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Heredity as a burden: causes of children's behavioural problems in Finnish psychiatry between the 1920s and 1950s

Katariina Parhi[1]

ABSTRACT This article analyses interpretations of the causes of children's behavioural problems in early child psychiatry in Finland from the 1920s until the 1950s. The era was pre-psychodynamic, and psychiatrists stressed biological explanations, which were based on hereditary factors. The source material consists of patient records of children diagnosed with psychopathy in Pitkäniemi Hospital, which operated as one of the state mental hospitals. The focus is on the ways in which the causes of behavioural problems were described, paying special attention to mentions of socioeconomic factors, and adopting a present-centred perspective on analysing the past. Although psychiatrists described details like family background and parental occupations, they did not necessarily use them to point out connections between socioeconomic factors and behavioural problems. On the contrary, in many cases, there was no indicated correlation. This is not to say that socioeconomic factors did not exist or were not acknowledged, but rather that they were discussed in a different light. The assumption of biologically oriented psychiatry, namely that behavioural problems were primarily hereditary, is prevalent in the case records. Some children improved while in hospital and subsequently returned home, or were placed with other families, or in children's homes. Those who were perceived to be permanently antisocial were placed in reform schools. The change in a child's behaviour seems to have been crucial in forming a prognosis, which implies that there was a clear belief in the curative atmosphere of the hospital, providing that the child's character was corrigible. The focus on socioeconomic factors contrasts with the ways in which psychiatrists at that time perceived and documented the causes of behavioural problems, and helps explain why something, which seems evident in retrospect, was not apparent at the time.

[1] Helsinki University and Helsinki University Hospital, Helsinki, Finland. Correspondence and requests for materials should be addressed to K.P. (email: katariina.parhi@helsinki.fi)

Introduction

Presentism has a bad name in historical research, but asking questions that are relevant in the present can sometimes help in understanding the past. There is a demand for a sharper focus on socioeconomic factors in relation to mental health in research (see Macintyre et al., 2018). The aim of this article is to expand understanding about the socioeconomic factors behind children's behavioural problems between the 1920s and 1950s: how they were described, and what kind of reasons were given for hospitalisation—not just those related to socioeconomic factors, but those that predominated in explanations. The focus is on the emerging field of child psychiatry and the ways in which psychiatrists described children in the children's ward in Pitkäniemi Hospital in Finland from the late 1920s until the 1950s.

Paying attention to socioeconomic factors is a present-centred criterion because biological psychiatry in the interwar years did not emphasise such factors. Although psychiatrists described details like family background and parental occupation, they did not necessarily use them to show connections between socioeconomic factors and mental problems. On the contrary, in many cases, there was no indicated correlation. This is not to say that socioeconomic factors did not exist or were not acknowledged, but rather that they were discussed in a different light. The assumption of biologically oriented psychiatry that behavioural problems were primarily hereditary is prevalent in the case records. Nick Tosh defends present-centred selection criteria in studying the history of science, despite the risks. Historians have the 'privilege of retrospection', which means that they know what happened afterwards (Tosh, 2003). The debate in which Tosh engages is multidirectional. My aim is only to show that focusing on a topical question that actors in the past did not address may actually provide more answers than the questions they did choose to address.

The focus here is on the diagnosis of psychopathy, as psychiatrists in Finland used it as a marker of problematic behaviour. The choice brings the topic closer to the history of children's behavioural problems in general. For example, in Britain, the diagnosis of 'behaviour disorder' was in use instead of psychopathy (Evans et al., 2008, p. 463). Focusing on children provides valuable information about conceptualisations of early personality development. Treating children in hospital settings presented an opportunity to re-evaluate whether badly behaving patients were really born with a pathology, or whether adversities in their life had affected their early development.

Child psychiatry in the interwar years

Psychiatric care was one of the ways to treat children who had problems, but not the most significant. First, there was preventive care. Two NGOs had a special role in child guidance in Finland: the Mannerheim League for Child Welfare for Finnish-speaking families, and *Samfundet Folkhälsan*, the Public Health Association of Swedish Finland, for Swedish-speaking families. Both promoted mental hygiene. Second, there was institutional care. Kari Ludvigsen and Åsmund Arup Seip (2009) describe children's mental healthcare in Norway prior to the Second World War as segregation, designating it as a solution to mental and social problems. Similarly, although preventive care was emphasised in Finland, in practice many children were placed in private homes and institutions. Until the late 1960s, around 15,000 children were placed in families annually, and around 5000 in reform schools. Compared to private homes, children's homes were aimed at those who had problems, while the most troubled children were placed in state-owned institutions (Hytönen et al., 2016, pp. 27–37). This raises the question of what the role of children's psychiatric care might have been, as its significance in resolving Finnish children's problems was minor in comparison to other institutions. It was not a matter of mental hygiene work because only those children that were seen to have the most severe problems were admitted to hospital. Hence, the treatment was no longer about prevention, but about handling the problems that mental hygiene sought to address in advance. The relationship between other institutions is more complex because the child was often sent from one institution, and could be placed in another after spending some time in the ward. Psychiatric expertise was needed to evaluate the child's condition and appropriate placement.

Between the late 1920s and 1950s, child psychiatry was still in its infancy. Likewise, in many other European countries, specialisation took place after the Second World War (see, e.g., Evans et al., 2008; Zetterqvist Nelson and Sandin, 2013), which could constitute a fruitful topic for further research. Finland gained independence in 1917, and a Civil War broke out the following year. The newly independent state was characterised by distrust between different social classes (see e.g., Siltala, 2009, pp. 461–519), which was one of the elements that fuelled the state's focus on children in the 1920s. The emphasis was on protecting the poorest children, orphans and those who were born out of wedlock (see *Lastenvalvojain käsikirja*, 1924; Korppi-Tommola, 1990, pp. 13–102). In the 1930s, children's mental health issues were still perceived as 'new' and sensitive, not least because there were other important concerns, as child mortality was high and many children suffered from hunger (Korppi-Tommola, 1990, p. 81).

The Pitkäniemi children's psychiatric ward was founded in 1927 by physician-in-chief Väinö Mäkelä. It operated in one of the state mental hospitals, in picturesque surroundings by the lake in Nokia, near the city of Tampere. The Pitkäniemi ward was small, as the number of children in total varied between 5 and 28 annually between the years 1927 and 1949 (Kalpa, 1950, p. 371). There were around sixty diagnosed psychopathy cases during that time, excluding psychogenic reactions, which were officially categorised as psychopathy but were perceived as temporary problems. At first, the Pitkäniemi ward consisted of twenty beds. Psychiatrists responsible for other wards worked in the children's ward on a part-time basis. The most renowned psychiatrists who worked there were Ilmari Kalpa, and in the 1940s and 1950s, Marjatta Selvänne-Varheenmaa, Gunvor Vuoristo, and Saara Torma, although none of them stayed longer. Most of the cases cited in this article derive from Kalpa's era. Kalpa was a firm believer in biological psychiatry, which stressed the hereditary causes of mental illness. According to his colleague Vuoristo, Kalpa was a 'descriptive'—as opposed to analytical—psychiatrist who was suspicious of psychoanalytical ideas but was very keen on developing the children's ward. However, Vuoristo, who had studied psychoanalytical approaches in Uppsala University Hospital and Ericastiftelsen in Sweden, also pointed out that Kalpa subsequently accepted all of the new ideas that she and her colleagues embraced (Vuoristo, 1996, pp. 179–181).

Pitkäniemi's archival resources are unique. It was not the only mental hospital that specialised in children as the Lapinlahti Hospital in Helsinki had also housed a small ward for children since the 1920s. However, I have found only seven child cases of psychopathy in the latter between the years 1924 and 1935, and the records reveal very little about the patients and their treatment. Terttu Arajärvi describes the development of child psychiatry before the end of the Second World War as sporadic. After the war, which halted the development to a great extent, child guidance clinics increased in significance, and child psychiatry gained more ground in hospitals as well (Arajärvi et al.,

1996). It took a little longer before the first professorship was established, with Arajärvi herself becoming the first professor of child psychiatry in Finland in 1974.

Psychopathy and the focus on heredity

Biological psychiatry in the children's ward was mostly observational, lacking in-depth analysis of the causes of mental illness, and reporting details matter-of-factly. The records focus on problems, not explanations. Sally Swartz (2018) analyses historiographical issues in research on lunatic asylums and investigates where unarticulated thoughts can be discerned in the records, duly questioning how much we can actually infer from them. This applies to children's psychiatric records, too. As my research material concerns children, whose experiences in general are even more non-verbal than those of adults, this question is even more essential than in the case of the latter; the same applies to the staff's communication with and about the children. The silences are also noteworthy in this respect. It is not clear what certain silences in the patient records mean. They are related to the difficulty in identifying the agency of the child (see, e.g., Gleason, 2016; Vehkalahti, 2010 on this topic), but also to the challenge of grasping what the psychiatric interpretations were, and what their significance was for the way in which the child was treated on a daily basis.

The diagnosis of psychopathy was applied in many contexts in twentieth-century psychiatry, including children with mental and behavioural problems. Greg Eghigian (2015) has described psychopathy as the diagnosis for dysfunctional children in Germany during the era of the Weimar Republic. Similarly, and unsurprisingly, as Finland adopted the diagnosis from Germany in the first place, it was likewise applied to children in the Nordic country. The diagnosis of psychopathy was a broad category for mental health problems that dealt with deviance and required medical intervention. At the same time, psychopathy enabled specialisation, as there were subcategories within this broad category, and first-hand experience helped in gaining knowledge about those categories. The broad category also explains why it was applied to children – the hospitals followed the nosology required by the Finnish National Board of Health, and psychopathy was deemed the most appropriate diagnosis available for describing children with behavioural problems (Parhi, 2018).

Bolette Frydendahl Larsen argues that in Denmark, where psychopathy was also applied, it was used as an explanation by the staff in girls' re-education homes for the inability to correct misbehaviour. It was also a way to obtain more resources to resolve problems (Frydendahl Larsen, 2017). Likewise, in Finland, assumed incorrigibility was a sign of psychopathy, but it was more than an explanation—it was based on scientific assurance. Sven Donner, a Finnish psychiatrist who was interested in children's problems, presented a paper about psychopathic children in a child guidance congress in Stockholm in 1927. According to him, child psychopaths were not mentally ill or deficient. Instead, their deficiencies occurred in their will, imagination, and character. They were born with a deviant nervous system (*Helsingin Sanomat*, 1927, p. 6). Although the diagnosis described problems at home and in different institutions, it was firmly predicated on medical grounds: degeneration and, later, constitution, which both emphasised that psychopathy was permanent and innate. The Finnish psychiatrist Martti Kaila framed the causes of psychopathy in juvenile delinquents in the 1940s as a combination of constitution—something that human beings are born with—and circumstances during early development. Those with psychopathy duly reacted strongly in different kinds of environments (Kaila, 1946, pp. 171–184). Kaila's thinking also sheds light on the medical interpretations in the children's ward.

The focus of attention in the records describing children's psychiatric problems was on their pathological behaviour and personality, not on their socioeconomic living conditions. In 1950, two members of staff in the Pitkäniemi children's ward, Saara Torma and Gunvor Vuoristo, conducted a follow-up study on former child patients who had been diagnosed with psychopathy—the same patients used in this study. Torma and Vuoristo summed up the symptoms for hospitalisation: restlessness and an inclination to bully others, strong affects and temper tantrums, stubbornness and defiance, self-assertiveness, withdrawnness, weak-willedness, lack of resilience, a tendency to run away, pilfering and deceitfulness, and problems in school. They concluded that most of the children had been sent to the hospital because they had disrupted their living environment (Torma and Vuoristo, 1950). This is also my observation based on archival evidence, and is what Martti Kaila meant by strong reactions in different environments. Interestingly, a Finnish survey on the drawbacks of child guidance illustrates how individuals who had been placed as children saw the reasons for their placement as socioeconomic, not behavioural, problems. Between 1937 and 1983, according to former placed children themselves, the placement reasons were mostly among the following: the illness or death of a parent, poverty, alcohol—either at home or consumed by the child—criminality of a parent, and violent or otherwise frightening home conditions, which then resulted in the child's street life and other problems (Hytönen et al., 2016, pp. 43–44). The reasons provided in the records were without exception related to the behaviour of the child. Ulf Jönson has studied the reasons why help was requested for some children in a child guidance office in Stockholm between the 1930s and 1950s. Similarly, among the most common reasons were problems with discipline or the law, quarrelsome or disturbing behaviour, bodily and mental symptoms, and character. Issues related to sexuality, intelligence, and the environment of the child were also in evidence (Jönson, 1997, pp. 92–99). Despite focusing on problems caused by the child, not the causes of the child's behaviour, the records also reveal details about the socioeconomic conditions, which I will analyse next.

Drunken fathers and nervous mothers

In many of the cases, the parents were described with terms like 'weird', 'prone to indecency', 'abnormal', 'alcoholic and morphinist', 'frivolous drunkard', 'epileptic and sterilised', and 'slightly odd'. The descriptions were attempts to track signs of degeneration or, later, hereditary evidence, as parents who had not lived with and brought up the child were also described. This was typical when describing all patient backgrounds in general, but had a special role in evaluating psychopathy (Parhi, 2018, pp. 26–30). In some of the records, other family members were also described to identify whether there was a hereditary burden in the family, such as a grandfather's suicide, an uncle's alcoholism, sibling deviance, and a grandmother's psychopathy. Although the standardised form that the psychiatrists used and that included a separate section for hereditary taints was intended to gather all the necessary details about the patient, it also emphasised the importance of heredity, whether it was relevant in the case in question or not. Anne Koskela and Kaisa Vehkalahti point out that in child guidance clinics, the forms produced normality and deviance (Koskela and Vehkalahti, 2017). Similarly, the structure of hospital records automatically enhanced the significance of hereditary factors.

Pathological tendencies as such had a hereditary basis, but not all personalities were seen to be affected by these abnormalities. In 1924, Karin Neuman-Rahn, the director of the Helsinki Nursing School and secretary of *Sielunterveysseura* (later renamed the

Finnish Association for Mental Health) wrote a guidebook for mental health nurses. *Sielullisesti sairas ihminen ja hänen hoitonsa* (*The Mentally Ill Person and their Treatment*, translated into Finnish from Swedish in 1927) became widely used in teaching. Neuman-Rahn described psychopaths as 'abnormal characters' whose judgment, self-control and control over their mental life were either underdeveloped or had disappeared. Neuman-Rahn's definition clarifies the distinction between so-called normal and abnormal individuals. No one was immune to hereditary weaknesses, but healthy individuals could resist their burden of abnormality (Neuman-Rahn, 2003). In other words, normal people were aware of these abnormalities that they, too, might experience. It was weakness with regard to resisting them that rendered the individual abnormal, and bad behaviour in children indicated such potential weakness.

An underprivileged background was typical among the children treated in the ward between the 1920s and 1950s. The majority were from working class—or underclass—families. Similarly, in Germany in the interwar years, the diagnosis was applied to working-class children, who were eventually also seen as inferior (Kölch, 2002). Class issues were evident in Finland, too.

A working-class background is evident in descriptions of the parental occupations. The format of the record file provides detailed information about each child. The patient's family background was routinely documented in most of the records. Occupations included worker, plumber, farmer, housemaid, and mechanic, but also musician, businessman, and even manager. Besides the profession of the parents, there were no other direct references to class background, but the child's socioeconomic situation is clear in most cases. For example, one girl whose father had died and whose mother was mentally ill was sent to a reform school because she had stolen while begging. The reform school then sent the girl to the hospital because she continued stealing (the National Archives in Hämeenlinna, Pitkäniemi Hospital Patient Records, H129, henceforth NAH). It is obvious that the girl was poverty-stricken.

It is essential to note that although the aforementioned socioeconomic conditions were described, they were not portrayed as causes. Times were harsh as such, and poverty was not exceptional. Historian Jarmo Peltola has studied the livelihood of working-class families in Tampere, the nearest city to Pitkäniemi Hospital, during the years of recession in the 1930s. He illustrates the prevalence of poverty, pilfering, prostitution, alcoholism, and other social problems (Peltola, 2008). It was not uncommon for children to be left alone, either out of financial necessity or because of problems in their parents' lives. Mental illness in the family or living with a single parent imply that the socioeconomic conditions were poor because it was unlikely that the parents could make a living. Single parents as breadwinners also often implied leaving the child alone for long periods of time, as was also mentioned in the records. If socioeconomic status is to be interpreted as the relative position of an individual in a social system (one of the definitions in Bornstein and Bradley, 2003), then those children with an unfavourable background may not have differed in the eyes of their contemporaries. This may have affected the tendency to interpret children's mental health as dependent on their character, not on their living environment.

It is hard to avoid the impression that socioeconomic issues influenced children's mental well-being. The following excerpt from the records in 1938 exemplifies this:

Mother nervous throughout pregnancy, took care of the child for one month after which brought the child to be cared for. Child got nutritional disorder and ear infection and was brought to the children's hospital for 4 months, was then cared for by [the mother's] sister until the child was 3 years old, after which mother took the child from one place to another, to at least five different homes before taking him to his grandmother when five years old. The grandmother took the child as a difficult case to a children's home, and from there to a help school [a special school for mentally retarded children] (NAH H90/857).

The child was born out of wedlock, his mother had spent time in a mental hospital, was described as a sex worker, and judging by the boy's various placements, life thus far had been unstable in many ways. The boy was admitted to the hospital because of restlessness, enuresis, and fecal incontinence (NAH H90/857). The child's father was not around, which put the mother in a desperate situation. The mother also had mental problems, which probably made earning a living more challenging. As a consequence, the child was moved from one household to another. Despite the description, the boy was diagnosed with a constitutional form of psychopathy.

Of the 30 children diagnosed with psychopathy that Torma and Vuoristo referred to in their study on psychopathy, 19 were born in wedlock, and 11 out of wedlock. Fourteen had been raised at home, and the remainder in institutions, by relatives, or by other people (Torma and Vuoristo, 1950, p. 3889). One boy had parents who both worked in middle-class professions (NAH H123/529). The boy's living conditions differed from most of the patients in the ward: his parents were still married and had a steady income. Wedlock symbolised decency, and in addition to probably wealthier living conditions, it also signified respectability and decreased the likelihood of hereditary influences in the eyes of the physicians. It is clear that the parents were suffering as a result of their son's fate because in a report, written later in 1950, they stated: 'Being in the hospital among the deficient caused our son depression at first, and some bitterness for us parents as well' (NAH H123/529). It sounds as if the family did not regard the ward as the right kind of place for their son. The middle-class boy's fate sheds light on the replacement issue; none of the children from better-off families were sent from or were in reform schools. Clearly the option was portrayed as a threat, as the boy in question had repeatedly pilfered items such as sweets, money, and cigarettes, and was described as being afraid that he would be taken to the police station or to a reform school (NAH H123/529). Reform school was the fate of many other children, possibly largely because those children did not have a 'respectable' family to return to.

The acknowledgement of environmental factors grew, and the interpretation of children's psychiatric problems changed, but the change was nonetheless gradual. It would appear that the diagnosis of psychopathy, focusing on the hereditary and inborn nature of deviance, was retained in Pitkäniemi, although during the course of the 1950s, the diagnosis ceased to be applied to children (Myllykangas and Parhi, 2016). Different time phases in the patient records offer some interesting insights into changes concerning interpretations about the socioeconomic status of the family. Some of the records include a follow-up survey regarding the life of former patients, distributed by Vuoristo and Torma. The following case exemplifies a possible shift, as earlier records emphasised different information than those that followed. In 1929, a patient's mother, who was interviewed as her son was being admitted to the hospital, was described as helpless and inefficient. In 1950, when the psychiatrist Saara Torma re-evaluated the patient's background, she explained the mother's situation differently. The father had left the family and the mother was forced to go to work. The financial situation in the family had been 'extremely poor' (NAH H58/145). What had initially been seen as the mother's inability to look after the child because of maternal shortcomings was subsequently explained in terms of the mother's financial despair.

A harmful environment as an enhancer of pathology

Whereas family background, and hereditary issues in particular, explained the predisposition to behavioural problems, environmental factors entailed the everyday life events that affected the child's later development. Obviously, environmental factors are connected to socioeconomic ones, but no differentiation was made at the time, and the emphasis was on the environment, not on those socioeconomic factors that caused environmental factors. Psychiatrists had acknowledged the impact of environmental factors on the development of children as early as the 1920s, when the children's ward started its activities. Even at the turn of the twentieth century, the reasons behind children's nervousness were seen as both biological, namely hereditary, and social because children could mimic their parents' bad behaviour (Ahlbeck, 2018, pp. 173–174). However, they were not crucial in the context of psychopathy. In the 1920s, the diagnosis of psychopathy, *Degeneratio psychopathica* in Latin, referred explicitly to degeneration. The nosology changed in the 1930s, however. From then on, psychiatrists used *Constitutio psychopathica*, the permanent hereditary form of psychopathy. Sometimes it was coupled with e.g. Reactio psychogenea, a temporary psychogenic reaction, which was a diagnosis for powerful life events (see Parhi, 2018, pp. 28–30). Environmental factors enhanced constitutional psychopathy, but were not regarded as the cause.

In some descriptions, people outside the hospital explicitly stated that environment had played a major role: 'The uncle's story about the home conditions seems to indicate that they provide enough reasons for the reaction', stated one wary description. The child had expressed unwillingness to return home to the mother and had expressed a wish to live with the uncle instead (NAH H107/610). In 1948, there is a mention in the records of another child that the staff at the children's hospital, where the child had been sent from, believed that the mother had significantly influenced the child's mental development. The mother was described as 'renowned for her weirdness', and had spent two years in bed 'for no reason'. The mother had 'fed powders' to her children since they were small, and 'fostered illness' (NAH H215/2462). Likewise, in another child's case, the home environment was emphasised as the child had lived in an 'extremely unfavourable' home environment together with four adults, one of whom had heart disease, and three children, one of whom had tuberculosis. The child spent hours awake at night and would do nothing but scream unless the mother stayed next to the bed. During the day, the child was grumpy (NAH H87/2334). Similarly, a boy, born out of wedlock to a mother who passed away some years later, had been in the care of his grandmother. The child guidance representatives described the grandmother as abusive and stingy, and pointed out that she had not spent money on food or clothes for the boy. The boy had grown up in the company of sheep and hens (NAH H63/90).

Accidents, such as being hit by a truck, and somatic illnesses, including syphilis, which could also lead to mental problems, were documented in the records. Experiences as war children in the 1940s are present in the records, but not as the original causes of problems. Some children were reported to have changed since they returned from Sweden, where they had been sent during the Second World War, further away from wartime troubles. Some of them were seen as spoiled, some had linguistic difficulties, some missed their Swedish foster parents, and all had adjustment problems. The mental health of former Finnish child evacuees has been studied in later decades. The results show that girls have had a higher risk of mood disorders in adulthood, whereas boys' risk of psychiatric disorders increased only marginally (Santavirta et al., 2015). These experiences were hardly exceptional, as nearly 80,000 were sent abroad in total. This may have affected the psychiatrists' interpretation.

By the 1950s, new knowledge about children's mental health changed the application of the diagnosis of psychopathy (Myllykangas and Parhi, 2016). Vuoristo and Torma's study in 1950 indicated that harmful environmental factors were crucial in catalysing symptoms that resembled those of psychopathy (Torma and Vuoristo, 1950). Two-thirds of the children diagnosed with psychopathy in the ward had done well since leaving the ward, whereas one-third had not succeeded. The criteria entailed finishing school, gaining professional skills, and living a harmonious family life. Maladjustment was the key concept in evaluating lack of success, although Vuoristo and Torma did not define what they meant by it. The questionnaire results showed that some of the children exhibited no symptoms of 'abnormality' later in life. For example, one boy, who had been sent to the hospital because his teacher stated that he was a psychopath who should not be in school but in a reform school, had spent five years on a smallholding since leaving the hospital. According to the report on his behaviour, he was completely normal and liked. A farmer in the same village, who was also his former classmate, wrote: 'My personal opinion is that he was never ill in the first place' (NAH H74/101). Another patient's father was described as a manager, but also as an alcoholic and morphinist. The parents were divorced. In 1938, it was stated that 'he was apparently unwell at his father's place'. The mother put the blame on the child: 'Since he was small, his care has been difficult due to his restlessness and grumpiness, and nervousness in larger groups', she wrote in a letter. In the report from 1950, the description was more specific: the boy had been afraid of his father his whole life and had become timid and fearful (NAH H67/834).

Hospital as a good environment

Pitkäniemi Hospital was the final place where children could demonstrate improved behaviour because the staff at the hospital evaluated where the child should be placed next. The hospital provided an environment that valued cleanliness, good manners, social skills, and obedience. Gunvor Vuoristo described the discipline as backward in comparison to Sweden, where she had studied before coming to Pitkäniemi (Vuoristo, 1996, p. 181); at the end of the 1940s, children were still expected to follow strict rules. The hospital was a change of environment for those who needed inpatient care, and it was a good environment for children by default. If a child's behaviour did not improve, then there was something wrong with the child. The biological interpretation of psychopathy emphasised this because the 'flaws' in the child's character could be attributed to heredity.

Sometimes children were explicitly described as abnormal even before their arrival at the hospital. For example, one child's school teacher defined him as a psychopath who should be sent to a reform school (NAH H74/101). Such descriptions were kept on file, but not necessarily interpreted as being the truth of the matter. A contradiction between a stepmother and her stepson illustrates this in one patient's case. The stepmother described the boy as a restless adventurer who often stayed out all night. He got frustrated when given orders that were not to his liking. The boy in turn told the hospital staff that he had walked out on those occasions when his stepmother had called him names and punished him for things he had not done, or had not considered wrong. In the ward, the boy was described as calm, quiet, obedient, happy, and sociable (NAH H121).

A psychopathy diagnosis did not always indicate a final decision. It is obvious from some of the descriptions that not all of the children diagnosed with the constitutional form of psychopathy were regarded as psychopaths later on. For example, a child who had lived in a children's home since his grandmother had died, and who had been sent to the psychiatric ward because he had

run away from the children's home, was described as 'a rarity', a kind child who looked after smaller children (NAH H116/1499). In other words, the child proved to be different than expected. The favourable hospital environment had ostensibly brought out the best in him.

By 1950, it was obvious that the impact of environment played a role in the interpretations, which also accentuated the permanence of a maladjusted character in some. For instance, one boy had been sent to the children's ward from a children's home. After a month in the hospital, according to the evaluation in the boy's records, his maladjustment was not a 'reactive phenomenon' but the result of a character defect (NAH H147/2956). The assumption was that both the children's home and the hospital were good environments, and since no character improvement occurred while placed in those two institutions, it was considered that the child should be sent to a reform school. Similarly, in 1950, the ward observed another boy for 7 months, and Saara Torma concluded that they were inclined to believe that the boy would develop into a person with a character defect. He was, according to Torma, reckless and violent. However, Torma emphasised that the observation time had been too short to establish a diagnosis of psychopathy. Although it is obvious that Torma was hesitant about the boy's prognosis, it seems that the boy had lost faith in himself. Reportedly, he spontaneously told the nurses: 'I wish my character was like yours—mine is so bad—I suppose I will become a criminal' (NAH H317/3126).

Seeing children as flawed characters and as a threat to others was related to evaluating dangerousness in individuals. In a letter to the children's ward, the local municipal board enquired whether a child who had been placed in the hospital was still 'a danger to society' (NAH H74/101). 'Dangerousness' was an import from German psychiatry. Finnish psychiatrist Akseli Nikula analysed it extensively in his article on dangerous individuals in 1922. He defined dangerousness not only in terms of criminal activity, but also as antisocial tendencies and non-criminal antisocial acts (Nikula, 1922, p. 489). It is evident that some children were perceived as a danger to others. A medical report about one child patient stated: 'Psychopathy comparable to the extent of mental illness. Corrupts other children, has not become easier to handle, considered dangerous' (NAH H99/866). There might have been some good in the child, but the bad side had apparently taken over. Similarly, the staff in a girls' reform school were asked about a girl who had been volatile, argumentative, and violent. They replied: 'We would like to know in which institution these kind of children should be placed. We have never had such a case before'. The hospital also regarded the child as volatile: 'There are moments when the good side is winning. Apologises when asked to do so, promises to be better. A moment later, possessed by the evil side again' (NAH H107/194).

As late as 1953, a child whose father had drunk so much that the family was starving, before disappearing completely, and whose mother was unable to work and was so nervous that she thought she would have to enter a mental hospital, was diagnosed as a psychopath based on hereditary and environmental causes. This may have been related to the child's behaviour in the ward; he was described as 'strongly schizoid', and someone who did not play with other children. Instead, he used vulgar language and bullied others (NAH H73/3836). Hence, it was considered that the child had not shown a noticeable improvement.

Silences

In addition to the factors that were explicitly mentioned as possible causes of psychopathy, there are also silences in the records, at least from a present-centred perspective, that catch the attention. Some of these silences raise questions about the causes of behavioural problems. I will focus on one topic in particular in this respect: girls' sexuality. Silence does not automatically mean not knowing. In their article on the historian's role in studying child sexual abuse, Adrian Bingham et al. describe the problems related to naming, categorising, and identifying sexual abuse in historical records. The textual traces do not shed light on the experiences of the children who underwent abuse, and the terms and practices have changed to the extent that child sexual abuse can be hard to identify. Historical research challenges teleological assumptions about ignorance or lack of abuse in the past (Bingham et al., 2016). In this light, the descriptions of children may have included hints of acknowledged abuse, despite the lack of terminological clues. It may be that information was exchanged in ways that do not reach the researcher.

Whereas boys' sexuality was mostly tied to the problem of masturbation, which was openly described in the records, promiscuity was a common problem among girls. The records lack analysis regarding environmental reasons for promiscuous behaviour—or the prevalence or predisposition of some girls to sexual abuse. In Pitkäniemi, the possibility of sexual abuse was mentioned in one case file only. In this file from the 1950s, the question in the typed description was written separately by hand: 'Has she experienced any sexual violence?' This possibility was not, however, discussed any further in the records. What was mentioned was the patient's hatred towards her stepfather, whom she described as a crazy drunkard and a lout who did not care for his family, and her fear towards her brother. It was also noted that she would not let anyone touch her (Tampere University Hospital, Pitkäniemi records, 14.135). Although such observations may have nothing to do with any kind of abuse, they could just as well be hints of violence that the patient had tried to express in a more socially acceptable way than by admitting abuse. Similarly, in the early 1930s, a girl who was described as a frantic eroticist was simultaneously reported to act coy about getting undressed for an examination: 'When it is time for the check-up, she runs away like an animal, on all fours, in the corner. Her movements are fast and agile, eyes wild' (NAH H107/194). The contradiction between the patient's reported 'willingness to copulate' and her fear of showing her naked body was not analysed.

Another child 'had been taught to socialise with boys', a euphemism used to express intercourse, when she was only four years old. Since then, according to her 'objective anamnesis', she had been morally dangerous and obscene. In Pitkäniemi, she was reported as telling other children about sexual issues, as well as lifting her skirt in the presence of male nurses. Her imagination was also described as oriented towards sexual issues. The psychiatrist concluded his analysis by stating that she was a psychopath, a sick-minded person, whose sexual drive had developed too soon and was unnaturally strong (NAH H99/866). This conclusion implies that the psychiatrist perceived the sexual drive of the child as something that could be taught and prematurely awakened. The child was responsible for her drive instead of being portrayed as a victim of abuse. The role of the sexual experiences in the patient's earlier life was not discussed further in the records. This is what Jutta Ahlbeck et al. describe as 'fragile subjects'; children are exposed to outer influences and are always at risk. Adult society can harm children and make them evil (Ahlbeck et al., 2018, pp. 8–9).

The whole topic of sexual abuse was seemingly non-existent in Finland. In 1952, psychiatrist Sven Erkkilä published an article on sexual violence in the Finnish medical journal *Duodecim*. He emphasised the importance of this topic, which he described as delicate, shameful and perplexing in society. Whereas some sex-related themes had been raised since the Second World War, Erkkilä perceived sexual abuse as one that had not received attention, although he deemed it essential regarding the

protection of children, especially young girls. According to Erkkilä, it was self-evident that the victims were minors who could not defend themselves. His study included a total of sixty minor victims under the age of eighteen. He concluded his article by stating that it was essential to educate children regarding sexuality. It would be the best way to protect them, and it would not lead to the destruction of their 'natural coyness', as, according to Erkkilä, was generally believed (Erkkilä, 1952).

Invisible information exchange relates to my research material in general. The records offer no specific insights into what the staff felt, and they do not address everything they thought. Expressed sympathy may have implied that not everything was seen as innate, or that something could be done in the hospital to improve the child's condition, or that every child is valuable. Lack of signs of sympathy does not mean that sympathy did not exist. So much remains out of reach, not only the everyday life not captured in the records, but also non-verbal communication, such as gestures, body language, and caring touches. For example, Ilmari Kalpa's colleague Vuoristo remembers Kalpa's presence in the children's ward as loving and endearing (Arajärvi et al. 1996, p. 181), something that the records fail to point out.

Discussion

This article has described the understanding of the assumed causes of psychopathy in children between the late 1920s and 1950s in Finland as they were portrayed in patient records. The psychiatrists in Pitkäniemi Hospital connected psychopathy to behavioural problems that were so severe that they required hospitalisation. Based on biological psychiatry, it was assumed that psychopathy was hereditary and permanent. Some children improved and were then returned home, or placed with other families, or in children's homes. Those who were perceived to be permanently antisocial were placed in reform schools. The change in a child's behaviour seems to have been crucial in forming a prognosis, which implies that there was a definite belief in the curative atmosphere of the hospital. While in hospital care, the psychiatrists evaluated the next appropriate placement for each child. The research material provides important information about an era that represents pre-psychodynamic thinking in early child psychiatry.

The special focus has been on the ways in which socioeconomic factors were present in the patient records. Yet making a note of the socioeconomic status of the child's family and interpreting its significance are two different matters. The status did not have crucial significance, at least it was not portrayed as such in the records, even though a detrimental environment, often entangled with socioeconomic factors, could intensify the symptoms of psychopathy. The focus on socioeconomic factors contrasts with the ways in which the psychiatrists at that time perceived and documented the causes of behavioural problems, and helps explain how something that seems evident in retrospect was not perceived as such at the time. Socioeconomic factors were duly noted, but interpreted in a different light.

Although the focus on socioeconomic factors is present-centred, it helps in contextualising the application of, and in expanding the interpretation of, the diagnosis of psychopathy. The history of psychiatry is not a causal chain of events; some theories vacillate back and forth. To exemplify this, I conclude by reflecting on some recent perspectives related to children's mental health and the significance of child adversity. Recently, an expert panel summed up findings about children's adverse experiences that lead to poor mental health or unhealthy behaviour. The report by the panel emphasised both that early experiences can become biologically embedded, and that some children are more susceptible to negative experiences. Genes listen to experiences (Herzman, 2013). For the psychiatrists in Pitkäniemi, hereditary disposition offered an explanation for the severity of the children's problems. Although from a scientific point of view, the psychiatrists did not have the same knowledge that experts in the fields of child psychiatry, genetics, neuroscience, epigenetics, epidemiology and developmental psychology do now, they were on the same track. Experts in the past and present both witnessed the poor life conditions that some children experienced—but connecting those events to mental health problems was less straightforward, and still is. Many children were subjected to poor living conditions, but most of them did not need inpatient care in the ward.

New scientific findings may be significant, but their value is secondary. Causes serve as models and explanations, not solutions to children's problems. The ways in which explanations affect treatment decisions, and how the conceptualisations of early development fuel political decisions regarding preventive measures, matter more than theories. The diagnosis of psychopathy could be used for or against the child's good. It offered children the care that they needed but, at the same time, classified —or one could say stigmatised—some of them as incorrigible.

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