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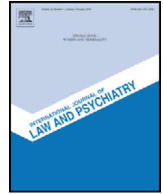

Sexual assault, irresistible impulses, and forensic psychiatry in Sweden

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ABSTRACT

After forensic psychiatry was firmly established in Sweden in the 1930s, many rapists and individuals charged with assaulting children underwent a forensic psychiatric examination. The physicians found that most of them had not been "in control" of their senses or not "in complete control" of their senses at the time of the crime. If the court ordered a forensic psychiatric examination, the defendant had a very good chance of either being discharged or having his sentence reduced considerably. By the 1950s psychological perspectives began to dominate in forensic psychiatry. In the forensic records of the 1950s we can notice a shift from a biomedical to a socio-psychological perspective, and crime was increasingly related to conditions that were not seen as mental derangement from a legal point of view. As a result, it became less and less common, from the 1950s onwards, for sentences to be commuted or defendants discharged.

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1. Introduction

In March 1943, a school teacher from the far north of Sweden appeared in court charged with conducting "offensive and indecent acts" with some twenty girls between ten and twelve years of age. He had been married for twenty years, was a well-respected member of the community, and was considered good at his job. However, he had violated his pupils repeatedly by touching their private parts, at times using force. The man did confess, but claimed that he had not committed the crimes in order to achieve sexual gratification. He said that by the time he was twenty-four and working as a supply teacher, he had begun to feel a powerful urge to touch one of his pupils and had not been able to resist his "inner voice". The court ordered a forensic psychiatric examination of the accused and he was found to be mentally sound. However, the examining physician found a number of extenuating circumstances and recommended that the court take these findings about his mental state into consideration. The forensic psychiatric report confirmed that the accused did not commit the crime to achieve sexual gratification, and that he had been compelled by an "inner voice" that he was unable to resist. The man was charged with "acts of public indecency", received a fine, and was set free (NAFP, 43-484).[1] It is obvious that, largely as a result of the high regard with which psychiatry was held by the Swedish justice system, the report had a decisive influence on this verdict.

In this article, I discuss the issue of criminal responsibility with regard to the attitudes to and notions of sexuality and gender in forensic psychiatry, and the impact of forensic examinations on lawsuits and verdicts in cases of sexual assault of women and children. What was forensic psychiatry's opinion of sexual assault in the past? Which aspects were considered significant in making an assessment? Which diagnoses were made and how? How much legal weight did the opinion of a physician actually carry? After a short background description of the historical development of forensic psychiatry in Sweden, I will focus on the period 1930 to 1960. During these three decades, emphasis shifted from a biomedical approach to a socio-psychological perspective. The main source material consists of forensic psychiatric records.

2. Historical and legal context

Examinations of the sanity of individuals accused of crime began making appearances in the Swedish judicial system as early as the eighteenth century.[2] The penal code of 1734 stipulated that insane individuals were incompetent to stand trial. It was suggested that a doctor could determine whether an act was committed in a state of insanity even if no signs of insanity were found at the time of the sanity examination, but during the eighteenth century this was rarely done. It was also very unusual for a mentally ill person to avoid conviction and punishment. In such cases, a doctor was required to determine whether the individual was simulating mental illness to avoid punishment (Qvarsell, 1993, p. 84). To ensure that the law

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[1] National Archive of Forensic Psychiatry, Huddinge Hospital, Stockholm, Sweden.

[2] Before the late nineteenth century, the most common expressions were *undersökning av den tilltalades sinnestillstånd* (examination of the defendant's state of mind) or simply *rättsmedicinsk undersökning* (medico-legal examination). *Rättspsykiatrisk undersökning* (forensic psychiatric examination) was common in the early twentieth century. With the Lunacy Regulation Act (1929), *sinnesundersökning* (examination of the mind) became frequent, and in the 1950s and 1960s *mentalhälsoundersökning* (mental health examination) was used in the traces of the mental health movement. Today *rättspsykiatrisk undersökning* (forensic psychiatric examination) is most often used. In this article, I will use "sanity examination" for the early period, and "forensic psychiatric examination" for the period after 1929.

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was being applied properly, an 1826 statute designated responsibility for making sure that physicians examined the state of mind of the accused if mental derangement was either suspected or invoked. The report of the physician would then be reviewed by a central authority – the Health Collegiate (*Sundhetskollegiet*), and later the National Board of Medicine (*Medicinalstyrelsen*) – that in turn provided the court with its own opinion. However, this opinion was not determinative, as the court made the final decision.[3]

Institutional care and treatment of the insane evolved during the first half of the nineteenth century. During the second half of the century, the religious-moral perspective on insanity that had dominated since the Middle Ages gave way to a scientific biomedical view. The result of this change was that all medical students received special training in psychiatry (Grönwall & Holgersson, 1992, pp. 17–21). The status of forensic psychiatry was strengthened by several scientific publications, including two doctoral dissertations (Ekdahl, 1893, diss.; Schuldheis, 1898, diss.; Wistrand, 1838, 1863; Wistrand & Wistrand, 1852). By the turn of the twentieth century, forensic psychiatry had become an independent discipline, and its perspective on criminality roused interest beyond medical circles.

According to the penal code of 1734, it was required that a defendant must be found permanently insane to be declared not responsible for his criminal actions. However, in 1864 a new penal code stipulated that the criminal's state of mind *when the crime was committed* was the decisive factor. Apart from insanity, other forms of mental deficiency were also considered. If the defendant was “not in control of his senses” (§5:5) at the time of the crime, he should be exempted from punishment. Further, if he had been “not in complete control of his senses” (§5:6), the penalty could be reduced significantly. Both §5:5 and §5:6 could imply a defence based on the notion of irresistible impulse. However, the law did not specify which psychiatric conditions this applied to, and the appraisal was in the hands of the forensic examiner.[4] Another potential judgement was partial insanity, but if §5:5 or §5:6 should be applied in such a case there had to be a clear connection between the partial deficiency and the criminal act. There was a tendency to free suspects on the basis of partial insanity in accordance with §5:5, and to use §5:6 only for minor cases of mental disorder (SOU 1996: 185, pp. 262–264). In the nineteenth century, Swedish courts applied the provisions concerning sanity examinations restrictively. With the passing of the Lunacy Regulation Act (*Sinnessjuklagen*) in 1901, which revised and expanded existing rules and regulations, a manual for sanity examinations was composed that made the examinations both more practicable and more reliable. The most immediate result was that the number of court-ordered examinations increased dramatically; the number of examinations tripled in just one decade.

Cases in which sanity examinations were conducted dealt primarily with serious violent crimes such as murder and arson (NASM,[5] B1A and B1B, 1826–1900; Börjesson, 1994, pp. 42–44). The first case concerning sexual assault is found in 1899 (rape of stepmother) and the first case concerning child assault in 1900 (NASM, B1A:63 and B1A:66, 1878–1914.). Cases involving sex crimes are a rarity in forensic psychiatric records a decade later. Simply, sexual assault was not considered to be a category of crime caused by an abnormal mental state (Bergenheim, 1998; Brouardel, 1883; Charcot & Magnan, 1882; Tardieu, 1860; von Krafft-Ebing, 1886). Before the turn of the twentieth century, the view about sex criminals was uncertain. Within early French forensic medicine, sex criminals were often described as infantile, alcoholic, of low intelligence, and overly sexual, but only in a few cases as insane. Sexual researchers viewed sexual assault as abnormal or extreme manifestations of normal tendencies in sexual life, likely caused by heightened sexual drive and lack of self-control. Richard von Krafft-Ebing was instrumental in European sexual research and psychiatry at the end of the nineteenth century, and his theories also influenced Swedish doctors. In the first Swedish doctoral thesis on forensic psychiatry, Axel Johannes Ekdahl adopted Krafft-Ebing's arguments, and recommended that sexual crime should prompt examination by a forensic psychiatrist (Ekdahl, 1893, pp 56–57). These ideas, however, were not readily accepted in Swedish courts (Qvarsell, 1993, p. 189; Stenbeck, 1927).

Forensic psychiatric practise oscillated between being too indulgent and too rigorous. If defendants falling under §5:5 were not considered to be dangerous, in need of treatment, or suffering from serious insanity, they were quite frequently sent home and sometimes put under family supervision, without any legal sanction. Furthermore, the defendants falling under §5:6 often received strikingly low penalties.[6] On the other hand, a decision to acquit someone and exempt him from punishment could also mean hospitalisation in a mental asylum for many years.[7] Hospitalisation could be for life, and the decisions were often made on weak grounds. Moreover, once the defendant was hospitalised he (it was most often he, as discussed below) was in the hands of the doctors and the medical committee at the mental asylum; the court no longer had any authority over the person's fate. The diagnoses made by forensic psychiatry could often appear to be more or less arbitrary. In many cases, it seems that it was taken for granted that the perpetrator was ill or abnormal in some way, and psychiatric examination was merely a tool to confirm this. In this way, the practise of forensic psychiatry differed greatly from the courts, where a pathological root of a sexual offence was not necessarily sought (SOU 1942: 59, pp. 126–139).

In 1929, a new Lunacy Regulation Act prescribed that forensic psychiatric examinations were only to be conducted in mental hospitals or a psychiatric departments of correctional institutions, by a physician specialising in psychiatry.[8] From the 1930s, forensic psychiatry was incorporated into Swedish social and criminal policy. This was a consequence of the growing influence of medicine in society, and the establishment of psychiatry as a medical specialism (SOU 1942: 59, pp 173–174; Börjesson, 1994, pp. 98–104). A new regulation made it possible to sentence criminals falling under §5:6, who were considered dangerous but unsuited for prison, to custody in a mental hospital. This regulation mainly affected individuals who were diagnosed as psychopaths. In the early 1940s, 80% of male psychopaths with reduced responsibility were hospitalised (SOU 1942: 59, pp. 6062). In the 1930s and into the early 1940s, psychopathy was viewed as a state of ill health and as such constituted a reason for discharge in accordance with §5:5, or for reduced punishment in accordance with §5:6. In the 1940s the diagnosis was frequently applied in different combinations, such as “schizoid psychopathy”, “sexual psychopathy”, and “homosexual psychopathy”. In practise, the psychopathy diagnosis could refer to a wide array of symptoms and seems to have been used more or less routinely in cases where a more exact diagnosis was not possible (Bergenheim, 2005, p. 201; Lidberg, 1977, pp. 555–571).

[3] Major research on the history of forensic psychiatry in Sweden is to be found in the following works: Roger Qvarsell, *Utan vett och vilja: Om synen på brottslighet och sinnessjukdom* (Stockholm, 1993); Mats Börjesson, *Sanningen om brottslingen: Rättspsykiatrin som kartläggning av livsöden* (Stockholm, 1994); Åsa Bergenheim, *Brottet, offret och förövaren: Vetenskapens och det svenska rättsväsendets syn på sexuella övergrepp mot kvinnor och barn 1850–2000* (Stockholm, 2005).

[4] The Penal Code (1864), §5:4–6.

[5] The National Archives of Sweden, Medicinalstyrelsen/Sundhetskollegiet.

[6] Swedish statistics do not show how many querydefendants under the §5:5 or §5:6 were sent home, in other people's care or under supervision and neither do they show how many of them were not institutionalized.

[7] From mid-nineteenth century to 1929, the word “hospital” (mental asylum) was used for institutions that provided treatment, and *asyl* (asylum) for institutions for individuals that needed care but not treatment, such as mentally handicapped people. From 1929 until 1958 *sinnessjukhus* (sanity hospital) was common and as from 1958 the official word is *mentalsjukhus* (mental hospital). In this article, I will use “mental asylum” for the early period, and “mental hospital” for the period after 1929.

[8] *SFS* 1929: 321, *Sinnessjuklag*, 6 chapter §§41–42.

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