic of religious madness, providing rare insight into his personal psychiatric ideas. Religious enthusiasm remains a prominent triggering cause of insanity, Hjertstedt claims, and adds that many zealous individuals refuse to admit to this fact. He concedes that religious brooding may be a symptom of insanity, but states firmly that in the majority of cases it is of the utmost aetiological significance. The article appears to be an entry in an ongoing debate regarding the status of religious practice in the treatment of insanity. The 1860 doctoral thesis of psychiatrist Carl Fingal Möller (1826–1897) was dedicated to the subject of religious insanity, and was the first publication on the subject in Sweden. Naturally, the clergy felt compelled to fight their corner. In 1864, Stockholm asylum preacher C.R.E. Bergqvist had supplied a four-page account of the pastoral care provided at that institution to the annual report of the Board of Asylums. The text is dedicated to the argument that even in cases of religious madness, religion itself is blameless, and that in all cases of insanity, appropriate spiritual guidance and comfort is beneficial.

In the annual report of the following year, Hjertstedt approaches the subject of religious insanity, displaying his critical attitude toward religion. While conceding that religious brooding may appear following the outbreak of illness, and therefore be considered a symptom, he asserts: “in most cases religion is the cause”. (It is presumed that the cases referred to are those in which religious musings or speech presents as a symptom, and not all cases of insanity.) Hjertstedt mentions prayer meetings and travelling evangelists as being responsible for religious brooding, indicating that it is specifically non-conformist religious activities which he perceives to be the problem. In the annual report of 1865, Hjertstedt provides a case history from his own practice in order to illustrate the harmful influences of non-conformist religion. Johanna P, a crofter’s wife, had been of sound health and a gentle tempe-

---

564 *Sw. Religionssvärmeri.*

565 *Underdånig berättelse för år 1865,* 46.


567 *Underdånig berättelse för år 1865,* 46.
rament prior to her outbreak of madness, nor had she ever held “erroneous ideas and opinions on the subject of religion”. Her encounter with a travelling preacher from Småland, whose meetings involved singing and the outbreak of rapturous joy among his followers, caused Johanna P to become brooding and confused to the extent where her husband had taken her to the asylum. Following her admission, Hjertstedt describes her “highly excited imagination”, her intermittent roaring laughter and desperate crying, and her inability to remain still for a single moment. “What one could gather from her confused chatter, her imagination was mainly consumed by religious ideas”, writes Hjertstedt. By including a lengthy case history, a very rare element in Hjertstedt’s annual reports, he draws on his professional experience and expertise to support his argument. Johanna P was cured of her confusion and violent symptoms within five weeks, and discharged to her home. However, Hjertstedt reports that the patient following her discharge went for a recuperative stay at the spa at Medevi, where she once again came into contact with “the converted”, and had to be immediately removed.

The case of Julia P illustrates how symptoms of religious exaltation were described similarly to signs of love, and how the two were often connected. The certifying physician notes with some concern Julia P’s involvement with a group of Mormons in the town, and attributes the outbreak of illness to the refusal of said congregation to allow the patient to work as a teacher in their community. There is, interestingly, no mention of any romantic relationship in Julia P’s past, and yet the certifying medical officer records the cause of illness as “religion, and most likely, love”. Upon arrival at the asylum, Hjertstedt’s observations seem to reinforce the hypothesis: “…her lively, dreamy looks and facial expressions show that the patient’s appetite for love is pathologically increased”. Julia P’s appearance and manners correspond to the perceived image of the love-mad woman, and this, along with her “dreamy, romantic” disposition is enough, it seems, for the conclusion to be drawn.

The combination of religious and erotic symptoms does not occur exclusively in female patients. In the case notes of Sigfrid H, a minister admitted in 1891, and Per P, a crofter admitted in 1885 and once again in 1890, religious brooding coincides with masturbation and erotic speech. The previous confinement of both patients – Sigfrid H is reported to have spent a year in the asylum at Lund from 1880 – suggests that the symptoms were reoccurring. Per P is reported in the casebook as having auditory hallucinations, in which voices, which he believes to be divine, command him to perform various acts of destruction. Under the influence of the voices, he is reported as having set his cottage on fire. The classification of Per P as erotic appears based enti-
rely on the physician’s interpretation during their first meeting; the phrases “by all appearances he is an onanist”, and “his thoughts probably very often revolve around intercourse” suggest that no direct evidence of either presented itself during the course of their meeting. Nor does the case note imply that the physician viewed Per P’s starting of fires as being in any way related to his erotic symptoms, a connection which was often made by those who sought to define pyromania as a distinct psychiatric concept.

The illness of Sigfrid H, diagnosed as mania in the casebook, is described as “ever-changing confused ideas. He imagines that both himself and those around him are historical figures come back to life, thus he fancies himself as King Charles IX, and that he has met Catherine Jagiellon”, Thorild, Stagnelius and others.” As an example of the nature of Sigfrid H’s religious broodings, Göthlin cites “the possibility of restitutio omnium”, and metempsychosis. Interestingly, the physician records as symptoms of illness musings on theological concepts which might be considered part of the patient’s vocation as a minister. Supposedly, the degree of brooding and the preoccupation with such concepts at the expense of his immediate worldly surroundings made Göthlin consider Sigfrid H’s thoughts pathological, suggesting that just as expressions of love and desire, manifestations of religious devotion were restricted by some perception of moderation.

Irregular sexuality

As we have seen, the end of our period sees an increase in patients at Vadstena whose illnesses are attributed to masturbation as well as love. Furthermore, the period 1885-1895 includes a number of case notes of erotic patients which are longer and more detailed than any which have previously been found in the Vadstena records, and dwell to a greater extent on patient behaviour and speech. Subtle changes in the physician’s vocabulary also appear around this time; expressions such as “increased sex drive” begin to appear in case notes under Göthlin, where Hjertstedt’s records were more likely to speak of lecherousness, shamelessness and indecency. Where Hjertstedt tended to describe patients’ behaviour in moral terms, and not generally

573 Sw. Katarina Jagellonica, 1526–1583, Polish princess and wife of King John III of Sweden.
574 Thomas Thorild, 1759–1808, Swedish author, poet and philosopher.
575 Erik Johan Stagnelius, 1793–1823, Swedish author and poet.
576 See for example FId:2 No. 2907, FId:2 No. 2967, FId:2 No. 3241, FId:2 No. 3210, FId:2 No. 3309.
577 Sw. Ökad könsdrift.
draw medical conclusions based on actions and speech, Göthlin and his assistant medical officer Gustaf Knös (1836-1899) more readily draw conclusions regarding patients’ sexual instincts and proclivities. The small sample of evidence does not permit the labelling of this development as a shift or a break with tradition, but does suggest an increasing emphasis on eroticism and sexuality as part of the illness, as well as an increasingly biological manner of explaining erotic behaviour.

Comments on patients’ sexuality or sexual drive, using those terms, begin to appear in Vadstena case notes in the 1880s. Prior to this, onanism, sexual assault and lewdness are described simply as symptoms, and no specific diagnostic label is attached to them. Masturbating patients were not automatically regarded as having an increased sexual instinct; onanism was a bad habit, and not necessarily indicative of any abnormality of the system. “Lewdness” was, as we have seen, either a symptom of insanity, a result of lacking morality, or a personality trait.579 When the expression “increased sexual instinct” does begin to appear, it refers exclusively to patients who express a desire for relations with the opposite sex. While masturbation remained a vice throughout the period; a harmful and immoral practice that a person chose to engage in, a morbid increase in sexual desire suggests a natural function which has been thwarted, and thus a somatic problem.580 No mention of homosexual behaviour has been found in the source material from Vadstena. Though not strictly speaking the jurisdiction of psychiatry, but of the courts581, it is surprising that an institution which records the irregularities of patient behaviour to such an extent would have no mention of such perceived sexual irregularity. It also comes as a surprise to the modern reader that the only case of a patient engaging in bestiality is attributed simply to an increased sexual instinct. Farm labourer Petter N, admitted in 1868582, is described as having always been “simple”. His propensity for sexual exploits with a variety of farm animals were well-known in the local community, reports the minister in his letter, describing how the patient has a habit of leaving the house at night in order to gain access to barns and stables. Petter N’s illness, which includes violent outbursts directed at his parents and an unwillingness to perform any work, is attributed to his increased sexual instinct, as well as to hereditary factors. This case appears to be the

579 During Georg Engström’s earliest practice, patients can be found in the asylum register with the comment “Lewd, not insane” in the margin, suggesting that the physician’s distinction between madness and lewdness did not correspond with that of family and community. Alternatively, the early asylum at Vadstena functioned in part as correctional facility, contrary to the express instructions of the Guild of the Royal Order of the Seraphim. Dla:1 No. 23, Dla:1 No. 27, Dla:1 No. 49.


581 The Swedish penal code of 1864 made all same-sex encounters criminal, and not until the end of the nineteenth century did homosexuality become a medical concern. See for example Laskar, Heterosexualitetens historia, 284f.

582 FI:17 No. 1860.
closest resembling state to what medical writers refer to as satyriasis, described as the male version of nymphomania. Although the term itself is completely absent from asylum records from Vadstena, the symptoms – an elevated state of sexual arousal rendering the patient unable to contain or control their desire, and eventually causing insanity or mental deficiency – are thus present.

In the case of Petter N, it is the degree of sexual excitation that is described as pathological; interestingly his passion is not described as unnatural or abnormal. Similarly, “raging, brutalish desire” is the explanation given for the violent sexual assaults committed by Carl F, admitted in 1874, and Karl O, admitted in 1880. The two cases are similar in symptomology; both patients have assaulted “defenceless women” in their hometowns, and their descriptions depict violent urges. Hjertstedt writes of Carl F: “During these ghastly and frequent attacks, his drive to satisfy his raging, animal lust has not shunned either daylight or the presence of others.” Six years later, Göthlin relates of Karl O: “He has, without worrying about whether onlookers were present or not, by force satisfied his sexual instinct on his wife and other women”.

In both cases, the fact that the sexual acts have been performed publicly appears to be significant, perhaps more so than the act of violence. Hjertstedt and Göthlin both interpret this as being testament to the potency of the sexual drive. The transgression here appears to be one of public indecency as much as one of violence. Sexual aggression in women is rare in the Vadstena records: only Augusta N admitted in 1892, is said to be prone to “attacking men” due to her increased sexual desire, though no details of what the attacks entail is provided. In these casebook testimonies, the Vadstena physicians illustrate the nineteenth-century medical view of the sexual drive as a powerful and dangerous natural instinct, capable of rendering the sufferer completely helpless to withstand its impulses.

The prognosis for love-madness appears to have depended greatly on the early detection of and treatment of illness. The certifying physician in Julia P’s case provides us with rare and valuable insights into the reasoning behind prognosis. Based on the fact that her illness has changed from melancholia to euphoria, and the intermittent outbreaks, the doctor does not believe Julia P to be incurable. However, he theorises that a cure cannot be achieved in a home environment or a regular hospital, but that the specialised environment of an asylum is required. It would appear then, that patients in fixed states which did not visibly alter over time were more likely to be considered incurable (as we have previously seen with certain masturbating patients). While the illness was new, erratic and volatile, hope endured that it might be reversed.

583 FI:31 No. 3343.
584 Dahlberg, *Bidrag till den psychiska aetiologien*, 17.
585 FIIc:9 No. 1218.
Case of Love Madness

Fredrika S, admitted in 1st class, 29th of January, 1892

The case of Fredrika S\textsuperscript{586} provides a fragmented and unresolved narrative of love-madness, which nonetheless contains many clues as to how her illness was interpreted by her physicians. Fredrika S was 27 years old at the time of her admission, a trained actress and opera singer, and accommodated in first class. Her admission documents contain one minister’s letter and two medical certificates, all of which add to the case history constructed in the asylum casebook. The patient’s mother believed, as recorded in the clergyman’s letter, that her illness was caused by fright, mentioning a shooting and a thunderstorm as two occasions on which her daughter had been traumatised.\textsuperscript{587} The certifying doctors, however, make no mention of these circumstances at all, but prefer to draw their own conclusions based on their examinations. The first medical certificate, issued by the renowned Stockholm physician and political radical Anton Nyström, describes the cause of illness in a single word, “sexuality”, while Vadstena asylum’s own Gustaf Knös, one of three assistant medical officers in residence in 1892, cites multiple contributing factors; “the common cold, delusions of love and religious meditations”. Nyström’s deduction is particularly interesting, and particularly puzzling, as no behaviour of a sexual nature or any inappropriate speech is recorded anywhere in the medical certificate. The patient was unmarried, and there is no note of any illegitimate sexual activity. Moreover, the single-word explanation does not tell us in what way the patient’s sexuality is presumed to have caused her illness, and we are left to wonder whether Fredrika S’s sexual desire was found to be unnaturally strong, somehow irregular, or whether it was unfulfilled desire which had an impact on her mental state. Furthermore, when the information from the admission documents was transferred into the asylum casebook, it was Nyström’s ascribed cause that was selected to feature in the text. The shooting incident and the thunderstorm, which the mother reported, are included in the account of the patient’s previous life, but not as cause, and the asylum physician’s own conclusions regarding aetiology are missing from the text. We may only theorise on the reason for this omission, but the question remains: what did both the certifying doctors perceive in the patient to make them draw the conclusion that her illness was sexual or erotic in origin?

Nyström records in his certification (and this information is transferred into the case history) that the patient is infatuated with “a well-known preacher”\textsuperscript{588}, that she writes poetry dedicated to him and expresses a wish to speak to him. There is no indication that the patient ever met the object of her affection, and thus no reason to believe that

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{586} FIId:2 No. 3280.
\item \textsuperscript{587} FI:30 No. 3280.
\item \textsuperscript{588} FI:30 No. 3280.
\end{itemize}
\end{footnotesize}
anything untoward ever occurred between them. Indeed, the text seems to imply that the affections are one-sided and that the preacher himself is not even aware of them. Knösg’s verdict, the frequently used “delusions of love”, would seem a more appropriate description of the patient’s state, and yet it is never included in the case history. It is possible that the assistant medical officer would favour the opinion of an already well-known and published (if controversial) physician of the nation’s capital, but we may also entertain the idea that the patient’s behaviour on admission as well as her status as a woman of the stage seemed to support the conclusion that the cause was of a sexual nature.

Upon admission, the unidentified medical officer at Vadstena found Fredrika S to be in good physical health, but restless; ever moving around, turning her head back and forth, and fiddling with objects within her reach. She smiled “cheerfully and kindly” when spoken to, but when questioned her answers were found to be both incoherent and confused. Upon examination, the genital organs were found to be normal, but, unlike the certifying physicians, no comment is made on the patient’s menstrual cycle – an unusual exception from the tendency to associate female insanity with the reproductive organs.

Aside from the evidence of excitation, which her admission documents also highlighted, few symptoms appear to have been visible on this first encounter. Three months pass following Fredrika S’s admission before the medical officer notes in the casebook that she “displays an erotic state of mind” by speaking eagerly to other patients “about men that she has seen, etc.” This is the only casebook entry that records any kind of erotic behaviour on the patient’s part; the remainder of the records dwell on her mercurial mood swings; her sudden outbursts of violent anger, the following displays of repentant affection towards those previously attacked, and intermittent vacant and dreamy periods. Fredrika S is portrayed as a most unusual character; her fierce temper and unpredictability is stressed by minister and physicians, as is her keen intellect and advertency. The minister signals his disapproval very clearly in his description: “She has in her previous life always been impatient, strange, rash and keen to learn everything thoroughly”. Although she is praised by the same source for having been “richly endowed” with reason, her inquisitiveness and interest in learning is noted with concern. Similarly, while the asylum physician notes her communicative nature and frequently quotes her speech, he condemns her outbursts of anger, her wild accusations and her need to have her way. Fredrika S is quoted as saying that anger simply “comes over her” and that she is unable to control it. It

590 FIId:2 No. 3280.
591 FIId:2 No. 3280.
592 FI:30 No. 3280.
appears that her mercurial temperament and uninhibited expressions thereof are the physicians’ main concern. The case history focuses almost exclusively on the patient’s mind and behaviour (no remarks on her appearance or bodily functions are made following the first case note entry), and she is thus not reduced to a case of problematic female biology. However, Fredrika S appears to have been an unusual woman for her time: angry, loud and quarrelsome, intelligent and inquisitive and apparently unapologetic about all of the above, she was difficult to control even in the asylum. Were all these undesirable characteristics – commonly associated with the female lunatic and especially the nymphomaniac – the reason why Anton Nyström ascribed sexuality as the cause of illness, and why the asylum physician apparently agreed? Given the previous evidence of how patient behaviour was interpreted, we may assume so.

Like so many other “erotic” patients, there is also a religious component to Fredrika S’s illness; she is reported to have indulged in religious fantasies, and both her certifying physicians report that she speaks about religious matters, although this does not appear to have been a prevalent symptom during her time in the asylum. The casebook author notes at one point that she appears to believe that “persons living far away can cause her immediate harm”, but he does not classify this as delusional, nor elaborate on the matter. Treatment in this case is standard and mild, but also typical of erotic patients. The chloral hydrate that she is repeatedly given may be prescribed to help her sleep, as she is often restless at night, and the potassium bromide to calm her when her outbursts of temper make her difficult to manage. However, both compounds were known anaphrodisiacs often used in cases where masturbation and erotic behaviour were prominent.

Fredrika S has a voice, or rather, while she was very much spoken about in the admission documents, her own voice is returned to her in the casebook. Although her speech and ideas are seen as disordered, the physician records her words with quotation marks and acknowledges her feelings. Having stormed to her room in a fit of rage one evening, Göthlin records that the patient attacked the nurse and the matron, saying, in a loud and resentful voice: “I will show you a furious woman! I am Norwegian and very fiery, I think you are man-crazy, every one of you!” When asked at a later date to sing a song, she is reported as saying: “I cannot, you have taken my voice away.” The inclusion of the patient’s direct speech in the case note may be partially explained by her social standing; she is admitted in first class, her mother’s address is in an affluent part of Stockholm, her occupation, and the fact that she was certified and treated by Nyström, all contribute to the image of a privileged patient of

593 Sw. Här ska ni få se en rasande qvinna! Jag är norska jag, och mycket häftig, jag tror ni är karlgalna allihop!
594 Sw. Det kan jag inte, ni har tagit bort min röst.
some importance. The case history is carefully crafted so as to not draw any attention
to the physician-writer, the tone is neutral and sober, and refrains from making value
judgements, but relates whole sentences of the patient’s speech and interprets her
actions for the reader. The effect of this is that Fredrika S remains a person in the text,
someone with intent and agency, rather than a passive collection of symptoms.

**Conclusion**

Determining what constituted an erotic patient in the eyes of the Vadstena physicians
is not an entirely uncomplicated task. Patients where the cause was believed to be of a
romantic or erotic nature who are also described as having erotic symptoms are
relatively rare during Hjertstedt’s period as superintendent. The case records indicate
that love may be viewed as a cause in any kind of insanity, and erotic symptoms may
be present in any kind of illness. A history of inappropriate sexual behaviour, physical
signs of excitation, undressing, masturbation, lewd speech and making advances
toward staff or other patients could all lead to a patient being considered erotic.
However, undressing and tearing of clothes may be considered simply a symptom of
mania; a history of immoral behaviour did not automatically lead the asylum physician
to attribute that as a cause, and lewdness might be interpreted as a personality trait
rather than a symptom of insanity. Relatively little information is included in the case
notes to indicate how physicians drew their conclusions; we rarely know which
symptoms were the most prominent, or considered the most worrying. Information on
patient behaviour is less specific than the historian might desire, as details of speech
and actions were not considered vital for patient treatment and care. To nineteenth-
century psychiatrists, love could cause any variety of madness, and any kind of
madness, no matter what the cause, could manifest itself in romantic, erotic or sexual
symptoms. The evidence suggests that where patients behaved in an “erotic” manner
doctors tended to look for romantic or sexual causes, and in some cases assume such a
connection without any information being given to support it.

As many of the symptoms overlap, the differentiating factor between nymphomania
and erotic mania, if somewhat arbitrary, appears to be simply the degree of obscenity.
While medical texts tended to describe nymphomania as explicitly sexual in its
symptoms and originating in the sexual organs, and erotomania more as the love
melancholy of ancient times and an illness of the imagination, the distinction does not
appear clear in the Vadstena material. The fact that the term erotomania only features
once suggests that for one reason or another, the Vadstena physicians did not believe it
useful as a diagnostic or descriptive term. Clearly the idea of the erotic as a character
trait of insanity itself was very much present in the minds of medical men, but the
absence of erotic diagnoses seems to suggest something less stable than a separate
illness. If we return to the description of erotomania in the introduction to this chapter:
“a psychical and verbal obsession with erotic and romantic matters” it appears an accurate description of many patients discussed herein. Whether the rejection of a specific diagnostic term in favour of more general descriptions (most often mania and melancholia) signals insecurity or a conscious decision is difficult to determine, but the trend seems to be true for nymphomania and masturbatory cases also.

Like love and licentiousness, religion features in the case notes as both cause, symptom and, less often, as a specific type of insanity. The combination of confused ideas about religion with erotic fantasies and behaviour appears to be relatively common, and the terms dreamy\textsuperscript{595} and fancies\textsuperscript{596} are used to describe sufferers and their symptoms respectively. Although commonly viewed as connected in females, the Vadstena material also contains cases of male patients where erotic and religious ideas occur alongside one another. The idea of “love madness” was similar to that of “religious madness” in that they both appear to have been widely accepted concepts in psychiatry as disorders which may result from emotional trauma and life-altering experiences. Towards the end of the nineteenth century, both are cited as triggering causes in individuals with hereditary predispositions to unsoundness of mind. Physicians believed that a well-ordered, virtuous life without excess of any kind, where passions were kept firmly under control, was the key to a healthy mind. However, patients are not generally held responsible for having caused their own illness, but rather described with words of pity and compassion for their suffering. To the medical observer, love might “happen” to a person in a way which causes the mind to become disordered, just as poverty, hardship, grief and physical illness might. The Vadstena casebooks indicate an increased medical interest in sexuality toward the end of our period. Hjertstedt rarely dwells on erotic or sexual behaviour, and tends to describe patients’ behaviour using morally charged words like “shamelessness” and “indecency”, while his successor Göthlin uses terms such as “increased sex drive”, and thus seems to veer toward a more biological explanation of behaviour.

The cases discussed give the impression that Hjertstedt certainly believed that erotic behaviour could be indicative of mental illness, but that it was not a major area of interest for him. Like other forms of behaviour which violated social and cultural norms, expressions of love or desire were identified as mad behaviour by the patient’s immediate surroundings. Following their admission at the asylum, it was the physician’s duty to assess the illness, and provide treatment. Hjertstedt’s case notes suggest that his judgement of patients was not so different from that which had already been given by the community; he identifies indecency, lewdness and excessive emotion, but rarely frames it in medical terms.

\textsuperscript{595} Sw. Svärmisk. 
\textsuperscript{596} Sw. Griller.
6. Treatment and management

The series of reforms which led to the restructuring of Vadstena in 1826 as Sweden’s first county asylum were heavily influenced by a larger European movement to ameliorate the living conditions of the confined insane. An instructional document for the new asylum’s board of directors was issued by the Guild of the Royal Order of the Seraphim, emphasising the main objective of the institution: to restore its insane patients to health and reason.\(^{597}\) The instruction clearly reflects the concerns of its time; the physician was to trace the causes of insanity, and its aggravating factors, to divide the patients into groups depending on classification of illness, humane treatment and non-restraint was emphasised, as well as cleanliness, order and strict daily schedules.

In the first instruction document for the physician at Vadstena, dated 15\(^{th}\) October 1826, the Board of Directors charged Georg Engström with the task of charting the true character of mental diseases, and the physical causes which might have brought them about. Such an understanding of the nature of insanity would guide Engström towards rational means of treatment, the Board stated, as experience had shown that medicines rarely had any amelioratory effect upon insanity.\(^{598}\) The document presents a monumental task for the physician: to investigate, develop an understanding of the various forms of mental illness, and develop “rational” treatments. The document as a whole makes clear the ambition to create a curative institution, and the unspoken expectation that the “rational” treatments should also be successful in curing patients is present between the lines. Finally, medical treatment is dismissed as ineffectual, indicating a desire for the treatment regime at Vadstena to be a modern one, influenced by the French and English doctrines of moral treatment. Engström did not abandon medical treatment, but spent his twenty-three years as head medical officer at Vadstena experimenting with a variety of pharmacological, mechanical and psychosocial interventions and remedies.\(^{599}\) Some of his more radical physical methods, like the rotating chair and the application of setons,\(^{600}\) appear to have been discarded from the therapeutic arsenal by the time of Hjertstedt’s succession.

\(^{597}\) Kongl. Maj:ts nådiga skrivelse till Seraphimer Ordens Gillet med en nådig instruction för en direction wid Wadstena Hospital, March 22\(^{nd}\), 1826.
\(^{598}\) CA FIII:1 Instruktion för Hospitalsläkaren i Wadstena 15/10 1826, § 6.
\(^{599}\) Qvarsele, Ordning och behandling, 141-165.
\(^{600}\) Sw. hank. An antimanicical remedy; a septic wound would be inflicted through a fold of skin, usually at the back of the neck or between the shoulder blades, with a ribbon threaded through. By pulling on the ribbon, the physician could make sure the wound remained open. The technique was believed to have a twofold effect; the resulting pain would distract the mind, and the discharge from the wound was believed to draw the illness from the body. See for example Cox, Practical Observations on Insanity, 151.
The term “treatment” will be used here to signify any measures taken by asylum physicians in order to improve the bodily health and mental state of an individual patient. In this chapter, for reasons of structure and clarity, the terms somatic and psychological treatment will be used, thus dividing methods of therapy according to which were applied to the patient’s body and mind respectively. While Hjertstedt does occasionally refer to psychic\(^{601}\) treatment when describing foreign asylums in his travel journal, the division used here was not a commonly occurring one in mid-nineteenth century Swedish psychiatry. In fact, the only collective term for a type of treatment that occurs in the material is moral treatment, Philippe Pinel’s \textit{traitement moral}; which had become the principal therapeutic doctrine of psychiatry by the middle of the nineteenth century. Hjertstedt uses the term when describing treatment at other asylums in his travel journal, but not in casebooks from Vadstena. Moral treatment also occurs in three admission documents, where certifying physicians describe the curative measures that have previously been attempted with the referred patient. The term “management” is included in the chapter title in order to include measures which were not believed to have any therapeutic benefits, often taken to restrict violent and destructive patient behaviour.

The Vadstena records include a series of separate casebooks specifically recording treatment for the period 1827–1846.\(^{602}\) These contain detailed records of treatments administered to patients housed in the curative ward in the specified time period, and are updated weekly or bi-weekly. Although the last volume has the dates 1842–1846 on the cover, the last patient entered was admitted in 1844, and the remaining pages are blank. This would appear to coincide with the time of Engström’s deteriorating health leading to his resignation in 1846, and no volumes dedicated exclusively to treatment exist after this point. Curative measures are entered instead in the regular casebook, and are significantly shorter and less frequently updated. The less meticulous character of these notes – only names of medications are provided, without dosage or frequency – also suggests a diminishing interest in curative measures on the part of the new physician. Upon Hjertstedt’s promotion to medical superintendent in 1849, the patient population was approaching 200, making detailed case keeping an arduous task, even when shared with an assistant physician.\(^ {603}\)

\begin{quote}
\textit{Psychological treatment: Building the curative asylum}
\end{quote}

Hjertstedt’s writings, consisting of case notes, annual reports and his travel journal, provide relatively little insight into his attitude to therapy. What does emerge,\(^ {601}\) Sw. \textit{Psychisk behandling}.
\(^ {602}\) Sw. \textit{Kurjournaler}.
\(^ {603}\) DA EIIa:1 \textit{Inspections-Journal för Wadstena Hospital}. 
particularly in the account of his travels, is his faith in the asylum itself as having a curative effect upon the disordered mind. The good asylum, that is, one that provides the insane with “all the protection and support from society which their pitiable condition demands”, would keep patients safe from harm, provide medical treatment, and regulate their daily existence so that they may be schooled back to an ordered and productive life. While Hjertstedt was travelling in Europe, his itinerary including many of the asylums widely considered to be the most progressive, his renowned colleague Carl Ulrik Sondén, head physician of the Danviken asylum in Stockholm, published a long article in Hygiea outlining all the shortcomings of Swedish asylums in comparison with those abroad. The article provides much that Hjertstedt’s travel account does not; while Hjertstedt’s account is careful and pragmatic to a fault, Sondén is outspoken and scathing in his criticism of the existing institutions for the care of the insane. Sondén provides his philosophy of treatment clearly and with conviction: “The curative asylum should be an instructive institution of sorts, where the physician is the first teacher.”

The doctrine of moral treatment as originally conceived by Philippe Pinel at the Salpêtrière sought to cure insanity by engaging the patient’s mind and emotions. The regime of the Tukes of the York Retreat, popularised by Samuel Tuke in his 1813 Description of the Retreat, added “self-restraint” to the mix, and framed the new and humane approach to insanity in a firmly paternalistic setting. The casebooks from Vadstena do not record any interventions in individual patients’ lives explicitly labelled as “moral treatment”. Evidence of Hjertstedt’s implementation of moral treatment is rather to be found in the improvements to the asylum environment which were carried out during the period 1849–1870.

After taking up the post of head physician at Vadstena, Hjertstedt appears to have immediately set about creating what he perceived to be a curative environment. The proximity of male and female patients could lead to unfortunate encounters with tragic consequences, and for this reason Hjertstedt first addressed the complete separation of male and female patients within the asylum, completing the new arrangement in 1853. In 1854 he obtained permission from the Guild of the Royal Order of the Seraphim to expand an existing structure, the former county hospital, to accommodate all of the male patients, leaving the old convent building exclusively for female ones. This meant that the male and female wards were separated by the main road through the asylum area which was walled on either side, effectively preventing patients from even seeing each other.

---

604 Sondén, “Om de Svenska hospitalerne”, 113-128, 125.
605 Tuke, Samuel, Description of The Retreat, 131-138.
606 Underdånig berättelse 1861, XLIII.
607 Sv. Hospitalsgatan.

160
Figure 11. Layout of the male ward of Vadstena asylum and surrounding buildings, 1861. Image from Bidrag till Sveriges Officiella Statistik, Kj Heilo- och sjukvården II, “Underdanig berättelse för år 1861”.
Figure 12. Layout of the female ward of Vadstena asylum and surrounding buildings, 1861. Image from Bidrag till Sveriges Officiella Statistik. K, Holbo- och sjukvården II, “Underdålig berättelse för år 1861”.
Upon his inspection of Vadstena in 1853, the general director of *Sundhetscollegium* Carl Johan Ekström (1793–1860) praised Hjertstedt’s work in general, but especially highlighted the complete separation of male and female patients as a major improvement. Furthermore, Ekström expressed his admiration for Hjertstedt’s efforts to provide patients with “useful occupation”, among them the newly established asylum school, the first of its kind in a Swedish asylum, with its especially appointed teacher. Hjertstedt himself displays some pride in the school and describes its organisation and operation in several annual reports. In 1854 30 patients of both sexes attended school, in 1854 the number had grown to 40, and out of these, nine previously illiterate patients had learned to “spell and somewhat passably read from a book.” Hjertstedt reports that aside from reading and writing, patients were taught religion, Swedish history and geography, arithmetic and singing. Teaching was, as far as possible, adapted to the patients’ ability to comprehend. The case notes give no indication that any of the erotic patients discussed here attended school; and the explanation may be drawn from Hjertstedt’s own description. According to the superintendent, the majority of tutees suffer from “mild dullness, supervened in childhood”, indicating that teaching was intended for a specific type of patient. The asylum would then provide rudimentary learning and skills for those whose illness had prevented them from ever gaining it, and those in which the onset of illness had caused them to forget.

The descriptions of the Vadstena asylum school which survive are in annual reports, and do not explicitly state that teaching was considered to have a curative effect. However, efforts to stimulate the intellect of insane patients were widely employed in foreign asylums that adhered to the doctrine of moral treatment. In 1845, Hjertstedt had visited the schoolroom at the Salpêtrière on his journey, and made a passing but favourable mention of it in his report. A much more detailed account by John Conolly, who made a tour of the asylums of Paris in the same year, was published in *The British Journal of Insanity*.
and Foreign Medical Review, and presented the teaching of patients as the next step, following the abolition of restraint, in the reform of asylums. Conolly writes:

> The troubled brain has been composed, and the heart of the insane tranquilized; it now remains to be seen how far the exercise of the intellect can be restored, and the still more valuable empire of well-ordered affections can be regained.614

Conolly’s grand writing style, perhaps infused with some bitterness at having to abolish teaching at Hanwell a few years prior due to financial constraints, contrasts with Hjertstedt’s more factual account of the school at Vadstena. Nevertheless, there are indications that the Vadstena asylum school was directly modelled on and inspired by foreign institutions. In his travel journal, Hjertstedt reported that patients at the Salpêtrière school recited poetry and performed songs under the supervision of the superintendent. Eight years later, general director Ekströmer wrote in his inspection report from Vadstena:

> I was present at an examination of some 20 students [at the school] and had reason to delight at the attention and assuredness with which they perceived and answered questions put to them, and performed the prescribed songs.615

The quote suggests that Ekströmer was treated to a demonstration very much like the one Hjertstedt had attended at the Salpêtrière, and was suitably impressed by the patients’ progress. Hjertstedt emphasised usefulness and the need to impart basic skills and knowledge in his description of the school, suggesting that the main objective was not to treat or distract the disordered mind, but to correct perceived intellectual shortcomings.616

**Work as treatment**

“Work is the most important means that science knows in the treatment of insanity,” wrote Magnus Huss in 1853, illustrating the faith that many of his contemporaries placed in labour, as well as other “useful occupation”.617 In his travel journal, Hjertstedt quotes Falret as saying that “nothing is more harmful than idleness and sloth”. The famous Frenchman’s opinion would only have strengthened what Hjertstedt had

---

615 *Sundhetscollegii underdåniga berättelse om medicinalverket i riket för år 1853*, 97.
616 Hjertstedt, “Årsrapport för Wadstena Hospital”, in *Sundhetscollegii underdåniga berättelse om medicinalverket i riket för år 1854*, 107.

164
already learned serving under Georg Engström, who sought to fill the days of his patients with productive and leisurely activity. Work was an integral part of asylum life at Vadstena throughout the period, and arguably the most essential component in the process of nurturing and training patients for their return to an ordered life. While much of what constituted moral treatment at Vadstena remains invisible in the casebooks, the ability to work is generally noted. Patients took part in much of the daily work required for the running of the institution; in the early years of the period males helped with the chopping and sawing of wood, the heating and pumping of water for the bathhouse, the cleaning of outdoor areas and gardening. Female patients aided asylum staff in the washing and mending of uniforms, scrubbing and baking. Equipment for spinning and weaving was acquired in 1830, and from 1836 the asylum had a designated workroom for female patients and a matron in charge of overseeing it. A carpentry workshop was established in 1846, and another for shoemaking five years later.\(^{618}\) In his annual report for 1855, Hjertstedt also mentions the recent establishment of a tailor’s workshop and a smithy, both of which employed two or three patients under the supervision of a keeper with training in the respective craft.\(^{619}\) In a passing comment, the superintendent relates that female patients are generally more hard-working, but that the introduction of workshops has created many more opportunities for male patients to find tasks that suit them. First class patients were not expected or required to take part in physical labour, but the importance of “useful occupation” and activity was stressed even for ladies and gentlemen of the better classes. In practice, such occupation appears to have consisted mainly of reading, needlework and walks in the asylum grounds.\(^{620}\)

Labour was not a final stage treatment in the sense that a patient had to qualify for it by making a certain amount of progress. The phrase “can at times be made to work”, as in the cases of Sven D\(^{621}\), Carl P\(^{622}\) and Jan J\(^{623}\) and several others\(^{624}\), seems to suggest that employment was suggested to patients alongside other treatment while relatively prominent symptoms persisted, suggesting a belief in the curative effect of labour itself.\(^{625}\) Employment was perhaps most important from a moral point of view; patients’ desire to work is always noted with approval, while refusal to occupy oneself

\(^{618}\) Qvarsell, *Ordning och behandling*, 144.

\(^{619}\) *Sundhetscollegii underrådninga berättelse om medicinalverket i riket för år 1855*, 156-157.

\(^{620}\) FIIc:6 No. 919, FIIId:2 No. 3210, FIIId:2 No. 3214, FIIId:2 No. 3241, FIIId:2 No. 3280.

\(^{621}\) FIIa:6 No. 908.

\(^{622}\) FI:17 No. 1834.

\(^{623}\) FIIc:20 No. 2192, FIIa:2 No. 88, FIIc:5 No. 726, FIIc:1 No. 139, FIIc:5 No. 832, FIIa:8 No. 668.

\(^{624}\) Roger Qvarsell has stated that working was considered a prerequisite for other curative treatment to be successful. Qvarsell, *Ordning och behandling*, 143.
is viewed with suspicion and disdain. Maria N, admitted in 1855 with nymphomania, remained in the asylum for fifteen years and could never be made to work. Her case note reads “slatternly and careless in all things, cannot be prompted to the slightest occupation” signalling strong disapproval of her lack of cooperation and conformity in spite of repeated efforts by asylum staff. Carl D, a masturbating patient admitted in 1890, did occasionally take part in outdoor chores, but apparently did so without the appropriate enthusiasm. “The patient appears vacant and dull /.../he does sometimes work albeit with little pleasure and perseverance”. Work then appears to function also as a means of measuring or evaluating a patient’s morality, and thus their mental state. Work was essential in the image of the ideal citizen; when describing a patient’s previous life, admission documents focus heavily on work (and the ability to carry out ones tasks in a satisfactory manner). Being a good worker was proof of moral soundness and normality. As guardian of public morality as well as public health, the physician had a responsibility to restore in his patients a desire to useful occupation and the ability to perform it.

It appears clear that physicians thought of work within the asylum as having a long-term curative effect. However, it is difficult to say with any certainty based on the primary sources, that the medical officers at Vadstena had absolute faith in work as a means of treatment that would completely restore mental health. A number of patients throughout the period are discharged “improved” or “harmless”, though not fully recovered. These patients are all described in a similar fashion; they are compliant and obedient; able and willing to work. It appears that in reality, work had a normalising function, and that those patients who were capable of performing adequately in the asylum workplace, and conducting themselves in an acceptable manner, were likely to be discharged even where there was no full recovery of the mental faculties. It is presumed that physical labour would also be useful as a means of distracting patients inclined to harmful behaviour, such as indulging in religious or romantic fantasies or indeed masturbation. As we have seen, idleness and excessive immersion in academic pursuits were two of the main underlying causes of masturbation according to the medical literature. While no such explicit reasoning, or indeed any example of work eliminating masturbation, is found in the case records, the case note

625 FI:13 No. 1151
626 Sw. Slampig och vårdslös, kan ej förmås till ringaste sysselsättning.
627 FIId:2 No. 3210.
628 Sw. Den sjuke förefaller loj och trögsam/.../han deltager någon gång i utarbeten, ehuru med föga lust och ihärdighet.
629 FI:18 No. 1860, FIId:1 No. 2486, FIId:1 No. 2436, FIId:2 No. 2986, FI:30 No. 3202, FIId:2 No. 3210, FIic:3 No. 516, FI:17 No. 1912.
630 The phrasing is similar in these cases, “diligent and orderly” (Sw. arbetsam och ordentlig), “quiet and diligent” (Sw. stilla och arbetsam), “industrious in his work and orderly” (Sw. flitig i sitt arbete och dertill ordentlig).
of Carl K.\textsuperscript{632} illustrates the physician’s belief that work may eliminate taxing physical symptoms. Admitted in August 1888 and diagnosed with mania caused by masturbation and financial difficulties, Carl K appeared to the superintendent calm, lucid and polite on his arrival to Vadstena.

“He is ever moving about,” writes Göthlin in the casebook, “marching back and forth at a steady pace across the room. He does not complain of any physical ill, only of his inability to remain still, and the fact that he is constantly forced to perform involuntary gymnastic exercises and movements.”\textsuperscript{633}

The physician’s certificate that accompanied Carl K contains similar information regarding his symptoms, and adds that at times the movements would carry on for whole days, leaving the patient dangerously exhausted and soaked with sweat. At the end of the month of August, Göthlin reports in the casebook that the patient “remains, like a second Jerusalem’s shoemaker\textsuperscript{634}, on an involuntary, perpetual peregrination back and forth”, but that the patient is now able to remain still at night. At the end of September, the record states that Carl K is now able to remain still for short periods during the day, and as such is able to help with cleaning and maintenance in the ward. One month later, the physician reports that the patient has begun to take part in outdoor tasks, and that “the compulsive walking and exercises do not trouble him, now that he has other strenuous physical activity”.\textsuperscript{635} At the end of the year, Carl K was employed in the shoemaking workshop, displaying no symptoms of illness whatsoever, and was eventually discharged to his home the following spring. No other treatment is recorded in this case, and no mention is made of the masturbation which the certification documents cite as cause of illness.

It is noteworthy that all work performed at Vadstena was in essence productive. In workshops and gardens, even in the tasks required for the daily running of the asylum such as the sawing of wood and washing of clothes, patients would see the result of their efforts. Small payments\textsuperscript{636} and “other rewards” were given as an encouragement to carry out their tasks, and perhaps in an effort to emulate an authentic occupational situation.\textsuperscript{637} Although gardening and the keeping of roads and paths around the asylum occupied a significant number of male patients in the summer months, Vadstena

\begin{thebibliography}{9}
\bibitem{632} FIId:2 No. 2987.
\bibitem{633} \textit{Ibid.}
\bibitem{634} This is a reference to “The Wandering Jew”, a mythical character who occurs first in medieval legend and continues to feature in European literature from the seventeenth century onward. The original legend was of a Jerusalem shoemaker who taunted Jesus Christ on his way to crucifixion. For his crime, he was condemned to wander the earth until the Second Coming. \textit{Nordisk familjebok. Uggleupplagan}, 12. Stockholm: Nordisk familjeboks förlag AB, 1910, 1379.
\bibitem{635} FIId:2 No. 2987.
\bibitem{636} Sw. Flitpenning.
\bibitem{637} \textit{Sundhetscollegii underdåniga berättelse om medicinalverket i riket för år 1855}, 157.
\end{thebibliography}
lacked arable land which would greatly enhance the opportunities for patients to work outdoors. The combination of fresh air and physical labour was believed to be especially beneficial, and Hjertstedt agreed with the general inspector from the National Board of Asylums that Vadstena needed to acquire a farm in order to provide more opportunities for outdoor work.638

Daily life within the asylum walls was strictly regulated; Hjertstedt and his colleagues sought to provide patients with opportunities for suitable leisure activities to occupy the hours not filled with work. “Appropriate diversion and amusement will liven up the downcast, focus the confused attention and correct the wild imagination” wrote Georg Engström in a quarterly report, and proceeded to petition the Board of Directors for a small sum to acquire appropriate reading material for patients.639 The asylum library, consisting of historical accounts and travelogues, was further expanded in 1854 by a gift from a Stockholm bookshop keeper, who donated 50 books and booklets, “a geographical map” and two posters.640 Both Engström and Hjertstedt had visited institutions abroad where musical instruments and games were available for patients’ use and both were enthusiastic about providing such opportunities at Vadstena.641 While Engström’s idea of building a skittles alley in the asylum grounds never came to fruition, Hjertstedt apparently succeeded in petitioning the Board of Directors and a pianoforte was purchased for the asylum a few years after his succession.642

Mechanical restraint

The case records indicate that restraint was used sparingly at Vadstena. Out of 150 case notes of erotic patients examined here, only 14 contain references to restraint being applied. There is however no way of being certain that restraint was always recorded in the casebook. The archive material contains examples of very violent patients where no mention of restraint is made, and where the lack of such measures is surprising. Unlike their English colleagues, Swedish asylum physicians were not required by any instruction or statute to record the use of mechanical restraint. However, the 1861 annual report of the Board of Asylums contains a summary account of the restraint used at Vadstena throughout the year. In the brief text that

639 Qvarsell, Ordning och behandling, 146.
640 Sundhetscollegii underdåniga berättelse om medicinalverket i riket för år 1854, 107.
641 Hjertstedt, Berättelse, 54f.
642 DA A1:3, Protokoll, 29th September 1851, see also Qvarsell, Ordning och behandling, 146.
accompanies the table, Hjertstedt stresses the caution with which restraint is prescribed, but makes the interesting distinction between restraint and discipline.\textsuperscript{643}

Punishment is used only for such patients who have the ability to realise the wrongness and malice of their behaviour, and only to alert the patient to self-control and recollection.\textsuperscript{644}

Punishment usually takes the form of reprimands and warnings, he explains, the exception from small treats and rewards, and in more severe cases isolation in a cell and a reduced food portion. Of these, isolation is the only measure found in the case notes of erotic patients. It is assumed that discipline in the form described was part of everyday asylum life, and not always administered by the superintendent himself, and thus reprimands and admonitions were not recorded in the casebook. The table which summarises restraint employed at Vadstena in 1861 records 44 patients being restrained by either straitjacket, isolation in a cell or the restraint chair on a total of 230 separate occasions.\textsuperscript{645} As patients are only identified by their illness form, it is possible that the same patient was restrained by different means on separate occasions, and thus features in the table more than once. The table further contains the average time spent in restraint on each occasion and the reason restraint was applied. The summary reveals that the straitjacket was by far the most commonly used means of restraint, used for 28 patients, isolation was used in twelve cases and the restraint chair, where patients would be tied using leather straps to a high-backed chair, four times. In the column “Reasons for applying restraint” violence is the most prominent symptom, either on its own or combined with destructive behaviour, or the somewhat ambiguous term “obstinacy”\textsuperscript{646} – presumably referring to patients who refused to follow instruction and orders.

\begin{flushright}
\textsuperscript{643} Sw. \textit{Straff}.
\textsuperscript{644} “Uppgift på tvångsmedel m.m., hvilka under 1861 blifvit för sjuke vid Wadstena Hospital använde”, \textit{Öfverstyrelsen öfver Hospitalen Underdåniga Berättelse för år 1861}, appendix G, xxxiii.
\textsuperscript{645} \textit{Ibid.}, xxxiii.
\textsuperscript{646} Sw. \textit{Uppstuđighet}. Forced feeding is not listed in the restraint table, suggesting it was not considered a coercive measure in the same respect. In his 1850 annual report, Hjertstedt describes force feeding a patient by means of a tube, but no such intervention has been found in the case notes examined here.
\end{flushright}
Figure 13. The male ward and asylum chapel at Vadstena with staff, 1890s. Image from Östergötlands museum.
Figure 14. View from the old asylum chapel at Vadstena with the convent church in the distance, present day. Image from Östergötlands museum.
The only forms of restraint to be referenced in the case notes of erotic patients examined here are solitary confinement and the straitjacket. Restraint was used primarily to prevent the violent from assaulting fellow patients or asylum staff, as well as destroying property.  

Emilia S was prone to sudden outbursts of rage, during which she was violent to those around her, and to smashing windows. Hjertstedt uses the phrase “at times so violent she has to be kept in a straitjacket for a few hours” four times in her casebook, with each note referring to a specific year. Sune V also had a proclivity for smashing glass and china and tore his clothes, but “without any real violence”. In the case note, Hjertstedt adds a rare piece of the patient’s speech: “When reproached for his destructive behaviour, he excuses himself in a refined manner by saying ‘I could not help it’. In this case restraint was applied in the form of isolation in a cell, but the case note does not specify for how long.

In the report from his visit at Hanwell, Hjertstedt had raised the unusually philosophical question of what measures should be considered restraint. Although fiercely in favour of “total non-restraint”, John Conolly and his followers did “not believe it should be called coercion when a patient’s violent outbursts and fury must be quelled with the physical strength of the staff, or when he is secluded in a cell.” Hjertstedt’s account indicates that he disagreed with this use of terminology, as well as with non-restraint as a policy. Although of the opinion that any intervention that limited the patient’s physical freedom constituted a form of restraint, his practice indicates that he prescribed such measures where he believed it necessary. Furthermore, his reasons for using restraint sparingly appear to have been practical: in his travel journal he states that the use of the straitjacket is often perceived as humiliating, and that it tends to make patients more violent as a result.

The same opinion frequently occurs in English medical journals from the 1840s, where critics of the non-restraint approach argued that certain symptoms of mental distress regrettably made restraint necessary. In an 1842 letter to the Lancet, an anonymous writer (“a superintendent”) outlined the “cases of insanity in which bodily

---

647 FIIC:10 No. 1298, FIIC:5 No. 885, FIIL:1 No. 2486.
648 FIIC:5 No. 885.
649 FIIC:5 No. 884.
650 Hjertstedt, Berättelse, 73.
651 Ibid., 41.
652 See for example David Yellowlees, “Mechanical Restraint in Cases of Insanity”, The Lancet 99 (2547), 1872, 880-881, in which the author states that: “In certain rare and exceptional cases of insanity, the use of mechanical restraint is for the good of the patient, and therefore justifiable and right.” The Lancet was decidedly in favour of non-restraint at the time of the publication of Dr Yellowlees’ letter, to the extent that the editor James Goodchild Wakley (1830–1886) added a note to the correspondence stating that Dr Yellowlees had “regrettably failed to appreciate the fundamental principles of the non-restraint system”. See also William C. Hills, “Mechanical Restraint in Cases of Insanity”, The Lancet, 99 (2545), 1872.
restraint is imperative”. The letter was a reaction to the recently published annual report from Hanwell (advertising the success of non-restraint there), and the writer identified two categories of patients requiring restraint: those where nymphomania or satyriasis was present and those who “feed on their own ordure”. Restraint is imperative (note the strong wording) in such cases, argues the writer, “for the health of the patient and the reputation of the asylum”. “Without it, the first rapidly throws away his strength, and the second, by feeding on corruption, as speedily and as effectually, destroys life.” The description of the first conditions (“those odious solitary vices satyriasis and nymphomania”) indicates that a particular type of behaviour (i.e. masturbation) is intended here, rather than a diagnosis. The writer emphasises the long-held medical view that masturbation weakens the body, and assigns the practice a special destructive power by singling it out as one of two behaviours which must be prevented by restraint. As we have seen, masturbation was not in its own right sufficient to warrant the use of mechanical restraint at Vadstena. Only five case notes have been located which contain such information, and of these three are dated prior to Hjertstedt’s time as superintendent. In the period 1849-1870, a significant number of patients were observed to continue their self-pollution while admitted, and the casebook contains no evidence that restraint was used to prevent the practice. Similar examples of masturbating patients who are never restrained occur both under Georg Engström and Gustaf Göthlin, suggesting that the reluctance to restrain erotic patients was not particular to Hjertstedt himself. Rather, it may be argued that Vadstena maintained, from its inception, a culture where restraint was used sparingly, and primarily to prevent violence and the destruction of property.

The material, although a small sample, seems to indicate a difference in ideas about the uses and application of restraint, and, by extension, a difference in emphasis on masturbation as dangerous to asylum patients. The leniency with which Hjertstedt appears to have treated his erotic and masturbating patients indicates none of the fierce prudishness that is often associated with mid-nineteenth-century morality. The English

653 “Cases in which Bodily Restraint is Imperative”, The Lancet, 37 (959), 544-545, 15 January 1842.
654 Ibid., 544.
655 “Cases in which Bodily Restraint is Imperative”, 544.
657 FIIb:5 No. 697, FIIb:5 No. 760, FIIb:3 No. 273, FIIc:5 No. 885, FIIc:10 No. 1298.
658 See for example the case notes of Anna J (FI:17 No. 1912), Carl P (FI:17 No. 1834) and Jan J (FI:19 No. 2164).
sources however, seem to reinforce the commonly held view of the Victorian fear of all things sexual; while an English physician was the first to establish non-restraint, his critics repeatedly draw on the lewd and immoral behaviour of asylum patients in order to justify the continued use of such measures. The English preoccupation with sexual morality, masturbation and its implications of contamination may also be glimpsed in the “Superintendent’s” letter; restraint is imperative not only for the health of the patient, but also for the “reputation of the asylum”. Here English psychiatry appears as a branch of medicine which has much to do with the maintenance of public morality, as well as with individual minds and morals.

The primary material from Vadstena demonstrates no belief in any immediately curative benefits as a result of restraint, nor can any such conviction be found in Hjertstedt’s annual reports, or in his travel account. We are left without an answer to the second philosophical question which arises in this matter: was restraint considered to be curative in itself? Was it considered a form of treatment? The official instruction for asylum physicians uses the phrase “where restraint and punishment is necessary for the treatment of the sick”, which may indicate that such interventions are in fact considered curative in themselves. Hjertstedt’s note regarding restraint and punishment illustrates that the desired effect was a moral one; only patients who are capable of comprehending the error of their ways are punished. Punishment was intended to modify patients’ behaviour through moral instruction, while restraint acted as a more managerial solution to prevent patients from causing physical harm to themselves and others and destruction of property.

Somatic treatment

The instructions for the asylum physician at Vadstena had stated, somewhat assuredly, in 1826 that medicines were not effective in the treatment of insanity. This assurance does not appear to have persuaded Georg Engström, who proceeded to employ a large and varied therapeutic arsenal in order to calm, cure and restore his patients. The category of somatic treatment contains all measures employed within the asylum which were applied directly to the patient’s body; including the use of chemical compounds internally and externally, as well as water cures.\(^6\)

Early nineteenth century psychiatry was largely lacking in what we might today view as specific treatments for psychiatric disorders; the great materia medica did not contain separate sections on the treatment of madness until the middle of the century (although some note the effects of certain drugs on ‘brain diseases’ or ‘the nervous

---

\(^6\) Qvarsell, *Ordning och behandling*, 165f.
However, early psychiatric textbooks frequently contained chapters on treatment (including mentions and recommendations of drugs), indicating that treatments drawn from general medicine were being employed on a somewhat experimental basis. The early-nineteenth century physician, the chosen rationale of treatment derived from the perceived nature and origin of the illness. Medical historian G.E. Berrios has identified this period as the point where the clinico-anatomical model of mental disorder becomes predominant. This model involves an emphasis on the brain as the seat of madness, and the establishment of venues of care that enable longitudinal and more or less consistent application of treatments.

The sources indicate that the bodily health of Vadstena’s patients was a primary concern for physicians throughout the period. Upon arrival, the initial examination carefully recorded the patient’s appearance, weight and nourishment, skin tone and physical strength, as well as signs of infection or injury. Casebooks contain much ink spent chronicling the physical condition of inmates, and their bodily functions. The asylum’s medical officers treated injuries and outbreaks of illness, and it is clear that the link between somatic and mental disease remains strong throughout the period. Thus, medicinal treatment may be prescribed for a somatic illness or disorder, or to ameliorate a patient’s mental distress, or both. It is not always possible to deduce the reasoning behind a course of treatment or specific drug prescribed, but assumptions may be made based on contemporary medical theory and discussions about therapeutics in prominent medical texts. The sources suggest that the asylum regime of order and regularity did not only apply to patients’ time, but also explicitly to their bodies and their functions. Restless and sleepless patients were sedated using calming substances to ensure a good night’s rest, those suffering from digestive problems or a lack of appetite were typically administered mild strengthening tonics such as the

---

664 Digitalis is favoured throughout the period. No discussion of its effects on the insane has been identified in Swedish medical texts, it was however among the preferred therapies of English mad-doctors from late eighteenth century. Joseph Mason Cox, whose influence on Engström has been noted elsewhere, linked madness in general to disrupted circulation and thus the digitalis plant, noted for its effects on the heart, was extensively used. Other sedatives include chloral hydrate and potassium bromide; the latter being especially useful in erotic patients due to its anaphrodisiac properties, as well as the milder valerian root.
one prepared from gentian root\textsuperscript{665}, and a myriad of laxatives were used liberally. Interestingly, menstrual irregularity is always noted with concern in female patients\textsuperscript{666}, but there is no record of any treatment for withheld or disrupted menses in the primary material.

Although the sources imply a belief in the effectiveness of physical treatment on the psychological state of the patient, the exact nature of the relationship between bodily and mental health is difficult to establish. It has been previously noted that Engström (perhaps following the theory of Pinel\textsuperscript{667}) regularly used laxatives as a standard first treatment, irrespective of the patient being constipated or not, indicating a belief that the purgative effect would have an influence on the mental disorder.\textsuperscript{668} The emphasis on evacuation, illustrated by the consistent and frequent use of emetics, laxatives and occasionally phlebotomy\textsuperscript{669}, suggests the lingering influence of Greek and Roman medicine, in which the idea of humour or principles which governed illness and health in the body were central.\textsuperscript{670} By drawing or expelling from the body that which was believed to be in excess (blood, bile or phlegm), balance would be restored and the mind allowed to return to its healthy state. Although humoural medicine was considered outdated in the early nineteenth century, the idea of medicine restoring balance within the organism remained strong.

Similarly, eroticism and sexual arousal in patients, leading to various forms of erotic insanity, is characterised even in the nineteenth century (as we have seen) in terms of excess heat and the presence of “irritation” in either the body or the mind of the patient. The specific forms of treatment employed in erotic cases therefore seek to restore balance by cooling the body using cold or tepid baths and showers, and cold wraps to the head and genitals, as per the recommendations of medical textbooks.\textsuperscript{671} A single case note, that of Emilia S\textsuperscript{672}, references “cold injections”\textsuperscript{673}, presumably into the vagina, as having been employed during the patient’s trial period in a regional...
hospital. There is however nothing to suggest that this particular technique was ever used by the Vadstena physicians.

One of the few treatment techniques to remain common throughout our whole period (alongside chloral hydrate, work and isolation) is bathing. The argument has been made for bathing as either a hygienic or moral treatment; undoubtedly the immersion of patients in water was useful in all these respects. Cleanliness and care of one’s person was part of the image of an ordered life that the asylum wished to instil in its patients, thus bathing may be considered a hygienic therapy. Cold baths and showers (especially to the patients’ head) were widely recommended as an effective shock treatment in cases of advanced dullness and catatonia on the one hand, and violent mania on the other; bathing thus used as a moral treatment. By the definition used here however, bathing – as a treatment applied to the patient’s body in order to alleviate or cure – may be considered medicinal. The use of bathing at Vadstena suggests a belief in the generally curative and beneficial properties of water; it is often the first treatment to be administered upon arrival to the asylum, and the last to be abandoned (both in cases of recovery and incurability).

The mind, where affected with lewd imaginings and erotic delirium, was most often disciplined with work and appropriate leisure activities. However, inflicting pain or discomfort in order to counteract feelings of lust and distract the imagination away from harmful thoughts was also a common method during Engström’s superintendency. Blistering, setons and counter-irritants had a multiple function in psychiatry; as well as distracting the mind, inducing inflammation and suppuration of the skin was believed to draw morbid action from the centre of the body towards its periphery. Although less frequently occurring in the Vadstena records than in contemporary English and Scottish source materials, the application of blistering agents and irritants does occur. The mustard cataplasm, a paste made from black mustard seeds and distilled water, appears to have been a favourite antidote of the asylum’s first physician. Mechanical means could also be employed in catatonic cases, as evidenced by Engström’s use of the rotating chair in treating Anna E. The chair, assembled in a cage-like metal frame and equipped with leather straps to restrain the patient, had been advocated as a means of treatment by English alienist Joseph Mason Cox, and was taken into use at Vadstena in 1832. Anna E had been admitted in a non-responsive state, and could not be made to get out of bed, or take any food or

674 Bucknill and Hack Tuke, Manual of Psychological Medicine, 535f.
675 FIIb:1 No. 309, FIIa: 1 No. 7, FIIb:2 No. 404, FIIb:2 No. 427.
676 Sw. Hank.
677 See for example Morison, Outlines of Lectures, 350f.
678 Sw. Senapsdeg.
679 FIIc:1 No. 139, FIIb:1, No. 309.
680 FIIa:2 No. 257.
drink. Providing no reason for this unorthodox choice of treatment, the case note states simply:

“The patient was placed in the rotating chair and was spun around for five minutes with no discernible effect. After a few minutes, the procedure was repeated for a few minutes longer, but even now without the slightest effect” 681

It is not clear from the casebook precisely what effect was intended, but we can safely assume that the aim of such a drastic measure was to shock the patient out of her catatonic state. Engström did own a copy of Mason Cox’s famous Practical Observations on Insanity (1804), in which the author describes the benefits to be had from such a treatment 682, and we may guess that the decision to acquire and test the device originated here. Though this is the only instance of use that has been found in the selected case histories, previous research states that the chair was used on less than a handful of occasions, each time with disappointing results. 683

Although more commonly used in psychiatry in general from about the middle of the century 684, narcotic substances feature very rarely in the Vadstena records. The use of extract of belladonna – a powerful narcotic believed capable of both causing and curing insanity – has only been recorded in a single case. 685 Gratiola, a herb from the same family as the digitalis plant and known for its effectiveness in acute mania 686, was similarly only prescribed once 687 Previous research on primary material from Vadstena has established that both opium and black hellebore were used in treatment 688, but no record of either has been found in the case histories examined here. This suggests a cautious attitude on the part of the physicians in employing psychic remedies for erotic patients. Both of the abovementioned patients were in extreme states of agitation and mania when prescribed the narcotics, and they may have been viewed as a last resort in a situation where other treatments had failed. The potency and terrifying power of belladonna had long been known to physicians, and gratiola remained a disputed remedy throughout much of the nineteenth century. 689

681 Sw. Patienten sattes i svängstolen och kringsvängdes 5 minuter utan någon märkbar effekt. Efter några ögonblicks uppehåll upprepades svängningen några minuter längre men äfven nu utan minsta verkan.
682 Cox, Practical Observations on Insanity, 152f.
683 Qvarsell, Ordning och behandling, 153.
684 Bucknill and Hack Tuke, Manual of Psychological Medicine, 521-525.
685 FIIe:1 No. 139.
687 Filb:2 No. 404.
688 Qvarsell, Ordning och behandling, 158.
It is notable that no mention has been found at Vadstena, or even in nineteenth-century Swedish medical literature, of surgical intervention in cases of female masturbation, erotic- or nymphomania. In 1809, the American surgeon Ephraim McDowell (1771–1830) had been the first to successfully remove an ovarian tumour, and although the ovariotomy procedure remained controversial, representatives of the gynaecological profession would soon begin to recommend it for other complaints.\(^{690}\)

In one of his 1829 Lectures on the External Organs of Generation, published in The Lancet, the English gynaecologist and obstetrician James Blundell (1791-1878) stated:

> I cannot forebear remarking that if the patient seems to be in great danger of losing her mind, a dreadful calamity, it might be worth consideration whether the disease (excess in sexual sensibility) might not be terminated by extirpation of the ovaries. In nymphomania, more especially, this remedy might deserve attention.\(^{691}\)

Blundell’s suggestion appears radical in its context; the ovariotomy procedure was attempted repeatedly in England throughout the 1820s and 30s and in all cases the patient expired during or shortly after the procedure. Not until 1838 would an English surgeon, Charles Clay (1801-1893), perform a successful ovariotomy, and cause a temporary flurry of interest among physicians. Historian Ornella Moscucci has shown how the debate on the extirpation of healthy ovaries swayed back and forth among surgeons and gynaecologists throughout the nineteenth century; to a medical profession which viewed the female body as designed primarily for reproduction, the removal of the organs which made childbearing possible would never be entirely unproblematic.\(^{692}\) In her study of early Swedish gynaecology, Ulrika Nilsson has charted the growing interest among Swedish practitioners in the ovariotomy procedure. The first attempted ovariotomy was performed at the Karolinska Institute in 1856, and in the following decades Swedish surgeons increasingly undertook journeys abroad to visit established English authorities in the field.\(^{693}\) Uppsala surgeon John Björkén (1833-1893), and gynaecologist Sven Sköldberg (1838-1872) both visited the practice of Isaac Baker Brown, with funds from Sundhetscollegium. Baker Brown had introduced the clitoridectomy as a cure for female masturbation, epilepsy and hysteria, and was for a brief period in the early 1860’s a major authority in his field. Björkén wrote favourably of his visit, and of Baker Brown as a professional: “Several of Baker

---


\(^{693}\) Nilsson, *Det heta könet*, 61.
Brown’s patients have since got married, had children and enjoy a happy family life. All have been thankful to the surgeon for the service he has done them.”

However, in 1866, Baker Brown began to be increasingly criticised in medical circles, following claims that he had performed clitoridectomies without the knowledge or consent of patients (and their husbands), and the controversy which followed led to his exclusion from the Obstetrical Society of London in 1867. Although the medical profession’s attack on Baker Brown’s professional claims as well as his personal virtue was partly motivated by his vigorous self-promotion, the scandal that ensued caused the clitoridectomy procedure to fall into disrepute. No mention of clitoridectomies being performed can be found in the British Medical Journal after 1867, though it remained in medical textbooks in England and America until the turn of the century. No evidence has been found of clitoridectomies being performed in Sweden to treat cases of insanity, nor do any of the medical textbooks in which nymphomania is described mention the procedure.

The role of the physician

Official instruction documents in the early decades of Swedish psychiatry charge the superintendent of the institution with an important role. He alone was ultimately responsible for maintaining order, comfort, cleanliness and safety within its walls, for prescribing and adapting treatment and care to each individual patient, and for selecting, hiring and dismissing all other staff. He was to visit all the wards and rooms of the institution once daily, keeping adequate records of patients’ progress or decline, treatment, admissions and discharges. In addition, he was to serve as a model of virtue, kindness and compassion in his interaction with patients. Hjertstedt’s travel account indicates a similar view, most notably in his descriptions of other alienists. In London, the Bethlem hospital system, where two visiting physicians held the medical responsibility for patients while the day-to-day care was entrusted to the apothecary, met with his disapproval. “Rightfully one might reproach [the Board of Directors]

---

694 Ibid., 62.
697 “The head physician himself should, through charitable behaviour toward the sick, endeavour to be an example for all other employees”, “Instruktion för Öfverläkare vid Hospitalen”, xxvii. See also CA FIII:1 Instruktion för Hospitalsläkaren i Wadstena 15/10 1826.
698 At the time of Hjertstedt’s visit the visiting physicians were Alexander Morison (1779–1886) and Edward Thomas Monro (1789–1856), who both ran lucrative private practices.
for not having the physicians in residence, and that their salaries are so small that they cannot exclusively devote their time and efforts to the sick, an error which many asylums in England share with those in France.\textsuperscript{699}

In spite of this criticism, a French visiting physician appears to have made the greatest impression on Hjertstedt out of everyone he met on his journey. When his European asylum tour brought him to Paris in the summer of 1845, the famous Salpêtrière hospital held 5300 patients, of which 1600 were insane and epileptics.\textsuperscript{700} “It is like its own little town, a confined whole in its own right”, wrote Hjertstedt, and went on to describe the little streets, the post office, church and market which served the small community within the hospital walls. At the time of Hjertstedt’s visit, the medical responsibility for the vast institution was shared between Jean-Étienne-Furmançe Mitivié (1796-1871), a nephew of Esquirol,\textsuperscript{701} and Jean-Pierre Falret with the latter as visiting physician. Both the medical officers of the Salpêtrière are described in favourable terms in Hjertstedt’s account of the visit, but Falret especially appears to have made an impression on his Swedish colleague. He is described as “fastidious and kindly” in his meetings with patients and even handing out small rewards “of his own means” to deserving patients. The image of the physician-superintendent as a stern but loving patriarchal figure whose approval and favour is coveted by patients emerges clearly in Hjertstedt’s notes, and the approach appeared very effective to the onlooker. The description echoes the accounts of other psychiatric reformers of legendary status which circulated around the middle of the nineteenth century. The canonical myth of Pinel striking the chains from lunatics at the Bicêtre, and the lingering hero-status of Quaker philanthropist and York retreat founder William Tuke both depict their subjects as father-figures.\textsuperscript{702} Pinel’s treatment methods were centred around the physician himself, whose ability to gently coerce, reason with, and appeal to the morality believed to be present in each human being, were the key to successful curative action.\textsuperscript{703} Tuke modelled the Retreat on an ideal of bourgeois domesticity, creating an institution based entirely on treatment by moral means, where staff, including the head of the institution, lived, dined and worked alongside their patients. Pinel in particular became the basis for a certain hero-image, eagerly reproduced by other psychiatrists, a shining addition to the medical profession; the benevolent mad-doctor, half enlightened professional in the service of science, half stern but loving father to his unfortunate flock.

\textsuperscript{699} Hjertstedt, \textit{Berättelse}, 47.

\textsuperscript{700} \textit{Ibid.}, 132.


\textsuperscript{703} Pinel, \textit{A Treatise on Insanity}, 107-110.
As the great majority of the primary material available comes from Hjertstedt’s own hand, we can only with difficulty infer to what extent his own professional persona was inspired by the great pioneers of psychiatry. His description of the use of punishment as a disciplinary tool has the tone of the fatherly physician, with patients being viewed with indulgence, as wayward children to be treated firmly but kindly. The case notes contain few clues as to the nature of the physician’s interaction with patients. The case note of the previously mentioned Hildegard C 704, admitted in 1859 with symptoms of nymphomania, contains indications that the patient was inappropriately flirtatious toward Hjertstedt; feigning illness during his visits and being “especially kindly and loving” when in his presence. However, nothing in the case note indicates how the physician himself managed the patient or the situation. A rare example of verbal admonition being recorded is found in the case note of Alfred W 705, admitted in 1868 and diagnosed with encoia 706. Upon arrival, the patient believed himself to be in a hotel, and when asylum staff did not attend to him swiftly enough, he became violent towards them. Hjertstedt records his own intervention and the effect it had upon the patient:

When the physician called upon the inappropriateness of his behaviour, and explained that he was not in a hotel but in a hospital, the patient appeared to understand and promised to conduct himself quietly and accommodatingly.

Melancholic Martin H 707, admitted in first class in 1879, had “something anxious and mournful” about his appearance, and eagerly asked for help on his first meeting with physician Göthlin. He is quoted in the case note as saying: “I am not insane, anyone might see that, but my body is so changed, so peculiar”. His delusions, of there being holes in his intestines and lungs, frighten him a great deal, the physician reports, and any attempt to correct them further increases his anxiety, causing him to cry and exclaim that no one understands him. When permitted to speak about his delusions, he seems comforted, and he wishes the physician to remain with him at all times. The prescribed medicine, chloral hydrate, he also found soothing, and asked for more. The case note of Martin H is unusual in the attention it devotes to the patient’s feelings and speech, and harrowing in the sense of distress and loneliness that it depicts in its brief format. In spite of considering himself not insane, the patient immediately turns to the physician for help, and appears calmed when his suffering is acknowledged in the exchanges with Göthlin. The physician’s attempts to reason with the patient might be

---

704 FIIc:10 No. 1298.
705 FI:17 No. 1849.
706 Sw. Vansinne, monomania. Kjellberg, Om sinnessjukdomarnas stadier, 33.
707 FIIId:1 No. 2436.
considered in themselves a form of treatment, however, such intervention is not usually recorded in the case note.\textsuperscript{708}

It is likely that Hjertstedt’s observations in his travel account on the role and responsibilities of the physician, and his subsequent recommendations, directly contributed to the new instruction for superintendents of 1861. It states explicitly that the physician must be resident, forbids him from having any other position, and emphasises the moral aspect of the role. However, as Hjertstedt himself remained physician to Vadstena’s venereal hospital until 1868, it seems both the physician himself and the Board of Asylums were willing to compromise on the second demand. In his 1845 article comparing Swedish asylums with institutions abroad, Carl Ulrik Sondén emphasised the importance of having a physician resident and noted that out of the Swedish institutions, only Vadstena did. In his conclusion, Sondén added: “Vadstena is the only Swedish asylum in which the maintenance, operation and results to any degree approach what is desired of a curative institution.”\textsuperscript{709}

\textit{Patients on treatment}

Patients who spent long periods within the asylum walls could throughout their stay be subjected to a startling amount of chemical and physical therapy. One such patient is Stina A\textsuperscript{710}, admitted in November 1829 and diagnosed with nymphomania. During her three-and-a-half year stay at Vadstena, Stina A was treated with every purgative listed in the appended table (as well as bathing on a daily basis and multiple mustard cataplasms to the back and calves), one after another in ever increasing dosage as they all failed to have any effect on her mental state. When, after two years of treatment, the patient is recorded to be suffering stomach pains, weakness and nausea so severe that she can no longer get out of bed, we may assume that the purgatives are at least partly responsible. Treatment is at this point discontinued, and the physician instead prescribes a regimen of strengthening tonics, and chronicles her gradual recovery over eight months, until she is discharged in March 1833, “cheerful, proper and hard-working”\textsuperscript{711}. Stina A is intermittently present in her own treatment record; her complaints of nausea and stomach cramps are noted, as is her wish to remain in bed (this is not granted; as Engström notes that she “has to be made to work”\textsuperscript{712}). With the

\textsuperscript{708} For the case history of a patient under Göthlin where such persuasion appears to have been the only treatment administered, see Cecilia Riving, “Komplotten i Köpenhamn” in Roddy Nilsson and Maria Vallström (eds.), \textit{Inspärrad: Röster från intagna på sinnessjukhus, fängelser och andra anstalter 1850-1992}. Lund: Nordic Academic Press, 2016.

\textsuperscript{709} Sondén, “Om de Svenska hospitalerne”, 113-128.

\textsuperscript{710} FIIc:1 No. 139.

\textsuperscript{711} FIIc:1 No. 139, Sw. \textit{Gladlynt, anständig och arbetsam}.

\textsuperscript{712} Sw. \textit{Mäste tvingas till arbete}.
disappearance of the separate records for treatment, notes on therapeutic intervention become more truncated and fragmented, as they must fit in the casebook alongside all other information. Where a patient is said to refuse medication, as in the case of Maria H,713 no indication is given that the treatment was administered forcibly. Hjertstedt notes simply “cannot be made to take her medicine”, and no further comment is made on the subject. Maria H, who suffered from delusions and believed her food to be poisoned or “devil’s food”, also did not eat sufficiently. Again, no mention is made of how asylum staff responded to the patients’ refusal of food. Hjertstedt’s annual report of 1850 describes the use of a tube to force feed a patient, but no recorded use of any such measures have been found in the casebooks. The English asylums which Hjertstedt had visited embraced the doctrine of non-restraint, but historians have found that forced feeding remained commonplace until the 1860s.714 Special techniques were designed and employed to force sustenance and medicines into patients’ mouths or stomachs, thereby ensuring sufficient nutrition. The use of such devices was described with regret by physicians, even as instruments and techniques were developed to be safer and less invasive to the patient, John Conolly concluded that forced feeding “was never quite devoid of evil”.715 The anxiety to ensure proper nourishment may be in part explained by the weakened physical state of many pauper patients in English asylums. Where hardship and poverty had reduced the physical strength of the insane person, it was psychiatry’s task to restore it, as an important step in restoring reason and sanity.

No sources other than casebooks exist from Vadstena to inform us of patient attitudes to their treatment. However, an account by a former patient of the asylum was published in pamphlet form in 1886. The text, entitled Memories from Vadstena asylum, chronicles day labourer Carl Fredrik Carlsson’s two-year stay at the institution.716 Carlsson describes the conditions of his confinement as horrific; staff and fellow patients continuously mocked, frightened and physically abused him, food was scant and of poor quality, and the sick-room freezing cold during the winter months. He describes meeting the head physician (Gustaf Göthlin, who remains unnamed) on three occasions, and each time being treated dismissively. On their first meeting, the superintendent is reported to have remarked only: “That one is in a sorry state”, and taken his leave.

Considering that patients were routinely examined on their admission for an initial evaluation of their mental and physical state, it appears unlikely that the incident is reported accurately.

The pamphlet was published by Isidor Kjellberg (1841–1895), journalist and editor of the local newspaper Östgöten. In the preface, Kjellberg implored his “good,
enlightened and righteous friends in the press” for their help in highlighting the abuses depicted in Carlsson’s text. It appears likely that Carlsson had assistance in authoring his account; the style is highly sentimental and has a literary flair unlikely to belong to a poor day labourer in the 1880s. While the validity of the account cannot be assessed, it seems to have been published by individuals with a clear agenda: to draw attention to the inadequacies of asylum care and question the authority of asylum physicians. The pamphlet offers the historian valuable clues as to how the institution was perceived by the surrounding community. Two different attitudes to the asylum appear in the text; the patient describes himself as having been terrified at the prospect of being sent to Vadstena. He refers to the institution as “the madhouse” throughout, evoking an old image of cruelty, unreason and disorder, far from the modern, curative institution that the physicians promoted and sought to create. Carlsson reports that following the decision by the local authorities to have him admitted to Vadstena, his mother pleaded with the head of the parochial committee to let her care for him instead. The answer was brief: “It is better for him to be in the care of a doctor.” Such a statement, if indeed truthful, indicates a well-established relationship between the asylum and the local authorities, with institutional care being regarded as the best solution in insanity cases.

Conclusion

In the annual report for 1850, Hjertstedt lamented the fact that the majority of patients arrived at Vadstena at an advanced stage of illness, when treatment was less likely to be successful. In the same report, he stated that most cases of insanity stemmed from a hereditary predisposition and emphasised the difficulty in determining a cause. The section might be interpreted as therapeutic pessimism, or as something of a disclaimer; a means of lowering expectations of therapeutic success. The latter seems the more likely one, as Hjertstedt appears in his travel journal genuinely to believe in the asylum and its strict regime of work and instruction. The curative intent which permeated the inception documents of the new asylum at Vadstena in 1826 was very much in line with the philanthropic ideal that dominated debates about the cure of the insane in Europe at the beginning of the nineteenth century. Humane treatment was the watchword and the aim of the asylum was to cure, and to return the recovered to a life outside the institution’s walls. The archival evidence strongly suggests that Georg Engström was dedicated to this end; the first twenty years of our period appear to have been a time of experimentation. Engström, himself a surgeon with no psychiatric training and no previous experience in caring for the mentally ill, applied himself diligently to his task – testing a startling range of medicinal, instructive and disciplinary techniques and treatments. The fact that something as rare and presumably expensive as a rotating chair was ordered and set up at Vadstena, as one of only two in
Sweden as a whole, demonstrates that Engström was supported and encouraged in his therapeutic endeavours by the Board of Directors as well as by the Guild.

As we have seen, Engström did not, however, believe that all insanity could be cured, and even in cases not classed as chronic in the casebook, a full recovery does not appear to have been the objective. A great number of patients were discharged improved; their disturbing or dangerous symptoms ameliorated enough that they could once again live somewhat regular, productive lives alongside others. The fact that the use of separate treatment books stops in the year before Engström’s retirement is difficult to interpret; as the former’s health declined, Hjertstedt was acting as medical superintendent of Vadstena before the post became officially his in 1849. Abandoning the treatment books may be the first indication of a shift in emphasis brought about by Hjertstedt; instead of attacking each individual patient believed to be curable with a battery of medicines and techniques, the new physician would focus on moral treatment and on improving conditions within the asylum to make the environment truly curative. The reforms carried out by Hjertstedt; the establishment of the school, the development of workshops for patients, the complete separation of the sexes, the acquisition of books, games and musical instruments, may all be interpreted as steps toward the ideal institution, of which Hjertstedt had seen examples in England and France. Because of its very nature, moral treatment is largely invisible in the casebooks, and thus the absence of long accounts of treatment may simply be evidence of a shift in emphasis in favour of psychosocial treatment.

The disappearance of the treatment books may also indicate that the initial emphasis on therapeutics – and perhaps also the belief in their efficacy – shifted toward a model more concerned with management as the century progressed. As asylum populations began to increase, superintendents would be the first to realise just how elusive the curative goal really was. The treatment prescribed and administered by Hjertstedt was largely directed at patients’ behaviour and symptoms, rather than what was believed to be the underlying cause. The patient category examined here – patients considered lewd or erotic – appears to have received less drastic medicinal treatment than what is representative of the patient population at large (this based on the work of Roger Qvarsell, whose cases were selected at random using a periodic sampling technique). Most likely, this was due to the moral character of erotic behaviour; eroticism is regarded as largely seated in the imagination, and at times the result of insufficient moral instruction; as such, treatment is moral rather than medicinal in character. However sedative medicines continue to be used; chloral hydrate, potassium bromide and opium are frequently prescribed to calm raving and violent patients, but no new medical compounds appear to be adopted. Notably, the former two are also believed to have anaphrodisiac properties, and the casebooks show that their use was preferred in cases where erotic and sexual symptoms were prominent.
Records of treatment and levels of restraint employed in erotic cases indicate that erotic behaviour, while undesirable and offensive, was not treated with the same diligence as violence, for example. In many cases of masturbation, Hjertstedt notes in the casebook that the habit continues after the patient has been admitted, but there is no record of restraint being applied to prevent it. While it is likely that verbal admonition and surveillance was used instead, such measures do not feature in the casebooks. Roger Qvarsell has found that Georg Engström did not consider sexuality as a key factor when determining the origin of insanity, but rather emphasised the importance of the emotions. Hjertstedt, having trained and served under Engström as assistant medical officer, appears to have shared his predecessor’s attitude to sexuality. Restraint was applied only when deemed absolutely necessary, and medicines prescribed to prevent and control symptoms that may harm the patient or others. In his travel account, Hjertstedt had highlighted the adverse effects of the straitjacket, calling it demeaning and counterproductive, and seemed to suggest that in some cases the device did more harm than good.

A chapter on treatment necessarily raises the question: to what end was treatment applied? If the goal of asylum treatment was to cure, what was meant by “cure”? The casebooks indicate that while some patients were discharged as cured, a significant number were released from the asylum “improved”. Final casebook entries often state, as in the case of Carl F, “the patient has of late been so composed and calm that he should be able to live outside the asylum. Discharged”. In practice, it seems, patients might be discharged with some symptoms remaining, as long as they were considered harmless and able to care for themselves, thus indicating that, in reality, the object of moral and medicinal treatment was rather to eliminate “mad” or “bad” behaviour than to attempt a cure in the traditional sense.

---

718 FIIc:20 No. 2160.
Table A. Medicinal treatments used at Vadstena asylum in the period 1826-1890

Please be advised that the Swedish terms provided are those recorded in the case-books, and not always synonymous with the common Swedish terms for plants and compounds.

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antimonial ointment (Sw. Antimonalasalva)</td>
<td>Counter-irritant. 719</td>
<td>To shaved scalp or back.</td>
</tr>
<tr>
<td>Camphor (Sw. Kamfer)</td>
<td>Stimulant, cooling agent, internally to obviate discomfort from purgatives. 720</td>
<td>Oral in emulsion form. Wraps to the head and genitals.</td>
</tr>
<tr>
<td>Chloral hydrate (Sw. Chloral)</td>
<td>Sedative.</td>
<td>Oral.</td>
</tr>
<tr>
<td>Compound extract of colocynth (Sw. Kolokvintdroppar)</td>
<td>Laxative 721</td>
<td>Oral.</td>
</tr>
<tr>
<td>Digitalis (Sw. Digitalis)</td>
<td>Sedative. 722</td>
<td>Oral.</td>
</tr>
<tr>
<td>Epsom salt (Sw. Sal anglicus)</td>
<td>Purgative 723</td>
<td>Oral.</td>
</tr>
<tr>
<td>Gratiola (Sw. Gratiola)</td>
<td>Purgative, “counter-stimulant” i.e. sedative (in cases of mania) 724</td>
<td>Oral, infused in spirit.</td>
</tr>
</tbody>
</table>

| **Hellebore**  
| (Sw. *Prustom*)  | Purgative.\(^{725}\)  | Oral. |
| **Infusion of ratanhy**  
| (Sw. *Rataniadroppar*)  | Astringent, stomach strengthening, “invigorating”.\(^{726}\)  | Oral. |
| **Iron albuminate**  
| **Iron iodine tablets**  
| (Sw. *Järnjodurpiller*)  | Strengthening increases blood volume.\(^{727}\)  | Oral. |
| **Iron tablets with quinine**  
| (Sw. *Järnklininpiller*)  | Strengthening increases blood volume.\(^{728}\)  | Oral. |
| **Mustard cataplasm**  
| (Sw. *Senapsdeg*)  | Counter-irritant.  | Between shoulders, on calves. |
| **Opium**  
| (Sw. *Opium*)  | Narcotic, sedative.  | Oral. |
| **Peppermint extract**  
| (Sw. *Pepparmyntvatten*)  | Cooling, stimulant.\(^{729}\)  | Oral. |
| **Potassium bromide**  
| (Sw. *Bromkalium*)  | Sedative, anaphrodisiac.  | Oral. |
| **Quinine sulphate**  
| (Sw. *Kininsulfat*)  | Muscle relaxant.  | Oral. |
| **Rhubarb root**  
| (Sw. *Radix rhei*)  | Emetic.  | Oral. |
| **Senna infusion**  
| (Sw. *Inf. Sennae*)  | Laxative.  | Oral, infused in spirit. |
| **Setons**  
| (Sw. *Hank*)  | Counter-irritant. A septic wound inflicted through a fold of skin with a ribbon threaded through. The pulling of the ribbon ensured the wound remained open.  | Back of the neck. |
| **Tartar emetic**  
| (Sw. *Tartarus antimonialis*)  | Emetic.  | Oral, antimony salt dissolved in wine. |
| **Valerian root**  | Sedative.  | Oral. |

\(^{725}\) Burrows, *Commentaries*, 630.
\(^{726}\) Thomson, *The London Dispensatory*, 381.
\(^{727}\) Nordisk familjebok 1884, 1152.
\(^{728}\) Ibid., 1152.
\(^{729}\) Nordisk familjebok 1915, 440.
<table>
<thead>
<tr>
<th>(Sw. Valeriana)</th>
<th>White hellebore root</th>
<th>Purgative,(^730)</th>
<th>Oral.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Sw. Radix veratri albi)</td>
<td>Whytt’s elixir</td>
<td>Digestive aid,(^731)</td>
<td>Oral.</td>
</tr>
<tr>
<td>(Sw. Kinadroppar)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Results and concluding analysis

The main purpose of this study has been to examine the medical interpretation of erotic behaviour in early Swedish psychiatric practice. The choice to focus on a single institution, and apply critical questions inspired by revisionist scholarship to a body of empirical research, was made in order to present a more nuanced image of nineteenth-century medical attitudes to sexuality. Previous research on the medicalisation of sexuality has focused on the ideas of the medical elite, and one of the major contributions of this study is its focus on medical practice and the everyday operation of the institution rather than on psychiatric theory. The results presented highlight the numerous complications, uncertainties and complexities of early psychiatric practice, where few answers are clear-cut and interpretations rarely follow a discernible pattern.

Vadstena was established as Sweden’s first modern asylum. The original instruction envisioned a specialised institution for the care and treatment of the insane overseen by a Board of Directors, with a resident physician in charge, run according to the principles of moral treatment. The instructions for the Board of Directors and the physician both emphasise cure as the institution’s ultimate goal. Both documents also allude to an already established psychiatric practice existing elsewhere; in both cases the documents speak of “other European countries”, and state outright that the Swedish system has fallen behind in this important field. The story of the Vadstena asylum as it appears in the casebooks during the period 1826–1890, under superintendents Georg Engström, Ludvig Magnus Hjertstedt and Gustaf Wilhelm Göthlin, is that of a medical specialty in the making. In Sweden, it seems, the institution and the physical structure of the asylum came first, and psychiatry followed.

Casebooks and admission documents from Vadstena have made up the rich, fascinating and frustrating source material for this study. As a whole, the material has served to answer the majority of the questions posed, if not always to the extent that was expected. The process of tracing the physicians’ process of interpretation has proved challenging, due to the varying length and quality of the casebook records. While some case notes stretch over four or five pages, and record the patient’s progress or decline in detail, many are brief and report only that the patient’s condition remained unchanged, sometimes for many years. Case notes continue to vary in quality following the introduction of official guidelines for case keeping in 1858. This has meant that forming an impression of general trends in the interpretation of symptoms and prescription of treatment has proved laborious and time-consuming. The length of case histories has been shown to correlate with the perceived prognosis of the patient; cases where the patient has recently fallen ill are documented more carefully, while patients who are considered chronic or incurable have brief case notes with few updates. Their intended purpose, as medical records primarily for the use of the physicians themselves and other asylum staff, means that the rationale behind
decisions of treatment and other intervention is not recorded. It has also become apparent that much of the moral treatment does not feature in the casebooks. While obliged to record the use of mechanical restraint and seclusion, Hjertstedt and his colleagues do not regularly make note of other disciplinary measures. In his annual reports to the Board of Asylums, Hjertstedt mentions depriving patients of “small pleasures and distractions” as punishment for mischief and disorderly behaviour, but no such intervention has been found in the casebooks. Furthermore, while patients’ ability and willingness to work is meticulously recorded, no information is given regarding their participation in the leisure activities which Hjertstedt made sure to provide at Vadstena. As head of a medical facility, Hjertstedt was obliged to submit an annual report of the operations at Vadstena to the Board of Asylums. These included figures regarding admission and discharge for each year, and general information on structural and therapeutic improvements made to the asylum. Occasionally, Hjertstedt would include cases of special interest, or comment on certain types of illness, and for this reason the annual reports for his period as superintendent have been included in the source material.

An additional source has been Hjertstedt’s account of his journey through Europe, a record of his encounters with modern European asylums – the models that the Swedish Board of Asylums aspired to emulate. His journey is also, alongside the experience gained while working alongside Georg Engström, the only specialised psychiatric education that the young physician acquired. Its inclusion as a source for this project has provided insight into the forming of Hjertstedt’s medical philosophy that the Vadstena records could not. It has also provided this thesis with the possibility to assess to what extent the impressions from these journeys and the influence of contemporary European psychiatry shaped asylum practice at Vadstena.

The first chapter outlines Hjertstedt’s impressions from abroad as they were recorded in his travel report. The accounts of his visits to English asylums are the longest and the most detailed, and comments made in the report illustrate that Hjertstedt was familiar with recent medical literature and ongoing debates about asylum care in England. It is argued that the visit shaped his view of the ideal asylum and its practice, as well as his belief in the institution as a curative environment. His subsequent reforms at Vadstena were inspired by the impressions gained on this journey, and the organisation and structure of daily life in the asylum is given much consideration in his report – at the expense of more scientifically oriented discussions regarding treatment and classification. Hjertstedt’s focus on work, discipline and moral instruction as the main tools of the asylum becomes apparent in subsequent chapters, and was inspired by the systems encountered on his journey. Many of the reforms that he carried out at Vadstena were practical in nature – separating male and female patients, refurbishing buildings, providing schooling and appropriate leisure
activities for patients – indicating a medical philosophy where the asylum environment itself was instrumental in treating and curing insanity.

Early psychiatry was to a large degree concerned with the nature, origin and classification of illness; its ideas and doctrines had metaphysical elements and were often abstract in nature. The Vadstena physicians appear to have been well acquainted with the theoretical psychiatry of their day, but their experience was practical in nature, as the majority of their time was devoted to their responsibilities as asylum superintendents. During his 29 years in the post, Hjertstedt was responsible for prescribing, administering and overseeing treatment and care to more than 1800 patients, keeping adequate patient records – often with help from his assistant medical officer – and for coordinating and delegating daily tasks to the asylum’s 35 members of staff. His written work during the period is limited to the required annual reports to the Board of Asylums, and although hailed as a progressive reformer by his contemporary colleague Carl Ulrik Sondén, Hjertstedt did not contribute articles or other textual accounts of his work at Vadstena.

The records of practice from Vadstena illustrate how each aspect of medical care and treatment, from the diagnostic process to choices of treatment, as well as the physical environment of the asylum, was under construction during this period. Sweden had no classification system for mental illness until 1861, no doctors specialised in psychiatry, and few textbooks on the subject. In the earliest years of operation, head physician Georg Engström experimented with medications and treatment techniques, dismissing some and continuing others, drawing his knowledge from foreign works on psychiatry and from experience gained on his journeys abroad. Hjertstedt’s more extensive journey throughout Europe was undertaken with the specific intent of developing Swedish asylum care to resemble that of modern institutions abroad. Through the import of ideas, practice at Vadstena was further developed, though Hjertstedt proves in his travel account as well as in his practice to be anything but an uncritical admirer. His regard for asylum physician and reformer John Conolly is evident in the text, but so is his critique of Conolly’s principles on the subject of mechanical restraint. Hjertstedt considered the non-restraint system to be an expression of excessive and misguided philanthropy, arguing that forcible containment was necessary in some cases of insanity. In his travelogue, he poses the rhetorical question: what measures should be considered as mechanical restraint? Under his supervision, both what was generally considered to be mild restraint (confinement in a cell) and more traditional methods such as the chair and the straitjacket were still used, albeit cautiously. The significant expansion of the asylum buildings and grounds which provided more patients with useful occupation and the opportunity to work outdoors, and the addition of games and musical instruments to add creative stimulation were certainly inspired by English asylums. The account of his journey in England is coloured by Hjertstedt’s admiration for the British gentleman reformers,
and his own attitude to his patients reveals a level of philanthropic sentiment. He was aware of the difficulties his patients suffered in terms of pauperism and domestic violence, and often considered such circumstances to be wholly or partially responsible for the outbreak of illness. Accounts of personal hardship are often written into the case notes in a sympathetic tone, and female patients in particular are cast as unfortunate victims rather than morally corrupt and culpable. Because Hjertstedt viewed social causes as aetiologically significant, it became even more important to create an asylum environment that was free of the strains of patients’ ordinary lives. Through his patient accounts and the measures taken to reform Vadstena, we can make out the central figure of moral treatment: the fatherly physician under whose benevolent authority the insane will be returned to health and moral strength. In, for example, finalising the complete separation of the male and female wards in 1853, Hjertstedt sought not only to promote order, but also to secure the moral and physical safety of his female patients, making himself their protector. He appears from the Vadstena records as a managerial figure; dedicated above all to establishing a truly curative asylum environment.

The book’s second chapter addresses the question of how erotic behaviour was explained in aetiological terms, and shows how a large array of both psychological, social and somatic factors feature as possible causes in the casebooks from Vadstena. Hjertstedt appears to have favoured the so-called psychic model of understanding insanity in focusing on moral causes and the influence of the emotions on the mind. While ascertaining the cause of illness was an important objective for physicians, the sources illustrate that Hjertstedt and his colleagues did not seek to identify a single cause. The casebooks list all the causes considered possible by the physician, indicating that in most cases of insanity a combination of factors were considered responsible for the outbreak of illness. The figures from Vadstena strengthen the impression given by the official statistics for Sweden as a whole; that throughout this period the most prevalent ascribed causes of insanity apart from hereditary predisposition were religious delusions, jealousy and the enduring, amorphous concept of disappointed love. Under Hjertstedt’s successor Gustaf Göthlin masturbation was more commonly described as cause of insanity in men, but also in women – this marks a change in the Vadstena statistics as Engström and Hjertstedt both appear to have viewed female masturbation as symptom, but not as a cause of illness. In answering the question of aetiology, another question arose regarding the correlation between cause and symptom. Chapter 2 shows how cases attributed to disappointed love were often described as exhibiting symptoms of an erotic nature, while masturbation continued to be a symptom, but the resulting illness was diagnosed as dullness or dementia.

Chapters 3, 4 and 5 in this thesis address the question of how and to what extent erotic behaviour was framed as disease, and examine the function and integrity of
diagnostic terms. Here, patients are divided into three groups based on the terminology employed by physicians to describe them. While the theoretical psychiatry of the nineteenth century divided insanity into ever more specific categories and new diagnostic terms appeared, the Vadstena records show the enduring influence of Philippe Pinel’s division of insanity into four types: melancholia, mania, dementia and idiotism. It became apparent at a relatively early stage of research that specific diagnostic categories for erotic patients were rare. Nymphomania is the only specific diagnosis for erotic behaviour that has been found in the case notes, and chapter 3 reveals its ambiguous status; although a recognised diagnosis in psychiatric theory, it is mostly used here in the sense of a descriptive term for a set of symptoms. Two cases diagnosed as nymphomania have been found during Hjertstedt’s period as superintendent, and four under his predecessor Engström. A remark in an annual report shows that Hjertstedt was familiar with the concept of satyriasis, described in medical texts as the male form of nymphomania, but the term has not been found in the patient records. The idea of a specific type of masturbatory insanity, well established in Britain, does not appear to have made it to Vadstena at all. Masturbation features in the casebooks as a cause or symptom of various kinds of insanity, of which dullness occurs most frequently. In male patients, physicians appear to focus less on the presence of desire, and more on its solitary fulfilment and its presumed harmful effects. Female masturbation is reported in a matter-of-fact fashion, and no preventive measures are recorded, indicating that the practice was not considered especially harmful in women, as some medical texts argued. The term erotomania as a diagnosis for insanity with romantic symptoms is used only twice, and other cases with similar symptoms are described using general terms such as mania and melancholia.

The use of specific terms like nymphomania and erotomania illustrates that Hjertstedt was conversant with contemporary psychiatric thought. However, each is short-lived as diagnosis in the casebooks. Hjertstedt uses nymphomania during the 1850s and 60s, but seems to have abandoned the concept completely after 1869. This gives rise to yet more questions about the function of diagnosis at Vadstena. How important was it to assign a label to each case? Why was it important? Each casebook record has a diagnosis entered on the first page; it is the first piece of information given, following the patient’s name and age, suggesting that labelling the illness was significant. However, while nineteenth-century psychiatric theorists devoted significant amounts of time and ink to the matter of illness classification, the records of practice at Vadstena suggest that diagnosis had little impact on treatment and care within the asylum. Patients diagnosed with nymphomania or erotomania were not subject to any specific courses of treatment, and their disturbing symptoms were dealt with in the same manner as violence and other disruptive behaviour. The case notes indicate that the important distinction for the physician was a classification of behaviour that allowed him to separate the violent from the calm, the noisy and
obscene from the quiet and orderly. The results indicate that Hjertstedt (and, to a lesser
degree, Engström and Göthlin) incorporates specific diagnostic terms in order to
illustrate their familiarity with contemporary theoretical psychiatry as part of a project
of professionalisation. The disappearance of nymphomania in the Vadstena case notes
can be linked to a growing scepticism toward Esquirol’s concept of monomania, and
the so-called special manias – nymphomania, dipsomania, kleptomania and pyro-
mania, in the latter half of the nineteenth century. Thus, in forsaking the concept
Hjertstedt illustrated his awareness of the latest tenets of international psychiatry.
Although both nymphomania and masturbatory insanity were amorphous medical
categories, their appearance – the image of the condition as it manifested in a patient –
was recognised by (“all discerning”) physicians. Hjertstedt and his colleagues attribute
illness to masturbation or disappointed love based on their observation of the patient’s
appearance and behaviour, showing that they possess the skill and have the authority
to assess not only health and illness, but decency and morality.

In chapter 6, the question of how therapeutic and disciplinary intervention reflected
medical responses to eroticism is raised. The infrequent use of specific diagnostic
terms to describe erotic behaviour should not be interpreted as an implicit acceptance
on the part of the physician, or as a failure to recognise symptoms. Therapeutic and
managerial intervention, including restraint, indicates that erotic behaviour was con-
sidered a disturbing symptom, if not a type of illness in itself. Thus, eradication of
such behaviour formed part of the general instructive character of the asylum, which
sought to eliminate vice as well as unreason and instead foster health, virtue, calm and
productivity. Treatment and management of disruptive or obscene patients was admi-
nistered not just for medical reasons, but also to maintain the curative environment for
other patients.

It has become apparent in the course of research that the sources cannot answer all
research questions satisfactorily. Perhaps the most prominent example is the difficulty
of establishing the extent of moral treatment. Because of its very nature, moral
treatment is elusive in the casebooks; verbal reprimands and stern conversations as
well as encouraging and cheering verbal interaction between staff and patients have
left no traces in the source material. Clues in the casebooks suggest that Hjertstedt
tried to reason with patients, that is, to convince them that their hallucinations and
ideas were not real, but we may assume that the majority of interpersonal intervention
went unrecorded. It is very likely that the physician and his staff admonished
masturbating patients to refrain from the habit, but no record exists of such
interventions. The majority of treatment recorded for erotic patients was designed to
ameliorate symptoms and behaviours which were perceived as disruptive, with
sedatives and calming compounds being the most commonly used. Case notes for
patients who were considered chronic or incurable often record no treatment at all,
except for medicines prescribed for bodily ailments.
The Vadstena case records and Hjertstedt’s travel journal contain enough information to permit us to piece together an impression of the head physician’s attitude to treatment. While his medical practice as discerned from the case notes does not appear to follow any single theoretical school or philosophy, or to be associated with any specific psychiatric writer, there is a structure and continuity to it. What emerges in the records from Vadstena is something resembling a medical culture, a core of beliefs which endures throughout the period. This medical culture was fundamentally concerned with providing instructive and environmental treatment, with a special emphasis on work and appropriate leisure activities, and was further characterised by a cautious attitude to physical restraint, and surprisingly, a relatively permissive approach to erotic behaviour. The latter impression is further strengthened by the brief mention of erotic and sexual causes in Hjertstedt’s annual report of 1850; he notes that “overindulgence in satisfying the sexual instinct” may cause insanity, but that erotic behaviour is more likely to be a symptom of mental disturbance. The passage is brief, and the tone less urgent than in the sections on excessive drinking and “disordered life”. By stressing that medicines had proved ineffectual in the treatment of insanity, the 1826 instruction for Vadstena emphasised psychosocial, moral treatment as the way forward. While the three head physicians employed all the main components of moral treatment as it was conceptualised in England and France, medicinal treatment was never abandoned. The decision to disregard the opinion of the medical authorities on the subject of treatment implies a determination on the part of the superintendents to establish their authority as professionals. Moral treatment, a lay-inspired movement when it emerged in England, challenged the medical profession’s ability to deal with insanity, and the value of standard medical interventions. By establishing a model of care and treatment that included both medical and moral therapies, early asylum physicians asserted their expertise in relation to the political authorities, as well as other medical practitioners. Under Hjertstedt as head physician, the fervent therapeutic experimentation of Vadstena’s early years is abandoned, and the asylum environment itself becomes the most important curative device. As disciplinary and normalising institution, Vadstena became a fully established facility during Hjertstedt’s superintendency. While the original task of the institution was to cure, physicians seem to have been content to discharge patients who were no longer considered to be a danger or a nuisance to themselves or others, even where some symptoms remained, and especially if the patient was able to work. Such an approach is connected to a general decline in therapeutic optimism in the second half of the century, but also motivated by the very practical need to free up beds as Vadstena was accumulating ever larger numbers of patients. Throughout his career, Hjertstedt continued to emphasise in annual reports to the Board of Health how patients arrived at the asylum too late, and how their advanced stage of illness rendered therapeutic intervention ineffective.
The analysis in this thesis has highlighted a gap between psychiatric theory and practice, and emphasised the unfinished, uncertain and experimental nature of practical psychiatry at Vadstena during the period examined. The asylum as it emerges from the analysis of case notes in this book is not the same place as the curative institution imagined by the Board of Health upon its inception. At the asylum, physicians were forced to confront the continuous build-up of chronic and incurable cases, and adapt their classification, treatment and ambitions to the practical realities of their situation. The asylum in Sweden came first and psychiatry followed, indicating that the asylum as a site of medical practice was separate from the theoretical doctrines of the discipline. Early psychiatric practice was messy, complex and at times inconsistent with theory, and it is a perspective that deserves to be taken into account when crafting histories of psychiatry.

The image that emerges from the archive material is inescapably the medical conceptualisation of the asylum, but it is one of an establishment with several functions. Though envisioned as a medical institution, the asylum also had a social function; it was both curative and normalising. It should be, in Hjertstedt’s mind, a place where intellectual and moral neglect in early life could be remedied by instruction and example, and a safe haven from want, poverty, domestic violence, stress and immoral influences. Swedish nineteenth-century psychiatry grew in awareness of and in relation to the latest medical and philanthropic ideas of the time, in a climate of negotiation and critique between medical professionals, relatives and politicians. The sources indicate an awareness of the complicated nature of the task at hand – curing the disordered mind – and a measure of understanding of the vulnerable position and suffering of its patients. Nevertheless, the road to recovery was one of stern moral instruction, and symptoms of illness were often the same as signs of depravity. During this period, the language of the Vadstena physicians contains both medical and moral verdicts. It is difficult to entangle one from the other, and for the doctors there was no contradiction. Erotic and sexual behaviour were symptoms of illness as well as moral and social problems. When Hjertstedt identified reading or non-conformist religious practices as causes of illness, his interpretation reflected an ideal image of middle-class morality and respectability, and provided a medical rationale for that morality to be maintained. The presence of diagnostic terms such as nymphomania reflects wider agendas of social control where women were concerned. Descriptions of male masturbating patients as wasting away, pale, passive and devoid of all strength served to reinforce the taboo about self-abuse by contrasting the onanist with the bourgeois ideal of masculinity. Comments made in the casebook in conjunction with patients being discharged also illustrate what it meant to be cured; to exert self-control in all things so as not to become a slave to one’s passions, to work hard, to exhibit an appropriate amount of protestant piety, and to be self-sufficient. However, little evidence is found in the casebooks to suggest a major influence from
the infamously puritan attitude of the Victorian medicine which Hjertstedt encountered in England. No euphemisms are used to describe sexually explicit behaviour, and body parts are referred to by their proper names.

In focusing on medical practice I have sought to apply nuance to the image of nineteenth-century psychiatry as unduly hostile to sexuality. While Hjertstedt acknowledged the potential role of sexuality in causing and exacerbating mental distress and disease, his relatively lenient attitude to preventing erotic behaviour suggests that erotic patients were an interesting but subordinate category in the archive material from Vadstena. During Hjertstedt’s period as superintendent an average of two cases per year were admitted where the cause or the symptoms were described as erotic, out of an average total of 40 new admissions per year. Any estimate of the extent of medicalisation of eroticism must take into account that the initial act of evaluation, the decision to have a person admitted to an asylum, was not made by medical professionals. Abnormal or antisocial behaviour was defined in relation to one’s immediate surroundings, and admission documents record transgressions against social and moral norms of behaviour. Prior to their arrival at Vadstena, patients were certified by a clergyman and a doctor, thus their behaviour had already been interpreted in medical terms. Only once the patient was within the asylum walls did their behaviour come under the asylum physician’s scrutiny. This was where the distinction was made between cause and symptom; a kind of ordering of observations already made and recorded, into an illness narrative. The fact that cases do occur in the material where lewdness is viewed not as madness but simply as a personality trait or a result of a faulty upbringing, suggests that the link between sexual morality and insanity was still being negotiated in this period. The types of therapeutic and disciplinary response on the part of the physician, and in some cases the lack thereof, strongly suggests that eroticism was mainly a moral concern; a disturbing and disruptive set of actions and attitudes which threatened the therapeutic environment of the asylum and the social order of the outside world.

Disciplinary power has been a constant theme throughout this study. Hjertstedt’s reforms aimed to make the asylum a controlled environment where each aspect of the patient’s life was carefully monitored and regulated. A system of rewards and punishments was designed to encourage good behaviour, and cultivate what physicians considered to be important values and virtues. However, the Vadstena records also contain indications of resistance, of patients challenging the asylum’s strict daily regime and rules of conduct. Refusing to take medication, get out of bed or eat represents small acts of insurgence on the patients’ part, and the frequently reported tearing of clothes – which were provided for patients – may be interpreted as a figuative revolt against their patient status and the physician’s authority, as well as an expression of despair. Where such acts are recorded in the casebook, means of coercion are curiously absent. No mention has been found in the casebooks of medi-
cine or food being given forcibly, although Hjertstedt mentions using forced feeding by tube in this annual report of 1850, indicating that he was familiar with the technique. Similarly, he mentions using punishments to correct disorderly behaviour, but none of the case notes examined in this study contain any punitive measures. Where restraint and isolation are recorded, they are presented as necessary measures to stop violent and destructive behaviour, and not as instructive or corrective.

The very presence of a concept like nymphomania, while the male equivalent satyriasis is completely absent from the archive material, indicates a medical interest in female sexuality. However, the case note findings do not support the assumption that female desire was viewed as pathological in itself. Rather, indications are found that physicians considered complete abstinence in adult women as a potential cause of insanity. While descriptions of female patients are sometimes eroticised, notably in first-class patients, and reproduce stereotypical images of the nymphomaniac in medical literature, Hjertstedt and the other Vadstena physicians do not automatically attribute female insanity to the reproductive organs. The fact that references to patients’ menstrual regularity are infrequent, and only a single case interpreted as puerperal insanity has been identified seem to support this impression. Nevertheless, nymphomania patients are described as transgressing all the norms of acceptable femininity; as selfish wantons in pursuit of pleasure, neglecting their duties to family and home. It appears that with each physician superintendent throughout the nineteenth century, the attention paid to sexual and erotic matters increases somewhat. It is therefore quite possible that the increasing medicalisation of erotic and sexual behaviour which previous research has identified and analysed occurs after the period examined here.

When Georg Engström uses the term nymphomania as a diagnosis, and occasionally as a description of a set of symptoms, he does not elaborate on the details of patients’ behaviour. Unlike Hjertstedt, he does not describe the appearance of female patients in appraising terms. Also, there is no indication of any kind of culpability on the part of the patient; Engström seems to view the disorder as a physical one which may manifest in any female patient irrespective of class or virtue. He notes masturbation where it occurs, but does not appear to have made great efforts to prevent patients from continuing the habit. Hjertstedt’s case histories of erotic women are longer and more detailed, and masturbation in men and women occurs more frequently in case histories, both as a symptom and increasingly as a cause, than under Engström. The records indicate that while nymphomania had disappeared as a diagnosis in the 1870s, the terms “whims” and “love” continue to feature prominently as symptom and cause respectively, until the end of the period.

This study has focused on the erotic as an area where the double nature of early psychiatry becomes visible, as physicians’ descriptions and interpretations of symptoms contain both medical and moral appraisals and assessments. It has found ample
evidence of medical concern regarding erotic behaviour, and a range of responses to such behaviour in the period examined. It has shown how practical psychiatry grouped eroticism in with drinking, vagrancy and petty crime into a collection of behaviours described as *irregular life*, and legitimised the dangers inherent in such a life with scientific explanations and terminology. This is practical medicine validating and supporting social norms and gender roles already in place. The insane patient represents the antithesis of an ideal member of society; industrious, modest, sober, and in control of one’s passions and emotions. The fostering of these qualities formed the main therapeutic response to insanity, linking psychiatric practice with a wider social project of modernisation in nineteenth-century Sweden.
Coda

This project has been concerned with medical practice and medical attitudes. It would however feel improper to finish it without acknowledging the Vadstena patients. The case notes read as fragments of lives long forgotten. For each doctor’s account of a case there was once another story, a personal one, which went unrecorded. Some patients were admitted while young and remained in care until old age and death, their entire lives spent within the asylum walls. Others suffered brief episodes of mental distress, and were discharged having recovered. Some only wished to return home, while others begged to stay, even after the physician decided that nothing more could be done for them. A few seem to have rebelled against the physician’s and the institution’s authority; refusing medication, fighting staff and destroying their clothes – these symbols of institutionalisation – while others pleaded with the doctor to help them. For many, the asylum was the final stop, a place of no return. For those more fortunate it was a temporary sojourn during a time of mental distress. While patients’ experiences have not been the focus of this study, their names and their voices have been present in my mind throughout this process.
Summary in Swedish

Erotiskt vansinne – sex och psykiatri vid Vadstena hospital 1849–1878

Introduktion


Syfte och frågeställningar


**Tidigare forskning**


**Material och metod**


Kapitelöversikt

Inledningskapitlet presenterar avhandlingens syfte och frågeställningar, samt innehåller en mer ingående diskussion om undersökningens källmaterial och metod. Där introduceras avhandlingens teoretiska ståndpunkter i förhållande till de tongivande strömningarna inom den moderna psykiatrihistorien. En översikt av tidigare svensk och internationell forskning om sinnessjukvård och psykiatri under 1800-talet presenteras, och avhandlingens plats i detta sammanhang preciseras.


I kapitel två, "The Aetiology of Erotic Insanity", analyseras informationen i patienternas intagningshandlingar, och dess överflyttning till journalböckerna för att belysa diskussionen om sjukdomens orsaker. I överföringen identifieras en urvals- och ordningsprocess av den information som tillhandahållits av patientens familj och närmaste omgivning, vilket synliggör läkarens tolkning av vad som var medicinsk relevant information. Genom att studera vilka orsaker som bedömdes ligga till grund för det erotiska beteendet kan vi närmare oss läkarnas medicinska och moraliska förklaringsmodeller, och peka på skillnader och likheter i läkarnas och lekmännens bedömning av avvikande beteende. Analysen visar att journalen hade en informationssamlande och kunskapskapande funktion, och att Hjertstedt vanligen noterade flera möjliga orsaker till sjukdomens utbrott. Genom att neleotika flera möjliga orsaker i många olika fall med liknande symptom kunde orsaksförhållandena studeras över tid. I
Vadstenamaterialet förekommer en mängd psykologiska, sociala och fysiska faktorer som möjliga orsaker till psykiskt sjukdom, men undersökningen visar att så kallade moraliska orsaker var övervägande i erotika fall. Dessa bestod av beteenden och händelser som ansågs ha frambringat starka känslor och passioner och innefattade till exempel läsning av erotisk litteratur, onani och olycklig kärlek.


Kapitel sex har titeln ”Treatment and management” och ställer frågan om vilken behandling som ordinerades erotiska patienter och hur behandlingen reflekterade den medicinska tolkningen av diagnoser och symptom. Vidare kopplas anmärkningar och rekommendationer i Hjertstedts reseberättelse till den medicinska praktiken på hospitaliet, för att belysa hur den insamlade kunskapen och erfarenheten från europeiska hospital kom till användning. Undersökningen visar att specifika behandlingsmetoder

Resultat och diskussion

Dock måste det konstateras att trots att Hjertstedt visar ett visst intresse för erotiska symptom, så urskiljs inte det sexuella som mer viktigt än någon annan typ av beteende i den medicinska praktiken. Snarare finns en tendens i journalhandlingarna att slå ihop liderlighet och erotiskt beteende med det som av läkarna kallas “oordentligt lefnadsstället” en samlingsterm som även innefattade lösdriveri, superi och småbrottslighet. I avhandlingen kopplas denna kategorisering till ett större samhällsreformerande projekt under 1800-talet där borgerliga uppfattningar om självständighet och anständighet blev tongivande.
Ett viktigt resultat är att handlingar och beteenden som av läkaren tolkades som erotikska inte nödvändigtvis sågs som tecken på psykisk sjukdom. Att vara ”liderlig”, ”oblyg” eller ”svärmisk” kunde även vara resultatet av en underrättad upphovstran, otillräcklig religiös undervisning, eller helt enkelt ett problematiskt personlighetsdrag. Där så var fallet var hospitalets och läkarens uppgift att bidra till tillfrisknandet genom att tillhandahålla den undervisning, moraliska upphovstran och träning i självbärande ensamhet som patienten saknade.


I Hjertstedts reseberättelse och de reformer som genomförs i Vadstena efter hans tillträdande som överläkare framträder ett formerande ideal – bilden av det moderna, kura viva hospitalet. Inspirerad av de stora engelska hospitalens fokus på patienternas sysselsättning genomförde Hjertstedt en rad reformer, han inrättade skolundervisning för de patienter som ansågs behöva den, och hospitalets enkla bibliotek utökades med en ansenlig mängd passande litteratur. Sällskapsspel och ett pianoforte inskaffades, och den enligt tiden vetenskap så viktiga utemiljön förskönades med en park. I journalhandlingarna framstår Hjertstedt som en praktiskt lagd person, vars mesta uppmärksamhet ägnades åt att skapa en institution för bot, trygghet och säkerligen för av de sjuka. I början av sin verksamhet som överläkare genomförde han en fullständig separat av de manliga och kvinnliga avdelningarna, som nu inrättades i separata byggnader som åtskiljs av hospitalsgatan. I journalerna skildrar Hjertstedt inte bara sina patienters symptom och sjukdomsåterkomst, utan även deras sociala och ekonomiska svårigheter med ett mått av medkänsla. En starkt moraliserande ton infinner sig i de fäl där patientens eget levnadssätt anses ha orsakat sjukdomen, och särskilt där alkoholmissbruk och våldsamt har vållat patientens familj eller nära omgivning skada. I avhandlingen framgår att hospitalet skulle finnas till för patienternas vård och trygghet, men även för lokalsamhället genom att ta emot farliga och besvärliga personer och försöka återställa dem till nyttiga och anständiga medborgare. Som överläkare var Hjertstedt beroende av patientens familj och nära omgivning som källor till den anamnes som var en viktig del av sjukdomens uttystande. Journalerna visar att hospitalet även var beroende av familjen och lokalsamhället som mottagare av patienten när denne skrevs ut.

Works Cited

Unpublished sources

*Regional archives at Vadstena (VLA)*

Birgittas sjukhus arkiv (BSA)

Överläkarens arkiv (mans)

Admission documents
FI:2 – FI:3 (1830-1835)
FI:9 - FI:20 (1848-1878)
FI:30 – FI:35 (1890-1895)

Treatment books
FIib:1-5 (1827-1846)

Casebooks
FIic:1-3
FIic:5-FIic:21
FIId:1-3

Archive of the Board of Directors

DA EIIa:1 Inspections-Journal 1859-1883

Archive of the superintendent

FIII:1 Instruktioner

*The Swedish National Archives (RA)*

Sundhetskollegiets arkiv

E3C:11 Ludvig Magnus Hjertstedts Reseberättelser från England, Frankrike, Belgien, Holland, Schweiz, Italien och Tyskland

*Lund University Library, Special Collections*

Ludvig Magnus Hjertstedt, Dag-bok under en resa kring Sveriges Kuster, samt till N. Canarie Öarne, West-indien, Södra och Norra Amerika, 1839 och 1840

210
Published Sources

Anon., “Cases of Insanity in which Bodily Restraint is Imperative”, *The Lancet*, vol. 57 (959), January 1842, 544


Anon., *Medel att åter erhålla helsa och styrka för dem som utsåxvat i fysisk kärlek och sjelfbefläckelse*. Stockholm: Nordström, 1833

Acton, William, *The Functions and Disorders of the Reproductive Organs* (2nd American ed. From the 4th London ed.) Philadelphia: Lindsay and Blakiston, 1867


Alm, Leopold, *Om osedligheten bland gossar och flickor*, Stockholm: For the author, 1869


--- and Anne Digby (eds.), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*. Amsterdam and New York: Rodopi, 2004


Batty Tuke, John, “A Pathological Classification of Mental Disease”, *Journal of Mental Science*, 16, 1871, 195-210


Bebel, August, *Woman in the Past, Present and Future*, San Francisco; Benham, 1897

Becker, Gottfried Wilhelm, *Rådgivare före, vid, och efter samlaget*. Stockholm: Olof Grahn, 1812


Berrios, German E., “Erotomania: A Conceptual History”, *History of Psychiatry* 3 (52), 2002, 381-400


*Bidrag till Sveriges Officiella Statistik K) Helso- och sjukvården II*, “Underdåningen berättelse för år 1861-1910”


Blake, Andrew, “The Humane System of Treating the Insane”, *The Lancet*, vol. 35 (910), 6 February 1841, 681-682


212


Brandt, Thure, *Gymnastiken såsom botemedel mot qvinliga underlifssjukdomar: Jemte strödda anteckningar i allmän sjukgymnastik*. Stockholm: Bonniers, 1884


Browne, James Chrichton, “Physical Diseases of Early Life”, *Journal of Mental Science* April 1860, 8 (33), 284-320


--- *Commentaries on the Causes, Forms, Symptoms and Treatment, Moral and Medical, of Insanity*. London: Underwood, 1828


Bynum, William and Roy Porter (eds.), *Brunonianism in Britain and Europe*. London: Wellcome Institute for the History of Medicine, 1988

--- “Onanism”, *The Lancet* 358 (9286), 1020

Carlsson, Carl Fredrik, *Minnen från Västergötlands Hospital*, Linköping: Isidor Kjellberg, 1886

“Cases in which Bodily Restraint is Imperative”, *The Lancet*, 37 (959), 544-545


--- “Notices of the Lunatic Asylums of Paris”, *The British and Foreign Medical Review* vol. 19, 1845, 281-298

--- “On the Characters of Insanity”, *The Asylum Journal of Mental Science*, vol.1 (5) 1854, 68-71

Consbruch, Georg Wilhelm Christoph, *Klinisk handbok uti praktiska läkare-konsten*. Stockholm: Johan Pehr Lindh, 1813-1815


Cutter, Calvin, *The Female Guide*. West Brookfield, Mass.; Charles A. Mirick, 1844


Farrer, William, *A Short Treatise on Onanism or, the Detestable Vice of Self-pollution* (2nd ed.). London: Fletcher & Co., 1767


Friedrich, Johannes Baptist, *Systematisk handbok i juridiska psykologin för läkare och jurister*. Örebro: Lindh, 1839


*Författningar angående medicinalväsendet i Sverige*. Stockholm: Hilarion Wistrand, 1860

216
“Förhandlingar vid Svenska Läkare-Sällskapets sammankomster 1842”, *Hygieia* vol. 6, 10 Maj 1842


“German Psychiatry; an Introductory Lecture, read at the opening of the Psychiatric Clinique, in Zürich (Summer Session, 1863)”, *The Journal of Mental Science* Jan 1864, 9 (48) 531-547


--- “The Eberbach Asylum and the Practice(s) of Nymphomania in Germany 1815-1849”, *Journal of Women’s History* Vol. 9, (4), 1998, 35-52


Hadwen, Samuel, “Remarks on the Necessity of Restraining Certain Lunatics by Instrumental Means”, *The Lancet*, vol 34 (889), 12 September 1840, 904-907


Hedin, Sven A. *Handbok för praktiska läkare-vetenskapen*. Stockholm: Holmberg, 1797 (2nd ed.)


--- *Anleitung für angehende Irrenärzte zur richtigen Behandlung ihrer Kranke*. Leipzig: Vogel, 1825


Hills, William C. “Mechanical Restraint in Cases of Insanity”, *The Lancet*, 99 (2545), 8 June 1872, 810-811


Hurwitz, Brian, “Form and representation in Clinical Case Reports”, Literature and Medicine, 25 (2) 2006, 216-240

Huss, Magnus, “Fall af superi-drift (Dipsomania)”, Förhandlingar vid Svenska Läkare-Sällskapets Sammankomster. Stockholm: Norstedts, 1855, 133-135

--- Kan eller bör hufvudstaden längre undvara en väl ordnad kuranstalt för sinnessjuka? Stockholm: Beckman, 1853

--- Om brännwinsbegäret och brännwinssuperiet i Sverige. Stockholm: Norstedts, 1853

Hwasser, Israel, Om kikhosta: Academisk Afhandling för Medicinska Gradens erhållande utgifven af Ludvig Magnus Hjertstedt. Smålännings, På medic. auditorium den 26 april 1837. P. v. t. e. m. I delen. Diss. Uppsala: Leffler & Sedell, 1837

--- “Om äktenskapet” (1841), Valda Skrifter. Stockholm: Oscar L. Lamms Förlag, 1868

Jarrick, Arne and Johan Söderberg (eds.) Människovärdet och makten: Om civiliseringsprocessen i Stockholm 1600-1850. Stockholm: Stockholmia, 1994


Jones, Kathleen, Asylums and After: A Revised History of the Mental Health Services from the early Eighteenth century to the 1990s. London: Athlone Press, 1993

Kaula, Georg Hermann, Praktisk afhandling om genitalretning och pollutioner. Stockholm: Huldberg, 1873


Kjellberg, Gustaf, Om sinnessjukdomarnes stadier: Utkast till en psychiatrisk diagnostik. Uppsala: Edquist, 1863


Koch, Carl August, Den tjenligaste Diét och det mäst passande lefnadssättet för hömorrhoidalpatienter. Jönköping: Lundström, 1830


Lafontaine, August, Sederegler för qvinnokönet. Stockholm: For the author, 1820-1822


Laskar, Pia, Ett bidrag till heterosexualitetens historia: Kön, sexualitet och njutningsformer i sexhandböcker 1800-1920. Stockholm: Modernista, 2005


Linné, Carl von, Afhandling om brännwinets werkningar på menniskokroppen (1st ed. 1742). Jönköping: J.P. Lundström, 1831

--- Om sättet att tilhopa gå, reprint from an original ca 1740, 4th ed. Göteborg: Zinderman, 1979

220
Linnström, Hjalmar, *Svenskt Boklexikon 1830-1865*. II, Uppsala: Bokgillets Förlag, 1884


Lutheritz, Carl Friedrich, *Slagfluss och lamheter*. Jönköping: Lundström, 1829


McIntosh, William Carmichael, “On Some of the Varieties of Morbid Impulse and Perverted Instinct”, *Journal of Mental Science*, Jan 1866, 11 (56), 512-533


--- *Body and Will (2nd Ed.)*. New York: Appleton & Co., 1884


“Middlesex Magistrates and Lunatic Asylums”, *The Lancet*, vol 35 (897), 7 November 1840, 238-241


Nyström, Anton, *Om sinnesrubbning och menneskans förmåga att motverka detta sjukdomstillstånd*. Stockholm: J. Bäckman, 1878


Oest, Johann Friedrich, *Nödvändig underwisning och warning för ungdom af begge könen, rörande otukt i allmänhet och sjelfbefläckelse i synnerhet*. Lund: Berlingska, 1810


Otto, Carl, *Om bränvinets förderfliga verkningar på menneskans kropp och själ*. Lund: Lunds Nyktherhetssällskaps förlag, 1845


*Pharmacopoea Suecica* (7th ed.). Stockholm: Norstedts, 1869

Philalethes, “Cases of Insanity Requiring Restraint”, *The Lancet*, vol. 35 (906), 537-538


Reil, Johann Christian, *Rhapsodien über die Anwendung der psychischen Curmethode auf Geistes-zerrüttungen*. Halle: Curtschen Buchhandlung, 1803

*Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor*. London: Bradbury and Evans, 1844

“Reports of Lunatic Asylums, published between 1857 and 1858”, *The Journal of Mental Science*, Jan 1859, 5 (28), 157-222

Ribbing, Seved, *Om den sexuela hygienen och några af dess etiska konseqvenser*. Stockholm: Gernandts, 1889

Richter, Friedrich, *Äktenskapets mysterier: En handbok och rådgivare i alla de hemliga fall inom äktenskapet, i hvilka blygsamheten nekar muntlig förfrågan*. Stockholm: Flodins förlag, 1840


--- “Komplotten i Köpenhamn” in Roddy Nilsson and Maria Vallström (eds.), 
_Inspärrad: Röster från intagna på sinnessjukhus, fängelser och andra anstalter 1850-

Roberts, Andrew, _Index of English and Welsh Lunatic Asylums and Mental Hospitals._

Rosario, Vernon A., _The Erotic Imagination: French Histories of Perversity._ Oxford:
Oxford University Press, 1997

Rutkow, Ira M., _The History of Surgery in the United States 1775-1900 vol. 2._ San
Francisco: Norman Publishing, 1988

Sacklén, Johan Fredrik, _Sveriges läkare-historia._ Stockholm: Beckman, 1853

Sankey, William Henry Octavius, “Illustrations of the different forms of insanity”, _The
British Medical Journal_ 1 (215) 1865, 175-176

“Schools in Lunatic Asylums”, _The American Journal of Insanity_, vol. 1, 1844-1845,
326-340

Scull, Andrew, “The Social History of Psychiatry in the Victorian Era”, in Andrew
Scull (ed.) _Madhouses, Mad-Doctors and Madmen: The Social History of Psychiatry

--- _Social Order/Mental Disorder: Anglo-American Psychiatry in Historical
Perspective._ London: Routledge, 1989

---“Michel Foucault’s History of Madness”, _History of the Human Sciences_ 3 (1),
1990, 57-67

--- Charlotte MacKenzie and Nicholas Hervey, _Masters of Bedlam: The
Transformation of the Mad-Doctoring Trade._ Princeton: Princeton University Press,
1996

---- _The insanity of place, the place of insanity: Essays on the history of psychiatry.
London: Routledge, 2006

Sellberg, Per Einar, “Birgittas sjukhus i Vadstena”, in Gunnar Lundqvist (ed.) _Modern
svensk sinnessjukvård._ Stockholm: Modern litteratur, 1949

Harmless Operative Procedure” in Roger N. Lancaster and Michaela Di Leonardo
(eds.), _The Gender/Sexuality Reader: Culture, History, Political Economy._ New York:
Routledge, 1997, 9-15

225


Skae, David, “A Rational and Practical Classification of Insanity”, *Journal of Mental Science*, vol. 9 (47) 1863, 309-319


--- “The Morisonian Lectures on Insanity for 1873 (Lecture II)”, *The Journal of Mental Science* Jan 1874, 19 (88) 491-507


Sondén, Carl Ulrik, “Meddelande om ett sinnessjukhus i Bordeaux”, *Journalen*, 100, May 2nd 1834.

--- *Danviks dårhus: En uppfordran till vederbörande att tidsenligt reglera vården om Stockholms sinnessjuk*. Stockholm: Beckman, 1853

--- “Om de Svenska Hospitalernes ståndpunkt i förhållande till de i sednare tider utomlands upprättade Kurativ-anstalter för sinnessjuk”, *Hygiea* 7 (2), 1845, 113-130


226


Söderström, Mikael, *Svängstolen vid Vadstena hospital*. Stockholm: For the author, 1936


Tebbutt, Francis, *Letter to the Magistrates of the County of Middlesex from the Rev. Francis Tebbutt*. Printed for the magistrates only, London, 1841


Tullberg, Hampus, *Försäkelse-wännen, eller några ord om det brända winets styggelser, och om bästa medlet till den skadliga dryckens utrotande*. Malmö: B. Cronholm, 1851


Urban, Sylvanus, *The Gentleman’s Magazine*, vol 34. London: John Bower Nichols & Son, 1858

Urquhart, Alexander Reid, “Skae, David”, *Dictionary of National Biography 1885-1900*, vol. 52, 320


Vering, Albrecht Mathias, *Psychische Heilkunde I-II*. Leipzig: Barth, 1817-21
Waldenström, Paul Petter, “Strödda tankar i skolfrågor”, Pedagogisk Tidskrift II. Stockholm: E. Westrell, 1866, 144-145


Weill, Alexandre, Om jag hade en dotter att gifta bort. Uppsala: Es. Edquist, 1884


Willis, Francis, A Treatise on Mental Derangement: Containing the Substance of the Gulstonian lectures for May 1822. London: Longman, Brown, Green and Longmans, 1825

Winkler, Eduard, Amor och Hymen, eller, Kärlekens och äktenskapets afslöjade hemligheter (8th ed.). Stockholm: J.W. Holm, 1884

Wistrand, August T., “Om läkarebetyg öfver nyfödda Barn med hänsyn till svenska lagens stadgande om barnamord”, Hygiea 6, 1844, 132-143

--- “Om mordbrandsdrift”, Hygiea 1, 1850, 715-725

Withering, William, An Account of the Foxglove, and some of its Medical Uses. Birmingham: M. Swinney, 1785


Wretlind, Erik Wilhelm, Sexuella frågor ur medicinsk och social synpunkt. Stockholm: Hällsvännens förlag, 1901


Yellowlees, David, “Mechanical Restraint in Cases of Insanity”, The Lancet 99 (2547), 22 June 1872, 880-881

Zürn, A.B., Hephata!: Anvisning att i skolorna bekämpa sjelfbfläckelse-lasten. Västerås: D. Torsell, 1843

228
Öhrström, Wilhelm, “Tvångsmedel för sinnessjuk”, *Hygiea* 28, 1866
Index

A
Acton, William, 86, 99, 117, 211
Andrews, Jonathan, 10, 14, 20, 23, 50, 93, 150, 176, 211
Anjou, Carl, 31
Armstrong, David, 11, 13, 211
Ashley-Cooper, Anthony, 38

B
Bebel, August, 118, 212
Berg, Henrik, 3, 86, 104, 132, 212
Berrios, German Elias, 135, 175, 212
Bienville, D. T. De, 74, 85, 100, 103, 215
Björkén, John, 179
Björkman, Jenny, 10, 16, 19, 212
Björnström, Fredrik Johan, 17, 74, 75, 82, 86, 106, 117, 136, 212, 217
Blundell, James, 179, 213
Brandt, Thure, 123, 213
Braun, Jonathan, 122, 129, 212
Brown, Isaac Baker, 43, 77, 127, 179, 180, 188, 225, 228
Busfield, Joan, 15, 16, 20
Button, George Peacock, 44, 213
Bynum, William, 21, 36, 43, 77, 127, 178, 213, 224, 226, 227, 228

C
Carlsson, Carl Fredrik, 184, 185, 213
Catherine Jagiellon, 150
Charles IX, King of Sweden, 150
Charles XIV John, King of Sweden, 25
Clay, Charles, 179
Conolly, John, 32, 42, 43, 44, 45, 46, 51, 79, 119, 163, 164, 172, 184, 193, 205, 214
Consbruch, Georg Wilhelm, 74, 75, 76, 80, 108, 136, 176, 214
Cotton, Nathaniel, 41
Cowper, William, 41, 227
Cox, Joseph Mason, 37, 158, 175, 177, 178, 214
Cutter, Calvin, 68, 69, 214

D
Dahlberg, Johan Leonard, 70, 73, 74, 75, 83, 84, 85, 106, 152, 214
Debay, Auguste, 86, 214
Defoe, Daniel, 40, 41, 215
Digby, Anne, 10, 14, 20, 21, 211, 215

E
Eggeby, Eva, 25, 33, 215
Eivergård, Mikael, 18, 33, 34, 121, 215
Ekenstam, Claes, 86, 97, 107, 120, 215
Ekström, Carl Johan, 33, 163, 164, 215
Ellis, Charles William, 60, 117, 215
Eriksson, Bengt Erik, 24, 25, 26, 216
Esquirol, Jean-Dominique Etienne, 36, 37, 60, 74, 75, 82, 108, 112, 119, 122, 135, 136, 144, 181, 196, 216

F
Falret, Jean-Pierre, 51, 164, 181
Foucault, Michel, 10, 11, 12, 13, 14, 15, 16, 17, 18, 211, 216, 219, 222, 225

G
Gadelius, Bror, 85, 217
Garborg, Arne, 69
Garpenhag, Lars, 10, 19, 217
Gay, Peter, 88, 217
Goffman, Erving, 12
Goldberg, Ann, 7, 20, 21, 144, 217
Groneman, Carol, 7, 217
Gustav Vasa, King of Sweden, 25
Göthlin, Gustaf Wilhelm, 7, 31, 59, 62, 69, 80, 84, 105, 113, 120, 129, 130, 142, 144, 150, 152, 155, 157, 167, 173, 181, 184, 191, 194, 196, 205

H
Harding, Gösta, 17, 217
Hartman, Carl Johan, 136, 218
Hedin, Sven Anders, 74, 75, 108, 176, 218
Heinroth, Johann Christian August, 37, 74, 76, 112, 218
Hill, Robert Gardiner, 42, 43
Hjertstedt, Ludvig Magnus, passim
Huss, Magnus, 25, 34, 64, 82, 164, 219
Hwasser, Israel, 30, 60, 108, 117, 120, 121, 219

J
Jewson, Nicholas, 13, 219
Johannisson, Karin, 17, 18, 59, 75, 87, 132, 135, 219

K
Kjellberg, Gustaf, 74, 75, 82, 106, 182, 184, 213, 220
Kjellberg, Isidor, 184, 213
Kleinman, Arthur, 102, 220
Knös, Gustaf, 18, 31, 151, 153, 154, 221
Krafft-Ebing, Richard von, 67, 84, 122, 220

L
Laing, Ronald David, 12
Laqueur, Thomas Walter, 21, 107, 173, 220
Laskar, Pia, 136, 151, 220
Lombroso, Cesare, 67, 84, 221

M
MacDonald, Michael, 10, 11, 107, 221
MacKenzie, Charlotte, 21, 23, 39, 221, 225
Mansén, Elisabeth, 3, 18, 42, 221
Marland, Hilary, 39, 221
Maudsley, Henry, 67, 222
Mayer, Alexandre, 86, 222
McDowell, Ephraim, 179
McIntosh, William Carnegie, 83, 136, 151, 221
Mitivié, Jean-Étienne-Furnance, 181, 221
Monro, Edward Thomas, 51, 180
Morel, Benedict Augustin, 67, 122, 136, 222
Morison, Alexander, 44, 51, 135, 136, 177, 180, 222
Mosucci, Ornella, 179, 222
Möller, Carl Fingal, 148, 222

N
Nilsson, Ulrika, 123, 179, 183, 222, 225
Nostitz und Jäckendorf, Gottlob Adolf Ernst, 36
Nyström, Anton, 75, 82, 119, 153, 155, 223

P
Pienitz, Ernst, 36
Pinel, Philippe, 23, 36, 37, 112, 159, 160, 175, 176, 181, 195, 223, 228
Porter, Roy, 11, 12, 13, 14, 17, 21, 23, 43, 77, 178, 181, 211, 213, 219, 223, 224, 226, 227, 228
Prichard, James Cowles, 65, 82, 224

Q
R
Reil, Johann Christian, 37, 76, 112, 224
Ribbing, Seved, 69, 86, 87, 108, 132, 224
Richter, Friedrich, 65, 224
Riving, Cecilia, 3, 10, 14, 15, 16, 17, 19, 57, 67, 76, 98, 102, 103, 183, 224
Rosario, Vernon, 14, 73, 107, 118, 122, 127, 135, 173, 220, 225

S
Scull, Andrew, 12, 15, 17, 21, 23, 40, 42, 43, 222, 225
Seidelin, Johannes Henrik, 35
Showalter, Elaine, 20, 85
Skae, David, 110, 111, 112, 226, 227
Sköldberg, Sven, 179
Small, Helen, 20, 79, 167
Stagnelius, Erik Johan, 150
Strindberg, August, 69, 223
Suzuki, Akihito, 15, 19, 43, 57, 226
Szasz, Thomas, 12, 15, 227

T
Tebbutt, Francis, 44, 227
Thorild, Thomas, 150

Tomes, Nancy, 13, 43, 227
Tukey, Daniel Hack, 83, 89, 101, 136, 137, 177, 178, 213
Tukey, Samuel, 23, 43, 160, 227
Turner, Bryan Stanley, 16, 227

V
Vering, Albrecht Mathias, 37, 112, 227

W
Wakley, Thomas, 43, 172
Waldenström, Paul Petter, 121, 228
Walton, John, 21, 228
Winkler, Eduard, 65, 228
Wistrand, August Timoleon, 25, 26, 119, 123, 216, 222, 228
Witt, Otto Manderup, 58, 60, 61, 63, 75, 101, 109, 110, 118, 119, 136, 228
Wretlind, Erik Wilhelm, 59, 86, 120, 132, 228
Wright, David, 15, 21, 212

Y
Yellowlees, David, 172, 228

Z
Zola, Émile, 69

Ö
Öhrström, Wilhelm, 17, 31, 46, 49, 217, 229