

Insane Criminals and Criminally Insane, Criminal Asylums in Norway 1895-1940

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Abstract

This article looks into the establishment and development of two criminal asylums in Norway. Influenced by international psychiatry and a European reorientation of penal law, Norway chose to institutionalize insane criminals and criminally insane into separate asylums. In 1895, Norway's first criminal asylum was opened in Trondheim. Kriminalasylet had 15 licensed beds (32 beds from 1900) for male patients with criminal convictions and declared insanity. In 1923, a second criminal asylum was opened, Reitgjerdet asylum. This asylum had 135 licensed beds, and a wider aim than Kriminalasylet. Reitgjerdet was established for insane male patients assessed as especially difficult or dangerous, even those who had not committed a crime. Both asylums quickly filled up with patients that often stayed for many years, some stayed their entire lives. The official aim of these asylums was to incarcerate and treat dangerous and disruptive lunatics. Goffman postulates that total institutions typically fall short of their official aims. This article looks into which patients were actually admitted, to see if the official aim was achieved.

Keywords: insanity; criminals; psychiatry; Norway; asylums; criminal law; institutions

Introduction

«The incarceration of people, whom are either assumed to be or in fact really do suffer from insanity in a manner that makes them dangerous, is absolutely necessary; but incarceration is also and will always be cruel and such should be limited when possible. It is not a benefit for the incarcerated. It is not first and foremost for their sake, but for society's sake, that the incarceration must take place»¹

(Psychiatrist Paul Winge, lecture, 1894)

Paul Winge gave this lecture called “On the treatment of insane criminals” to the Nordic Criminalist Society in 1894. One year later the first criminal asylum, Kriminalasylet, was opened in Norway. In 1923 a second criminal asylum, Reitgjerdet asylum, was opened. These asylums constitute the empirical foundation of this article. The quote above reveals the grounds for incarcerating such patients. Long-term incarceration was deemed necessary in order to protect society from dangerous or disruptive insane. This quote also reveals humanitarian considerations when ascertaining incarceration as cruel, even though incarceration was partly viewed as a therapeutic intervention as the asylums were thought to provide a curative and safe environment for the patients. These patients would typically fall into two descriptive categories, hence the distinction given in the title: ‘insane criminals’ and ‘criminally insane’.² This dichotomy might seem arbitrary, but was commonly accepted by psychiatrists around 1900. The ‘insane criminal’ was a term describing “intellectually and morally challenged or defected individuals, such as psychopaths and habitual delinquents”, whilst the term ‘criminally insane’ was used to describe those whom had committed crimes while being acutely bewildered by their insanity.³ Both categories would be eligible for these criminal asylums. The practical reason for establishing such asylums was also a judicial reason. In the 1840s two laws were passed in Norway; a new Criminal Act in 1842 and a new Insanity Act in 1848. Both acts were considered to be some of the most humane laws in Europe at the time.⁴ The Criminal Act prohibited punishing the insane, and such offenders could therefore not be imprisoned. On the other hand, the Insanity Act prohibited admitting anyone with a criminal record or criminal behavior into ordinary asylums. Insane criminals and criminally insane consequently became legal “inbetweeners” and a judicial headache for the authorities. In spite of the ban, many of these “inbetweeners” would still be placed in ordinary asylums. This caused the issue of “insane criminals and criminally insane” to be repeatedly addressed by several asylum directors in the following years.

Asylum directors, who were also psychiatrists, regarded the first group, the ‘insane criminals’, a constant disadvantage to any asylum. Such patients were thought to have a low potential for improvement, and to cause disturbance to the treatment of ordinary patients.⁵ The second group, the ‘criminally insane’, was regarded unpredictable and difficult to treat. Norwegian asylum directors kept pushing for new solutions on the issue of insane criminals and criminally insane, many of whom were thought to be dangerous. The label ‘dangerousness’ can justify society’s expulsion of certain individuals. This description has been applied to a number of groups, as it is not firmly defined and can encompass different things. As the quote disclose; dangerousness was also linked to insanity. And gradually the task of such labelling was granted to professionals. Psychiatrists became the holders of special knowledge about ‘dangerousness’ towards the latter part of the 1800s.⁶ Branching out from medicine and engaging in criminological research on criminals, psychiatrists would serve as specialists assessing dangerousness both in court and outside. Criminological research thus transformed the relationship between psychiatry and criminal justice, turning it into a symbiotic one.⁷ The societal expulsion of dangerous individuals was tantamount to institutionalization. However, this required institutions tailored for such a purpose.

New humanitarian ideas on treatment and punishment sparked various reforms in the 1800s, such as asylums. The core of humanitarianism was a moral of kindness, benevolence and sympathy extended to all human beings. Humanitarian ideas developed parallel to modern science, and contributed to the values and ideals formed in modern medicine.⁸ This included the new discipline psychiatry. Some have claimed that medicine has since grown a distance to humanitarianism.⁹ However, in the 1890s debates about these “inbetweeners”, the humanitarian perspective seems to be of vital importance to those involved. Whilst most of Europe and the US established high security wards connected to asylums or prisons, Norway chose a British model.¹⁰ Kriminalasylet and Reitgjerdet were high security asylums established separately from ordinary asylums and prisons, and the only two of that kind in Norway.¹¹ Both institutions were located in Trondheim, due to a lack of suitable constructions in the capitol.¹² Whilst these asylums became a permanent residence for many of the patients, they served as merely a temporary stay for others. In many ways these asylums constituted a society within society, a secluded world upholding most sides of everyday life.

The concept ‘Total institutions’ was developed by the sociologist Erving Goffman. These are isolated, enclosed social systems whose primary purpose is to control most aspects of its participants’ lives.¹³ According to Goffman “it is widely appreciated that total institutions

typically fall considerably short of their official aims".¹⁴ While this article's aim is to give some insight into these asylums and the patients there, this single concern from Goffman makes an interesting focal point. Cause in the matter of asylums, this indicates that what they aimed to achieve and also who they aimed to treat, could turn out different in practice. Did Kriminalasylet and Reitgjerdet fall short of their official aims, and if so; in what way?

Method and theoretical approach

This article discusses patients in high security asylums in Norway in the period 1895-1940, drawing on patient records from two institutions; Kriminalasylet and Reitgjerdet, both located in Trondheim, Norway. All patients here were male. Their aim was 'criminally insane' or 'insane criminals', preferably those considered dangerous to the public. The analysis in this article is based on the asylums archives; patient journals written by staff, routine protocols and letters written by patients or to patients. These archives have never before been opened to research, and this study is therefore the first to use this set of data. These documents the asylum practices and the patients admitted. The characteristics of the patients will be explored along three lines; socially, medically and criminally. The intentions and visions that constitute the official aims of these two asylums are derived from various lectures, debates, Green Papers, White Papers and the judicial framework of the institutions. When compared, this might answer whether these asylums fulfilled their official aims, or if they fell short, just as Goffman postulates.

The admission procedures

Patient records were used to analyze the process of admission to the asylums. These records consist of two types of patient journals. The main journal was written by the Medical director, who was also head of the asylum. He was obliged to give some mandatory information about the patients, but otherwise had great literary freedom. These journals are therefore semi-standardized. The second type of journals contained day-to-day-notes about everything that happened in the asylum, when it concerned the patient in question. This included individual behavior and special incidents, and was written by the inspector in charge.¹⁵ Both types of journal-writings reveal what was conceived as dangerousness or disruptive behavior.

Assessing insanity and dangerousness is a legal procedure based on psychiatric knowledge. Legal professionals played a decisive role in all of these patient histories, as these asylums operated within legal frames. Many legal decisions rested upon psychiatric assessments and declarations, and psychiatric arguments also played a part in law making processes. Because

of this symbiotic practice, law and psychiatry has been called “partners” and even “uneasy bedfellows”.¹⁶ The liaison between these two professions is evident in, and of importance to, the establishment of forensic psychiatry, as in the case of these two asylums. Firstly through the debates leading up to establishing these asylums, as the participants mainly consisted of psychiatrists and legal professionals. Secondly through the asylum practice as psychiatrists and legal professionals continued to cooperate. To the patients these two professions represented the authorities, a counterpart that could be both allied and enemy. Goffman included these professions in his term ‘mediators’.¹⁷

The asylums

After Reitgjerdet opened, Kriminalasylet gradually achieved a more specialized function as a facility secluding the most absconding patients from Reitgjerdet. The two institutions actively cooperated until Kriminalasylet closed in 1963, at which point all patients were transferred to Reitgjerdet. Even though both asylums were established to incarcerate insane criminals, they were authorized through separate laws, had different admission criteria and different regulations, were of different sizes and located in two very different building types. Consequently, it is natural to sometimes view them as two different institutions.

The attempt to hospitalize criminal insanity and incapacitate dangerousness happened in the early years of social liberalism in Norway. At this time there was a growing perception of the evils of industrialized society. The rising idea was that the state should foster and protect the social, political and economic environments in which individuals would have the best chance of acting according to the best of their conscience. Thus, criminal lunatics were considered a social problem best solved by the authorities. Up until this time, such individuals were mostly left in the care (or lack of care) of their families, if not confined in gaols or madhouses.¹⁸ The term ‘asylum’ was modern, indicating a new and improved era, its Latin origin meaning “sanctuary”. Through the nineteenth century, institutions such as asylums were established for a variety of purposes and with the best of intentions. These institutions have inspired several studies and theories thereafter. In the field of historical psychiatry research, a number of authors cannot be dismissed, such as Michel Foucault, Roy Porter, Erving Goffman and Andrew Scull. The theories and narratives told by these authors created an image of all asylums that can only be adjusted through studies using actual patient records and asylum data. All though these authors have a natural influence on any study concerning the history of psychiatry, only Goffman is made an explicit theoretical source in this article.

Goffman

The total institution model was first presented in Erving Goffman's widely known and much quoted study of a mental hospital in the 1950s.¹⁹ His book "Asylums" was met with substantial recognition, but has since also been criticized from many angles.²⁰ In his study, Goffman used qualitative data to describe the meaning of mental hospitalization for patients. He depicted the hospital as an authoritarian system, and through the model of total institutions viewed it as equivalent to prisons, military camps, monasteries and concentration camps. This touches a main point of critique aimed at Goffman's use of this model in his study of mental institutions. Some critics see his portrayals as exaggerated and overdrawn, and that his generalizations about mental hospitals are inadequate. However, this article discusses two criminal asylums that resembled institutions such as prisons more than ordinary asylums did, like St. Elizabeth's Hospital, where Goffman conducted his field work. Hence, these criminal asylums could fit both Goffman's second and third type of total institutions.²¹

Another main point of critique has been on how Goffman understates the fact that the patients are actually *suffering* from illness. In Goffman's early view, mental illness was a label and one of the most discrediting and socially damaging of all stigmas.²² But the patients at Kriminalasylet and Reitgjerdet had obvious individual experiences of suffering, and cannot be described simply as labeled. Other measures had failed many times over before these patients were admitted to the criminal asylums, or as Goffman says: "*offenders who are eventually hospitalized are likely to have had a long series of ineffective actions taken against them*".²³ Critics have also argued that some of the meaning and privileges the patients lost as a result of their illness while being "outside" can be reclaimed on the "inside", going against what Goffman called "mortification of self". Some of the patients in this material seemed to thrive within the walls of the asylum, and even Goffman admitted that to some patients: "*entrance to mental hospital can sometimes bring relief (...)*".²⁴ Goffman conducted his study more than two decades later than the period of this article, and society had changed remarkably by then. It might seem as if society progressed and left the asylums behind, increasingly affecting their legitimacy. If so, these asylums had greater legitimacy in the period 1895-1940.

The official aims

In 1894, a government-appointed committee gave recommendations for the establishment of a criminal asylum, published as an official parliament proposal that same year. The need for such an asylum was described in the introduction as following; "*Since this country has no criminal asylum, insane criminals have been admitted to ordinary asylums, but this has caused severe*

*disadvantages, and the idea of a separate asylum for insane criminals has therefore repeatedly been discussed, and such an asylum could also obtain criminally insane”.*²⁵

The claim for criminal asylums had been raised several times since the mid-1800s, but towards the end of the 1800s some medical directors of ordinary asylums took this discussion to a new level. Their main arguments were cited in the parliament proposal. Michael Holmboe, the Medical director of Rotvold Asylum, argued that ordinary asylums were not designed and organized for the detention of criminals. They lacked the proper means of treatment for this group of patients, and had few means to prevent patients from escaping. Further it was argued that the presence of insane criminals and criminally insane had a disruptive effect on ordinary patients and the treatment regime in general. Axel H. Lindboe, the Medical director of Gaustad Asylum, claimed a new solution was urgent. Others agreed.

After presenting the various options possible, the decision fell on converting a former penal ward in Trondheim into a criminal asylum. This was meant to be temporary, as the building was described as; *“scary and prisonlike, surrounded by a tall wooden fence which deprives the rooms of sunlight”.*²⁶ From a therapeutic perspective the building did not meet the demands. Nevertheless, Kriminalasylet opened the very next year, and did not shut down until 1963. 68 years of operation became the outcome of what was meant to be a temporary solution. The 1894 committee called for a more permanent solution to be explored elsewhere as soon as possible, but stated that Kriminalasylet would; *“In a somewhat satisfactory way make room for such a number of patients that at least the most dangerous of them could be removed from ordinary asylums”.*²⁷ This constitutes the primary official aim of Kriminalasylet, a third option next to prisons and ordinary asylums, meant to incarcerate the most dangerous of insane criminals.

A separate law for Kriminalasylet was finally passed in 1898; three years after the asylum had opened. This law transferred the responsibility of admittance and discharge to the Ministry of Justice rather than leaving it with the asylums medical director, as was the case with ordinary asylums. This makes Kriminalasylet the only health institution governed by someone other than the Health Authorities in Norway. The idea was to ensure that not just medical factors would be considered in this process. The patients here were not just insane; they also posed a hazard to society. This is concurrent with the asylums primary aim, to protect society. This law also stated which patients the asylum was meant to obtain. § 1 contained two descriptions; firstly: *“male convicts that were declared insane”* and secondly: *“male insane persons that had committed illegal acts, or were so morally degenerated or so dangerous to society,*

that they are not suitable for treatment in ordinary insane asylums".²⁸ As the 1894 proposition stated, the asylum was intended for; "*not only insane criminals, but also so-called criminally insane*". These criteria, along with the described intentions in the proposition, give away the all-round purpose of this asylum. Male criminals with insanity and assessed dangerousness were the targeted group, and incarceration was the measure. However, the low number of licensed beds did not provide a satisfactory solution. In its first five years of operation, Kriminalasylet had only 15 beds. This shortage in beds was foreseen already in the 1894 proposition. The Head of Medicinal affairs in Norway said that: "*At the end of 1891 there were 36 criminally insane patients being cared for in ordinary asylums and there is reason to believe that this number has since increased. When the intention now is, that the planned institution Kriminalasylet shall obtain such patients, the committee should know that the fittings of the ground floor, suited for 15 patients, will soon prove inadequate*".²⁹ Its first floor was not operative until 1900, but then gave the asylum an extra 20 beds. The demand for high security asylum beds was still not met. Psychiatrists and legal professionals soon began debating the need for a bigger criminal asylum. Since the 1894 proposition had stated that Kriminalasylet had too few beds, this debate was no surprise.

In 1919 a new proposition was published, debating the possibility of converting a former leprosy hospital in Trondheim into a criminal asylum.³⁰ This asylum was to have 135 licensed beds for: "*especially disruptive and dangerous insane males*". The 1919 proposition stresses the urgent need for such an asylum in the introduction. Existing asylums were overcrowded, and there was a reported increase in disruptive patients: "*The state asylums as well as the county asylums have these past few years been so overcrowded, that it has proved difficult to get new patients admitted, and the (ordinary) insane have therefor often had to wait several years for treatment. (...) The conditions are now so grave, that inspectors, district doctors and asylum doctors find it necessary to bring this to the attention of the Head of Medicinal affairs and the Ministry of Social affairs*".³¹

Once again, social reality was the driving force behind the discussion. The participants' professional background and position gave legitimacy to the arguments behind why the situation was unsatisfactory as well as the arguments on what the solution should be. The quote above reveals a somewhat different primary aim; this asylum was designated to incarcerate not just the "dangerous", but also the "difficult and disruptive" insane. Dangerousness was the initial worry when establishing Kriminalasylet, but the target group had now expanded. In the debate on establishing Reitgjerdet, dangerousness and the element of crime was not stressed upon. The argument of overcrowding and the argument of

protecting the society remained the same. Thus, the primary aim of Reitgjerdet was wider and less rigid than that of Kriminalasylet. Psychiatrists and legal professionals opted for a new and bigger criminal asylum saying that: *“In connection with these concerns we must stress the urgency of converting Reitgjerdet into a criminal asylum for men, so that the ordinary asylums can get rid of those troublemaking criminal elements, currently disgracing the asylums. It is outrageous that people should have to put up with having their relatives (ordinary patients) spending time with such thugs”*.³²

The immediate concern at that time was the leprosy patients still remaining at Reitgjerdet. A further discussion in the 1919 proposition addresses the various options concerning the care of these patients. The other main concern was the economy. It was eminent for the government that the cost would be kept as low as possible. The budgetary decision was still in favor of converting the leprosy hospital into a new and bigger criminal asylum.

Reitgjerdet asylum also had its own law passed. As was the case with Kriminalasylet, the responsibility of admittance and discharge was transferred away from the asylums medical director. This task was granted the Ministry of Social affairs, subjecting this asylum to the health authorities and not the judicial authorities, as was the case with Kriminalasylet. This difference in authoritarian affiliation divulges an intention based less on confinement, and more on treatment. Still; the proposition emphasizes that *“the purpose [for Reitgjerdet] is not solely the treatment and care of the criminally insane, but mainly the satisfactory confinement of disruptive and dangerous male individuals”*.³³ Both asylums had the protection of society as their official aim, whilst the aim of treatment and care was secondary. Treatment optimism was declining around the turn of the century, and the group of insane assessed as dangerous, difficult and disruptive was no exception to this. The idea was to *“incapacitate the incurable”* as the Norwegian law reformer and politician Bernhard Getz put it.³⁴

The law on Reitgjerdet was processed in 1922, and endorsed by the government soon after.³⁵ This law stated that Reitgjerdet asylum was meant to obtain *“especially disruptive and dangerous insane male persons, not considered suitable for treatment in ordinary asylums”* (§1). This gave Reitgjerdet a wide-ranging aim regarding potential patients. The element of crime was not mentioned, behavior and conduct was emphasized as the main measurement of intended patients. The words *“especially disruptive and dangerous insane”* points towards the types of individuals the ordinary asylums was looking to get rid of. This difference in criteria between the two criminal asylums is evident when reading the patient journals from

Reitgjerdet, where a substantial portion of the patients had no criminal record. These might have been difficult and disruptive, but hardly ‘insane criminals’ or ‘criminally insane’.

The asylum population

Norway’s estimated population in 1900 was 2, 24 million; by 1940 the population was 2, 97 million. Other European countries had larger populations; and thus larger patient populations. The period 1895-1940 held a total of 687 patients for both institutions, in all 916 admissions, since some patients were admitted more than once. Kriminalasylet had 128 patients in the period 1895-1940, with an average age of 33, 8 years when first admitted.³⁶ Reitgjerdet had 559 patients, with an average age of 35.3 years when first admitted.³⁷ All patients were male.

Kriminalasylet opened in February 1895 and received ten patients that year, five less than it was licensed for. The patients came from all parts of Norway, except for one Finish man who was soon returned to Finland. Most patients were transferred from jails or labor prisons. In the following year another seven patients was admitted, in 1897 there were three new patients, in 1898 two new patients and then four new patients in 1899. When entering year 1900 the asylum had 15 patients, as they were licensed for. 11 patients had by then left the asylum; four of them had died while the others were transferred to ordinary asylums. Even after the asylum was expanded in 1900, the turnover in patients was low. After 1923 a lot of the new patients at Kriminalasylet were transferals from Reitgjerdet.

Reitgjerdet was significantly bigger and received 135 patients its first year, as it was licensed for. Partly due to the larger number of patients and partly due to the different admittance criteria, these patients were a less homogenous group than those at Kriminalasylet. This was as intended; Reitgjerdet was to serve a wider demand than Kriminalasylet. The patients admitted to Reitgjerdet came from all parts of the country, but were more often transferred from other asylums than from jails or labor prisons. Many had spent childhood or adolescence in various disciplinary homes for poor, sick or misbehaving children. Some died shortly after arrival, mainly from tuberculosis. The most dangerous among the patients at Reitgjerdet would be transferred to Kriminalasylet if possible and necessary. At Kriminalasylet the security was higher and the staff was more experienced at handling dangerous patients.

The patients in this study will be described based on their pre-patient phase and their inpatient phase, as did Goffman.³⁸ There is little to be found in this material to describe the ex-patient phase, but information about the patients’ social background, their crimes and their behavior is found. So who were these patients; socially, criminally and medically?

Social characteristics

The patients' social characteristics are based on information about family background, upbringing, occupation and marital status. This was part of the mandatory information registered by the Medical director. The information on 'family background' also hold descriptions about alcohol use, history of abuse and violence, illness in the family and prior stays in other institutions. The registrations also include information on whether other members of the family had a known history of mental illness, alcohol abuse, violence or institutionalization. Sometimes only the correct noun is mentioned under the tab "insanity in the family"; such as "mother", "father" or "uncle". Other times it's followed by a description; such as "*mother and aunt both very nervous*", "*father and all 6 siblings are drunkards*" or "*father was retarded, as was the mother, and two brothers committed suicide by hanging*". Descriptions like; "*both parents lazy and prone to drift about (vagabonds)*" or "*father a vagabond and thief, mother took to the streets (prostitution)*" also reveal hardship or poverty.

Upbringing was often emphasized as the cause of the patient's illness. One example is Lars, admitted to Kriminalasylet in October 1895; "*the patient was born in 1863. His mother died when he was 4 or 5 years old, and the father, who supposedly married into a great fortune, then started drinking and ruined the family by doing so. The family soon ended up on welfare, and the boy was placed in different homes over the next years. His upbringing was severely neglected, and soon he was known for his cold and emotionless state of mind*" (PJ, KG, L.nr 8). The commonness of descriptions such as these leads to the conclusion that most patients at Kriminalasylet and Reitgjerdet came from families with great social, medical and economic challenges. As such, these patients were part of the lumpenproletariat; a term first coined by Karl Marx. The term identifies a class of outcast, degenerated and submerged elements which include "beggars, prostitutes, gangsters, racketeers, swindlers, petty criminals, tramps, chronic unemployed or unemployables, persons who have been cast out by industry and all sorts of declassed, degraded or degenerated elements", and is sometimes translated into "dangerous classes".³⁹

This conclusion is substantiated by the listings of the patients' occupational background. The most frequent occupation is the loosely descriptive term "worker" or "day laborer", indicating that these patients were not steady employees, but took bodily work when available. The second largest group of occupancy is "farming", "fishing" and "sailor". These types of labor were common in Norway at this time. The agricultural revolution in the mid 1800's had brought Norway from self-sufficient based farming to sales-based farming, as a part of the industrial revolution. Some of the patients are listed as both "farm boy" and "fisherman",

suggesting they took employment were and when they could. Employment at sea was not rare. The number of “sailors” in Norway increased drastically after 1865, and reached as many as 60.000 in 1890.⁴⁰ Many of them left home at a young age, seeking adventure as well as income. Harsh working conditions, little stability and lots of alcohol became a breeding ground for mental illness. There was also a heightened risk of syphilis among sailors, known as a cause of insanity at the time.⁴¹ Many of the sailors returned to Norway only to spend the rest of their life in institutions. This occupational background still distinguish them from another large group of patients listed as “vagabond”, “tramp” or “vagrant”. This group stands out. While most patients had low income, this last group probably had close to no income. A larger percentage of the patients at Kriminalasylet than at Reitgjerdet are listed with such a background, but this is concurrent with the admission criteria in the Law passed for Kriminalasylet; “male convicts”, “illegal acts” (such as vagrancy) and “dangerous”.

Marital status is a somewhat unreliable characteristic at an individual level, but it is indicative at a general level. In the 1890s, and well into the 1950s, only about two out of ten among the adult population in Norway were unmarried.⁴² For the patients at Kriminalasylet and Reitgjerdet it was the other way around. Only about two out of ten of these patients were married, divorced or widowed, giving the opposite proportion of the general population. Marriage was a key to achieving social acceptance. Marriage meant access to care and a supportive environment. However, it also meant obligations and responsibility; you need something to offer into a marriage in order to get married. The patients at Kriminalasylet and Reitgjerdet seem to have been deemed unattractive as partners, even before being declared insane. They simply did not meet the social requirements and fell through in the selective processes. A few patients had wives that kept in touch, and a few even begged to have their husbands sent home. Others filed for divorce after their husbands were admitted. And of course, some patients were admitted because they had brutalized or killed their wives or families. A patient named Amund was admitted in 1924 to Reitgjerdet, partly for violence towards his family. The journal describes in short; *“he has behaved brutally towards wife and children, and threatened his neighbors many times. Hi is not wanted back home”* (PJ, RG, L.nr 158). The impact of romantic relationships on mental health was accentuated by the psychiatrists at Kriminalasylet and Reitgjerdet. Three patients were in fact registered with the bittersweet remark: *“misfortunes in love”* as the cause of their insanity.⁴³

For most patients it was the parents or siblings who kept in touch and that they tried to keep in touch with. To do so, they wrote letters. The numbers of letters addressed to “mom” are

numerous. Many of these letters are filled with excuses, pleas to be allowed home, promises of better behavior in the future, or declarations of their love and devotion.⁴⁴

Crime characteristics

This category is challenging, primarily because the journal registrations on crime were not structured. More likely it was based on information the staff found to be of interest or what was available to them. In some patient records a number of crimes are listed, in others there are just shallow descriptions of acts and offences the patients had committed. In some records there is a list of the patients' convictions with dates and names of the court, while others say little about what repercussions these acts might have had. A second challenge is the variety of acts and offences described. Patients had often committed more than one offence. Whilst crime was a main criterion for admission at Kriminalasylet, it was not a mandatory criterion at Reitgjerdet. The difference is striking. All the patients at Kriminalasylet have remarks about criminal acts, and often convictions.⁴⁵ Meanwhile, roughly 42 % of the patients admitted to Reitgjerdet in this period had no remarks on crime. Some of these fit the criterion "disruptive" or "dangerous", but most of them were admitted simply due to a lack of other options. This fact was pointed out by the Head of medicine at Reitgjerdet, Karl Andresen, in the asylum's annual report for 1923. According to him, Reitgjerdet was compelled to accept a large group that was neither criminally insane, insane criminals nor disruptive or difficult, simply due to the urgent need for hospital beds: *"It was soon evident, that there was a great need for beds also for ordinary insane male patients, especially from the northern parts of Norway, and Reitgjerdet have thereafter given admission to several of these, whom no other asylum was able to make room for"*.⁴⁶

The analysis of the patients in this study is in broad agreement with Andresen's statement. It stands out as a main deviation from the official aim. However, more than half of the asylum population at Reitgjerdet and all patients at Kriminalasylet had prior convictions or criminal behavior of some sort. Their crimes are various and not easily quantifiable. For the sake of simplicity I divided the various acts and offences into six categories; 1) murder, 2) profit crimes, 3) violence, 4) sex offences, 5) arson and 6) intimidation.

Murder was stressed as a main criterion when discussing dangerousness prior to the establishment of both asylums and prevention of dangerousness was an eminent part of the official aims. Yet only 21 patients at Kriminalasylet and only 28 patients at Reitgjerdet had committed murder. The low number of murders seems dissonant with how the concept 'dangerousness' was discussed prior to establishing the asylums. In fact, the registered

murderers amongst the patients are not those described as the most dangerous either.⁴⁷ A patient at Kriminalasylet, Karl Oscar, had: *“changed character around the age of fourteen, became increasingly defiant with uncontrolled anger fits. From the age of twenty-three he developed delusions of persecution and a fear of being poisoned. Often got into fights and murdered a man during one of these”* (PJ, KG, L.nr 81). He is not described or declared as dangerous. He was admitted in 1914, and stayed until 1940 when he was discharged as “still insane”. He was never re-admitted to Kriminalasylet or Reitgjerdet.

‘Profit crimes’ was focused on in debates and White Papers all through this period, thus it is no surprise to find this category well represented in both asylums, especially Kriminalasylet. From the descriptions in the journals it is evident that these patients were not admitted on single counts of petty theft, their criminal behavior was more disruptive and externalizing than that. Most of these patients are described with terms such as “habitual thieves”, “notoriously fraudulent” or “arrested numerous times for thievery”. About Alvin, a patient at Kriminalasylet, it was said: *“poor upbringing and poor abilities. Dishonest and thieving already as a youngster, both at home and at school. Repeat offences, carried out several rude and idiotic burglaries. Arrested numerous times”* (PJ, KA, L.nr 79). The description reveals that such behavior was often seen as a chronic personality trait and thus not preventable by other measures than incarceration. Of course, profit crimes represented a ‘danger to others’, in the sense that homes, businesses and the economic balance in society could be threatened by high levels of profit crimes. Such behavior qualified as both disruptive and criminal.

Violence was a particularly difficult category to define, since so many acts and offences might be described as violence. An explanation is therefore necessary. Murder and sexual offences are not included as they are made separate categories. Attempted murder is however included, since this is clearly a violent act, and not registered in the ‘murder’ category. Verbal threats are included in the category ‘intimidation’, and not registered as violence. Even with such a strict definition the number of violent patients is relatively high, for Reitgjerdet it surpasses all the other categories. Common descriptions are; *“behaves brutally”, “violent behavior”, “unmotivated attacks on others”* or *“brutal towards others”*. And more specific descriptions; *“attacked his fiancée with an axe”, “comes from a long line of brutal men”, “has violent fits, destroying everything around him”* or *“numerous attempts to strangle strangers”*.⁴⁸

Sex offences were politically and emotionally loaded crimes that sometimes got attention from media, the public and politicians. Many of the patients in Kriminalasylet and Reitgjerdet

had committed offences against minors or highly violent rapes against women. 3 of these offences had resulted in the victim dying, all of which were children. Sexual offences were debated often in the years before and after 1900, and it represented a special type of dangerousness. Especially the Women's Movement in Norway was concerned with the threat such behavior posed towards women and children.⁴⁹ It is therefore not surprising to find relatively high numbers in this category. These offenders were also declared as dangerous more often than others.⁵⁰

Arson is still generally linked to mental illness; sane people aren't believed capable of just setting fire to homes and buildings. All the patients registered with arson were also diagnosed with 'idiotia', 'insania degenerativa' or 'dementia', a diagnosis indicating intellectual disability. Arson represents possible fatalities as well as huge material loss, and was central to the discussions on dangerousness leading up to the establishment of these asylums. Although the offence may be grave, they were scarcely described in the journals, only a couple contains descriptions of what the patient had set on fire. One patient, Nicolai, had for instance: "*set fire to the coal storage at Gaustad asylum*" while he was a patient there. It is further remarked that: "*he was never charged or sentenced for the offence*" (PJ, KA, L.nr 49). He was transferred directly to Kriminalasylet after the arson and remained a patient there for 28 years.

The category intimidation holds many different types of behavior. Intimidation involves threats or threatening behavior, and is the crime of intentionally or knowingly putting another person in fear of imminent bodily injury. Examples would be stalking people, lurching around people's homes or acting weird in public places. Arson and intimidation are almost evenly distributed in the two asylums, and quite a few of these patients had no other registered offences. Their actions were deemed as dangerous enough to keep them admitted for years.

Medical characteristics

Since the psychiatric classification was not stringent in this period, it is difficult to analyze the medical characteristics solely based on the diagnoses. The psychiatric classifications were developed and continuously influenced by new research from other countries. During the 1800s, the main influence in Norway was German psychiatry, in particular that of Emil Kraepelin, but also remnants of Italian and French psychiatry is evident, such as Jean-Étienne-Dominique Esquirol, Bénédict Morel and Cesare Lombroso.

In French psychiatry, Jean-Étienne Dominique Esquirol anticipated modern views when he suggested that some mental illnesses may be caused by emotional disturbances rather than by

organic brain damage. Esquirol also provided the first accurate description of mental retardation as an entity separate from insanity as early as 1838. Even so, in the period 1895-1940, people with intellectual disabilities were still classified as insane in Norway, and thus were admitted to asylums. In fact, as many as 21, 8 % of the patients at Reitgjerdet in 1923-1940 were diagnosed 'idiot' or 'imbecile'. Most patient 'idiots' or 'imbeciles' had criminal records and can easily be described as either 'dangerous' or 'disruptive', and this might explain the high proportion of intellectual disabilities in Reitgjerdet. The diagnosis used at Kriminalasylet does not clearly pinpoint intellectual disability. In opposition to the leading theories of his time, French psychiatrist Kraepelin did not believe that certain symptoms were characteristic for specific illnesses. Clinical observation led him to the hypothesis that specific combinations of symptoms in relation to the course of psychiatric illnesses allowed one to identify a particular mental disorder. The second Medical director at Kriminalasylet, Hans Evensen, did his psychiatric training under Kraepelin.⁵¹ Italian psychiatry was at this time obsolete biological and strictly neuroanatomical. The explanatory approach postulated by academic institutions was awkwardly implemented in asylum practice in Italy. This seems very different to the practice at Kriminalasylet and Reitgjerdet, which resemble Kraepelin's clinical approach. The concept of degeneration was first made influential in psychiatry by the French psychiatrist Benedict Morel, through his "Treatise on Degeneration" from 1857. Later, this concept was picked up by the Italian doctor Cesare Lombroso, who in 1876 applied it to his phrenological studies on inmates in prison. The concept of degeneration is present in this material, but in ways that resemble Morel more than Lombroso.

Tracing the exact influence of the psychiatrists working in Kriminalasylet and Reitgjerdet is difficult, if not impossible. Diagnosis shift between 'Insania degenerativa' and 'Dementia praecox', as well as 'Insania paranoides', 'Insania alcoholica', 'Insania epileptica', 'Psychopatia' or 'Melancholia'. And as mentioned, a substantial proportion was given the diagnosis 'idiotia' or 'imbecile'. The descriptions connected to the diagnostic process are therefore important additions and sometimes reveal more about the medical characteristics outlining the asylum population. These descriptions focus mostly on the patients' behavior and state of mind, and are not strict adaptations to the given diagnoses. Thus, the diagnoses itself appear to be of less value in this individually oriented approach. The first patient admitted to Kriminalasylet, Alexander, was described as follows: "*Admitted to Rotvold asylum on Nov 25th 1893 with the diagnoses 'paranoia'. The patient has been quite a drunkard and thereto very immoral in his behavior. His temperament is described as very vehemently. He is convicted of*

murder, as he stabbed a woman whom had the misfortune of getting in his way. While in prison he has been depressed and frustrated about not getting a reprieve. The spring of 1892 he complained of sleeplessness and appeared confused, upon which the prison physician suspected him of simulating insanity. His suspicions was changed when the patient later on started to talk incoherently and at one point stabbed himself in the arm, and he soon stopped eating and talking. He was transferred to Rotvold asylum for observation, before admittance here” (PJ, KA, L.nr 1).

This is only an excerpt of the journal that was handwritten, stretching over four pages. This patient was 38 years old when admitted to Kriminalasylet, and spent 22 months there before being transferred to an ordinary asylum closer to his hometown. In the journal he is entered as suffering from ‘paranoia’, as was the diagnosis he got while under observation at another asylum. Apart from this, the diagnosis is not mentioned at all. The entries in the day to day protocol describe the patient’s chores and moods and make no effort trying to identify the cause of his illness, as they often would. Another patient, Bernt, who was admitted a few years after, illustrates how the cause of illness was sought found: *“As a child he was headstrong, hot tempered and wild. At young age he started using tobacco and kept bad company, although he is reported to have had good abilities and a quick perception. Confirmation completed in due time, diligent and well behaved in school” (PJ, KA, L.nr 12).* The journal then continues by describing an identifiable break in his upbringing: *“At some point in his late childhood both his parents started drinking and left their home and work unattended. Sometime after this the patient developed an inclination to steal. He was then imprisoned several times during 1891 and 1892. From his last stay in prison, he is described as rude and impolite, unreliable and wanton” (PJ, KA, L.nr 12).* This patient was diagnosed with ‘insania degenerativa’, indicating his illness was inherited biologically, socially or morally. The term ‘degenerativa’ point to the widely influential concept of degeneration, as formulated by Bénédict Morel, following the theory of ‘progressività’, a progressive development of symptoms from one generation to the next.⁵²

Although the medical staff was obviously up to date on psychiatric research and theories, the diagnosis seems to have been of little importance to the clinicians in their daily work. A diagnosis was a ‘classification’ of the symptoms found in each patient; it did not provide a ‘recipe’ or ‘clue’ as to what treatment the patient would benefit from. The diagnosis did not give any guidance to how each patient should be handled in everyday life. From a humanitarian perspective, the diagnosis failed to ‘meet the patient’, which seems to be of great importance to the psychiatrists and staff during this period. It was imperative for them to get to know each patient in order to provide good care and to secure a safe environment for

everyone living there. Like the founders of moral treatment in England, who rejected medical theories and techniques, their efforts focused on minimizing restraints as well as cultivating rationality and moral strength. This way, the patient's autonomy was recognized. Security was also about more than just walls, fences and locked doors. To them, security was upheld through good communication and care.

Discussion

Goffman's model proved to have only limited value when analysing these two asylums. Although these institutions resemble the conditions of total institutions and the patients were generally admitted for long periods without the possibility of leaving, they were also cared for and included in a community of sorts. The cold and instrumental establishment Goffman describes seems miles off what this material reveals. The reasons could be many; different countries, different cultures, different period in time and different perspectives. After all, Goffman admitted that he: "came to the hospital with no great respect for the discipline of psychiatry nor for the agencies involved with psychiatric practice."⁵³ I probably didn't share that same lack of respect, or more importantly, my respect grew while reading these journals.

These criminal asylums seem different to Goffman's asylum in two ways; firstly, those involved in the establishment and operation of these asylums all comes across as having genuine humanitarian concerns. The humanitarian intentions are vaguely evident in the official aims, but clearly an aim for the directors and the staff. They were concerned with the interest, the needs and the care of all their patients. This intention was perhaps most clearly expressed by the psychiatrist Paul Winge when he said: "*May these discussions contribute to making Norway a humanitarian model nation for the treatment of the insane*".⁵⁴

Institutionalization was viewed as a humane option, benefitting both society and patients. This noble intention didn't stop at the front door, but was an ideal for the staff as well.⁵⁵

Secondly, they all acknowledged these patients as exactly that: patients. Goffman uses the term inmates many times over in his study, as if to accentuate the patients demeaning situation. But a patient was someone with rights and dignity. According to Goffman their status as mental patients inflicted a stigma concurrent with "mortification of self", but most of them were stigmatized long before becoming patients. As Porter points out, patients feel their sense of identity is eroded both by psychiatry and society.⁵⁶ These institutions did strive to achieve a meaningful everyday life for their patients. Everyone was clothed and fed, work

was varied and voluntary, coercion was actively avoided and it was possible to keep in touch with family. This exceeded what many of them were able to achieve in the “free world”.

Both asylums had to deal with the reality of funding and resources. These were often not adjusted to the ideals and visions embedded in the laws that authorized the asylums. The institutions functioned in a span between treatment facility and high security asylum, and the patients became subjects in the everyday negotiations concerning their life in the institution. They were not expected to just passively adapt, but also to actively interact with their surroundings. Many of the patients also enjoyed liberties and freedom within the walls of the institutions. One patient at Kriminalasylet, Ludvig, wrote numerous newspaper articles while he was admitted, and even did fundraising for various charities (PJ, KA, L.nr 22). Another patient was discovered to have a set of keys to Reitgjerdet. It turned out he had had the keys for many years, but never used them to run away. The Medical director politely told the patient this was neither intended nor acceptable, and the patient then handed the keys back (PJ, RG, L.nr 372). With the antipsychiatry movement in the sixties and seventies, an intellectual and societal focus on power, discipline and control was raised. But the everyday notes from Kriminalasylet and Reitgjerdet illustrates how the social realities of the asylums were more nuanced, and that patient freedom was also part of the asylum life.

Goffman’s postulate; that total institutions typically fall short of their official aims, is still worth addressing. Did Kriminalasylet and Reitgjerdet fall short of their official aims? The answer cannot be a simple ‘yes’ or ‘no’. These asylums had quite different terms of operation. Laws, target group, size and location was eminently different. All of these factors affected the outcome. Kriminalasylet seems to have met its official aims to a greater extent than Reitgjerdet did. The wide admission criteria at Reitgjerdet allowed a situation where patients were admitted simply because there were no other options. Because ordinary asylums were full, the newly opened Reitgjerdet asylum took a lot of these patients in, even if it contradicted the intentions. This factor alone took Reitgjerdet further from the intended aim.

Still, in these first few decades of operation these asylums did not fall *too short* of their official aims. The main deviation is found in the number of patients admitted to Reitgjerdet without criminal behavior, assessed dangerousness or disruptive conduct. The asylums still obtained patients intended for high security incarceration, but also utilized their capacity by admitting others. In many ways, these asylums displayed an ability to adapt to the needs of society and the needs of the patients they admitted. The Medical director, the Department of

Justice and Department of Health, all seemed to view the shortage of hospital beds as a common challenge, one they shared with ordinary asylums. Addressing Goffman's concern requires an understanding of how the measured need before establishing the asylums turned out to be a different need once the asylums were in operation. The ongoing reality dictated which patients ended up in criminal asylums, just as much as propositions and laws did. When Hitler occupied Norway in 1940, the situation got worse. The Germans requisitioned many of the asylum buildings, and ordinary insane patients were sent wherever there was room. Reitgjerdet nearly doubled its patient population during the war. But up until that point, the operation stayed close to the official aims at both these asylums.

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Notes:

¹ Published lecture, originally held by Paul Winge at a meeting held by the Nordic Criminalist Society in 1893, National Library. (This, and all further quotes, are my own translations)

² This translation creates a small linguistic confusion in English, but I chose to leave it like this in order to stay as close as possible to the Norwegian original terms.

³ The Official Statistics of Norwegian asylums. Addendum in the 1929 Edition; «Sinnssykeasylenes virksomhet», by Rolv Gjessing, Hospital Director at Dikemark Asylum.

⁴ Riaunet, Åse (2014:25): «Oppdrag, pasienter og praksiser. Kriminalasylet i Trondheim 1895-1905», Master Thesis, NTNU, Trondheim.

⁵ Kringlen, Einar (2004): "A History of Norwegian Psychiatry." In: *Journal of History of Psychiatry*, vol.15 nr.3.

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⁷ Wetzell, Richard F. (2000:3): *Inventing the Criminal. A History of German Criminology 1880-1945.* University of North Carolina Press, Chapel Hill and London.

⁸ Wifstad, Åge (2007): Humanistisk medisin. In: *Tidsskrift for den Norske Legeforening*, 2007; 127:2967 – 9

⁹ Nylenna, Magne (2000): De «to kulturer» i medisinen. In: *Tidsskrift for den Norske Legeforening*, 2000; 120: 3732 – 5.

¹⁰ Thomassen, Øyvind (2015:31): «Asylene for de sinnssyke og farlige mennene – Kriminalasylet og Reitgjerdet» In: Norsk rettsmuseums skriftserie nr.3: Galskapens fengsel. NTNU fagtrykk, Norway.

¹¹ Two resembling asylums in Great Britain would be Broadmoor (in Berkshire) and Dunderum (in Dublin), both separate institutions for criminal lunatics, and not wards.

¹² Sth.Prp.No. 73 (1894:597) «Indstilling fra Næringskomiteen No.2 angaaende Bevilgning til Anlæg og Drift af et midlertidig Kriminalasyl I den nedlagte Afdeling B af Trondhjems Straffeanstalt.»

¹³ Such as prisons, military camps, orphanages and asylums.

¹⁴ Goffman, Erving (1961): "Asylums", Anchor Books, Doubleday & Co, UK.

¹⁵ Thomassen, Øyvind (2010:82): «Diagnosing the Criminally Insane in Norway 18895-1915", In: Andresen; Hubbard and Ryymin: *International and Local Approaches to Health and Health Care.* Novus Press, Oslo.

¹⁶ *Partners*: Schaanning, Espen (2002:35): «Kampen om den forbryterske sjel». Unipub forlag, Oslo. *Uneasy bedfellows*: Greig, Deirdre N. (2002): «Neither bad Nor Mad». Jessica Kingsley Publishers, London.

¹⁷ Goffman, Erving (1961:127): "Asylums, Anchor Books, Doubleday & Co, UK.

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- ¹⁸ Blomberg, Wenche (2005): "Some traits of Norwegian pre-medical reactions to madness." *History of Psychiatry*, March 2005, vol. 16, 1: pp. 99-105.
- ¹⁹ Goffman, Erving (1961): "Asylums", Anchor Books, Doubleday & Co, UK.
- ²⁰ Such as; Levinson & Gallagher (1964), Linn (1968), Siegler & Osmond (1971), Karmel (1969), Lemert (1981).
- ²¹ Goffman, Erving (1961:16): "Asylums", Anchor Books, Doubleday & Co, UK.
- ²² Note that Goffman's views on mental disorders is altered in his article from 1969; "The Insanity of Place". Some argue this evolution was influenced by his personal experience, such as: Dmitri N. Shalin (2013) "Goffman on Mental Illness: 'Asylums' in: 'The Insanity of Place' Revisited" *Symbolic Interaction*, Vol.37, Issue 1.
- ²³ Goffman, Erving (1961:125): "Asylums", Anchor Books, Doubleday & Co, UK.
- ²⁴ Goffman, Erving (1961:124): "Asylums", Anchor Books, Doubleday & Co, UK.
- ²⁵ Sth.prp.No. 73 (1894:596): «Indstilling fra Næringskomiteen No.2 angaaende bevilgning til Anlæg og Drift af et midlertidig Kriminalasyl i den nedlagte Afdeling B af Trondhjems Straffeanstalt.»
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- ²⁷ Sth.prp.No. 73 (1894:599): «Indstilling fra Næringskomiteen No.2 angaaende bevilgning til Anlæg og Drift af et midlertidig Kriminalasyl i den nedlagte Afdeling B af Trondhjems Straffeanstalt.»
- ²⁸ Oth.Prp.No.4 (1898): «Angaaende Utfærdigelse af en Lov angaaende Kriminalasylet».
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- ³⁰ St.prp.nr. 206 (1919): Om bevilgning til å omdanne Reitgjerdet pleiestiftelse for spedalske til asyl for særlig vanskelige og farlige sinnssyke. Socialdepartementets innstilling av 27de juni 1919.
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- ³⁴ Mæland, Henry John (2002:329): «Fra Kriminalloven til Straffeloven», In: *Tidsskrift for Strafferett*, 2002;4. Gyldendal Forlag, Oslo.
- ³⁵ Ot.prp.nr.51 (1922): «Om utfærdigelse av en lov om Reitgjerdet asyl.»
- ³⁶ The youngest patient was admitted at 18 years old, and the eldest 61 years.
- ³⁷ The youngest patient was admitted at 16 years old, and the eldest 65 years.
- ³⁸ Goffman, Erving (1961:121): "Asylums", Anchor Books, Doubleday & Co, UK.
- ³⁹ <https://en.wikipedia.org/wiki/Lumpenproletariat>
- ⁴⁰ <http://www.arkivverket.no/arkivverket/Arkivverket/Bergen/Kjelder-og-arkiv/Kilder-om-sjoefolk>
- The Norwegian population reached 2000000 around 1900.
- ⁴¹ Koren, Elisabeth (2008): «Beskytte, forme, styrke. Helsefremmende arbeid overfor norske sjøfolk i utenriksfart med hovedvekt på perioden 1890-1940.» PhD-theses, University of Bergen.
- ⁴² SSB (1965): «Marriages, births and migrations in Norway 1865-1960.» *Samfunnsøkonomiske studier* nr.13.
- ⁴³ PJ, KA, L.nr 93; PJ, RG, L.nr 475; PJ, RG, L.nr 72.
- ⁴⁴ Thomassen, Øyvind (2015): *Kriminelle sinnssykes brev c.1900-1950 [Criminally insane patients' letters]* (Unpublished article), NTNU, Trondheim.
- ⁴⁵ In Norway, the prosecution can refrain from pressing charges if a trial is not likely to lead to a sentence, or if a trial is not likely to change the outcome. Being assessed as insane, prison would be an unlikely outcome.
- ⁴⁶ The Official Statistics of Norwegian asylums, Reitgjerdet annual report 1923.
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- ⁵⁰ Dahl, Hilde og Thomassen, Øyvind (2015:191): «Om sikring og farlighetserklæringer – sikkerhetspsykiatrien etableres» In: *Tidsskrift for strafferett*. Vol 2, 2015. Gyldendal Forlag, Oslo.
- ⁵¹ Hans Evensen (1868-1953), Norwegian psychiatrist and Medical director at Kriminalasylet 1901-1915.
- ⁵² The concept of degeneration became influential in psychiatry through the work of Benedict Morel (1809-1873), and as influential in criminology through the work of Cesare Lombroso (1835-1909).

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⁵⁴ Discussion in the Norwegian Criminalist Society (1894): Stensiltrykk, H.Aschehoug &Co, Kristiania.

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