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Crime, Victim and Perpetrator: The Attitude to Sexual Assault Against Children, 1850–1910

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At the outset of the 1980s, incest and sexual assault against children became the subject of serious discussion in Sweden and, although the problem had already been the object of several Swedish studies, it was now seen as something new by many people.¹ Despite this common apprehension, forensic, sexological and medical literature began dealing with sexual child abuse as early as the middle of the 19th century.

In bourgeois culture, childhood was idealized and described as a period of innocence and vulnerability. However, closer examination of the living conditions of children brought child labour, the maltreatment of children, prostitution and sexual abuse into focus, too. While child labour, prostitution and maltreatment were seen as social questions, sexual abuse became a question for medical science. In medical publications the underlying causes of the crime were sought in the state of the mental health, sexual drive and social conditions of the perpetrator. The possible complicity of the child itself was also discussed.

Did these ideas lead to any changes in legal or medical practise? Were a larger number of crimes brought to trial? Was the mental health of the perpetrator examined? Which conceptions of the crime, the victim and the perpetrator were reflected in legal and medical discourse and practise? In this paper, I will try to shed some light on the present-day Swedish discourse on sexual assault against children, by focusing on ideas broached by early sexology, forensic psychiatry, witness psychology and psychoanalysis, and the extent to which these ideas were reflected in legal practise.

Sexuality, children and science

In the first decades of the 19th century, Malthusianism became an integral component of middle-class ideology in England. Sexual restraint was seen not only as proof of self-discipline and refinement, but also as a sign of social responsibility and a way of obtaining social, psychological and physical well-being. In the 1850s, a debate was initiated regarding the relationship between health and sexual restraint. Physician George Drysdale maintained that carnal needs were as “morally elevated” as intellectual and spiritual ones. Moreover, suppressing the sexual drive could have dangerous consequences, especially for men.² Criticism against repressive sexual morality was initially expressed by radical artists and intellectuals, but human sexuality soon became a scientific field within medicine. The sexologists set out to study human sexual life in a scientific manner, free from moralising. Since the sexual drive was a natural phenomenon, it had to be accepted as it was. If it could not be satisfied in a natural way, it would seek satisfaction through acts of perversion.

As a result of the transition from peasant to industrial society, social problems increased, especially in England and other countries which had become industrialized at an early stage. Philanthropic organisations were established all across Europe, with the aim of coming to the aid of proletarian women and children. Sexual assault on children was among the problems discovered by the philanthropists.³ They worked chiefly among the working class, but sexual assault occurred in the middle and upper classes as well.

During the course of the 19th century, the concept of the innocent, defenseless child reached its culmination and became a part of bourgeois ideology. The child was in fact the main project of the bourgeois family. But this did not mean that children were better treated than before. On the contrary, the idealization of childhood increased the pressure on real flesh-and-blood children. Within the middle class, the relationship between children and parents was built on emotions pregnant with erotic elements. Concealed behind a façade of happiness and harmony was often a reality filled with frustration, violence and anguish.⁴

The new concept of childhood was rife with contradictions. The child was seen as both innocent and potentially vicious, and therefore in need of protection, control and character — building fosterage. Consequently, the living conditions of children were focused on as probably never before. As a result child labour was forbidden by law.⁵ Another result was that attention was paid to child abuse and sexual

assault against children, mainly by the medical profession. Why? After all, sexual assault is not primarily a medical matter, but a legal one. During the 19th century, medicine confirmed and entrenched its scientific status. New medical disciplines developed, including sexology, medical jurisprudence and forensic psychiatry. This rapid development consolidated the position of medical science and like other contemporary sciences it incorporated quantitative techniques. Patients were meticulously examined – the physician weighed, calculated, measured, and observed – and clinical findings were statistically analysed. The resulting mean was seen as normal and healthy, while that which diverged from the mean was defined as unhealthy. The borderline between health and sickness was examined and normality was established scientifically.

In the interaction between physician and patient, the latter was reduced to a scientific object. With his penetrating gaze, the physician could see through his patient, diagnose the patient's condition and prescribe proper treatment. The medical doctor became a figure of unprecedented authority. This manifested itself in medico-legal practise, where medical judgement also carried legal validity. The medico-legal expert acquired a double status: While his knowledge and competence (as well as his profession) was medical, his task was neither to cure nor to save life, but to assist the judiciary. For him the human body was but an object, a source of truth about guilt and crime. And one of these crimes was sexual assault against children.

The medico-legal debate

In the mid-19th century, sexual assault against children began to be discussed in medico-legal publications. The debate seems to have been initiated by Ambroise Tardieu, professor of medico-legal medicine in Paris, who in several publications attempted to contextualise the many cases of sexual child abuse he had come across in his role as medico-legal expert.⁶ These publications started a heated debate within forensic medicine.⁷

According to Tardieu's studies, sexual violence against children was on the increase, particularly among children under six years of age.⁸ The higher the offender's age, the younger the victim seemed to be. In many cases there was a blood relation between perpetrator and child, usually father-daughter.⁹ Tardieu generally assumes that the offender is male and the victim female. In conformity with contemporary opinion about male and female sexuality, he considers men

as playing the active role in the sexual act. Boys are only mentioned as victims when the perpetrator is a woman, which according to Tardieu's studies is extremely rare.¹⁰

Ambroise Tardieu distinguishes between rape and other kinds of sexual assault, and stresses the fact that only rape leaves obvious signs on the child's body.¹¹ However, sexual assaults against children are usually excesses without penetration. The examining doctor must be aware of the fact that an assault may have taken place without leaving any physical traces.¹²

Furthermore, Tardieu polemicizes against the common opinion that a majority of the accusations are false. In most cases, the facts indicate that a sexual assault has actually taken place.¹³ A different opinion was expressed by Paul Brouardel, Tardieu's successor to the chair of forensic medicine, who stated that 80% of the accusations were in fact unfounded.¹⁴ The examining physician must therefore harbour scepticism towards accusations that cannot be proven by objective facts, such as genital injury.¹⁵ Many physicians and psychologists shared Brouardel's attitude. According to forensic psychiatrist Auguste Motet, children are easily influenced and imaginative and therefore untrustworthy. Sometimes a child even lies and simulates an assault, in order to extort money from the accused man.¹⁶ A similar opinion was held by forensic physician Alfred Fournier, who stated that unmasking and reporting cases of simulation and false accusation was a crucial task of the medico-legal expert.¹⁷

Consequently, the trustworthiness of children became a central question of the day and the object of several scientific studies beginning in the 1890s. One of the most extensive research projects was carried out by the famed psychologist Alfred Binet in 1900, who stated that most children were far too easily influenced to be considered trustworthy in the legal sense.¹⁸ At the turn of the century, the discipline of witness psychology developed in Europe, with German psychologists at the fore. In this discourse, men were seen as more reliable than women, and adults as more reliable than children. Most reliable of all was an adult man, least reliable an adolescent female. Naturally, these ideas influenced attitudes toward accusations of sexual assault against children.¹⁹

Focus on the perpetrator

Sexual assault against children had been a central concern of French forensic medicine since the 1850s. However, thus far very little attention had been paid to the perpetrator. An important question was: What kind of person was capable of sexually assaulting a small child? Answering this question became a task for the early sexologists and forensic psychiatrists.

Early sexologists like Richard von Krafft-Ebing and Havelock Ellis viewed sexual assault primarily as an unfortunate result of an unsatisfied and irresistible male sexual drive. Male sexuality is by nature aggressive and impatient, and subordination of the sexual object – the woman – is a crucial element in the sexual act. If not satisfied in a normal way, i.e. sexual intercourse with a woman, sexuality is forced to seek other outlets. As children are both charming, trusting and available, these unfortunate men may easily turn their desire toward them. Hence, the only difference between the sexual offender and the man in the street is one of degree.²⁰

Moreover, Krafft-Ebing states that sexual child assault is a perverted act, though this does not mean that the perpetrator is mentally deranged. The offender may very well be a normal man seeking new types of sexual excitement. Sexual crimes against children are seldom caused by pedophilia – abnormal fondness for children – but rather by an increased sexual drive in combination with mental and moral weakness, manifestations of e.g. senile dementia, epilepsy or alcoholism. Pedophilia is one thing, sexual assault against children quite another.²¹

Richard von Krafft-Ebing and Havelock Ellis refuse to consider sexual child abuse as the result of a sick mind or as a class-bound crime. However, early German forensic scientists disagreed. In their opinion sexual assault against children was either the result of a pathological mind, or a consequence of poverty, unemployment, overcrowded living conditions and cultural destitution.²²

According to these forensic psychiatrists, the perpetrator might also have been tempted by a seductive girl; this did not render him blameless, but should be taken into account as an extenuating circumstance. Conversely, boys are never seen as capable of seductive behaviour but exclusively as blameless victims.²³ Either way, in the end the general opinion was that sexual assault, if not too violent, rarely led to severe and permanent damage to the child.

In other words, regardless of whether the offender was mentally disordered or not, both sexology and forensic psychiatry refused to hold him fully responsible for the assault. These ideas also emerged in practical contexts, particularly in legal usage.

In Swedish courtrooms

Swedish legislation against incest and “indecent assault on a minor” was rigorous, and the law prescribed severe punishment. Between 1734 and 1864, sexual intercourse with girls under 12 years of age was ranked in the same category as rape, and thus punishable by death. After 1864, the law no longer imposed death penalty, but the punishment was still severe. If the girl was under 12 years of age, criminal law prescribed 4 to 8 years’ imprisonment, longer if she had been injured. For sexual intercourse with a girl 12 to 15 years of age, the law imposed imprisonment for between 6 months and 2 years.²⁴

Incest between parent and child was regarded as a grave crime, for which the law prescribed long imprisonment at hard labour. Incest was seen as a crime with two perpetrators, and consequently both the adult and the younger party were penalised. Since underage children were not criminally responsible, the law – in order to be able to punish the younger party – required that the child had reached the age of 15 when the incestuous act had taken place. However, the law neither took under consideration whether incestuous assaults had begun when the child was still very small, nor if violence and threats had preceded the criminal acts.²⁵ All sinners must be punished. Behind this outlook one can distinguish a strict taboo, with its roots in Judeo-Christian law and morality. The crime of incest was not committed against a person or the state, but against nature and God Himself. A similar point of view is also expressed in relation to other sexual crimes, such as bestiality and sodomy.

Thus in Swedish legislation, both incest and sexual child abuse were seen as serious crimes. Despite this, prison lists and court records from 1850–1910 show that remarkably few sexual crimes were brought to trial in Sweden, and only rarely sexual crimes against children.²⁶ This is also confirmed by official statistics; during the period in question, only a few cases of incest and sexual assault against children appeared before the court each year, with a slight increase after the turn of the century. Furthermore, I have not been able to discover a single case in which the victim was a boy. This is however logical, since existing law only mentions underaged females.²⁷ In Swedish

legislation as well as in early forensic medicine and sexology, boys were not seen as potential victims of sexual crime. It is also interesting that no significant difference between urban and rural areas can be detected.²⁸

Since children, especially young girls, were not considered reliable witnesses, their stories were met with scepticism in court. The result was that the accused was often found not guilty, sometimes despite the existence of eyewitnesses to the criminal act itself. I have found no case in which a conviction was based solely on the child's statement. Furthermore, it is obvious that girls are considered less trustworthy than men, and there are also indications that the courts were more sceptical towards a woman's testimony than a man's, particularly if the woman's morals could be challenged.²⁹ In fact, for conviction the courts seem to require a confession from the accused man himself. In some cases the verdict seems totally incomprehensible. An incest case from 1904 between a father and his underaged daughter may serve to illustrate this. The daughter is pregnant, and no evidence whatsoever indicates that she has had sexual intercourse with anyone other than her father. Not even the father expresses any such suspicions. In spite of this, and although there are disclosing, concordant and unequivocal testimonies, the father is found not guilty due to lack of evidence.³⁰

If the court finds the accused guilty, it imposes between 6 months and 6 years' imprisonment at hard labour, depending on circumstances and the age of the victim. Sometimes a guilty verdict in the lower court is appealed and later reduced or rejected in the appellate court. At times there is a striking discrepancy between the verdicts of the lower and superior courts. From its very beginning, the superior court in Sweden had a supervising and mitigating legal function. But this is insufficient for explaining the discrepancy. Court records reflect a disagreement between lower court and superior court, which seems to be founded on two different attitudes to crime, guilt and punishment, namely a "traditional" and a "modern" one. The court of first instance was manned by laymen who probably arrived at their judgements in accordance with Tradition and Law. In lower courts there was probably very little patience for "new-fangled" ideas on crime, guilt and punishment. The members of supreme courts usually had an extensive juridical education, which probably made them more receptive to modern ideas from forensic psychiatry, witness psychology and criminology than their colleagues in the lower courts. This could explain the remarkable discrepancy between the verdicts made on the two legislative levels.

In another case from 1904, the lower court sentences a young man to five years' imprisonment at hard labour for indecent assault on a ten-year-old girl. The man comes from an affluent family, while the girl is the daughter of a poor crofter. The case seems as clear as day – several persons have actually witnessed the criminal acts. Yet the man appeals to the superior court and for more than a year the case is cast back and forth between the two legislative levels. In letters, appeals and verdicts the evidence and testimony of the witnesses is evaluated and challenged. The credibility of each and every witness is questioned and objections are raised. Nothing new turns up. However, the superior court does not deem the testimony trustworthy, apparently because the witnesses are women and children. This upsets members of the lower court, who criticise the decision of the higher court. More than once the polemic becomes very sharp. Yet finally, when the superior court closes the case, the man is found not guilty due to lack of evidence.³¹

The results of the medical examination of the child is a major factor in all cases concerning indecent assault against children. This examination is usually conducted by a general practitioner, who delivers a report to the court. The discovery of genital injuries is crucial to the outcome of the case, but no comments are made regarding possible mental or emotional wounds. In all the cases I have come across, the examining physician reports that there are no obvious signs of violence to the child's body. We have seen that as early as the 1850s, French forensic experts paid attention to the fact that sexual assault against children seldom leaves traces on the victim's body. However, this does not yet seem to have influenced general practitioners in early 20th-century Sweden. Only occasionally does the examining physician point out that absence of injury does not necessarily mean that a crime has not been committed.³² In 1904, two doctors provide the court with contradictory answers to the question of whether coitus could have taken place without complete penetration.³³ In this case, the medical statement appears to be a personal opinion and not as a scientific truth. This must have been controversial in a time when medicine claimed to be an objective science, based only on solid facts. In forensic medicine, this attitude was probably more palpable than in other medical disciplines, since the opinion of the medico-legal expert was also given legislative validity.

However, nothing indicates that the courts lay any blame on the child, even if she had been proven to have taken the initiative to the forbidden act. If the child is under the age of 15 then the specific

circumstances do not matter; the adult man is held solely responsible for the crime. In several cases of incest between father and daughter, the daughter was found not guilty even if she was 15 years old when incestuous acts took place. If she resisted, if the acts had begun when she was underage or if the father used violence, then the courts avoided convicting the daughter or at least imposed only a light sentence on her.³⁴

According to court records, the courts do not take into consideration whether the perpetrator had been drunk at the time of the crime, which – as we shall see – was a crucial point in the forensic psychiatric examinations. This silence indicates that forensic ideas about a close relationship between alcohol and crime had not yet begun to influence Swedish lower courts. This is noteworthy, since such ideas had been expressed and accepted in European medicine, criminology and forensic psychiatry for quite a long time. In Swedish lower court rooms, intoxication was rather seen as an aggravating circumstance.

In court records from the period 1850–1910, very few comments are made about the mental health of the accused. It is obvious that forensic psychiatry had not yet influenced Swedish legal practise.

In the eyes of forensic psychiatrists

Already during the 18th century, physicians occasionally commented on the mental health of a person accused of having committed a crime, but the legislative status of medico-legal opinions was unresolved for a long time. When psychiatry evolved into a medical discipline, confidence in psychiatric perspectives and methods increased, which meant that physicians and psychiatrists exercised more influence over the administration of justice.

Since 1826, the law obliged the court to order an examination of the state of the accused's mental health if it suspected mental derangement.³⁵ At the time Sweden boasted no psychiatrists working solely within the psychiatric field, and consequently no forensic psychiatrists either. The examinations were usually carried out by general practitioners or prison doctors. Knowledge of mental diseases was still very limited, and in order to obtain a trustworthy opinion all examination reports were scrutinized by an official body, the National Board of Health, which delivered a final opinion to the court. However, the courts were not obliged to act in accordance with its opinion.³⁶

Early forensic examinations focused principally on the accused's reputation, lucidity and clarity of speech. During the 19th century, forensics concentrated on a general judgement of understanding and responsibility. The idea of an obvious connection between intellect and mental state was gradually challenged, and it was emphasized that a person could be mentally disordered even if he or she seemed both lucid and sensible. At the turn of the century a close relationship between certain crimes and certain mental disorders was regarded as an established fact by forensic experts. The crime itself not only proves whether the perpetrator is mentally ill, but is also indicative of the mental disorder he or she suffers from.³⁷ Naturally, this idea influenced the attitude of forensic psychiatrists toward sexual assault against children.

Initially, the National Board of Health delivered only a few forensic reports annually, which indicates that the courts seldom put the law of 1826 into practice.³⁸ Sexual crimes are not among the criminal acts leading to forensic examination during these first five decades, and only after the turn of the century can we find more than occasional forensic reports concerning sexual crimes. Obviously, sexual assault against children did not lead to forensic examination, as did murder, arson, infanticide, violence against parents and trespassing. The question is why?

Before the turn of the century, the image of the sexual offender was very unclear, and it was not an established fact that he was very likely mentally ill. French medico-legal experts did not see sexual child abuse as pathologically determined. Perpetrators are often described as infantile, unintelligent, and addicted to alcohol, but not as mentally disordered or deficient. Richard von Krafft-Ebing stated that sexual offenders have an increased sexual drive, and if the victim is a child, mental illness could very well be the explanation. Havelock Ellis considered sexual assault against children to be merely an abnormal manifestation of a normal tendency in human sexual life. Unlike Krafft-Ebing he did not recognise any psychopathological grounds for this crime. Krafft-Ebing had a strong position within European psychiatry and sexology during the second half of the 19th century, and it is obvious that his ideas also reached psychiatrists in Sweden.³⁹ However, for a very long time his theories do not seem to have exercised any influence on Swedish legal practise.

During this early period there seems to exist uncertainty about how to view sexual relations between adults and children. Are they basically criminal acts or sexual acts? Can you compare these acts

with exaggerated or misdirected sexual behaviour, as homosexuality was apprehended at the time? Should all sexual acts between adults and children be regarded as criminal assault? Should the cause of the crime be sought in increased sexual drive, criminal tendency, lax morals or mental disease? In other words—is it in fact a crime with which we are dealing?

After the turn of the century, it became more common to view a child abuser as mentally ill or deficient. As in Germany, forensic psychiatrists began referring to mental deficiency, senile dementia, epilepsy and other psychopathological conditions.⁴⁰ At this point forensic examinations of sexual offenders began to be performed. The first forensic report concerning sexual assault on children dates from 1900, and the next one does not occur until two years later.⁴¹ During the period 1903–1910, only a handful of forensic examinations of men accused of sexual child assault were carried out annually. This low figure indicates that examinations were ordered only if the court clearly suspected that the offender had not been in full possession of his senses at the time he committed the crime.

Forensic judgement was based on two criteria. Firstly, whether the offender had been in full possession of his senses at the time of the crime. Secondly, whether treatment could lead to correction or not. Though there was no legal authority for the latter, several forensic psychiatrists at the time stated that it was this above all that should be conclusive when making forensic judgements.⁴² Usually the National Board of Health arrived at the conclusion that alcoholism or mental deficiency was the cause. A majority of the accused men came from the working class, and if an accused was wealthy or/and well-educated, this elicited special commentary. The diagnoses are to some extent class related. When mental deficiency or dementia is stated, the case usually concerns working-class men. If the accused comes from higher social strata, the diagnosis is more often epilepsy, neurasthenia, moral insanity or mental illness.

In more than 50% of the cases concerning sexual child assault during this period, the accused was declared exempt from punishment, in accordance with Criminal Law of 1864, § 5:5 and § 5:6. If the offender was regarded as dangerous, or suffered from a mental disease, or at least was clearly receptive to correction, he could be sent to a mental hospital. If not, he returned home. However, at the time this was for the the National Board of Health to decide, not the court.

The examining physicians often based their judgements on testimony from people close to the accused. This was in compliance with forensic praxis at the time. In an appendix to the Mental Health Service Law (1901), the examining physician was advised to obtain information from "the sick person's" relatives and friends. They were to express an opinion about the accused's mental health, signs of illness, disposition, abuse of alcohol, mental derangement in the family, general abilities and possible cause of mental illness.⁴³ Sometimes the family bore witness to past illness that transformed the accused's personality, somatic weakness or epileptic attacks. Sometimes the accused himself complained of headache, abnormality or mental derangement.⁴⁴ The examining doctor also tried to form an opinion on the alleged perpetrator's sexual life. Therefore he investigates the accused's relations with his wife or fiancée, if his sexual drive is strong and possible to control, perverse tendencies and whether he is a "masturbator".⁴⁵ Sometimes family and friends report sexual perversities or criminal sexual behaviour, such as indecent exposure, attempted rape, bestiality or masturbation, also seen as signs of mental illness.⁴⁶ The traditional conception of injurious masturbation was expressed by the physician as well as by the accused, his relatives and friends. There are numerous indications that both offenders and witnesses are aware of medico-legal theories about crime, guilt and mental health.

However, it became increasingly common that the physician examined the alleged perpetrator himself, both physically and mentally, in accordance with the instructions in the Mental Health Service Law. The body and skull is carefully measured, all by the book.⁴⁷ This procedure is in accordance with contemporary criminology, as well as with those aspects of physiognomy and phrenology that remained important elements of human science.⁴⁸ The body was meticulously examined, and an opinion on the patient's general condition was made. Comments such as "loose flesh" and "slack posture" are not uncommon.⁴⁹ Physical health was at the time closely related to mental health, and it was stated that physical weakness could cause, or be a sign of, mental weakness.⁵⁰

After the physical examination, the physician would judge the patient's mental condition and intellectual capacity. Facial expression, movement pattern, speech and demeanour were commented upon.⁵¹ The accused's behaviour while being examined was closely observed and noted; was he restless, obsessive, agitated, anxious? Intellectual capacity was judged according to conversational skills and general

knowledge questions, concerning e.g. the name of the months, the name of the king and crown prince or basic facts about farm work. If unable to answer, the accused was often diagnosed as an "imbecile".⁵²

The accused's attitude to the crime and its consequences was significant in these examinations. Indifference and a strong sense of guilt alike are seen as signs of mental derangement. A sound, normal man should be able to control his feelings, since lack of emotional control was seen as a female characteristic. The accused had to be remorseful, but in a moderate and stoic manner without losing emotional control. These ideas are often clearly expressed in forensic reports.⁵³ In some cases the physician stresses the accused's lack of ethics and character, along with his inability to distinguish right from wrong.⁵⁴ This corresponds to the diagnosis "moral insanity", which was frequent at the time. In some reports the crime itself is seen as a sign of mental derangement. An act of this kind – child assault – could not be committed by a mentally healthy individual, and therefore there must be a psychopathological explanation. As stated above, a similar opinion was expressed by the sexologist Krafft-Ebing and contemporary German forensic psychiatrists. Sometimes the quest for an psychopathological explanation seems almost preposterous. In a case from 1909, a man is accused of sexual assault against a six-year-old girl. The forensic examination shows that he is intelligent, has a normal emotional life, is hard-working, has a good reputation and calm and decent manners. No perverse tendencies whatsoever can be discovered. What psychopathological explanations could there possibly be for this awful crime?

According to his mother, the accused injured his head severely at the age of three, but this does not lead the examining physician to draw any conclusions. The man himself testifies that there is a history of alcoholism in the family, and that he becomes muddle-headed after drinking. He has also been treated for alcohol abuse. His friends testify that he sometimes behaved strangely after consuming alcohol, occasionally not even remembering what he has done. According to the arresting officer, the accused was upset but not drunk at the time. However, his breath indicated that he might have been drinking a few hours before performing the criminal act. According to the forensic report, the man suffers from dipsomania and committed the crime in a state of pathological intoxication. Obviously the physician feels sympathy for him, and points out that he has a "nice and friendly appearance", that this criminal behaviour is totally unlike him and

that he has expressed regret for what has happened. The man was found not responsible for his actions, and therefore discharged without penalty.⁵⁵

Three diagnoses are especially interesting, namely "epilepsy", "senile dementia" and "dipsomania". The relationship between sexual crime and epilepsy was generally accepted by both forensic psychiatrists and sexologists at the time. Epilepsy was believed to increase the sexual drive, and at the same time cause mental deficiency. Furthermore, the crime itself was seen as a symptom of the disease. If there were indications of epilepsy, the offender was usually discharged without penalty. It was not necessary for the physician to have seen the accused suffer an epileptic attack with his own eyes; it was not even necessary that anyone else had witnessed an attack. In fact, it sufficed that the accused himself certified that he had suffered "strange attacks" once or twice in the past.⁵⁶ The same remarkable situation can be noted in England and Germany; the suspicion itself was enough to absolve the offender from guilt. At the time the only certain sign of epilepsy were the attacks themselves, and the physician was therefore reduced to relying on these testimonies in order to make a diagnosis. Since epilepsy was seen as absolutely crucial to the judgement, this diagnosis was sometimes far too easily resorted to.

The same can be said about the diagnosis "senile dementia". Old age was seen as an extenuating circumstance, and the crime itself was understood as a symptom of dementia. Both epilepsy and dementia were common diagnoses in forensic reports concerning child assault. So was "dipsomania", periodical abuse of alcohol. If the accused could show that he had been drunk when committing the crime, the forensic physician would in all likelihood find him "not in full possession of his senses" and therefore not responsible for his actions. Sometimes the reports refer to "pathological intoxication" or "acute alcoholic poisoning".⁵⁷ Consequently, discovering that the offender suffered from alcoholism, and that he was inebriated at the time of the crime, was a crucial factor in all forensic reports concerning child assault.

The borderline between senile dementia and ordinary infirmity due to old age, as well as between imbecility and "silliness", is very unclear. So is the dividing line between mental illness and eccentricity. Contemporary forensic psychiatry emphasized the importance of examining the interface between sickness and health. It was stated that there were some conditions that could not be classified as mental illness but were still significant from a medico-legal point of view.

This opinion is clearly expressed in forensic reports, where the borderline between normality and abnormality is fluid and the diagnosis often is based on subtle personal judgement. In this respect, psychiatry in general and forensic psychiatry in particular held an exceptional position within medical science. As we have seen before, medicine was viewed at the time as a natural science and consequently deeply rooted in positivistic ideals and quantitative methods. For obvious reasons, psychiatry had difficulty being accepted as a scientific discipline; for forensic psychiatry the difficulties were probably even greater. The most important task of forensic psychiatry was to examine the borderline between mental sickness and health, and since no truths or even guiding principles existed, responsibility rested solely on the sound judgement of the individual forensic physician. Furthermore, the opinion expressed by forensic psychiatrists had obvious consequences for society, consequences that might prove to be fatal.

We have seen that the courts did not lay any blame on the child, and the same can be said about forensic psychiatry reports. Occasionally the accused tried to blame the child, in one case pleading that the nine-year-old girl “expressed a wish to have sexual intercourse with him”. The court ignored this assertion.⁵⁸ The choice of words found in the court records may indicate some unwillingness on behalf of the courts to see men as fully responsible for their sexual behaviour. Very often an underaged girl is referred to as a “woman”, while a male of 16 years is still a “boy”.⁵⁹ This is consistent with the contemporary bourgeois perception of childhood. Girls were apprehended as having reached adulthood much earlier than boys. However, in these reports there is no sign of a tendency explicit in German forensic psychiatry to see the girl as an accessory to the act of sexual indecency. If the man was “in possession of his senses” at the time of the crime, then he alone was responsible for the actions. The behaviour of the girl was not considered relevant.

Conclusion and epilogue

Coming into contact with forensic medicine, sexology, forensic psychiatry and Swedish legal practise from 1850 to 1910 has been a fascinating experience for me. The discourse on sexual assault against children seems very familiar, despite the passing of nearly a century.

After the turn of the century, increasing numbers of alleged perpetrators were examined by forensic psychiatrists, often a general practitioner or a prison doctor. In their reports, the perpetrator is

markedly often adjudged to not be “in full possession of his senses”, and therefore not responsible for his actions. Inspired by theories of heredity and degeneration, the medico-legal experts usually explained sexual crimes with psychopathological arguments. A person who had assaulted a child was often considered mentally ill, and the cause of this illness was assumed to be either hereditary disposition or social penury. Consequently, the perpetrator stood in focus, and very little attention was paid to the vulnerable child. The general opinion was that sexual assault did not damage the child mentally, at least not permanently, and therefore the child victim required no special treatment. The perpetrator, on the other hand, was found mentally deranged and in urgent need of psychiatric care.

The state of ill health referred to by early sexologists and forensic psychiatrists had very little to do with sexual disposition or even sexual perversity. A person who assaulted a child was believed to suffer from mental deficiency, senile dementia, epilepsy or dipsomania, but rarely of pedophilia, i.e. pathological and abnormal fondness for children. Furthermore, far from every child offender was mentally ill. Perfectly normal men were capable of performing perverted acts, too. It was stated that when the strong sexual drive of an adult man was not satisfied in accepted ways, it would seek other outlets. Male sexuality is dominant and demands subordination; a child's powerlessness and innocence may therefore have a sexually stimulating effect on ordinary men. Consequently, sexual assault against children was seen basically as an act of power with sexual overtones. Pedophilia was something else altogether.

Swedish legislation relating to sexual assault against children was rigorous, but the accused was seldom brought to trial. The court often did not believe the child's story; the same can probably be said about adults in general. It was in fact commonly held that children often made false statements out of a desire for revenge, blackmail, or the inability to distinguish between reality and fantasy. If a child's statement was to lead to the filing of a police report, legal prosecution and ultimately, a guilty verdict, then the evidence submitted needed to be extremely strong.

In German forensic psychiatry, girls were often seen as accessories to criminal sexual acts and the victim was often described as the real perpetrator. Precocious and seductive girls can entice a perfectly normal and ordinary man into performing indecent sexual acts, which must be seen as an extenuating circumstance. As we have seen, it took a long time before these ideas began influencing Swedish legal

practise. Neither the courts nor forensic psychiatrists lay any guilt on the child at this time. If the perpetrator was found to be in full possession of his senses, as an adult he was held solely responsible for the forbidden activities.

In the 1930s, sexual assault against children became the subject of serious discussion in Sweden, both in government inquiries and in legal, psychological, forensic and medical literature. Having previously apprehended incest as a crime involving two perpetrators, it was now being described as a sexual assault involving a perpetrator and a victim. In this discourse there is a shift in meaning between incest and sexual assault against children. Attention is mainly paid to the crime of incest, but the reasoning is extended to also include sexual child assault in general. This was the case in the so-called "Incest Inquiry" of 1935.⁶⁰ In 1937, a new law regarding sexual crimes came into force, which in some respects reflected a different view of child assault. In cases of incest, the younger party was declared exempt from prosecution, if she or he had been under 18 years of age when the act occurred. Moreover, the age of consent was raised from 12 to 15 years of age, and the word "child" replaced the term "underaged female".⁶¹

In order to free the child from guilt, attention was paid only to the perpetrator and the fundamental cause of the crime. Sexual assault against children was now described as highly class-related. It was stated that incest was exclusive to the lower social classes, and that living at close quarters, social degradation and alcoholism were important factors for explaining why such assaults occurred. The same was said about child assault in general; he who assaulted a child was usually unemployed, poor and uneducated. This approach is interesting when we recall that already at the end of 19th century, French medico-legal experts had shown that this was actually not the case at all. Many child offenders were in fact wealthy, well-educated and respected men from the middle or upper classes. However, according to Swedish statistics, a majority of the sexual assaults brought to trial were committed by men from the lower classes, which may corroborate such an opinion. On the other hand, investigators as well as debatteurs were aware of the fact that there was a considerable margin for error, though they did not view this from a class perspective. Perhaps sexual crimes occurring among the middle or upper classes were discreetly covered up, while crimes by lower-class individuals were more easily discovered.

In common with early forensic psychiatry, the child offender was also viewed as mentally ill, abnormal or deficient. This is clearly expressed in both the inquiry of 1935 and the publication *Incestproblemet i Sverige* (1943), in which incest is discussed from a socio-medical perspective.⁶² Furthermore, a fundamental cause of sexual crime is said to be the offender's sexuality; his sexual drive may have increased and he is undoubtedly sexually unsatisfied. If married, some of the blame could consequently be laid on his wife. From this socio-medical point of view, blame may also be laid upon the girl. Seductive or not, her behaviour is one factor that must at least be considered.⁶³ The conclusion is nearly fatal: The offender is not responsible for his actions, but is actually a victim himself. Moreover, the problem must be solved through a prophylactic social programme, including steps to raise the general educational level and standard of living, eliminate unemployment and prevent biologically inferior individuals from procreating.

These ideas about sexual assault against children also emerged in practical contexts outside the judicial system, such as child mental health care. In contemporary journals from child psychiatry clinics, very little attention is paid to sexual assault, even when suspicions that a particular child has been exposed to sexual assault are voiced. As in early forensic psychiatry, general opinion among child psychiatrists and psychologists is that sexual assault, if not too violent, rarely leads to severe and permanent damage to the child.⁶⁴

In the early 1950s, a new argument emerged in the debate: The child's own sexuality can, in retrospect, make non-sexual acts appear to the child to have had a sexual aspect. Furthermore, sexual contact with adults or other children can be initiated by the child itself, a result of the child's own sexual desire. These theories have been directly inspired by the psychoanalytical school, and it is mainly psychologists and psychoanalytically-oriented psychiatrists who propose them. Ideas of the child's libidinous wishes and incestuous tendencies have left their mark on our own time, and the view of incest and sexual assault against children which is reflected in modern legal cases seems to be highly influenced by psychoanalytical theories.⁶⁵ But that, as they say, is another story.

Notes

1. The present study is part of my comprehensive project "Övergrepp, önskningsar eller sexuella fantasier: Om den svenska diskursen kring incest och sexuella övergrepp 1850–2000" (Assaults, wishes or sexual fantasies: The Swedish discourse on incest and sexual child abuse, 1850–2000). This project is financed by HSFR and the Faculty of Arts, Umeå University.
2. *Physical, Sexual, and Natural Religion* (1854). The book was published in Swedish translation in 1878 as *Samhällslärans grunddrag eller Fysisk, sexuell och naturlig religion: En framställning af den verkliga orsaken till och af det enda botemedlet för samhällets tre förnämsta olyckor: Fattigdom, prostitution och celibat*.
3. A representative figure of Swedish philanthropy is Agnes Lagerstedt, who mentions this complex of problems in *Stockholms arbetarhem: Dess förhistoria och utveckling* (Stockholm, 1900), pp. 3 and 41–43. See also Jeffrey Weeks, *Sex, Politics & Society*; Tinne Vammen, *Rent og urent: Hovedstadens piger og fruer 1880–1920* (Köpenhamn, 1989), pp. 172–210; Judith R. Walkowitz, *Prostitution and Victorian Society: Women, Class, and the State* (Cambridge, 1980); Linda Mahood & Barbara Littlewood, "The 'Vicious' Girl and the 'Street-Corner' Boy: Sexuality and the Gendered Delinquent in the Scottish Child-Saving Movement, 1850–1940", *Journal of the History of Sexuality* 4 (1994):4.
4. Bryan Strong, "Toward a History of the Experiential Family: Sex and Incest in the Nineteenth-Century Family", *Journal of Marriage and the Family* (1973), pp. 457–466; Stephen Kern, "Explosive Intimacy: Psychodynamics of the Victorian Family", *History of Childhood Quarterly* (1974), pp. 437–461.
5. See Per Bolin-Hort, *Work, Family, and the State* (Linköping, 1989).
6. E.g. Ambroise Tardieu, *Etude médico-légale sur les attentats aux mœurs* (1857), 6. ed. (Paris, 1873).
7. See also e.g. Adolphe Toulmouche, "Attentat à la pudeur et du viol", *Annales d'hygiène publique et de médecine légale* 2. ser., 6 (1856); idem, "Attentats à la pudeur: des tentatives de viol sur des enfants ou des filles à peine nubiles et sur des adultes, et des grossesses simulés ou réelles suivies ou non d'infanticides, particularités pratiques", *Annales d'hygiène publique et de médecine légale* 22 (1864); Jean-Martin Charcot & Valentin Magnan, "Pathologie mentale: Inversion du sens génital", *Archives du neurologie* 4 (1882); Alexandre Lacassagne, "Attentats à la pudeur sur les petites filles", *Archives d'anthropologie criminelle et des sciences pénales* 1 (1886); R. Garraud & Paul Bernard, "Des attentats à la pudeur et des viols sur les enfants. Législation-statistique", *Archives d'anthropologie criminelle et des sciences pénales* 1 (1886); Paul Bernard, *Des Attentats à la pudeur sur les petites filles* (Paris, 1886); Sigmund Freud, "Heredity and the Aetiology of the Neuroses", "Further Remarks on the Neuro-Psychoses of Defence" (1896), in *Standard Edition of the Complete Psychological Works of Sigmund Freud*, ed. James Strachey et.al, vol.12; idem, "The Aetiology of Hysteria" (1896), in *Standard Edition*, vol. 3.
8. Tardieu, pp. 20–25.
9. Ibid., p. 63.
10. Ibid., pp. 66f.
11. Ibid., pp. 34–37, 50–59.
12. Ibid., p. 75.

13. See e.g. *ibid.*, pp. 125–136, and case 5, 8, 30.
14. Paul Brouardel, *Les attentats aux mœurs* (Paris, 1909), pp. 56–62.
15. *Ibid.*, pp. 30, 35.
16. Auguste Motet, "False Testimony Given by Children Before Courts of Justice" (1887), in Jeffrey M. Masson, *A Dark Science: Women, Sexuality and Psychiatry in the Nineteenth Century* (New York, 1986).
17. See e.g. Alfred Fournier, "Simulation d'attentats vénériens sur de jeunes enfants", *Annales d'hygiène publique et de médecine légale* 4 (1880).
18. Alfred Binet, *La suggestibilité* (Paris, 1900), especially chapter 2 and 5. See also J. Allen Gilbert, "Researches on the Mental and Physical Development of School Children"; William Stern, *Zur Psychologie der Aussage: Experimentelle Untersuchungen über Erinnerungstreue* (Berlin, 1902); Emile Young, "Suggestibilité à l'état de veille", *Archive de psychologie* 8 (1909); J. Cohn & Dieffenbacher, "Untersuchungen über Geschlechts, Alters, u. Unterscheids bei Schülern", *Zeitschrift für angewandte Psychologie und psychologische Sammelersforschung* 2 (1911).
19. William Stern, "Abstracts of Lectures on the Psychology of Testimony and on the Study of Individuality", *The American Journal of Psychology* (1910):21, p. 274; Astrid Holgerson, *Fakta i målet – vittnespsykologins bidrag vid bedömning av sakfrågan i enskilda rättsfall* (Stockholm, 1990), pp. 19f.
20. See for example Richard von Krafft-Ebing, *Psychopathia Sexualis* (1876), 12. ed. (New York, 1965), pp. 1, 8f; Havelock Ellis, *Man and Woman: A Study of Secondary and Tertiary Sexual Characters* (1894), 8. ed. (London, 1934).
21. Krafft-Ebing, pp. 369–374.
22. See Gustav Aschaffenburg, "Zur Psychologie der Sittlichkeitsverbrecher", *Monatschrift für Kriminalpsychologie und Strafrechtsreform* 2 (1905), pp. 399–416; Fritz Leppmann, "Die Sittlichkeitsverbrecher: Eine kriminalpsychologische Studie", *Vierteljahrsschrift für ger. Medizin*, 3. Folge XXIX; Erich Wulffen, *Der Sexualverbrecher: Ein Handbuch für Juristen, Verwaltungsbeamte und Ärzte: Mit zahlreichen kriminalistischen Originalaufnahmen* (Berlin – Groß – Lichterfelde, 1910).
23. See e.g. Leppmann, pp. 298–300; Aschaffenburg, p. 411; Wulffen, pp. 408 ff, p. 419.
24. Criminal Law 1864, chap. 18.
25. See also Jan Sundin, *För Gud, Staten och Folket: Brott och rättskipning i Sverige 1600–1840* (Lund, 1992), pp. 45ff, 55.
26. This section is based partly on a study of court records from the rural courts (*häradsrätt*) in Ljusdal area 1849–1867, and 1877, 1887 and 1897, and partly on prison lists from the prison in Härnösand (H) 1850–1910 and the prison in Sundsvall (S) 1899–1910. Cases concerning incest or sexual assault against a minor have been followed up in the judgement book in question. Altogether I have used court records from the rural courts (*häradsrätt*) in Ljusdal, Resele, Ramsele, Skön, Själevad and Njurunda, as well as from the municipal court (*rådhusrätt*, *rådstufvurätt*) in Sundsvall and Svea court of appeal (*Svea hovrätt*). The representativity of the source material is difficult to assess. However, since very few cases of sexual child abuse were brought to court in Sweden during this period, the risk of a significant distortion is probably small.

27. Criminal Law 1864, §18:7 ("sexual intercourse with a minor") uses the expression "underaged female". Sexual intercourse with a boy is included in § 18:10, "Sexual assault which is against nature", or § 18:13—"indecent behaviour, or indecent actions".
28. See *Bidrag till Sveriges officiella statistik* (BiSOS), Rättsväsendet, 1841–1912. The statistics are difficult to interpret; since the notation varies the numbers are not fully comparable over time.
29. Sköns häradsrätt, dombok 1906, 25/8 bil. 4a; Sundsvalls rådstufvurätt, dombok 1901 nr. 464, bil. C.
30. Sundsvalls tingsrätt arkiv, Sundsvalls rådstufvurätt, dombok 1905, ärende 82/05, 9/3, 16/3, 2373, 30/3, 6/4 samt 6/5.
31. FH, DIIIa:51, fångrulla 1904, nr. 211; Själevads häradsrätt, AIa:143, dombok ht 1904, 4/11, 19/11, 28/11, 19/12; Riksarkivet, Svea Hovrätt, Justitierevisionen, Utslagsakt 12/12 1905 nr. 1373.
32. Sköns häradsrätt, dombok 1906, 25/8 bil. 4a; Sundsvalls rådstufvurätt, dombok 1901 nr. 464, bil. C.
33. Riksarkivet, Svea Hovrätt, Justitierevisionen, Utslagsakt 12/12 1905 nr. 1373.
34. See e.g. Sundsvalls rådstufvurätt, dombok 1906, 22/9, 30/10 and 3/11.
35. "Kongl. Maj:ts och Rikets Swea Hof-Rätts universal, angående föreskrift huru förfaras bör då en för brott tilltalad person upgifwes wara eller wid gerningens begående hafwa varit wansinnig, och fråga om hans befriande, på sådan grund, från answer upstår; Utfärdat i Stockholm den 12 april 1826", *Svensk författningssamling* (SFS) 1826, p. 561.
36. In 1877 the tasks of Sundhetscollegiet were taken over by Medicinalstyrelsen.
37. Mats Börjesson, *Sanningen om brottslingen: Rättspsykiatri som kartläggning av livsöden* (Stockholm, 1994).
38. This information is based on a study of the forensic reports from Sundhetscollegiet/Medicinalstyrelsen 1826–1910. Riksarkivet, Medicinalstyrelsen/Sundhetskollegiet, B I A, "Koncept", and B I B, "Register till koncept".
39. Axel Johannes Ekdahl, *Om rättsmedicinska undersökningar rörande sinnesbeskaffenheten hos för brott tilltalade personer* (Uppsala, 1893), pp. 56f. This was the first forensic doctoral dissertation in the country.
40. See e.g. Axel Herrlin, *Tillräknelighet och själssjukdom: Till straffrättens filosofi* (Lund, 1904); Olof Kinberg, *Brottslighet och sinnessjukdom: En kritisk studie över det rättsliga förfaringssättet i Sverige rörande för brott tilltalade personer av tvivelaktig sinnesbeskaffenhet samt över behandlingen av kriminella sinnessjuka* (Stockholm, 1908).
41. B1A:65, p. 800; B1A:74, p. 2536.
42. See e.g. Herrlin, pp. 200, 224, and Bror Gadelius, "Straffrätt och psykiatri" I, *Allmänna svenska läkartidningen* 7 (1906).
43. SFS 1901:48, Sinnessjukvårdslagen, bilaga A och B.
44. B1A:88, p. 3455; B1A:82, p. 1191; B1A:80, p. 4255; B1A:81; B1A:77, p. 940; B1A:88, p. 3455; B1A:65, p. 800; B1A:80, p. 4255; B1A:90, p. 1212; B1A:90, p. 1513.
45. B1A:103, p. 3033; B1A:82, p. 1191.
46. B1A:80, p. 4255; B1A:77, p. 83; B1A:91.

47. SFS 1901:48, bilaga A, II.
48. See Torbjörn Gustafsson, *Själen's biologi: Medicinen, kulturen och naturens ordning 1850–1920* (Stockholm/Stehag, 1996).
49. See e.g. B1A:80, p. 4255.
50. See e.g. Karin Johannisson, "Folkhälsa: Det svenska projektet från 1900 till 2:a världskriget", *Lychnos* (1991), pp. 139–95; idem, *Medicinens öga*, pp. 42–71; Eva Palmblad, *Medicinen som samhällslära* (Göteborg, 1990); Roger Qvarsell, "Familj och hälsa", in idem, *Skall jag taga var på min broder? Tolv artiklar om vårdens, omsorgens och det sociala arbetets idéhistoria* (Umeå, 1993).
51. B1A:103, p. 2661; B1A:90, p. 1513; B1A:65, p. 800.
52. B1A:90, p. 1513; B1A:92, p. 3243; B1A:90, p. 1513
53. B1A:103, p. 2661; B1A:74, p. 2536; B1A:103, p. 3033; B1A:77, p. 940.
54. B1A:77, p. 940; B1A:88, p. 3455.
55. B1A:103, p. 2661.
56. B1A:80, p. 4255; B1A:90, p. 1513.
57. See e.g. B1A:82, p. 1191; B1A:103, p. 2661.
58. B1A:103, p. 2661; B1A:77, p. 83; B1A:77, p. 940.
59. B1A:77, p. 940; B1A:92, p. 3243; B1A:94, p. 1230.
60. SOU 1935:68.
61. SFS 1937:242.
62. SOU 1935:68; Olof Kinberg, Gunnar Inghe & Svend Riemer, *Incestproblemet i Sverige* (Stockholm, 1943).
63. Kinberg, Inghe & Riemer, e.g. pp. 48 and 107–112.
64. See Åsa Bergenheim, *Barnet, libido och samhället: Om den svenska diskursen kring barns sexualitet 1930–1960* (Grängesberg, 1994), pp. 186–204.
65. See *ibid.*; idem, "Övergrepp, önskningar eller fantasier: Idéhistoriska reflexioner kring synen på sexuella övergrepp mot barn", *Kritisk psykologi* (1994):1; idem, "Övergrepp, önskningar eller fantasier: Synen på incest och sexuella övergrepp mot barn ur ett idéhistoriskt perspektiv", in *Idéhistoria i norr: Rapport från en konferens 1996 med idéhistoriker från Uleåborg och Umeå*, *Idéhistoriska skrifter* 23 (Umeå, 1998). In my project, I am presently dealing with the period 1910–1960.