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On unsafe ground: the practices and institutionalization of Danish psychiatry, 1850–1920

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The aim of this paper is to characterize the efforts of late nineteenth-century Danish psychiatrists to have their field recognized as a discipline in its own right, and their fight to be accepted as practitioners of science, following common scientific standards of exactness and proof. This struggle took place on two fronts: with colleagues in the somatic branches of medicine, and also with lay people and the general public. According to the psychiatrists, laymen persistently contested psychiatry's legitimacy in diagnosing and treating mentally ill patients. Criticism of its scientific objectivity made it difficult for psychiatry to gain respect on an equal footing with other branches of medicine.

Keywords: *Denmark; folk psychology; medicine; professionalization; psychiatry; scientificism; specialisms; 19th century*

The first asylum in Denmark was established around 1800 outside Copenhagen. It accommodated not only the mentally ill, but also poor people suffering from somatic diseases as well as people suffering from venereal diseases. Between the mid-nineteenth century and 1915, five asylums exclusively for the mentally ill were established throughout the country. In 1875 a combined psychiatric and neurological ward was set up in one of the main hospitals in Copenhagen. A number of small local institutions – without any psychiatric inspection – took care of incurable and chronic cases of mental disorder, and many mentally ill individuals were still taken care of in the private households if possible. However, the asylums played a major role in the establishment and institutionalization of psychiatry as a special branch of medicine, not

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least because they provided clinical material from which experience could be obtained and theories developed. Medical textbooks were published in the Danish language from the late 1880s, and at the University of Copenhagen a readership in psychiatry was established around 1890, which became a chair in 1916. Before these developments, which are often regarded as important signs of a developing medical speciality, there were several decades when doctors in the asylums were trying to unravel, explain, classify and treat mental disorders. As pointed out in a number of studies, the mentally ill were hospitalized and treated long before there was a special branch of medicine called psychiatry (see, e.g., Qvarsell, 1985: 96; Skålevåg, 2000: 368). The clinical work in the asylums played a crucial and fundamental role in the long and complex process of establishing psychiatry.

My studies have been carried out from the psychiatrist's point of view, and the aim has been a hermeneutic focus on how Danish psychiatrists saw themselves and perceived their science and practice. Below, I will take a closer look at the concept of mental illness as well as the practices of explaining and classifying mental illness, and the troubles that psychiatrists faced in their efforts to follow certain scientific standards. I will argue that focusing on psychiatric *theory* as represented in medical textbooks and published lectures, as well as psychiatric *clinical practice* as represented in annual reports,¹ enables us to get a closer and far more detailed picture of some of the ambiguities and discrepancies in the work of the psychiatrists.² Furthermore, I will address how psychiatry as a scientific enterprise was in some ways special and different, no matter how much the psychiatrists attempted to look and work like their colleagues in the somatic branches of medicine. These specific characteristics of psychiatry and its practices were, in a peculiar way, both the strong and the vulnerable points of psychiatry. Most of the attempts to become fully recognized as a scientific branch of medicine took place on an internal battlefield with other medical practitioners. However, according to the psychiatrists themselves, they also had to fight on an external battlefield to try to convince lay people that psychiatrists were the best and only qualified experts to judge the sane from insane. I will argue that this relationship with the general public played rather a significant role in the recognition of psychiatry as a special branch of medicine, as well as in its reputation.

The internal battlefield

In Denmark, as elsewhere, nineteenth-century psychiatrists aspired to have their field of work recognized as a part of medical science, and also as a discipline in its own right. They wanted to emulate their colleagues in the somatic fields.³ This eagerness to be like the others was shown especially in the psychiatrists' concept of disease and their interest in anatomical pathology, as well as in their discussions about classification and causality.

Concept of disease

The psychiatrists insisted that psychiatric disease was comparable with any other somatic disorder, that it had similar causes and conditions and therefore should be perceived as literally the same kind of thing. This strong somatic orientation among psychiatrists became very explicit in their concept of mental disease as a disease of the brain, as stated by the psychiatrist Christian Geill (1860–1938): ‘A mental disease is a disease of the brain, in exactly the same way as pneumonia is a disease of the lungs’⁴ (Geill, 1899: 10). At the same time, anything to do with mind or mentality was definitely excluded. The concept of disease was described in a mechanical and materialistic language. It was not the soul itself that was suffering but the ‘bodily instruments of the activity of the soul’, as Harald Selmer (1814–1879), consultant of the first new-build asylum (1852), maintained. When a person suffered from mental illness it was ‘the material organ of the soul’ that suffered and had become incompetent (Selmer, 1846: 15). Matters relating to the psyche or the soul were, in any case, outside the psychiatrists’ field. Consultant Knud Pontoppidan (1853–1916) held that mental symptoms were only of interest as long as they were expressing a disturbance of the brain. The object of interest was the physical body, as Pontoppidan pointed out with reference to his British colleague John Hughlings-Jackson (1835–1911):

What we are to deal with, in our capacity of medical doctors, is the body. If there is such a thing as illness of the soul, we cannot deal with it. ... Mental symptoms are only expressions of what is going on and what is not going on in the higher nerve centres. (Pontoppidan, 1891: 3)

The establishment of mental illness as a disease completely similar to any other physical or organic disease was an essential part of the profiling of psychiatry as a medical and scientific enterprise. The definition of mental disorder as a biological abnormality implied that psychiatry was a biological psychiatry, and therefore theoretically a discipline with exactly the same research methodology and pathological findings as the somatic branches of medicine. As a consequence, psychiatrists wanted to work towards similar specific scientific standards of objectivity, exactness and proof.

However, these idealistic ways of working and looking at things did not correspond very well with the actual material that psychiatrists had to deal with in clinical practice. The pathological picture was, in many cases, different from that in somatic conditions because of a large number of emotional expressions and symptoms. Psychiatrists very often had to deal with mental symptoms, or descriptions of symptoms and behaviours that had been seen before admission to the asylum. Far from being able to view the symptoms and conditions themselves, they often had to rely on descriptions from the patients, relatives or other members of the local community.⁵ Such subjective information did not fit in well with standards of objectivity, and the psychiatrists complained that

they were not able to see and observe cases themselves (Pontoppidan, 1891: 4–5; Schröder, 1916: 1271).

Pathological anatomy

The lack of evidence was another problem that psychiatrists had to deal with. It turned out to be rather difficult to identify where exactly the insanity was located in the brain, and what had caused it. The psychiatrists had great confidence in pathological anatomy as being the field that could provide psychiatry with certain and exact knowledge. The increasingly detailed accounts of dissection results in annual reports of mental asylums indicate how eagerly psychiatrists were trying to locate pathological anatomical changes in the organs of mentally ill patients.⁶ However, psychiatrists had to admit that their results from the dissecting room were still insufficient, and that their pathological anatomical knowledge was rather limited (Friedenreich, 1901). Although they had an undaunted confidence in the possibility of one day being able to locate specific pathological anatomical changes somewhere in the brain, they admitted that it was not possible for the time being.

Classification

The difficulties in pointing to and proving specific pathological anatomical changes considerably influenced attempts to establish psychiatric classifications and to develop a psychiatric disease nomenclature. As a consequence, psychiatrists could not set up classifications based on pathological anatomical findings, but had to continue using classification schemes based, to a large extent, on symptoms. Discussions on classification and its principles were an important topic in the psychiatric literature, as the ability to classify was essential to a field trying to establish itself as scientific.

These attempts to classify are characterized by the fact that classifications changed remarkably over time and by the great variety of ways that almost all psychiatrists chose to distinguish and classify. Psychiatrists clearly regretted their inability to classify according to a pathological anatomical division and complained about the arbitrariness and subjectivity involved in their attempts to establish categories and classifications. A symptoms-based classification scheme would prove, if not unscientific, then simply not good enough according to a number of psychiatrists (Beretning, 1871: 13; Friedenreich, 1901; Hallager, 1906: 144; Pontoppidan, 1891: 5; 1901*b*: 536). Furthermore, they complained that almost every psychiatrist and every medical textbook used a different classification scheme, which made comparisons almost impossible (Helweg, 1886: 201; Pontoppidan, 1901*a*: 686).

From around 1890, psychiatrists seemed more reticent about outlining a single diagnosis or describing cases. Rather than considering single and distinct types of diseases, they attached more importance to the course and the stages of a disease. In a lecture, Pontoppidan (1891: 9) emphasized to his students the importance of analysing conditions rather than working

towards specific diagnoses: ‘Neither should you expect [the lecture] to attach weight to the making of specific diagnostics, which plays a major role in the other medical branches. ... it is far more important to understand how the pathological process in each case has developed than to name a disease.’ The influence of Emil Kraepelin is clear, but the Danish psychiatrists had not yet given up the possibility of identifying the causes of specific diseases. Around the turn of the century Alexander Friedenreich (1901) stated in his medical textbook that ‘for the time being psychiatry works on various forms of courses of diseases meanwhile waiting for pathological anatomical and aetiological examinations to establish for us a more secure foundation’. Theoretically and ideally, psychiatrists wanted to classify mental diseases in accordance with their causes and based on pathological anatomical findings. In practice, they had to classify, to a large extent, according to the appearance and symptoms of mental diseases – that is, classification based on symptoms. In 1918 the psychiatrist, and later consultant, August Wimmer (1872–1937) reported that, with a few exceptions, all medical textbooks opened with complaints and regrets about the incomplete aetiological knowledge and therefore imperfect and insufficient classifications and nomenclatures (Wimmer, 1918: 18). Over time the nomenclature of the medical textbooks expanded, and the number of diagnoses and classifications rose significantly towards the end of the nineteenth century. Part of the expansion was due to the addition of nervous and neurotic disorders to the working field of psychiatry, especially the categories of hysteria and neurasthenia.⁷

A similar increase in diagnoses is found in annual reports. In the early twentieth century, these reports consisted of a detailed and differentiated system of classification, indicating that asylum psychiatrists had twice as many diagnoses and categories to use compared with the number available around 1850. There were, however, notable differences between the classifications outlined in the medical textbooks and the classifications used in the annual reports. Whereas the former varied from author to author, the latter consisted of relatively few categories (around six) for several decades at the end of the nineteenth century. Based on symptoms and behaviour, these categories – *mania*, *melancholia*, *confusion*, *stupor*, etc. – remained relatively constant in the annual reports until 1905. At this time the categories were expanded to include a number of new diseases, such as psychoses related to alcohol or morphine, the so-called *circular psychosis* – *dementia praecox*, *hysteria*, *neurasthenia*, *traumatic neurosis* – as well as the category ‘*other mental diseases*’, in which asylum psychiatrists could place cases that did not fit in elsewhere. The categories represent a mixture of symptom-based and aetiological distinctions, and the open category of ‘*other mental diseases*’ did not contribute to uniform classifications. To a certain extent each psychiatrist was left to classify his clinical material as he wished. The most obvious explanation of the differences between the classifications in the medical textbooks and the annual reports is the fact that psychiatrists working in clinical practice could not wait for an ideal classification scheme to

be established, but had to continue to classify their actual empirical material. Even if the classification schemes were inferior (and this was also discussed by asylum psychiatrists), they were seen as central scientific working tools and an important way to sort things out (Beretning, 1871: 13–15; Beretninger, 1895: 8–9; Hallager, 1909).

Causality

A last example of the discrepancy between what was outlined in the medical textbooks and what actually went on in clinical practice was the problem of the aetiology of mental disorders. Another important issue for psychiatrists was their ability to explain mental diseases; claiming specific causality was an essential part of legitimizing psychiatry as a distinct part of medical science.

According to the medical textbooks, a mental disease was most likely to be due to an inherited disposition or for some physical reasons. In a person with such a disposition, occasional conditions could eventually cause a mental illness. These conditions could be of physical or psychological nature, or what we call today psycho-social causes, for example, poverty. Towards the end of the nineteenth century the focus on heredity and disposition was intensified. There was an unambiguous distinction between hereditary and occasional causal factors, with the latter inferior to the former. This view on heredity was emphasized in the thesis by the consultant Frederik Lange (1842–1907), *The Influence of Heredity on Mental Diseases* (1883). According to Lange (1883: 20), during the period of a generation, the importance of heredity had become clear and acknowledged, and a number of studies had shown that the frequency of hereditary disposition was 52.5%. Lange's (1883: 27–8) definition of hereditary disposition consisted of insanity established in first-degree relatives (parents) and also in collateral branches, as well as cases of insanity and other 'abnormal illness' in the family.

In general, the psychiatrists were eager to point out the exact frequency of the hereditary disposition. However, the way it was calculated differed, and the frequencies reported varied significantly (Koch, 1905: 77; Reisz, 1894: 339–40). Furthermore, the definition of a hereditary disposition differed from one psychiatrist to another. Hereditary disposition was a rather open concept framing heredity in a narrow sense as well as theories of degeneration, i.e., gradual decline through generations. The concept of hereditary disposition was ambiguous and seems to have covered mental illness due to heredity without degeneration, as well as so-called degenerative conditions. An ordinary hereditary disposition was far less fatal and determinate than degeneration. People with a hereditary disposition would not necessarily develop a mental disease, and this would depend on living conditions and the kinds of occasional causes that he or she eventually experienced (Geill, 1899: 37). A hereditary or degenerative disposition was primarily identified as a physical or moral condition, very often based on appearance or behaviour – for instance, eyebrows that joined (Koch, 1996: 31). The newly established theories about heredity

and genes (phenotype/genotype) had not yet found their way into the psychiatric understanding of heredity and predisposition (Geill, 1916: 125; Koch, 1905: 97–98). In a book on children and degeneration, Wimmer (1909) admitted that psychiatrists were facing difficulties in defining what actually constituted a hereditary disposition, as well as in detecting it. The psychiatric concept was still, according to Wimmer (1909: 9–10, original italics), a clinical concept and consisted of demonstrating abnormalities in the father or mother of the insane child and ‘the *supposition* that this was the reason for the mental disturbances in the child’. Before World War I psychiatrists’ assumptions of predisposition and heredity had a rather hypothetical and presumptive character.

In Danish clinical practice, as represented in the annual reports and their specification of aetiology, there was no hierarchy between hereditary and occasional causal factors. The concept of occasional causes did not figure in the schemes of aetiology. Instead, physical, psychological/mental as well as hereditary causes were listed side by side (Møllerhøj, 2006: 120). Typical physical causes were masturbation, headache or physical disorders of different kinds, whereas psychological causes could be grief, unhappy marriage, financial difficulties or disappointments. (Masturbation could also figure as a psychological cause dependent on whether the moral guilt or physical damage was pointed out as the main problem). Furthermore, the list of causal factors in the annual reports included a number of more spectacular and infrequent causal factors such as *political agitation, Mormonism, travelling to America, being a bookworm*, etc. (Møllerhøj, 2006: 128, 145). The variety of causal factors in the annual reports reflects an aetiological practice marked by multi-causality. Furthermore, the variety illustrates that hereditary disposition was not identified as often and as synonymously as prescribed in the medical textbooks. Towards the turn of the century, the frequency of mental/psychological and psycho-social causes declined, but it continued to appear in the specifications on a smaller scale. Also, there were marked differences between the asylums and between psychiatrists in their assessment of the influence of mental causes. Two of the asylums (Århus and Vordingborg) tended to give more weight to psychological and mental causes, whereas others (Sct. Hans Hospital and Middelfart) had a very strong somatic orientation in their aetiology. Some of these differences may be ascribed to variations in patient populations, but the psychiatrists themselves noticed the heterogeneity and considered it a matter of subjectivity and different opinions on the role of mental causes (Krarup, 1905; Selmer, 1879: 102). The discrepancies between the aetiology prescribed in medical textbooks and that of clinical practice illustrates an ambivalent and unclear view of the meaning and importance of vague psychological factors. Psychiatrists probably saw a great variety of causes, some of which were extremely difficult to justify because they tended to be difficult to measure, and therefore did not fit in well with the scientific standards.

Such ambivalence was present in one of Pontoppidan’s (1885) cases. A female patient, with no established hereditary disposition, had witnessed the huge fire

at Christiansborg Castle in Copenhagen in 1884 and thereafter developed a depression.⁸ The case interested Pontoppidan because it was ‘an example of how a mental emotion could be the original cause of the development of a psychosis’. However, he was not going to describe the experience of the fire as monocausal. Even though he could not, for the time being, point out other obvious causes, he maintained that one should be very careful in accepting mental causes as the only cause. The patient in question was pregnant and had a record of nervousness and some sort of mental disturbances during pregnancy. The aetiological role of pregnancy in relation to mental disorders was very well known and, according to Pontoppidan, one would therefore have to await the birth and ‘lying-in’ before a conclusion of the causality of this case could be finally established (Pontoppidan, 1885: 107). The case clearly illustrates how Pontoppidan, in accordance with his own doctrines, accentuated somatic factors as the decisive cause (the pregnancy). At the same time it is obvious how tempting and simple it seemed to him to point out the experience of the fire as the trigger point. Mental experiences and feelings, however, did not fit in well with a somatic and biologically orientated psychiatric science, focusing on what could be observed and measured. It obviously proved hard for psychiatrists to abandon these causes, because they were so often confronted with them in the single cases of mental disease in clinical practice, not least because the patients themselves or their relatives often pointed out these kinds of causes (Beretninger, 1885: 10). Some psychiatrists attempted to reduce the importance as well as the extent of mental and psychological causes, but could not ignore them completely. Mental and psychological factors kept appearing in clinical practice and could not always be reduced to occasional and unimportant causes. The efforts of psychiatrists to establish not just any aetiology but a certain type of aetiology, similar to that of the somatic branches of medicine, illustrates their keenness to work within the current frameworks and standards of medical science.

The two faces of psychiatry

Although standards on scientific classifications and causal explanations had been established and outlined at a theoretical level, in practice they were proved difficult to meet. The psychiatrists referred metaphorically to their field as a ‘ship’, a ship without a rudder, a ship that should take a more pathological course, go ashore and become connected with the mainland, i.e., medical science in general (Beretning, 1871: 27; Pontoppidan, 1889: 326; Steenberg, 1873: 182). In one of his lectures to medical students, Pontoppidan (1896: 464) described ‘the psychiatric laboratory’ as part of the ‘big workshop of natural sciences’. The use of these specific concepts and metaphors illustrates that there was absolutely no doubt among psychiatrists as to where their ship was heading.

In reality, however, psychiatry and its practices had serious problems in meeting the scientific standards of exactness and proof, and in being recognized as ‘scientific’ (Beretning, 1871: 13–17; Krarup, 1909: 283; Pontoppidan, 1891: 4–5; Schröder, 1917: 380–2). Colleagues in the somatic branches of medicine, especially neurologists, constantly criticized psychiatrists for being subjective, vague and unscientific in their approach (Christiansen, 1906a: 82; Krarup, 1907: 29–30). The critique did not address the therapeutic nihilism in psychiatric practice or the increasing lack of accommodation in the asylums due to the large number of chronic and incurable patients. Rather, attention was focused on psychiatry as a scientific enterprise. While the legitimacy of psychiatry as an independent field dealing with mental disorders was not questioned, its procedures were criticized. Although it might have been recognized as a definite field working with a specific group of diseases, it was not considered to be practising real science in accordance with common scientific standards of exactness and proof.

On the other hand, there were also signs of a growing awareness among psychiatrists about the specific characteristics of psychiatry and their ownership of these. One example was the way psychiatrists talked about normality; another was their awareness of the influence of time and place on their concepts, and the realization that mental disorders were changing in form and content, as well as prevalence over time.

Normality

Around the middle of the nineteenth century, psychiatrists insisted that there were definite distinctions between what was normal and what was pathological in relation to mental disorders, but the next generation of psychiatrists seemed more reserved about making absolute definitions (Selmer, 1847: 407).⁹ In a lecture, Pontoppidan (1889: 327) remarked that ‘the conventional wisdom that we are all more or less insane is, as far as it goes, true if none of us are completely mentally healthy nor physically sound. Absolute health is an abstraction, an ideal, which no human being achieves’. Some other psychiatrists said how difficult it was to diagnose mental diseases, and that no definite criteria could be established for what constituted sound mental health versus pathological mental health (Christiansen, 1906a: 282; Gædeken, 1895: 27–8; Geill, 1899: 67). Such a distinction was difficult to make because of the character of the mental disorders. It was most often characterized by strange behaviour or abnormal psychological symptoms. Vague psychological symptoms could not be measured with an average model of behaviour, reason or rationality but, according to Pontoppidan (1891: 6–7; 1893: 13), should be understood in relation to the individual patients and themselves as they used to be, prior to the outbreak of mental disease. This point of view differed radically from medical science in general, where the focus had changed from the individual patient towards an average based on generalizations for larger groups of patients (Bynum, Hardy, Jacyna, Lawrence and Tansey, 2006: 78; Porter, 2006, 82: 154).

The Achilles' heel

Another sign of a growing awareness among psychiatrists about the speciality of their field was their acknowledgement that time and space and the surrounding society affected and influenced their practice and concepts. The consultant of one of the provincial asylums, Fr. Lange, stated in his medical textbook (1894) that it was well known that the form and content of mental disorders varied. The reasons for this were complex, but one important factor, according to Lange, was the psychiatrists themselves; he admitted that the categorization of a certain condition by one psychiatrist could easily differ considerably from that of another psychiatrist. Some of his colleagues also described how disorders might change and sometimes disappear and how new disorders came into play, and he admitted that this also depended on the judgements of the psychiatrists themselves (Geill, 1899: 43; Lange, 1894: 16; Poulsen, 1899: 251).¹⁰ This seems to imply that psychiatrists were well aware that diagnoses and classifications were not fixed reflections of reality and real conditions, but ways of sorting out such conditions. There seems to have been a high degree of discussion and awareness among the psychiatrists about their practices and the consequent implications. At the beginning of the twentieth century there also seems to have been a stronger emphasis that the main task of psychiatric science was to make detailed descriptions of psychiatric conditions. To counter the view about the scientific inferiority of psychiatry, Wimmer emphasized that careful anamneses and observations were the best diagnostic tools of the psychiatrist. Furthermore, he stressed that this approach was not 'a psychological or metaphysical speculation' but 'an *objective* scrutiny and description of the insane' (Wimmer, 1918: 24–5; original italics).

While such statements underlined the fact that the objects of psychiatry were somewhat different from those of somatic medicine and therefore had to be dealt with in different ways, this was simultaneously the Achilles' heel of psychiatry. The psychiatrists' discussions and moderate statements confirmed the assumptions of the neurologists that psychiatry was vague and subjective and, in the words of Christiansen (1906a: 82; 1906b: 361), one of the most critical neurologists, it was far more a guessing game than a scientific practice. In addition to such criticism from fellow medical practitioners, the psychiatrists and their practices were also watched attentively by lay people; this also caused psychiatrists a considerable amount of concern.

The external battlefield

Psychiatry has a long record of being a scapegoat. The scientific authority and self-perception of psychiatrists was questioned by the outside world in a number of settings during the nineteenth century. Probably the best-known Danish example of lay people criticizing and interfering in psychiatric practice is the 1894 controversy about the psychiatric ward in Copenhagen and its consultant Pontoppidan. The affair involved the admission of the Danish-Norwegian

author Amalie Skram (1846–1905) who later published two autobiographical novels describing her admission and treatment by the consultant as far from pleasant (Skram, 1895*a*, 1895*b*). The novels contain a strong focus on the power relations between the female patient and the male consultant.

Until 1938 when a detailed law about admissions to psychiatric hospitals was formulated, admissions and committals were carried out according to different regulations and statutory instruments for each asylum. However, the law in relation to the psychiatric ward in Copenhagen was uncertain, and the question of whether a patient should be admitted and confined was to a large extent decided by the consultant. The 1894 controversy was complex; it was partly about the insufficient regulations on admissions and committals to this specific psychiatric ward, partly about psychiatric judgements in general and the scientific authority of Knud Pontoppidan in particular. Thanks to the newspapers, the controversy had considerable publicity and it highlighted the question of who were and should be capable of determining whether a person was insane or not. The judgements and scientific approach of Pontoppidan were questioned; for example, one headline during the debate asked ‘isn’t the professor himself insane?’, and the whole affair resulted in the consultant resigning his post (Kelstrup, 1983: 157). The controversy is often represented as the first antipsychiatry movement in Denmark, and as a forerunner of the antipsychiatry of the 1960s and 1970s; however, this is misleading and rather anachronistic since at that time no alternative explanations of mental illness had been set out, and there was no explicit agenda aimed at abolishing psychiatry as a science.¹¹ It seems more reasonable to consider the affair as criticism by lay people or as part of a more general relationship with the public that psychiatrists had a long record of dealing with (Fogt 1998: 86–8; Møllerhøj, 2007*a*: 72). I will not go into further detail about this case, but make the point that this was one of a number of examples of lay people being critical or sceptical of psychiatry, psychiatrists and their practice. The 1894 controversy was probably the most aggressive and widespread, because it was articulated through the Copenhagen newspapers, but previously the relationship with lay people had been discussed in some psychiatric texts.

First, the psychiatrists complained about the prejudices and ignorance of the families of the mentally ill, who often, according to the psychiatrists, obstructed admission to an asylum. Lay people were afraid of the mental institutions, did not want to leave their relatives there and did not understand that it was an institution of intervention and rehabilitation (Geill, 1895: 43; 1899: 1; Gjersing, 1847: 186; Selmer, 1846: 3; Steenberg, 1881: 545; Wimmer, 1916: 80). Pontoppidan (1891: 13) complained about the ‘deeply rooted prejudices against the asylums’ and argued that this often caused mistrust of the psychiatrists. In their opinion, the prejudice and ignorance often went hand in hand with a tendency among lay people to claim that they themselves could determine whether their relative was insane or not. This annoyed psychiatrists, probably because the specific knowledge of the profession, as well as its monopoly

in defining and explaining mental diseases, were being questioned. Psychiatrists also asserted that the authorities interfered in psychiatric practice and questioned psychiatric judgements. The fact that those in authority also deemed themselves capable of determining whether or not people were insane excused, to some extent, the ignorance of lay people, as Pontoppidan (1891: 16) explained to his students in a lecture: 'when authorities can take up this kind of attitude towards an empirical science, the foolishness of the lay people is excusable. Therefore you will have to accept the fact that old aunts of the patients appear, not to hear our opinion on the patient but to inform us about their own view.'

Although the ideas of lay people were constantly warded off by pleading the legitimacy and authority of scientific psychiatric knowledge, it is obvious that the situation bothered the psychiatrists. The interference of lay people was even mentioned in textbooks written for medical students, which shows how seriously the problem was taken. The consultant of Sct. Hans Hospital outside Copenhagen stated in an annual report for 1887 that:

everybody, except the doctors of insanity, seems to assume it is an easy matter to judge, whether a person is insane or not. This is an indication of the low scientific standard of psychiatry, compared to other branches of medicine. For the less a disease is scientifically explored, the more likely people are to think they know its diagnosis, cause and treatment in and out. (Beretninger, 1887: 19)

Thus, it seems as if psychiatry, more than any of the other special branches of medicine, was questioned and constantly had to legitimize its scientific authority and its monopoly in judging sane from insane. In this sense, psychiatry had a rather chronic, if not incurable, problem with an interfering general public.

Concluding remarks

The aim of the study has been to throw light on the practices of explaining and classifying mental disorders, and to show how these practices played a major role in efforts to establish psychiatry as a special branch of medicine. Psychiatrists explicitly aimed at becoming part of the mainstream of scientific medicine, and they struggled to be accepted as practitioners of science in accordance with common scientific standards of exactness and proof. This battle was with colleagues in the somatic branches of medicine, especially neurologists, as well as with lay people and the general public. According to the psychiatrists, laymen persistently contested psychiatry's legitimacy in diagnosing and treating mentally ill patients. The criticism of scientific objectivity, as well as lay people's attention to psychiatric practices, caused difficulties in gaining respect on an equal footing with the other branches of medicine. Furthermore, the psychiatrists had to face a number of discrepancies between their theoretical and clinical practice. When following Ackerknecht's urge to look at what was

done in medical practice, in addition to what was thought and written, it becomes clear that psychiatrists were struggling with inconsistency between what they could actually do and what they would have liked to be able to do. As a consequence, psychiatry remained on unsafe ground.

Psychiatry has a long record of being a scapegoat – for more than 150 years it has been subject to criticism and interference. This continuity may help to explain why, even today, despite a strong biological and genetic orientation and notable treatment successes, thanks to psychoactive drugs, psychiatry in Denmark and elsewhere is still at the very lower end of the hierarchy of medical specialities, and is accorded very little prestige.

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Notes

1. Annual reports from each asylum were made on the basis of patient files; in my study they are considered to be representations of clinical practice. In the annual reports the asylum psychiatrists gave an account of a number of topics, especially patient population, work therapy, aetiology and classification. The inclusion of discussions about the value of the reports, how they should be made, and how to establish comparisons between the institutions and their practices, all emphasize the scientific ambitions and specific agendas of the asylum psychiatrists. See also Møllerhøj, 2006: 220–2.
2. As Erwin Ackerknecht (1967: 214) has maintained, it is important to have a look at ‘what doctors did in addition to what they thought and wrote’. Suzuki (2006: 42) has likewise emphasized the importance of dealing with medical science and knowledge as well as medical practice in the history of psychiatry.
3. For a closer examination, see also: Jönsson, 1998; Qvarsell, 1985. Somatic medicine was not necessarily a uniform whole at this time, but the point is that it worked as a homogenous ideal for psychiatrists and represented desirable exactness and esteem.
4. All translations are by the author.
5. The role of the family and local community in the labelling and judgement of insanity has attracted much attention in recent studies; see also: Bartlett & Wright, 1999; MacDonald, 1987; Porter & Wright, 2003; Prestwich, 1994; Suzuki, 2006.
6. The section of autopsy results in the annual reports expanded remarkably during the second half of the nineteenth century. From 1872 it consisted of a ‘list of findings’, which illustrates that psychiatrists were looking for specific changes in the brain. From 1907 the paragraph became more detailed: each deceased patient was listed separately along with his/her results.
7. This expansion has been described as an addition of the ‘half-mad’ to the working field of psychiatry (Goldstein, 1993: 1364), but it also included pathological sexual behaviour, neurosyphilis and alcohol psychoses. See, for instance, Shorter, 1997: 48–64.

8. Pontoppidan used the concept 'depression' to describe the condition, but it was not a separate category at that time. However, the case notes do not give the patient's exact diagnosis.
9. See also Goldstein, 1993: 1364.
10. One example of the rise and fall of psychiatric categories is the category of *puerperal insanity*, which was established at the beginning of the nineteenth century and phased out around 1900. See also Marland, 2004; Møllerhøj, 2007*b*.
11. Antipsychiatry has a number of meanings and connotations. In this case, I stress that the aim of antipsychiatry was to reject a medical understanding of mental disorders as well as psychiatry as a special branch of medicine. See also Wulff, Pedersen and Rosenberg, 1999: 119, 134–5.

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