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Crisis and Caring for Inner Selves: Psychiatric Crisis as a Social Classification in Sweden in the 1970s

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Abstract

This article aims to contribute to the understanding concerning the introduction of crisis psychotherapy in the 1970s in psychiatric clinics in Sweden. The article discusses how this psychotherapy became central in the work of the clinics in supporting patients to well-being and inner growth. The ambition was that patients in an acute crisis-situation would be offered care immediately, aiming at a short and intensive contact with the professionals to avoid hospitalization and long-term sick leave. These ideas were by no means new; in the 1960s, a Western debate had emerged in which the hospitalization in psychiatric clinics had received criticism. In Sweden, the psychiatrist Johan Cullberg was a key actor during the 1970s in the introduction of the psychiatric crisis perspectives. Here, his publication 'The psychic trauma' from 1971 is analysed. The publication inspired psychiatric clinics to introduce crisis psychotherapy in three different pilot projects. The projects were presented in articles in the *Swedish Medical Journal*. These articles have also been analysed here. Self-care is highlighted through this material as a concept to be analysed. The question is discussed as to how the concept of the psychiatric crisis initiated and institutionalized a new form of social classification in which the patients were to take more responsibility for their own inner growth.

Keywords: Psychiatric crisis, crisis psychotherapy, inner growth, self, self-care, social classification, classificatory looping

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Introduction

> We all are likely to run into psychiatric crises – the person who never does, is rather to be pitied. It is also a situation where we all should have the right to receive help – help to listen to our own capabilities of finding a solution, not to run away from the sometimes painful self-defining that the situation often contains (Cullberg 1971:3, my translation).

In the publication 'The Psychic Trauma: About Crisis Theory and Crisis Psychotherapy' from 1971, the Swedish psychiatrist Johan Cullberg presented the concept of the psychiatric crisis. In this text, the crisis is presented as something essential for the human being and something we must *not run away from*. The psychiatric crisis should instead be seen as an important part of how humans define their inner self, almost necessary for the individual in order to develop a strong and complete self. In this article, the psychiatric crisis will be used as a starting point for discussing how crisis psychotherapy in the 1970s manifested a specific psychological being that was expected to take responsibility for his or her own inner self, a form of self-care. Focus is on how this form of self-care is institutionalized; how patients in crisis are categorized in an outpatient care unit in Sweden.

In his book, *Inventing our Selves* the sociologist Nikolas Rose argues that there has been a transformation in the Western society; the individual is increasingly regarded as a psychological being with an inner mental process of growth. This has changed 'our conceptions of what persons are and how we should understand and act toward them, and our notions of what each of us is in ourselves, and how we can become what we want to be' (Rose 1998:11). Rose links this change to the growth of psychology in Europe and North America in the twentieth century and to how the psychological knowledge has come to have a central role for how individuals are *caring for their inner selves*. Emphasized by the philosopher Michel Foucault, the care of the self is an old idea from the classical and late antiquity concerning how the subject relates to his or her own actions (Foucault 1990). This idea was accentuated when psychology made the self into a psychological knowledge. From this theoretical perspective, the psychological knowledge highlighted by Rose's Foucauldian perspective can be regarded as a form of self-caring project that is placed upon individuals, making them responsible for their own inner growth. As we will see in this article, conceptualizing the self with psychological knowledge in this way provides a new perspective for what the human being can be and for what she or he can strive. In this article, this theoretical argument will be analysed from a Swedish perspective using the psychiatric crisis as a case of how crisis psychotherapy in the 1970s initiated and institutionalized a new form of psychological knowledge in which patients were to take increasing responsibility for their own inner growth. More specifically, the subject of the analysis is the *crisis psychotherapy* that was introduced in the psychiatric treatment in clinics during the 1970s. In this article, the crisis psychotherapy is utilized as a case for discussing how care of the self has become part of the Swedish psy-

chiatry, and how cultural ideas about self-care received practical form in a specific psychiatric treatment.

The crisis psychotherapy was a treatment, which in Sweden presented an alternative to more traditional psychiatric treatments in the 1970s. The ambition was that patients in an acute crisis-situation would be offered care immediately, with the aim of a short and intensive contact with the professionals to avoid hospitalization and long-term sick leave. These ideas were by no means new; in the 1960s, a Western debate had emerged in which the hospitalization in psychiatric clinics had received criticism (Goffman 1961; Szasz 1961; Scheff 1966; Foucault 1967). It was not just an attempt to find a new psychiatry, but also a process of finding other ways to perceive the patient who consulted the clinic for treatment (cf. Micale & Porter 1994). In Sweden, the psychiatrist Johan Cullberg was a key actor in the 1970s in the introduction of the psychiatric crises perspectives.[1] Particularly, the previously mentioned publication from 1971, 'The Psychic Trauma', became central for many of the psychiatric clinics that introduced the crisis-treatment (Cullberg 1971).[2] A main point in Cullbergs publication was how the psychiatric crisis was presented as having a developmental potential for the individual; meaning that the crisis could be something beneficial and normal to go through. This alternative psychiatric treatment can be considered as a means for the clinic to give the patient more responsibility for his or her own potentials to grow as a human being. In this article, this matter is analysed as a change in the attitude of the psychiatric clinics, which implied avoiding hospitalization of the patients and instead focusing upon the patient's possibilities to handle the psychiatric crisis on their own under the care of a psychiatric treatment.

Method

In the psychiatric disciplines – the clinics, as well as the psychiatric researchers – paying attention to the patient's acute crisis situation was a perspective creating a new classification of when a patient had a crisis and what care that patient needed. In the early 1970s, the theories of the psychiatric crisis were gradually applied in psychiatric treatment in Sweden. Consequently, the classification of what a crisis is also started to interact with certain kinds of behaviour among the patients. This is what the philosopher Ian Hacking defines as *classificatory looping*; meaning that *social classifications*, in this case the psychiatric crisis, interact with the behaviour that has been classified (Hacking 1999). Social classifications can be studied methodologically through what Hacking names a *style of reasoning*. In which way is social classification associated with an ontological discussion concerning the different kinds of behaviour that should be incorporated in the specific classification that is identified as the psychiatric crisis (Hacking 2004)? Through the theories about the psychiatric crisis, psychiatry gained a territorial extension that provided the professionals new principles, or logical sentences, for their style

of reasoning concerning some specific human behaviour. In examining those sentences closer, it is possible to study the social classifications that are associated with the psychiatric crisis supporting the objectivity of the theoretic framework behind the concept (of the psychiatric crisis). Hacking points this out when he writes, 'The truth of a sentence (of a kind introduced by a style of reasoning) is what we find out by reasoning using that style. Styles become standards of objectivity because they get at the truth' (Hacking 1992:13). In this article, the style of reasoning in Cullberg's publication is studied. The style of reasoning is also examined in articles of other psychiatrists on how crisis psychotherapy initiated a new form of psychological knowledge implying that the patients should take more responsibility for their own inner growth.

For my analysis, two different empirical categories have been used to study the style of reasoning concerning the psychiatric crisis. The first category consists of Cullberg's short publication 'The Psychic Trauma' from 1971 (Cullberg 1971). This publication was the first longer and more comprehensive introduction to crisis theory and crisis psychotherapy in Sweden.[3] The publication is of importance since it introduced the psychiatric crisis perspective, but also started to inspire other psychiatrists to introduce crisis psychotherapy in psychiatric clinics. Cullberg's main reasons are presented in the article and are analysed with Hacking's theoretical perspective arguing that the style of reasoning can unfold those social classifications that give the arguments their truth (Hacking 1992). Focus is on those sections in the publication where Cullberg claims that patients ought to be more responsible for their own inner growth. These arguments are analysed in relation to the criticism of the psychiatry in the mid 1960s and 1970s (see *Psychiatric Crises and Selves*).

The second category comprises the articles of other psychiatrists, in which they present and analyse their introduction of the new crisis psychotherapy in clinics. Through a search in *Swedish Medical Journal*, I have found three articles from the 1970s that present these clinical introductions. The articles are 'Crisis Intervention in an Outpatient Care Unit – Alternative Psychiatric Care' (Stenstedt 1973, my translation), 'Crisis Therapy – An Alternative' (Boëthius et al. 1977, my translation) and 'Two Years of Experiences of Crisis Therapy' (Ardelius et al. 1978, my translation). As the titles proclaim, these articles represented trial projects at different clinics in Sweden, where crisis psychotherapy had been introduced, used and evaluated. The question for the three different trial projects was whether crisis psychotherapy could be used in clinics and if it had any benefits for the patients. The first article – 'Crisis Intervention in an Outpatient Care Unit' – is probably the first documented example of interventions applying crisis psychotherapy in Sweden. The pilot project started as early as December 1971 at the Psychiatric Clinic, Karolinska Hospital in Stockholm. Thus, this was the same year that Cullberg's publication 'The Psychic Trauma' was published. The reason why everything started the same year is that the psychiatrist Karin Stenstedt, the writer of

the article, was a colleague of Cullberg's and well versed in his reasoning. By analysing the article, it is possible to give a perspective on how the arguments in the publication were transformed to the clinic. For this reason, my analysis is focused on the first article from 1973. The two other articles are mentioned to illustrate the fact that the arguments of Stenstedt and Cullberg were used in other clinics. Stenstedt's reasons are analysed with regard to Hacking's classificatory looping. The introduction of the concept of the psychiatric crisis in clinics started a form of interaction with the kinds of behaviour that had been classified (Hacking 1999). First, this interaction is presented as a new classification that is introduced in clinics (see *A New Classification*); thereafter, the new classification is analysed as a form of self-care (see *Individualized Care*).

Psychiatric Crises and Selves

From the mid-1960s, an increasing amount of actors articulated a criticism of the kind of psychiatry that was practiced internationally as well as in Sweden. Among many things, it was a critique of an individual approach to how to care for people's mental health problems. This was seen as a structural problem. A central point was also the critique of those norms in society that concerned what was considered as normal development and adaptation to society. The criticism was directed towards a prevailing belief that people would adjust to what was considered normal, and that this would bring about a more harmonious society; if people behaved 'normally', the society would also function more normally (Ohlsson 2008; Jönsson forthcoming).

Cullberg's publications from this period originated from the criticism of regarding people as a form of individual normality. Instead, Cullberg came to join those who preferred to regard people as part of the community. A principal matter in this critique, and this was pointed out very clearly in Cullberg's publication, was that the individual had the right to occasionally feel bad and receive appropriate treatment for this malaise (Cullberg 1971). Considering the publication more closely, we can see how Cullberg integrated this theoretical view of the self and at the same time presented his perspectives in a medical mode, more appropriate for the psychiatric disciplines. For example, we find that traditional medical case histories were presented, representing typical traumatic situations that may lead to crisis. The typical traumatic situations that are presented by Cullberg comprise object loss, loss of autonomy, reproductive problems, problems with relationships, social shame, changes in the societal structure and external disasters. In the publication, Cullberg also describes a model to understand the course of the crisis, as well as symptomatology and treatment. In this way, the psychiatric crisis was a concept with inherent opportunities to see each patient as a psychological individual who was entitled to self-defining and psychological help.

In the principles of crisis psychotherapy, Cullberg points out that the therapist had the role of a catalyst for the healing process. He writes, 'He should give the patient an opportunity, under as decent conditions as possible, to go through the crisis so that he achieves a new direction and preferably with experiences that increase his self-knowledge' (Cullberg 1971:31, my translation). The patient had the responsibility to not repress the crisis, but instead promote a healing process that would give him possibilities to go through the crisis. The professionals had the role of supporting this process of the patient's quest to feel better. Accordingly, not only the healing process was important, but the crisis was also a way to conceptualize the self.

Cullberg reveal that this provided the professional a new role in the healing process in which the responsibility should not be the doctor's or the therapist's, but the patient's. Hence, he saw two immediate consequences for the professionals. The first point was 'The therapist's task is *not* to give back what the patient has lost or to take away the painful reality'; the second point was 'The therapist's task is not *primarily* to cure or remove the 'symptoms', because these are part of the process and the reality' (Cullberg 1971:31, my translation). Of course, if the patient had too much pain or self-destructive manifestations he or she should be given some form of alleviating treatment. Nevertheless, the fact of the matter was that the patient should take responsibility for the painful reality involved in the crisis.

This can be seen as the first step to find new perspectives on patients that had a psychiatric crisis. Moreover, the primary step was taken for a classificatory looping in which theories about psychiatric crises could be used by psychiatric clinics to identify the kind of behaviour that had been classified in theory (Hacking 1999, cf. Blumer 1971). In this classificatory looping, the patient's psychiatric crisis was something that he or she should be encouraged to understand as a self-caring project. It was in enduring the painful reality that the patient had the possibility to invent himself (Rose 1998). For this reason, Cullberg's point of views can be seen as a rationalized programme for the patient.

A New Classification

In December 1971, a pilot project started at the Psychiatric Clinic, Karolinska Hospital in Stockholm, offering crisis psychotherapy. The project was later presented in the article 'Crisis intervention in an outpatient care unit' in *Swedish Medical Journal* (Stenstedt 1973, my translation, see also Falk & Stenstedt 1973). The background for the project was that the clinic was to be rebuilt and the beds reduced from 77 to 31. At the same time, the responsibility for the patients should not be affected. An outpatient care unit consisting of nine professionals was assembled, with two psychiatrists, one psychologist, one social worker, two psychiatric nurses, one occupational therapist and one part-time physiotherapist. Assis-

tant manager was Karin Stenstedt. The aim for the unit was to receive patients in emergent crisis situations and provide them with swift and individualized care. It was vital to offer various kinds of activities and be flexible to the patients' needs. This might involve individual conversations, movement treatment, occupational therapy and so on. Consequently, the ideas of the psychiatric disciplines were implemented in actual practice by professionals with set guidelines for how the crisis treatment should be managed (Rose 1998). The theories about the psychiatric crisis were transformed into guidelines and practical counselling with patients.

Although there were no medical diagnoses for crises, the crisis treatment affected how to classify the patient. In the article, Stenstedt highlights the matter '[…] at the beginning of the work of the outpatient care unit, the concept of crisis was not very consistently defined among the professionals in the unit' (Stenstedt 1973:4157, my translation). The professionals used the definition of the psychiatric crisis that Cullberg had described; but at the same time, it was a definition that needed to be more consistently applied in the outpatient care unit. As Stenstedt points out in the article, the definition of the psychiatric crisis became more solid the longer the professionals in the outpatient care unit worked together. Returning to Hacking, this can be seen as a classificatory looping in which the psychiatric crisis gave rise to new classifications; this provided new cases, which created more knowledge about the cases, generating more experts, which created a need for more research and so on (Hacking 1999). The psychiatric crisis should be seen as a concept that constantly was changing while it was in the loop.

However, the classification was also confirmed while it was in the loop, giving the professionals possibilities to distinguish between patients that had a psychiatric crisis and those who had not. Thirty-nine percent of the patients who came to the clinic were classified as having a psychiatric crisis. The remaining were classified according to three, at that time, traditional diagnoses: psychosis, neurosis and borderline.[4] Those who received the psychiatric crisis classification had been affected by an event that was said to trigger crisis. The description of these triggers was largely taken from Cullberg's publication 'The Psychic Trauma'. In Stenstedt's article this is pointed out:

> The most common cause for crisis is undoubtedly more or less acute relationship problems; about a third of the cases concern infidelity. In frequency after relationship problems are problems at work. […] Next are those who have consulted us because of object loss, particularly due to the death of a close relative. Then there are those who consulted us in relation to reproductive problems (Stenstedt 1973:4157-4158, my translation).

The triggers can be regarded to be so common that we can expect many cases that could confirm the classification of the psychiatric crises. However, there were other projects in the 1970s that confirmed these classifications. One example is reported in the article 'Crisis Therapy – An Alternative', using Cullberg's psychiatric crisis criteria from 1971 (Boëthius et al. 1977, my translation).[5] In 1978,

'Two years of experiences of crisis therapy' was published (Ardelius et al. 1978, my translation). In the later article, there was not only a confirmation of the classifications presented in the articles from 1973 and 1977, but also a statement from the authors that this treatment was something society should offer patients suffering from a psychiatric crisis:

> In recent years, the acute crisis reaction that people may develop has received ever more attention. A crisis reaction means that a previously healthy and functioning human being is affected by a substantial setback in life; the loss of a relative or any other matter that places new demands on the individual. […] In these cases, society must be willing to provide crisis treatment (Ardelius et al. 1978:4147, my translation).

Social classifications, here in the form of the psychiatric crisis, interacted not only with the kinds of behaviour that had been classified, in this case the acute crisis reactions, but also became something that could be used in an argumentation that society should invest resources in this treatment. Psychiatric crisis, crisis reactions and crisis psychotherapy were parts of a classificatory looping in the 1970s; which confirmed the importance and established the need to work with this psychiatric perspective in society (cf. Hacking 1999). Cullberg's psychiatric crisis criteria were vital points in this looping, but it was in clinical practice that the classified behaviour started to interact and create a classificatory looping. It was in the psychiatric clinic that a transformation from psychiatric crisis theory to care practice took place (cf. Mol et al. 2010). When these theories were introduced, the professionals attained new perspectives on what a patient was and which responsibilities the patient had for his or her own well-being.

Individualized Care

Likewise, the introduction of the psychiatric crisis in clinics had an impact on, what may be termed as *the care practice*, in which the introduction of the psychiatric crisis created other forms of cultural and social practices in the clinic (cf. Mol et al. 2010). Regarding Stenstedt's article, some of these practices can be analysed in relation to the criticism of psychiatry in the 1960s and 1970s. Primarily, there was a concrete aim for the outpatient care unit at the Psychiatric Clinic, Karolinska Hospital: the intention of not hospitalizing the patients. This idea must be understood regarding the context of the general criticism of psychiatry in the 1960s and 1970s (Ohlsson 2008). In the article, this criticism can be discerned:

> The aim was therefore to try to organize a small outpatient care unit, which without waiting time, would be receiving patients in emergency crisis situations and for a limited time giving them an intensive problem-focused contact. An exceedingly important point was the possibility of individualized care. This should be adapted in a flexible way to the specific needs of each individual. Firstly, the intention was to be able to offer various forms of activities; secondly, and above all, to provide patients with an opportunity to work through their current problems in group discussions or private conversations (Stenstedt 1973:4154, my translation).

Returning to Rose's arguments, the psychiatric disciplines, here in the form of a new small outpatient care unit, were generated to meet the requirements that the patients at this time were considered to have (Rose 1998). The aim of the care was to be flexible in view of the individual's needs, with no waiting time and designing a problem-focused contact with the patients.[6] This specific psychiatric discipline was created in contrast to the old psychiatry care; consequently, it defined what the discipline should not be. Simultaneously, this redefinition of psychiatric care also influenced the idea of what a patient is and should be. The patient appeared as an actor that was expected to be interested in individualized care, having specific needs of this care. Thus, the objectives with the outpatient care unit were to transform the mental health services for some of the patients who needed treatment.

The outpatient care unit organized a new type of treatment; the focus was said to be on adjusting the care for the patients' needs. In this reorganization, the patients were increasingly regarded as isolated individuals, separated from a unifying patient category. This is a cultural process that arose during the 1970s and that has been widely analysed within individualization theories (Giddens 1991; Lasch 1991; Beck & Beck-Gernsheim 2001). In these theories, the character of the individual is pointed out as increasingly negotiable and less governed by traditions and norms. A person's character tends to be more of 'for the time being' and less consistent. Based on such cultural process, I want to argue that Cullberg's psychiatric crisis criteria provided a possibility for the psychiatric clinics to meet this new group of patients, and at the same time create this patient within the social classification of the psychiatric crisis (cf. Hacking 1999). A central point for this line of reasoning is that the patient should now feel that he or she was in a process of psychosocial development, that every stage in life contains experiences and challenges for the human development.[7] In the practical work in the outpatient care unit, as described in the three articles, focus was on helping the patient to understand and explore his or her own feelings. In Stenstedt's article, this is pointed out very clearly: 'The patient must be allowed and encouraged to express those feelings of sadness, shame, hostility, anxiety etc, that are associated with the crisis situation and are often perceived as forbidden' (Stenstedt 1973:4155, my translation). The patients ought to take their feelings seriously and be encouraged to talk about how they feel.

The Swedish researcher Claes Ekenstam, historian of ideas and sciences, has stressed that in the 1950s and 1960s a representation of people as *feeling human beings* became more common. This was not a new idea but it attained a strong position in disciplines such as psychology, sociology and biology. It was a representation that emerged in a polemic against the understanding of humans as being rational and calculating, an idea that can be found in the description of man as mechanical, economic or stoic (Ekenstam 2007). Reasoning concerning the feeling human being is vital in the understanding of how the psychiatric crisis, not

only became part of the perspectives of the psychiatric clinics in meeting the individualized patient, but was also significant in the presentation of a treatment that could interact with the behaviour that had been classified through the psychiatric crisis (cf. Hacking 1999). It became essential for the care that the patient was encouraged to take his or her emotions seriously; through her feelings, the patient could take responsibility for her own potentials as a human being. This was highlighted in Stenstedt's article: "An important aspect on crises, that needs to be emphasized, is that these are not necessarily entirely negative life experiences, but contain positive aspects and provide opportunities for development. The crisis holds, as Lydia Rapoport (1967) puts is, significant 'growth-promoting potentials' (Stenstedt 1973:4155, my translation). An important part of this reasoning was the change in the responsibility of the psychiatric clinic for the patient; the psychiatric crisis became something for which the patient had responsibility for as well.

The psychiatric crisis became a social classification that affected how the professionals should take care of the patients and what responsibility the patient had for his or her well-being. I would like to draw attention to the shift towards encouraging the patient to take responsibility for the 'recovery' and for the opportunities of development embedded in the psychiatric crisis. The psychiatric crisis interacted, not only with the behaviour that had been classified, but it also evoked a new moral for which responsibilities the patient had for his or her own well-being.

Discussion

As pointed out in this article, theories about the psychiatric crisis and crisis psychotherapy in the 1970s created opportunities in the psychiatric clinics to respond to the patient as *the feeling human being* (cf. Ekenstam 2007). A significant conception during this period was the representation of the human being as a feeling person; another prominent idea concerned individualisation. In the following quotation, we can sense how the professionals in the outpatient care unit felt that their ideas were well suited for the times:

> When we started, we did it entirely according to the conviction, based on our experiences on the weekly ward, that an activity like this should be able to fill great practical needs. Like many others, we had been inspired by Johan Cullberg's publication 'The Psychic Trauma' (1971) and had begun to be interested in psychological crises and crisis therapy (Stenstedt 1973:4154-4155, my translation).

The impression is that it was conviction that made them start using the psychiatric crisis as a possibility to regard the patient in new perspectives (cf. Foucault 2003). This conviction has many similarities to Hacking's explanation of how social classifications can change our consciousness and let us enter new worlds (Hacking 1992). Using theories about the psychiatric crisis is one example of how professionals attained new perspectives in the 1970s and regarded the patients from

the ward in a slightly new way. At the same time, it is important to point out that this feeling of conviction is related to the self-fulfilling potential in the psychiatric crisis theory. There must be a classificatory looping when the social classifications interact with the behaviour that has been classified (Hacking 1999). This perspective could be confirmed by interaction with the patient, and with other professionals. Further, if we go back to the quotation, Stenstedt stresses that 'many others' had been inspired by Cullberg's publication.

Partly, it was an expected change in the psychiatric clinics. Patients were not to be hospitalized, but were instead provided with a psychiatric treatment that could give individuals possibilities to handle the psychiatric crisis largely on their own. The crisis psychotherapy was now to be a support for the patient on his or her way to well-being and inner growth; this is an argumentation that has been highlighted in previous studies (Frykman 1994; Rose 1998; Ekenstam 2006). Through this change, the internal and mental self-control of the patients emerged, replacing the external control. On the basis of this reasoning, my claim is that the psychiatric crisis can be seen as a form of a self-caring project for the individual. Not only do social classifications interact with the behaviour that has been classified, but they also interacted with a moral category of what a patient was and should be.

Finally, if we once again return to Hacking, he discusses how social classifications can change our experience of which moral category we belong to (Hacking 1999). I would argue that the psychiatric crisis had this effect in the 1970s when new conceptual meanings changed how a crisis situation could be experienced, altering the responsibilities of the individual in this situation. Thus, self-care should be understood as a central part in the classificatory looping of this specific social classification consisting of the psychiatric crisis. When the psychiatric crisis as a social classification interacts with the patient's behaviour, this is when self-care also can be activated and be institutionalized as a practice in the care unit (cf. Mol et al. 2010). Therefore, self-care must be analysed in relation to those social classifications that are a part of a historical and cultural context.

In order to understand this change, it is important to relate the transformation in the psychiatric clinics to a more general change in the historical and cultural context. Using these different cultural expressions, the article shows how self-realization and individual development became embedded as a cultural ideal. It can provide us with perspectives on how self-care came to be used in practice in the beginning of the 1970s and influenced both healthcare and the everyday lives of people.

Conclusion

In this article, I have studied how the psychiatric crisis became a social classification in the 1970s, not only providing new perspectives on some specific kinds of behaviour, but also transforming this behaviour to be part of a self-caring project.

I have traced this historical development to international psychologists and psychoanalysts; it was introduced in Sweden through the psychiatrist Cullberg, in the publication 'The Psychic Trauma' from 1971 (Cullberg 1971). In the 1970s, these theories about the psychiatric crisis and crisis psychotherapy were tested in different pilot projects at psychiatric clinics. In the article, the pilot projects are understood as answers to the need of encountering patients with individualized requests, which enhanced the need for a treatment that took the feelings of the patients seriously. The patient's care for him or herself became more important than external control. This provided opportunities for the crisis psychotherapy to be regarded as a self-caring project.

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Notes

1 The concept of the psychiatric crisis developed theoretically in the 1940s and onwards; many psychologists and psychoanalysts from America came to use the word. See for example the psychiatrist Eric Lindemann (Lindemann 1944), the psychoanalyst Elliot Jaques (Jaques 1965) and the psychoanalyst Erik Homburger Erikson (Erikson 1993).

2 In 1975, Johan Cullberg published the book *Crisis and Development* (1980), which became a very popular textbook in Sweden. However, the shorter publication from 1971, which was used in the alternative psychiatric treatment, is studied in this article.

3 In the 1970s and the beginning of the 1980s, more crisis-titles were published in Sweden by both Swedish authors and translated authors. See for example: Ekselius et al. 1976; Fried 1978; Folksams sociala råd och TCO:s socialpolitiska råd 1979; Ewing 1980.

4 The classification was divided into the following categories: psychosis 7 percent, neurosis 45 percent, borderline 5 percent, "crisis" 39 percent and others 4 percent (Stenstedt 1973:4157).

5 Moreover, a similar point was the focus on preventing long-term hospitalization and that the patients should go back to work as soon as possible.

[6] Another vital matter for the outpatient care unit was to reduce medication of psychotropic drugs. With this form of crisis treatment, the attempt from the outpatient care unit was to get away from medicalization and instead try to find other forms of care for those patients who needed psychiatric help. Psychotropic drugs were in the article defined as the less desirable option for treatment, and were considered to make the patient passive and regressive in the course of his or her illness (Stenstedt 1973).

[7] Here, I use Erik Homburger Erikson's terminology (Erikson 1993). The terminology was introduced in Sweden by Cullberg (1980).

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