Psychodynamics in Swedish child psychiatry: from political vision to treatment ideology, 1945–85

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WORKING PAPER, PLEASE DO NOT CITE.

Abstract
The present article examines changing treatment ideologies in Swedish child psychiatric outpatient services from 1945 to 1985. When mental health services for children began to be provided in the mid-40s, psychoanalytical thinking was used a rhetorical device to legitimize the new political project. It spurred the notion of children as emotional beings who must build close relations to adults was as a radical alternative to the allegedly old-fashioned stress on habit formation and moral education. The psychoanalytical idea was intertwined with the Social Democratic optimism of engineering away ill somatic and mental health central to Sweden’s developing welfare state. The initial services for children, however, continued the early child guidance tradition’s more pragmatic approach. At the beginning of the radical era of 1960s the situation changed dramatically. Child psychiatric practice increased in number of units and began to use a more fully articulated treatment discourse based on psychodynamic theories of ego development. In the 1970s psychodynamics reached a hegemonic position in Swedish mental health services for children only to be challenged by proponents of family therapy from inpatient services.

Key words: child psychiatry; ideology; out-patient services; psychoanalysis; treatment discourse.
Introduction
The present article discusses the development of treatment policies in Swedish child psychiatry in the period 1945–85, in the light of contemporary conflict over psychotherapeutic treatment. The current debate was first occasioned by a literature review of the evidence supporting various psychiatric treatment methods for depression carried out by Statens Beredning för medicinsk utvärdering (the Swedish Council on Health Technology Assessment) (SBU 2004). Cognitive and/or behavioural treatment approaches had proved in experimental settings to be as effective medical/psychiatric treatments, while the empirical support for psychodynamic methods was weaker (ibid. 39–40). That conclusion prompted a debate on psychodynamic versus cognitive behavioural therapies that was similar to its well-known international counterparts (see, for example, Lambert 2004; Wampold 2001). These controversies had international parallels dating back to the 1950s, when the British psychologist Hans Eysenck argued that there was no evidence supporting the curative effects of psychoanalysis (Eysenck 1952; see also id. 1985). Unlike in other countries, however, the controversy in Sweden only engaged representatives of the adult psychiatry and mental health services; the lack of contributions from Sweden’s child psychiatrists is striking. The tenor of the international debate would not lead one to expect such passivity. In the US and Britain, psychoanalytically informed child therapy has indeed been a widely used treatments, and also one that has been much discussed (Levitt 1957; Rous and Clark 2009, 443); consequently, the debate on the scientific status of psychological treatment has concerned the treatment of both adults and children. Not so in Sweden, however. Child and youth therapy has not featured in the scholarly and professional debate in Sweden, and, what is more, the treatment of children for mental health problems has for the most part been synonymous with psychodynamic child therapy (Jönsson 1997; Qvarsell 1985, 1993; Bergenheim 1990; Johansson 2003; Luttenberger 1989; see also practitioners’ recollections in Karlén 1985). Psychodynamic thinking seems to have attained a special status in Swedish child psychiatry, specifically in the development of treatment ideology and policies, and unlike in other western countries it clearly went unchallenged by the launch of cognitive behavioural approaches to adult treatment at the end of the 1990s. How can this be explained? Let us begin by outlining the research background against which Swedish developments can be interpreted and understood.

Research perspectives and issues
Given that the organization of child guidance services varies enormously between countries, it is unsurprising that the Swedish experience should display some special features. The philanthropic endeavours of the American Child Guidance movement and the Child Study Movement in the early twentieth century created an intellectual legacy that in turn was moulded by specific domestic and ideological concerns in nations throughout Western Europe (Horn 1989; Ludvigsen and Seip 2009; Parry-Jones 1989; Richardsson 1989; Steward 2006). The influence of the mental hygiene movement was also significant throughout the area, particularly its strong emphasis on social rather than individual processes. This intellectual shared inheritance was also part of the various precursors to child psychiatric provision in Western Europe. Previous research has established that child psychiatric disorders was discussed clinically and scientifically before the Second World War, but that child psychiatry as a medical speciality remained an undefined area until the post-war period, when it was first acknowledged as a distinct scientific field (see, for example, Baethge, Glovinsky & Baldessarini 2004; Evans, Rahman & Jones 2008; Parry-Jones 1989; Smuts 2006). Most importantly for our argument, the development of child guidance services and child psychiatric services for children in Western Europe was also closely related to the structure and character of the respective state welfare systems (see, for example, Jones 1999; Ludvigsen and Seip 2009; Ludvigsen 2010; Steward 2009). Consequently, an analysis of treatment ideologies and policies must therefore take into consideration the interaction between state actors’ political visions, institutions and professional pioneers and agencies. In these interactions, social science findings and expertise also played a crucial role in all countries, as historian Judith Sealander says of the United States: “Psychological and sociological theories grounded a wide variety of government initiatives, sometimes long after their original proponents abandoned them.” (Sealander, 2003).

Moreover, to study governmental policy for children also requires a study of the social and cultural construction of childhood in specific times and places (Hendrick 1997; Sandin 1986, 2003; Turmel 2008; Sealander 2003, 2004). In this article, the examination of treatment ideology and policies in child guidance services and child psychiatric services for Swedish children will also be discussed in terms of notions of children and the political visions of childhood held by therapists and policy-makers. The notion of childhood in Sweden gained a number of distinctive features after the Second World War, the most important of which was a strong emphasis on children’s individuality and autonomy under the protection of the state – a transformation that also led to a discourse of childhood which, far from stressing children’s
differences from adults, stressed the similarities. Moreover, in the late 1950s, parallel with the establishment of child psychiatry, these developments brought a new emphasis on children’s rights to physical and mental integrity (Sandin 2003, 2011; Zetterqvist Nelson, forthcoming).

The focus of the present article is on Sweden’s out-patient services, which have dominated the organization of child psychiatry from the start. The period 1945–85 was marked by the expansive development of child welfare and health services in general, in which child psychiatry was one of many government initiatives. This article will consider the development of psychological and psychiatric treatment policy, and more specifically the dominance of psychodynamic approaches. Has psychodynamic treatment ideology been challenged by other treatment ideologies, and if so, what were these treatment alternatives?

**Methodological considerations**

The analysis is based on a close reading of the arguments and conceptual patterns in psychiatric and psychological treatment guidelines and policies in the light of their socio-historical context. Sweden’s new mental health service for children, in carving out its organizational space in the welfare and medical system, came up against other agencies with similar aims – social services and the school health service – as well as the national health service as a whole. Child psychiatry’s self-image, centred on its ambitions for the treatment of children, is also important to analyze, but equally so is the way in which its image was defined by repeated official inquiries. Finally, the identification of centrally placed individuals who helped change policies will also be considered in the context of the negotiations and conflicts that defined the treatment ideology that dominated different periods.

To this end, surveys and official statistics from a number of child psychiatry departments and out-patient units, as well as data on the number of professionals working in child psychiatry, are used as the source material for our analysis of the ideological processes at work in the development of treatment policies for Swedish children. The bulk of the material analysed consists of official government reports and policy documents that deal with child psychiatry services in Sweden in the period in question – the fruit of a wide range of official government inquiries and studies. In addition, clinical textbooks and professional and scientific journals have been used as background material, as have a selection of the biographies of people involved. The present study starts in 1945, the year that saw the beginning of a state-funded child psychiatric service in Sweden – *psykisk barna- och ungdoms vård* (Child and Youth Psychological Service) – and finishes in 1985, when such
heavy criticism was directed at the child psychiatric service from representatives of the social services that? what happened?

**A radical vision of children and childhood**

Originally named the Child and Youth Psychological Service, child psychiatric services began as a new organization to provide mental health services for children and young people as outlined by a government inquiry in a report published in 1944 (SOU 1944:30). The inquiry, *Ungdomskommitteen* (the Youth Inquiry), was commissioned by the Parliament (?) in 1939 to deal with rising levels of youth delinquency and crime. The so-called ‘youth problem’ had been on the government’s agenda as a major social issue since the mid-1930s (ibid. 11). Among the local child-welfare initiatives designed to support parents and prevent wider social problems, advice bureaus and child counselling centres had been founded in the 1920s and 1930s in the larger Swedish cities. With the appointment of the Youth Inquiry, the government made it a national issue. The Youth Inquiry began work in 1939, but the outbreak of war delayed its work for two years. In reconvening the inquiry at the end of 1941, its goals were reformulated (SOU 1944:30, 12). Instead of investigating crime defined as the acts of specific groups of young people, i.e. juvenile delinquents, the social dimension of delinquency was now stressed. The Inquiry’s organizers argued that the young people in to be studied should not be viewed as a group of failed individuals. Instead, they asserted, the rising number of youth crime was a sign of the failure of society to care for its young. It was thus the state’s obligation to change society in order to produce socially well-adjusted adults. The Youth Inquiry published twelve wide-ranging reports; the first was the outline of a new kind of mental health service for children and young people, followed by eleven reports on subjects such as youth’s labour market, leisure activities, sexual behaviour, etc (SOU 1951:41, 6–8).

The symbolic meaning of *Psykisk barna- och ungdomsvård* (SOU 1944:30) as the first of the many reports produced by the Inquiry reflects the significance ascribed to psychological knowledge in this new approach to the ‘youth problem’. It was not a moral problem or a biological problem; it was a social problem that could be solved with a psychological understanding of the influence of family environment and emotional relationships. Before a detailed analysis of of the content of this new approach, its organizational development should be laid-out.

In February 1945, the Minister of Social Affairs signed a government bill (Kungl. Maj:ts Proposition nr 211 1945), based on the official inquiry report *Psykisk barna- och
ungdomsvård (SOU 1944:30), outlining a new kind of health service for children and young people. The designation ‘psychological service’ thus conveyed that it was neither ‘psychiatric care’ nor ‘child guidance’ – it was something new. Furthermore, it was planned that this new form of mental health service, called the Child and Youth Psychological Service like the eponymous official report, would be located at local hospitals, as part of the national health services, controlled by the landsting (county councils). In 1945 Sweden was divided into twenty such county councils. These councils were distinct from the municipal administration, except in the cases of the three largest (?) municipalities of Stockholm, Gothenburg, and Malmö.iii Each county council was responsible for organizing its own health service; one which followed national governmental guidelines and gave due consideration to the specific needs of the region. Professionally (?) the national authority responsible for the health service was Medicinalstyrelsen (the National Medical Board). So, the decision to create a new kind of mental health service for children and young people to be run by the county councils implied a determination to distance it from previous child guidance work that had been carried out under the aegis of the municipal child welfare boards.

The placing of the Child and Youth Psychological Service under the county councils’ health care organizations was at one with Social Democratic strategy at the time mirroring its vision of health care for all people on equal terms and run by a strong nation-state (Berge 2007). The proposal to set up mental health services for children within the wider health service was welcomed by most of those involved in the change and attracted cross-party support. It was only opposed by representatives of the municipal child-care services and school health services (SOU 1944:30, 177). Their criticisms were largely discounted at the time, but, as we will see, similar arguments would be advanced forty years later.

It was not entirely clear where in the existing medical institutions these new organizations were to be housed, though in some county councils initiatives had already been taken to develop special hospital departments for children with mental health problems. For the most part these departments were located in paediatric clinics, and in a few cases in psychiatric clinics. An initial trial period of three years was proposed, during which the regional medical authorities would receive earmarked financial support from the central government and would be compelled to follow central directives. The fact that the funding was earmarked was an indication of the importance accorded the initiative. In 1948, at the end of the first three years, the trial period and funding (?) was prolonged to 1960, when the organization went through some major changes that will be described below.
At this stage we can conclude that the development of Child and Youth Psychological Service was a state initiative in response to a historic situation and, significantly, its creation preceded the existence of the professional groups expected to occupy the positions in the new service. It was also intended that the agencies would be placed in local hospitals before any departments had been developed for this purpose. And Child and Youth Psychological Services was initially defined as a psychological speciality in a medical context, headed by a child psychiatrist. Yet only one independent department of this kind existed (run by Värmland county council), though in the larger cities similar departments had been established in paediatric departments or, in some instances, in psychiatric departments.

The stress on psychological understanding in the rhetoric used to create this new organization for children and youth was elaborated quite fully in the official documents (SOU 1944:30; see also Kungl. Maj:ts Proposition nr 211, 1945). After a short introductory chapter on the political terms of reference, a new way of understanding children and childhood was outlined (SOU 1944:30, p. 20-24). The main message was that positive emotional relations to adults during childhood were decisive for the proper social and psychological adjustment of children and youth. It was not only a question of education to ensure that children learned the proper rules and to appropriate good habits, their proper social adjustment was also based on mental processes (Ibid, p. 21). Child-adults relations were played out in the “emotional field” (Ibid, p. 21), argued the authors of the report; and that became it became the rhetorical basis to which the Inquiry then returned in discussions of social maladjustment and faulty psychological development. Rhetorically the new vision of children and childhood was positioned as scientifically updated and modern as opposed to the conservative ideas of habit formation and learning schemes.

In the report’s description of various problematic conditions (?), concepts such as “emotional conflicts”, “pleasure” and “unpleasure”, “envy” and “neurotic” hinted at a psychoanalytical frame of reference (Ibid. p. 20-24). No explicit references to psychoanalytic writing was made, but we know from other sources how psychoanalysis was ingrained in the left-wing intellectual tradition of the 1930s and 1940s (Luttenberg 1997; Johansson 2002). A small group of Swedish child psychoanalysts had also been formed, some of whom were child psychiatrists in the Stockholm child guidance centres (Jönsson 1997; Johansson 2002; Bergenheim 1994). In general, psychoanalysis drew important individuals who would go on to play a key role in shaping the new organization. One of them was the legendary
paediatrician Gustav Jonsson, who was to become the first head of a Child and Youth Psychological Service clinic.

Jonsson played a key role in the first years of the Child and Youth Psychological Service’s existence. He began to practise in the late 1930s as a paediatrician, which required close collaboration with child counselling units at the municipal level (Bergenheim 1994; Vinterhed 1980; see also Jonson 1985). His decision to turn to paediatrics and child health was prompted by his experiences in psychiatry. After a period working in forensic psychiatry, Jonsson concluded that ‘the psychopath is the former problem child’ (Jonsson 1985, 136). Rejecting biomedical psychiatry and eugenic theories as far too conservative, Jonsson instead saw huge potential in treating childhood and youth problems as the result of detrimental social and psychological relations.

Jonsson was long a member of Socialistiska läkare (Socialist Doctors), an informal association originally started by his colleague, Gunnar Inghe, in the early 1930s. Both were very active in the expansion of preventative social medicine (Inghe was appointed the first professor of social medicine in Sweden in 1958). Their vision of fighting against detrimental social conditions and for increased social welfare as steps toward improved health, both physical and mental, fit well with the Social Democratic utopian goal of a society in which not only physical ill health but also mental and psychological ill health could be engineered away. There was a growing sense among those like Jonsson and Inghe that the individual was mouldable by social relationships, which in turn meant seeing all children as the bearers of a future society; one that they hoped, if children were treated properly, would be a democratic society that had distanced itself from the authoritarianism of fascism and communism. In this context, psychoanalytical thinking provided intellectual inspiration.

Jonsson was to serve as one of the experts on the Youth Inquiry. From his extensive study of children who had come to the attention of the municipal social services he concluded that at an early stage these youths had displayed psychological symptoms that the social services had simply ignored (SOU 1944:30, 178–261). For him, such findings confirmed the idea that a new kind of psychological health service was overdue. Later in 1944, Jonsson was appointed head of the first Child and Youth Psychological Service unit at the hospital in Karlstad, which was run by Värmland county council, and so found himself in the position to begin to put into effect the ideological and political programme initiated by the Youth Inquiry. iv
This ambitious political plan itself formulated a new vision of children. Most importantly, it posited that as children developed into adults they were moulded by their emotional relations to adults. Equally important, children’s problems or disturbances could be prevented from resulting in negative outcomes if detected in time and addressed through proper social and psychological interventions and care, i.e. Child and Youth Psychological Service.

The pragmatic approach

The Child and Youth Psychological Service was tasked with both identifying and treating emotional problems facing Swedish children. In their early years, the new units followed in the footsteps of previous child counselling measures offered by the social services and school health service (Jönsson 1997; Qvarsell 1985, 1993; Bergenheim 1990). Advice and counselling for parents of children with so-called adjustment problems, learning difficulties, or behavioural issues such as truancy dominated their daily caseloads. Furthermore, collaborating with schools and institutions took a great amount of time (SOU 1944, 59–77; Beskow 1952; Lindberg 1948, Jonson 1985). The upshot was that for the first ten–fifteen years, problems were largely defined in terms of social and psychological character, as was evident in the use of expressions such as ‘social maladjustment’, ‘behavioural problems’, and ‘psychological developmental deviancy’. The different kinds of treatment offered by the units were mostly of a social and psycho-educational character. The individual treatment of children was rare; instead it was the adults surrounding the child in question who were addressed. However, in the 1950s the range of psychological treatments and interventions was extended and the treatment discourse began to change. The individual child began to be identified as a direct object of therapeutic care in two contexts: the psychoanalytical treatment discourse and the child psychiatry discourse. Before considering these two discursive strands, it is worth outlining the salient features of the social and political context of the 1950s that helped spur these changes.

Ten years after its start in 1945, a total of ten Swedish county councils, including the larger municipalities of Stockholm, Gothenburg, and Malmö, had established Child and Youth Psychological Service units. In 1951 child psychiatry was recognized as a medical specialty, followed in 1958 by the appointment of the first professor of child psychiatry, Sven Ahnsjö. The concept of ‘child psychiatry’ had won acceptance and was at times even used interchangeably with the Swedish term for ‘child and youth psychological service’. However, in the early 1950s the service was re-examined by another, smaller commission,
Mentalsjukvårdsdelegationen (the Mental Care Sub-Commission). The sub-commission was part of a larger government inquiry commissioned in the early 1950s to look into the condition of the national health service in general. Within this wider commission, a select group of experts – two child psychiatrists, Ahnsjö and Erik Reinius; Elsa Jansson, a child psychologist; and Margit Jonasson, a social worker – were assigned to look at the progress made in mental health care for children (SOU 1957:40, 5–6). Their work resulted in yet another official government report, this time with the same name as its predecessor of 1944, *Psykisk barna- och ungdomsvård* (SOU 1957:40). The similarities did not stop there, for it too was a broad and thorough analysis of the provision of mental health care, and was intended to form the basis for future development. It was a presentation that in turn was embedded in a political vision that was Social Democratic in origin, but that vision had changed since the first report was issued and thus so did the charge given to the units. This time the main message was that Child and Youth Psychological Services should be offered by all county councils, and thus be incorporated in a national health service (SOU 1957:40, §§§). And, as already noted, the treatment discourse had broadened.

In *Psykisk barna- och ungdomsvård* (SOU 1957:40), treatments were discussed in far greater detail than in the previous report of 1944. The treatment discourses include ‘talk treatment’, ‘heilopedagogical treatment’, ‘insulin coma treatment’, and ‘medical treatment’, as well as a variety of expressions based on the concept of ‘therapy’, such as ‘psychotherapy’, ‘climate therapy’, ‘group therapy’, and ‘movement therapy’ (SOU 1957:44, 24–6). A similar discourse was evident in the first Swedish textbook on child psychiatry, *Elementär barnpsykiatri* (Basic child psychiatry) published in 1959 by child psychiatrist Anna-Lisa Annell. The headlines in the section on child psychiatric treatment pointed to various treatment approaches such as medical treatment, psychotherapy for the child, pedagogical treatment, parent treatment, and, finally, environmental treatment (Annell 1959, 300–17). In such a manner new kinds of treatment practices enlarged on past years’ more pragmatic approach of advice to parents, the social case-work approach, and educational assessments and testing.

Furthermore, in the Child and Youth Psychological Service Inquiry’s proceedings (SOU 1957:40), when child problems were discussed, a psychoanalytic discourse was used more frequently but without it being explicitly invoked. For example, in one section the authors argued that children’s bonding with their environment is emotional in character, and that such bonds are not only directed toward parents but also ‘teachers, staff at child institutions, friends...
etc.’ (SOU 1957:44, 21). This notion of the child was to a large degree created through a psychoanalytic discourse; it was a child outlined as an emotional being, with inner conflicts and feelings. Expressions such as ‘psychological conflict situations’, ‘conflicting elements’, ‘mixed feelings’, ‘inclination and disinclination’, and ‘neuroticization’ recur, as do descriptions of how a negative relationship with one particularly important (?)person in the child’s life, such as the mother, resurfaces in other relationships of a ‘similar character’, in this example with say a female teacher. A concrete example was also provided of ‘the child who steals from his employer, who actually represents what for the child is the unpleasant father’ (ibid. 22). In this increasingly psychoanalytical discourse, psychological (unconscious) conflicts were also depicted as the cause of later symptoms of distress, ‘the causes behind the development of social maladjustment’. The Inquiry also repeatedly highlighted an environmental perspective in its descriptions of children’s problems. Furthermore, the more explicit assertion of a causal relationship between children’s inner conflicts and social maladjustment and behavioural problems was also visible in another way. The Inquiry (SOU 1957:40) stressed the need to ‘psychologically clarify’ the mental processes that lay behind any problem in a child’s development. It also urged therapists to go beyond ‘theories of learning’ or ideas of ‘habit formation and moral education’ (ibid. 21) and instead to ‘go deeper’, meaning deeper into the ‘mental processes’ in the ‘area of emotions’. This was a new way of thinking, it was argued, based on modern scholarship and supported by modern medical(?) science (ibid.).

A main idea perpetuated by the psychoanalytical discourse highlighted in the 1957 Inquiry was that psychological problems in children were caused by specific circumstances in the child’s social environment. The challenge was to find the main cause and initiate change. However, despite the use of psychoanalytical thinking to explain children’s psychological problems and ailments of various kinds, it was not used by professionals in practice, as a diagnostic tool and form of treatment. Psychoanalytical child therapy was not yet a clearly designated or even fully legitimate (?) option among the professionals in Child and Youth Psychological Service. Instead it was an approach being studied and used only by a small group of specially trained professionals in Sweden. The institutional base for psychoanalytical child therapy was the Erica Institute in Stockholm, where both advice and treatment for children and training for child therapists were offered. As we will see below, Erica played an important role in the development of treatment ideologies in the Child and Youth Psychological Service. But, as noted above, the 1950s was a period that saw an open search
for analytical and professional tools – and not only ones limited to psychoanalytical modes of understanding. During that decade we see a growing interest in scientific findings in the relatively new area of child psychiatry among Swedish therapists, to which we will return after describing its primary source: The Erica Institute.

**The Erica Institute – bastion of child psychoanalytical psychotherapy in Sweden (?)**

The Erica Institute was founded by Hanna Bratt (1874–1959), a former headmistress of a private school for girls. At the start of the 1930s Bratt visited England to study progressive education and recent findings of child psychology. When she returned to Stockholm Bratt began to expand her small private practice for what she termed socially and psychologically maladjusted children (Bratt 1945). Owing to her efforts, the Erica Institute was established in 1934, and in coming decades it grew into an important institution in the field of child health care and welfare, and remains an influential institution for child therapy training today (Bergenheim 1990a; Blomberg & Carlberg 2004; Boalt Boethious, Kihlbom & Orrenius 1994; Zetterqvist Nelson, forthcoming).

At the Erica Institute, parents sought advice and therapy was provided for children, both in groups and individually. In 1936, its activities expanded to offer advice for parents. Moreover, due to the obvious lack of professionals with training in child therapy for parents, a series of seminars were established in 1937, which was the first step towards formal training for child therapists in Sweden (Bergenheim 1990a, 182). From 1938 on, Erica received financial support from municipal authorities, becoming in the process a mixed private and public enterprise. A formal training programme for child therapists was initiated, its research activities were expanded, and both activities were closely intertwined with clinical practice. School health professionals, social workers, and not least other kinds of institution all referred children and parents to Erica, but also parents sought help on their own initiative, for themselves and their children. The problems were defined in a range of ways, which often demonstrated who had referred the child: the school, the family, an institution, and so on. In yet another change in therapeutic vocabularies, categories such as ‘troublesome child’, ‘nervous child’, ‘disobedience’, ‘children with school problems’, ‘difficult child’ were common, while references to problems of a constitutional or genetic origin were absent. The activities at Erica reflected the intellectual currents of the time in much the same way as the Child and Youth Psychological Service. So-called difficult children were explained in terms of social and environmental processes rather than along moral and constitutional lines. Instead
of punishing or reconditioning children, the idea was to change their psychological development. Bratt wrote in 1945 of her ‘discovery’ of modern psychology and how it instilled in her the idea that no child is an impossible case: ‘in most cases the “impossible” child was not, is not, impossible, if only the fosterer could find a way to the child’s inner life, to the secret hiding-places of intellectual life’ (Bratt 1945, 82).

During the 1940s and 1950s, the Erica Institute offered training programmes for different professional groups who intended to do psychological work with children as special teachers, social workers, or psychologists. The intellectual tradition was psychoanalytical to a degree, primarily thanks its reliance on child psychoanalysts based in London. In the first years, Dr Margareta Lowenstein had been the inspiration for the development of the well-known sand-tray therapy (Zetterqvist Nelson, forthcoming). Anna Freud was later to become even more influential. There were also a handful of Swedish pioneers carving out child therapy approaches against the background of Erica such as Gudrun Seitz, Allis Danielsson, and Gunnar Harding. When in the 1960s child psychotherapy training was put on a formal footing by ?, Erica (or the Institute) was considered an important provider of child therapy training and had been at least since it was so recognized by a government inquiry in 1955, *Psykologisk utbildning och forskning* (Psychological training and research) (SOU 1955:11). As a part of that inquiry, a group of expert psychiatrists investigated whether psychologists should be allowed to carry out psychiatric treatment in the form of psychotherapy. In their special report, the group declared adamantly that psychiatric treatment was a matter for physicians; psychologists, they asserted, were not to be allowed to conduct treatments of any kind, since their mission in the psychiatric setting was psychometric testing. However, the situation was different when it came to child psychiatry, argued the group of psychiatrists. They granted child psychologists an exception when it came to treatment. The psychiatrists concluded that child psychotherapy required advanced psychological training, suitability on a personal level, and special training in psychotherapy. Meeting these extraordinary demands, they argued, justified the creation of a special category of psychologists (ibid.) to work with children who suffered from profound emotional disturbances (SOU 1955:11, 26).

Turning back to the Child and Youth Psychological Service and the treatment offered in its units at the time, the previous decades’ handfast advice and testing procedures were slowly broadened with child psychotherapy becoming an alternative form of treatment if child therapists were employed at the unit in question. Erica filled an important role in this process by setting up a child therapeutic practise and schooling a generation of child psychotherapists
with a background in child psychology and child psychoanalysis. However, running parallel to these developments was the emergence of a child psychiatric discourse, a medical speciality, and it is to this we will now turn.

**The emergence of a psychiatric discourse**

In the 1957 Child and Youth Psychological Service Inquiry (SOU 1957:40), a psychiatric discourse appears in various ways. Perhaps the least obvious is through the way the treatment alternatives are framed in the Inquiry. In one section the child mental problems and diagnostic categories to be used by the Child and Youth Psychological Service are brought up. Irrespective of what kind of problems, each is framed as a medical issue and for each and every one a specific treatment alternative is suggested (SOU 1957:44, 25–6). For example, a condition such as social maladjustment was to be treated by measures such as institutional care or support for the parents, neurotic behaviour was to be treated by child therapy, and so on. The concept of diagnosis-treatment serves as a model here, even though the problems outlined were more of a social or psychological character. But the psychiatric discourse also appeared in a more straightforward way. A new medical category was introduced: mentally ill children (SOU 1957:44, 119). The Inquiry’s medical experts, who in most cases specialized in paediatrics, singled out specific conditions such as schizophrenia and childhood psychosis to illustrate the new category. These conditions, they asserted, were problematic and difficult to understand without a psychiatric frame of reference. This partly new way of defining specific problems in childhood, through the adherence to psychiatric terminology, was also evident in other materials produced in the era. Expressions such as ‘the mentally ill child’ began to appear in scientific articles and textbooks (Ahnsjö 1954; Annell 1959). A very obvious way in which the psychiatric discourse began to be used was the emergence of mental hospitals expressly for children as a new issue. It was psychiatric terminology that was used to legitimate an alternative to what was described as the highly unsatisfactory solution of placing children in adult mental hospitals. And more than rhetoric and terminology was involved. The Inquiry commissioned a special survey to establish the total number of children with ‘grave psychiatric disorders’ in Sweden – taking it for granted that such disorders could be defined in such a manner – and used it to conclude that a mental hospital for children was called for (SOU 1957:44, 119–40; see also Zetterqvist Nelson 2009). This suggestion was never taken any further but the mere fact that it was proposed was significant.
By the end of the 1950s a psychiatric way of talking about specific problems in childhood had now been introduced even though it was used with notable caution. Professor of child psychiatry Ahnsjö began one article about ‘schizophrenia in children’ by saying, ‘It seems probable that for every child psychiatrist, child schizophrenia has been a problem, perhaps to the extent of questioning whether it exists’ (Ahnsjö 1954, 1605).vi His comment as to whether the condition even actually existed exemplifies a recurrent hesitance over the use of psychiatric discourse for children despite its new acceptance. Such ambivalent attitudes toward the psychiatric approach were common among many of his colleagues. And even after the Child and Youth Psychological Service was re-named after 1960 to Child and Youth Psychiatric services, the hesitance and ambivalence with regard to child psychiatric classifications and treatment persisted in the years to follow. The refusal to embrace completely psychiatric classifications and treatments indicates a lack of ideological acceptance of psychoanalytical treatment discourse, which seemed a matter of course in the policy documents in general. But as we shall see, it can also be understood in terms of the growth of the professions and institutional expansion.

**Mandatory child psychiatric provision**

As already noted above, in 1960 the organization not only changed its name to Child and Youth Psychiatry service, all of its units were granted state funding. The organization (or the units?) was to be run by the county councils, supervised the National Medical Board (Memorandum 1959; Kungl. Maj:ts kungörelse 1960:619). Two years later the Board issued standardized instructions (Kungl. Maj:ts kungörelse 1962:17), in which the main tasks of child and youth psychiatry were outlined. These were more or less in line with previous years’ formulations, with their strong emphasis on ‘medical, psychological, pedagogical, and social measures’ for children and young people in order to overcome such social conditions as may lead to ‘psychological disturbances’, as well as treating affected children and young people (ibid. 4).

Child psychiatric care had now become a mandatory part of the burgeoning national health service. As already noted, the 1960s were characterized by an immense expansion in child psychiatric services in terms of actual clinical units, from just 1 unit in 1945 to 10 in 1960, 13 in 1965, 27 in 1968, and ultimately 30 in the 1970s. By that point reorganizations of existing clinics had began, with for instance the creation of special in-care units in the larger cities specifically designed for children and young people with grave psychiatric problems.
Yet despite the sheer size of the expansion, it was implemented with a budget that fell far short of that for state child-care.

The expansive years of the 1960s also saw the beginning of a huge increase in professional groups – which all had a stake in the treatment of children with problems. In the mid-1950s the total number of professionals involved in child diagnostics and child treatment, making up the child counselling teams in out-patient units, amounted to 47 child psychiatrists, 32 psychologist, 13 child therapists, 23 teaching assistants, and 46 social workers (SOU 1957:40, 48). The figures changed dramatically, and not to the medical profession’s advantage. By the middle of 1975 there were 146 posts for child psychiatrists, 261 for child psychologists and 234 for child psychiatric social workers (Socialstyrelsen 1980, 26–7). These numbers demonstrate the increase in numbers of professionals in child psychiatric provision in general, but primarily in the non-medical professions such as psychologists and social workers associated with out-patient services. By now the child psychiatry discourse was formally recognized with the new designation ‘child psychiatry’, but it was not integrated into the ideological commitment of the new organization. In these years of expansion, it was the child psychoanalytical perspective that began to take shape as a main treatment ideology. The child psychologists were as we have seen a growing professional group – and, moreover, a professional group that was already recognized by the medical authorities as qualified by dint of their child expertise to carry out child psychiatric treatment. The theoretical basis for most of them was child psychology and, more specifically, child psychoanalytical theory.

One of the leading figures was the psychologist and child therapist Inga Sylvander (1920–2001) (Gieser 2009; Rigné 2002). Sylvander trained as child therapist at the Erica Institute in the 1940s and was then appointed as the first psychotherapist at the child counselling service in Stockholm. Her professional career started in the 1960s, and in the coming decades she published several influential books and articles on children and child psychotherapy (see, for example, Sylvander 1978; ead. 1982). Sylvander’s works on child psychotherapy were used in psychologist and child therapist training. Her first book, Barnpsykoterapi (Child Psychotherapy) from 1974 was published in a second edition in 1978, and republished in 1983, with some revisions and a new title, Psykologiskt arbete med barn: diagnostik och terapi (Psychological work with children: diagnostics and therapy), and this in turn came out in two more editions, in 1987 and 1996. In addition, Sylvander was influential in the publishing world, and in 1972 was elected chairperson of Psykologförbundet (the Swedish Society of Psychologists), a position she held until 1982. In the same period she took
up a similar position in an association for psychodynamic therapists, *Föreningen Psykoterapicentrum* (National Federation Psychotherapy Centre) (Rosengren & Öfverström 1971, 259–60). Last but not least, she was chosen to sit on several governmental inquiries on children’s issues. An important example here was Sylvander’s participation in the inquiry commissioned to investigate the strong criticism of the state of child psychiatric provision (SOU 1985:14), to be discussed below.

Sylvander’s position in the public eye, her professional influence on the child counselling service in Stockholm, and her child therapy research made her a central figure in the development of psychodynamic therapy as a main treatment alternative in child psychiatric care in the 1960s. In a 1962 article published in the Danish journal *Nordisk psykologi* (Nordic Psychology), she presented a new direction in child therapy (Sylvander 1962). The article revolves around a case-study of a psychotherapeutic process with a six-year-old boy that outlines the new theoretical approach to, for example, psychology. An important feature of this approach was the stress on ego function, which was in turn originally inspired by Anna Freud’s writings (1946) (see also Geissman & Geissman 1998, 251–70; Ludvigsen & Seip 2008, 18). Ego psychology was characterized by its rejection of the view that the ego was ‘the helpless rider of the id horse’ (Sylvander 1962, 110), and Sylvander draws on American representatives of the approach such as Eric H. Ericson (1959), Rapaport (1959), Bellak (1956), and Wolberg (1954). Her discussion of ego psychology in relation to child therapy emphasizes how the aim of psychotherapy was to assess and support child ego development. The diagnostic procedure that preceded any choice of therapeutic intervention consisted of an evaluation of the ego strength, which was carried out during sessions with the child consisting mainly of play and talk, in order to correctly judge whether the patient needed supportive therapy or insight-oriented therapy (Sylvander 1962, 112).

The treatment approach was clearly defined as a *child* therapy approach, and the differences to therapy for adults were discussed by Sylvander, of which the most obvious was the child’s dependence on their parents and their surroundings, but also aspects such as linguistic ability. This implied a call for alternatives to verbal communication such as playing and drawing with the child in question (Sylvander 1962, 112–13). But differences were not only discussed in regard to *adult* therapy, for Sylvander also stressed the distinction between the ego psychological approach and psychoanalytic-oriented child therapy, or child analysis (ibid.). In comparison to past child therapy provision at the Erica Institute, the ego psychological approach to some extent developed along similar theoretical lines. Anna
Freud’s approach had played an important role in the development of a child therapy tradition in the therapeutic activities at the Erica Institute. What was new with Sylvander’s approach was a clearer adherence to American scholars of ego psychology, as well as a stricter adherence to one psychodynamic approach, in contrast to previous decades’ eclectic mix of different theoretical outlines of child therapy (Zetterqvist Nelson, forthcoming). The American tradition placed stronger emphasis on the importance of adjustment with regard to psychological health, which to some extent rang true with the American ideals of individual independence and rationality (Roazen 1980; see also Tryon 1986). But before looking at the policies of the 1970s and 1980s, the standing of the child psychiatry discourse will be discussed.

The vagaries of the child psychiatry discourse

_Mentalvårdsberedningen_ (the Mental Health Care Working Committee), which was commissioned in the early 1950s to oversee Sweden’s mental health services, produced a memorandum dated 14 March 1968 that summarized the development of child psychiatric services from their earliest beginnings to the present (PM 1968). The sections dealing with diagnostic processes and treatment drew on a paper authored by the child psychiatrist Anders Torold (PM 1968, 37–8). In various situations Torold had presented himself as a radical socialist aligned with past generations of socialist doctors who had been active in building up both child psychiatry and social medicine as new medical specializations (§§§). During the 1960s Torold joined others in loudly questioning traditional psychiatry, with its intellectual inheritance from the Freudo-Marxists and the Frankfurt School. Torold’s radical ideas had their counterparts elsewhere in Scandinavia, such as those advanced by the famous Norwegian psychiatrist Svein Haugsgjerd in his well-known textbook _Nytt perspektiv på psykiatrien_ (New Perspectives in Psychiatry) (1971). Torold argued in favour of a ‘critical social psychiatry’, one that directed criticism toward what he termed the hegemonic position of expertise and professionals in child psychiatry as in other welfare and health services (Torold 1976). It was, he argued, an expertise based on a scientific tradition that valued objectivity and evidence, which in turn represented a hierarchical and repressive society with all its inherent injustices. The alternative, according to Torold, was to take seriously the idea of _political consciousness_. By doing so, he contended, psychotherapy became the main alternative in psychiatric treatment. It was a therapeutic approach with emancipatory aims.
Working paper

15 June 2011

Torold’s perspective was thus presented with the help of a rhetorical rejection of diagnostic practices, which he defined as repressive.

Returning to the question of how child psychiatric treatment policies for out-patient services developed (?), what did the 1968 memorandum reveal in light of Torold’s critique? Diagnostic practices were discussed with similar disparagement as being relics of the child psychiatrists in the 1950s, including their ambivalence towards medical diagnostic classification. In the memorandum, contemporary diagnostic classifications in child psychiatry were also criticized for failing to be systematic because of competing theoretical schools, and for being based on the classifications used in adult psychiatry without paying heed to child developmental issues (PM 1968, 36–8). The alternative, it was argued in the memorandum, was a ‘multidimensional perspective’ in the practise of child psychiatric diagnosis; by implication, this would be a diagnostic process that went beyond individual symptoms to consider aspects of the child’s life such as heredity, somatic status, age, biology, and social milieu. Such diagnostic approaches, where used, should therefore be of a descriptive character (ibid).

Ironically, this critical discussion in the memorandum was immediately followed by a presentation of child and youth psychiatric conditions, mostly in terms of psychiatric disorders of a descriptive character but some also etiological in character. It is beyond the scope of this article to go into detail here; the point is that a detailed presentation of contemporary diagnostic categories was framed by a critical discussion of the same, a familiar rhetorical turn in the policy documents we have studied for this paper. (ibid. 38–45).

Turning to the more specific discussion of treatment alternatives, unlike the debate of previous decades the memorandum proposed a new approach. Diagnostic categories, it urged, should no longer be related to specific treatments. In contrast to the discussion in the policy documents from the 1950s, in which diagnostic categories were tied to specific treatment approaches, the memorandum stated that diagnostic categories should now be separated from treatment alternatives and vice versa. The treatment approaches dealt with in the 1968 memorandum were also related to the kind of care organization in question: outpatient or inpatient care (ibid. 46–54). Treatment alternatives were only presented according to the kind of care that was proposed. Thus in comparison with the discussions in the 1950s, where diagnostic classification codes and socially and psychologically defined categories alike had been linked to specific treatments, the discussion in the 1960s changed course. Whenever diagnostic classification was on the agenda, it was not only handled critically, it was also
discursively separated from discussions of treatment. Qualified out-patient care was not associated with diagnostics of the problems but with only with treatment practices (ibid. 46). If we look more specifically at child psychiatric out-patient care, the treatment discourse of ego psychology encompassed a similar rejection of classic medical diagnostic procedure. Before turning to the ego psychological views of diagnostic procedure, the political radicalization of the time must be considered, for it enforced treatment policies and ideological traditions in the Child and Youth Psychiatry Service.

**Radicalization and the ‘new psychiatry’**

Beginning in 1968 a process of radicalization began to permeate the public sector as it continued to grow (Ohlsson 2008). The psychiatric services and mental hospitals, and their coercive approach towards mental patients, were strongly criticized in public debates and the media. Anti-authoritarian, client-oriented approaches were presented as alternatives, often with a strong emphasis on psychodynamic theories as a contrast to previous biological–medical thinking that, according to its critics, had dominated Sweden’s psychiatric wards and mental hospitals.

The government authorities were quick to adopt these new approaches. A report from the National Board of Health and Welfare in 1973 on the state of psychiatric care and mental hospitals outlined the ideology of the so-called new psychiatry (Socialstyrelsen 1973). The main message was the importance of seeing that psychiatric problems were related to social circumstances and political context (ibid. §§§). Organizationally speaking the focus was on out-patient care, with geographical proximity the goal, along with treatment programmes based on a psychodynamic approach combined with a multi-dimensional view of the causes individual psychological disturbances. The psychodynamic perspective was launched as an important alternative first and foremost to biomedical psychiatry, but also to treatment methods based on behavioural learning theories (see also Cullberg 1971). What mattered ideologically was the notion of the human being as a dynamic subject, in contrast to allegedly mechanistic views of both biologically oriented psychiatry and behavioural approaches. Where did Child and Youth Psychiatry fit in this new context of political radicalism?

Child psychiatric provision was hardly dealt with at all in the 1973 report, being limited to a short, two-page description (ibid. 73–4). But this short section deemed the activities positive, not the least in comparison to what was described as the harsh conditions of mental hospitals and psychiatric care for adults. A psychodynamic notion of human subjectivity and
emphasis on a multi-dimensional perspective in assessing psychological and psychiatric ailments were mentioned favourably as characteristics of child psychiatric care. Furthermore, the strong position of the psychodynamic treatment approach was highlighted. Given the overall message of the report, this amounted to implicit approval. So even if there was a touch of criticism of the time costs of child psychiatric assessments and treatment programmes, as a whole the report treated child psychiatric care quite positively (ibid. 74). And indeed, the ‘new’ in the ‘new psychiatry’ was not new in relation to the Child and Youth Psychiatry organization and its precursors. The visions of a new child and a democratic society in the development of Child and Youth Psychological Service, which permeated the policy documents of 1944 (SOU 1944:30) and 1957 (SOU 1957:40), predated by twenty years the visions of ‘new psychiatry’ in the 1968 and 1973 reports. The arguments from those earlier years that children should be brought up in psychologically healthy environments, with due consideration of their emotional conflicts and dynamic inner worlds, were in accord with the ideas of anti-authoritarian and emancipation of the ‘new psychiatry’ aimed at the adult psychiatric patients. Thus the Child and Youth Psychiatry organization predated radical changes in “new psychiatry” branch of medicine. However, in this time of political change and radicalism Child and Youth Psychiatry itself began to take another route, most obviously in its outpatient treatment ideology.

**Hegemonic psychodynamic treatment ideology**

In the 1970s the goals of the child psychiatric services were significantly (?) fundamentally (?) re-formulated (Socialstyrelsen 1980, 11–12; see also SOU 1985:14, 57). The content was the same as before, pointing at both the preventive societal mission and the task to identify and treat individual children. But what had previously been defined as the second goal in policy guidelines was now rated the first, namely to identify, treat, and relieve psychological disturbances in children and the young. On a rhetorical level what had once been the priority was now subordinate to the more practice-oriented goal of helping individuals. (anslaget här är jag lite osäker på ?) These changes in child and youth psychiatry were shaped by both the ideological climate and policy issues of the 1970s as well as by the piecemeal development of the medical profession and its close interaction with the expanding psychologist profession. This is illustrated by an extensive survey of on-going child psychiatric provision carried out in 1975 by the National Board of Health and Welfare as a direct response to the survey of other psychiatric activities. The report, published in 1980, was written by a group of experts and
was entitled *Barn- och ungdomspsykiatrisk verksamhet i Sverige* (Child and youth psychiatric provision in Sweden) (Socialstyrelsen 1980)

Responses to extensive questionnaires sent to 70 clinical units revealed a situation in which out-patient care suffered from a significant lack of physicians (a total of 146 posts, of which 25 had not been filled full-time); while all the psychologists together numbered 261 with only a few vacant posts; and social workers numbered up to 234, with a total of 10 vacancies (Socialstyrelsen 1980, 27). The survey responses also revealed a situation in which the majority of child psychiatrists, psychologists, and social workers lacked formal therapeutic training. There was clearly a great demand for psychotherapy training, and the ones most sought after were individual child therapy and family therapy (ibid. 112–13). This lack of training mirrored the training situation on a national level, since formal therapy training at the universities had not yet been initiated (Gieser 2009).

The answers to the survey’s questions about daily practices in child psychiatric out-patient units document a situation in which the professionals in those units had shaped their daily practices as they saw fit, with little recourse to universal models of treatment (ibid. 44–54). Firstly, formal medical diagnostic classifications such as the WHO’s model were rejected in favour of other kinds of description of the children’s problems, such as ‘concise classifications’ or ‘functional descriptions’ (ibid. 47–8). These descriptions were primarily based on anamnestic talks with children and parents, sometimes in combination with psychodiagnostic testing procedures. However, many of the clinical units reported a decline in the use of psychodiagnostic methods in the previous five years (ibid. 52). Instead, the diagnostic procedures carried out by professionals were embedded in an overall treatment discourse that was psychodynamic in character. In such a situation, the diagnosis of the child’s problems was defined as part of the treatment plan and accordingly continuously updated relative to the treatment process. The introduction to the report’s section dealing with diagnosis and treatment noted: ‘To identify and demarcate the problems is a prerequisite for adequate treatment. Diagnostic thinking should permeate and pervade the treatment processes’ (ibid. 44). It was an approach that clearly differed from diagnostic procedures in based on medical classifications. The latter approach had been strongly rejected in the ‘new psychiatry’ discourse, and in a similar manner the actual provision of child psychiatric services demonstrated an opposition to medical diagnostic thinking. Thus we can see how the anti-diagnostic approach encouraged by the radical ideas of the day was amplified by the ego psychological school and its way of seeing diagnostic categories as a continuous part of the
therapy process. This implied that the professional’s interpretation in actual daily practice was privileged, since the diagnosis was established in the therapy room with only the therapist and child/parents present. A common thread in descriptions of both diagnostic procedures and treatments alike was the emphasis on ‘talk’. If we look specifically at what kind of talking treatment was carried out, the most common alternatives for both child and teenage patients were ‘ego supportive psychotherapy’, ‘supportive contact’, and ‘insight therapy toward specific goals’ (ibid. 52; 103–104). For younger children, psychotherapy nearly always implied seeing children and their parents in parallel. Alternative treatments that were reported in the questionnaire included ‘behaviour modification’ and ‘relaxation’, ‘suggestions-treatment’, ‘casework’, and less frequently ‘psychoanalytical treatment’ (ibid. 52).

The professional groups that can be identified in the government report as responsible e for outpatient treatment in Swedish child psychiatric units stressed psychotherapeutic talk as their main tool, both with regard to diagnostic procedures and treatment, but they also reported a lack of formal training. So at the same time that Child and Youth Psychiatry had ‘grown up’ in the sense of becoming a mandatory part of the national health service, its professional competence had not developed at the same speed. Bearing in mind the primary aim of the work – to identify problems and offer therapeutic treatment – it was still very early days when it came to professional training. The pragmatism of the 1950s, with all its different activities, was long gone, and in its place we can see the growing influence of psychodynamic thinking toward a position with hegemonic claims on definitions of children’s psychological health and problems and on treatment strategies. The specific position of psychodynamic thinking in policy documents of the time was not only evident in the descriptions of actual individual treatments; it was also a seemingly self-evident starting-point when other issues were put on the agenda. For instance, in the 1980 report Barn och ungdomspsykiatrisk verksamhet i Sverige (Child and youth psychiatric provision in Sweden) (Socialstyrelsen 1980), the introduction to a section on child psychiatric diagnosis and treatment began by stating that a child psychiatric perspective implied the comprehensive assessment of the child and her or his family situation, as well as other aspects of their lives such as schooling, social life, genetics, and so on. But this formulation was followed by the assertion: ‘Symptoms for a serious disturbance that originated in early age and for an age-specific crisis may sometimes the same, even though the need for intervention in both these cases is entirely different’ (ibid. 44). The sentence conveys two important concepts: psychological ‘disturbance’ and “early age”, the latter referring to child development as a process of evolution towards higher
developmental stages, against which the ‘disturbance’ takes place. Disturbance was a concept from the ego psychological framework implying an obstacle to the child’s development, which in turn could be the result of social, societal, environmental, or biological factors. Thus in talking of ‘disturbances’ the differentiation between ‘early’ and ‘late’ disturbances is important. If an ‘early disturbance’, then it required more treatment interventions; ‘a disturbance at an early stage requires extensive interventions’ (ibid. 45). In other cases it could take the form of a transitory psychological crisis, requiring a shorter intervention (ibid.). Furthermore, it was stated that, irrespective of cause, the main aim of the therapeutic talk was to create possibilities for the child or young person to come to terms with the therapist, and even create a more fruitful relationship, and thus be able to overcome a pathological disturbance (ibid.). In these descriptions it was taken for granted that children and youth were assessed from a psychodynamic point of view, for example by stressing how it was necessary to examine whether the demands put on the child or teenager were adequate relative to her or his ‘ego-strength and developmental level’ (ibid. 44).

The policy documents, textbooks, and other material outlining the treatment of child psychiatric problems, such disorders were also defined as primarily related to the child’s inner psychological world, be it conscious or unconscious. The psychodynamic approach was an individualizing approach but it did not contest the emphasis on a so-called multidimensional perspective on children and young people. The following example taken from the official government report Den barn- och ungdomspsykiatriska verksamheten (SOU 1985:14) demonstrates such a common discursive pattern:

Psychological disturbances in childhood and youth can overall be defined as a result of disturbances in the individual’s conditions of personal growth and development. Such conditions can be constitutional or intra-psychological in nature, or anchored in or outside the family’s circumstances. Irrespective of the objective localization of these conditions – within or outside the individual – they affect in some way the individual’s conscious or unconscious psychological world. It is by means of this influence that they have a disturbing effect on the individual’s development. (SOU 1985:14, 57, our italics)

Social and cultural factors were discussed, but always in relation to how they may affect the child’s inner psychological world. Thus the psychological dilemma was related to the individual child, irrespective of external factors such as family and school situation, social
class, and so on. According to the explanatory framework provided by ego psychology, the inner world of children was thus moulded in childhood in such a way as to determine their psychological well-being well into youth and adulthood. The inner world of the child admitted to a child psychiatric out-patient unit was considered the main focus in any diagnostic assessment and therapeutic process.

The adherence to psychodynamic theory was also evident in more general descriptions of children. In a chapter entitled *A little about children’s needs and development* (SOU 1985, 29–38) a psychodynamic framework is the accepted conceptual approach to explain child development and children’s needs. Brief mention is made of the American psychologist and child therapist Margaret Mahler (1984), as well as the grand old man of ego psychology, Erik H. Eriksson (1977), yet there is no reference to alternative theories or ideas when children, child development, or psychological problems are discussed. The ego psychological framework, now augmented by Mahler’s object relation theory and ideas of separation–individuation, remained the dominant discourse in discussions about problems and treatment alternatives, but it did not go unchallenged. It was called into questions by newcomers in the field of treatment ideologies, namely family therapists.

**Family therapy treatment as a challenge**

The psychodynamic treatment ideology was challenged by alternative ways of thinking about psychological disturbances and problems, primarily by family oriented therapeutic work (Socialstyrelsen 1980, 54, 98; SOU 1985, 63, 67). With origins in the US, mostly in in-patient psychiatric care and articulated by child psychiatrists, this approach encouraged a move to redefine child and youth psychiatric problems in a more socially oriented explanatory frame. Children and young people’s problems and symptoms should be related to familial interactions rather than to the inner life of the child or youngster (Weinstein 2002).

The introduction to this new approach in the Swedish Government Official Report of 1985 illustrates the – dominant – hegemonic position of psychodynamic thinking: “Psychological disturbances can be described and treated through different theoretical points(?) of departures. A family dynamic approach is generally accepted within the Child Psychiatric activities” (SOU 1985, 63, authors italics). The acknowledgement of different theoretical points(?) of departures stands in contrast to the way psychodynamic thinking is taken for granted elsewhere by the Inquiry, thus turning the latter into one of several theoretical perspectives. But the new family therapy approach to treatment consisted of a
range of different versions, as reported in the 1975 survey, from psychoanalytical and communicative/structural approaches to more eclectic versions (Socialstyrelsen 1980, 54). So even if family treatment was a new trend, in comparison to the individualizing trend of psychodynamic thinking in child therapy, it was not a unified approach and the professionals who adhered to it mostly lacked formal training and could not challenge seriously the dominance of the psychodynamic tradition. Family therapy treatment was an alternative, but it was used to a lesser extent and mainly carried out in the in-patient wards (Socialstyrelsen 1980, 105–106). The family therapy approach also seemed to engage child psychiatrists to a greater extent, far more than the psychologists trained as child psychotherapists.

Consequently, the introduction of the family therapy approach also posed a professional challenge, and one led by a group of radical child psychiatrists.

Another kind of challenge was also emerged during these years. It was brought about by a broader critique of the child psychiatric activities articulated by agents outside the Child and Youth Psychiatry. As mentioned above, the official government report entitled Den barn-och ungdomspsykiatriska verksamheten: Slutbetänkande från BFU 1981 (SOU 1985:14) was the result of a government inquiry that had been commissioned to investigate the growing criticism of child psychiatry from official representatives of social services, child health care, public child-care, school health care, and so on. The child psychiatric services were accused of failing in their obligations since the organization only dealt with motivated clients, avoiding those with social troubles; had long waiting lists; was troubled by inner conflicts over therapeutic schools; and was unable to co-operate with other welfare institutions (SOU 1986:14, 9). Furthermore, the child psychiatric services as a provider of medical care was called into question when critics pointed out that municipal services such as state child-care and family counselling that offered similar kinds of services. Was the Child and Youth Psychiatric organization really a medical health unit (?)? Why not place the organization within municipal services?

The BFU Inquiry included representatives from professional unions and national associations, which resulted in an inquiry with a large group of people representing various parts of the child welfare services. An extensive survey was carried out to examine the collaboration between the child psychiatric service and the welfare state services for children and parents (SOU 1985:14, 133–68). The report, published three years later, confirmed that while the criticisms were to some extent warranted, changes were not necessary because as an organization Child and Youth Psychiatry had already began to remedy the situation, not least
by collaborating with other child welfare institutions (SOU 1985:14). In that way the critics were fended off and child and youth psychiatric services were left organizationally intact, retaining their place in the welfare system hierarchy. The specific nature of child psychiatric services demanded that it continue as part of the medical health care system, and thus it was regarded as a specialist organization to which other services – closer to children and families in the course of the daily provision of schooling, day care, and child health care – could turn to for advice, training, and, when needed, specialist assessments and treatment of children in need (SOU 1985:14, 13–18). An assessment of this institutional collaboration lies beyond the scope of this article, but the main message was that the child psychiatric service was not to be changed in any way; it fulfilled an important role and had all the interaction necessary with social services. No change was needed. The criticism heard from outside the organization had been partially deserved, it was said, but several measures had already been put in place that would improve collaborations and the formal competence of the child psychiatric professionals. A smaller investigation carried out by the Inquiry did point to some failings in the complex relationships with other child welfare services, but these were never mentioned in the Inquiry’s concluding discussion, and was only added as an afterthought (ibid. 169–80).

Child psychiatrists and child psychologists rejected any criticism of the child psychiatric services and its place in the national health services. They argued in a manner similar to the medical doctors by defending the idea of the Child and Youth Psychological Services as a health matter within the Youth Inquiry of 1944 (SOU 1944:30). In that way the two main professional groups in the organization participated in a joint mission to preserve the child and youth psychiatric services as a part of the national health organization, which implied a medical hierarchy in which the psychologists had a privileged position to define problems and outline treatment ideas.

**Concluding remarks**

The present article examines the historical development of treatment ideology and policy in child psychiatric outpatient activities in Sweden between 1945 and 1985. It pays particular attention to the seeming dominance of psychodynamic approaches in treatment ideology and policy.

The outline of a nationwide organization of child mental health care placed within the national health care services was carried out by the 1944 governmental Youth Inquiry commissioned to deal with issues concerning youth delinquency. By framing the problem as a...
societal problem rather than moral problem, mental health care services for children and youth was considered as an important step in the prevention of youth problems. By placing theses services within the national health care services, thus open to all social classes, the idea was to avoid the stigma connected to income based (?) municipal social child care services. The radical political discourse that permeated the outline was informed by psychoanalytical theory, presented as ground breaking because of its way of explaining child psychological problems. It challenged the image of the inhibited child of authoritarian education, subdued by loveless upbringing and physical punishment, by providing an alternative image; namely children as emotional beings with strong bonds to adults in their surroundings be it parents or other family members or teachers and other important adults. The way the problems were defined and the way children were accounted for demonstrate how psychoanalytically informed concepts and explanations were taken up and used in an ideological fashion, i.e. without theoretical references, as if being the only alternative to the old and conservative concept (?) of the inhibited and subdued child.

During the first fifteen years of the child mental health care activities, the treatment practice was dominated by the more pragmatic approach that previously had been developed in municipal social child care and school health services. The professionals dealt with parent advice, psychometric assessments and a great deal of social care issues related to placement in institutions and school situations. In this period two new discourses began to appear that dealt with the treatment of children’s mental health problems in a more direct way. Firstly, a psychoanalytical child therapy discourse began to develop with the specific aim to treat children in accordance with psychoanalytical theory. Simultaneously a psychiatric discourse began to emerge outlining specific child psychiatric disorders and psychiatric treatment for them. Renaming the organization formally child and youth psychiatry was a sign of the formal recognition of the latter discourse, which had now turned into a medical speciality and scientific tradition. However, in practice, among all professionals including child psychiatrists themselves maintained a critical distance from psychiatric diagnostic classifications. As a result, the former discourse, which encompassed theories of psychoanalytical treatment for children, remained a central element in the child psychiatric activities, specifically outpatient care. In the 1960s child psychiatric activities became mandatory for all county councils and psychodynamic child therapy ideology assumed a strong position within child psychiatric outpatient care. It was supported by child psychologists as a professional group, who increased in numbers and influence during these years. When the radical turn made its appearance in adult
psychiatry in the end of the 1960s, its message of equality for all social classes, an anti-psychiatric approach and psychodynamic therapy as a central treatment alternative, was in reality similar in content to that of the founders of the child psychiatric health care services. Ironically, the treatment ideology of child psychiatric outpatient activities had by now begun to turn away from traditional child psychoanalytical child therapy. Instead the American ego-psychological treatment discourse had become a central source of inspiration, an approach that in turn focused on the individual child and its inner emotional world as the central point of therapeutic change. In this way the ideological heritage of a psychoanalytical approach lived on, but instead of being allied to a political discourse of change with a new vision of childhood it was now integrated into a treatment discourse focusing the child and the inner world of the child.

The development of child psychiatric treatment policies in Sweden from 1945 to 1985 encompassed strong visions of a new childhood and a new way of seeing children as emotional beings. In this process the psychodynamic thinking has played an important role, first as a part of the ideological rhetorical underpinning of the new organization for mental health care for children and youth, then as a part of the treatment ideology in the child psychiatric outpatient care.

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1 The article is based on a study funded by the Swedish Council for Working Life and Social Science (FAS: 2005-0643).
2 See Appendix 1.
3 Sweden’s central government controls a bevy of national and regional government agencies along with the various regional and local political authorities. The elected Parliament appoints the cabinet; central government in turn regulates the form and general decision-making framework of elected local government, but not the political content. The political majority is often different at the local, regional, and central levels. Responsibility for child-care and social policy is divided between these various bodies in different ways in different periods, and the system of governance has been known to alternate between a focus on centrally issued directives and a general legislative framework that offers local government greater leeway to set independent policies. It is the political interaction between these different levels that is the heart of Swedish political culture.
4 Jonsson’s career in Psykisk barna- och ungdomsvården ended when he became head of Barnbyn Skå, an institution run by the social child welfare in Stockholm, where he continued to develop new treatment approaches to children with so-called behavioural problems.
5 The members were Rune B. Johansson (MP), Bertil von Friesen (MP), Dr Gunnar Inghe, Per G. A. Svensson (MP), S. A. Alarik Hagård (MP), Inga Thorson (MP), and the psychiatrists Dr Curt Åmark (divisional head at the National Board of Health and Welfare) and Dr Bo Gerle.
6 The article was published in Läkartidningen (Swedish Medical Journal).
For example, the total cost of child psychiatric provision in the 1960s was always less than half of the cost of the state ‘summer camps’. The cost of child and youth psychiatric services in 1960 was 700,000 Swedish kronor, while the cost of the official summer camps was 1.7 million Swedish kronor. In 1970 the proportion was 1.6 million to 4 million.

In addition to these groups, professional groups involved in in-patient services such as nurses totalled some 125 people.

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