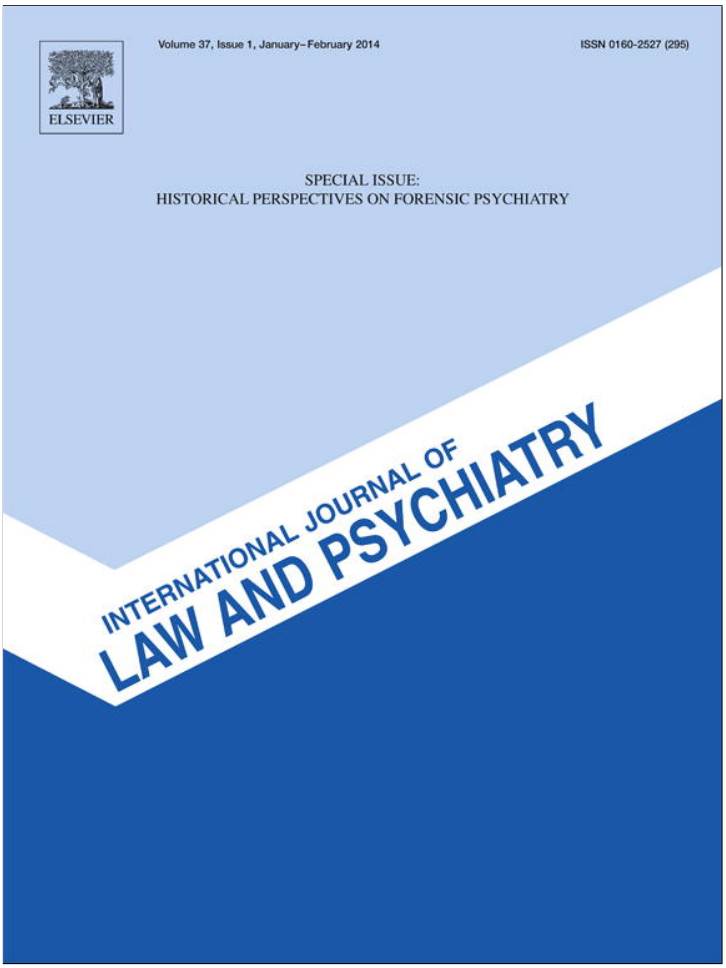
Treatment as punishment



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Treatment as punishment: Forensic psychiatry in The Netherlands (1870–2005)

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ABSTRACT

This article provides an overview of the development of forensic psychiatry in the Netherlands from the late nineteenth to the early twenty-first century. The first part addresses the ways forensic psychiatry established itself in the period 1870–1925 and focuses on its interrelatedness with forensic practice, psychiatry's professionalization, the role of the government, the influence of the so-called New Direction in legal thinking and (Italian and French) anthropology of crime, and the debates among physicians as well as between psychiatrists and legal experts on the proper approach of mentally disturbed offenders. From the mid-1920s on the so-called 'psychopaths laws' anchored forensic psychiatry in the Dutch legal system. The second part zooms in on the enactment of these laws, which formalized special measures for mentally disturbed delinquents. These implied a combination of sentencing and forced admission to and treatment in a mental institution or some other form of psychiatric surveillance. The article deals with the meaning, reach and consequences of this legislation, its debate by psychiatrists and legal experts, the number of delinquents affected, the offenses for which they were sentenced and the (therapeutic) regime in forensic institutions. The goal of the Dutch legislation on psychopaths was ambiguous: if it was designed to protect society against assumed dangerous criminals, at the same time they were supposed to receive psychiatric treatment to enable their return to regular social life again. These legal and medical objectives were at odds with each other and as a result discussions about collective versus individual interests as well as about the usefulness and the effects of this legislation kept flaring up. To this day the history of this legislation is characterized by the intrinsic tension between punishment and security on the one hand and treatment and re-socialization on the other. Whether at some point one or the other prevailed was largely tied to the social climate with respect to law, order and authority.

1. Introduction

This article provides an overview of the development of forensic psychiatry in the Netherlands from the late nineteenth to the early twenty-first century. While this branch of psychiatry established itself later in the Netherlands than in neighboring countries, from 1925 on it became firmly anchored in the Dutch legal system, mainly on account of the so-called 'psychopaths laws'.

This article, which highlights the role of psychiatrists rather than the contribution of lawyers in the development of forensic psychiatry, consists of two parts. The first part addresses Dutch forensic psychiatry's struggle to establish itself in the period 1870–1925, whereby I emphasize its interrelatedness with psychiatry's professionalization, the influence of the so-called modern school in legal thinking as well as Italian and French criminal anthropology, and the debates among physicians and between psychiatrists and legal experts on the proper approach of mentally disturbed offenders.

The second part zooms in on the enactment of the psychopaths laws, which formalized special measures for mentally disturbed delinquents. They could be 'placed under a special restriction order', authorized by the government (*Ter Beschikking van de Regering*, TBR). This implied a combination of sentencing and forced admission to and treatment in a forensic–psychiatric asylum, or some other form of psychiatric surveillance. Specifically, I deal with the meaning, reach and consequences of this legislation, its debate by psychiatrists and legal experts, the number of delinquents affected, the offenses for which they were sentenced and the (therapeutic) regime in forensic institutions. By way of conclusion I connect developments in forensic psychiatry with the wider sociopolitical context.[2]

2. The rise of forensic psychiatry (1870–1925)

From the late nineteenth century, physicians who worked in Dutch asylums began to break the isolation of their professional domain and also sought to expand it. The leading members of the Dutch Society of Psychiatry (*Nederlandsche Vereeniging voor Psychiatrie*), established in 1871, were liberal and positivist-minded physicians who viewed

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science and social responsibility as crucial to social progress. Despite their focus on scientific medicine, they did not point only to the biological causes of insanity and nervous disorders, such as heredity. They also blamed the spread of mental disorders on a wide array of harmful behaviors and social–cultural influences: pauperism, poor hygiene, immorality, excessive consumption of stimulants, sexual excesses, bad upbringing, the heightened struggle for survival, the hasty and hectic pace of urban life, the shift from physical to intellectual labor, and the new rapid means of transportation and communication that tested people's mental balance. The assumed danger of degeneration and the growing number of new clinical pictures such as neurasthenia, moral insanity, and criminal psychopathy, whereby not so much people's rational powers but their emotional life and moral awareness were affected, provided psychiatrists with arguments to expand their intervention domain from mental asylums to society at large. They aligned themselves with the hygienic movement, in which the effort to prevent people from falling ill through reforming their living conditions and way of life was center-stage. To counter modern society's debasing influences assumed to undermine people's mind and nerves, psychiatrists pointed to the relevance of proper hygiene and also self-control, willpower, a sense of duty and responsibility, moral awareness, and moderation as ways of thwarting insanity (Abma & Weijers, 2005; Oosterhuis & Gijswijt-Hofstra, 2008; Sillevis Smitt & Jansen, 1971; van der Esch, 1975: I and 1980: II; Vijselaar, 1995).

It was against this backdrop of professional expansion and social hygienic activism that forensic psychiatry developed. Already in 1853 one of the founders of the Dutch Society of Psychiatry, the asylum-doctor J.N. Ramaer, tried to promote the professionalization of asylum physicians by publishing a journal that afforded a prominent place to forensic medicine, the *Nederlandsch Tijdschrift voor de Geregtelijke Geneeskunde en voor Psychiatrie* (Dutch Journal for Forensic Medicine and Psychiatry). Thus Ramaer sought to bring psychiatry to the attention of lawyers, notably those in public service, in order to boost the government's interest in the care of the insane. Because of a lack of subscribers, however, the first Dutch psychiatric journal folded after two volumes. Nor was Ramaer's effort to push the psychiatric professional domain towards the practice of criminal law successful (Vijselaar, 1995; cf. van der Esch, 1975: I).

The then prevailing legal views in the Netherlands offered only limited room for involving physicians in legal matters. The *Code Pénal*, introduced in 1811 during French rule under Napoleon and in force until 1886, was based on the classic criminal law principle that originated in the Enlightenment. It stipulated that suspects should be judged only on their actions for which they were responsible. Partly to do away with legal uncertainty and arbitrariness and make the punishment fit the crime and the degree of guilt (the so-called proportionality principle), the offender's past, personality, and social background had to be ignored. Only suspects who were undeniably insane (and hence of unsound mind) were eligible for discharge from prosecution. In such cases the public prosecutor or relatives could arrange forced admission to a mental asylum through a civil procedure. This marked the point at which a physician became involved, because a medical declaration was needed to be admitted to an asylum. Until the late nineteenth century, however, Dutch legal practice rarely invoked medical expertise to determine whether suspects were mentally ill. Asylum physicians who wanted to change this were hardly listened to; the young field of psychiatry made little impression on the established judicial powers. The *Code Pénal* only allowed the qualification of individuals as either fully responsible or fully irresponsible, and judges apparently felt no need for medical advice. Judgments on the (ir)responsibility of offenders were a matter of legal, not medical competence, while discharge from prosecution because of insanity was rare (Koenraadt, 1995; Tammenons Bakker, 1957; van Ruller, 1991; Weijers, 1995, 1996, 2003).

Forensic psychiatry developed later in the Netherlands than in France and Great Britain, where already from the mid-1800s physicians made inroads in law and managed to keep suspects with mental disorders from being sentenced. Based on newly defined syndromes such as monomania, insania moralis, and psychopathy, which were assumed to undermine people's emotional life and moral conscious while leaving their rational powers largely intact, physicians put forward that some suspects were partly mentally disturbed even if it was not directly noticeable. Given their affected sense of guilt and responsibility these delinquents deserved medical treatment rather than punishment (Becker & Wetzell, 2006; de Smaele, 2002; Foucault, 1978; Goldstein, 1987; Harris, 1989; Smith, 1981; Velle, 2002; Weijers & Koenraadt, 2007).

In the last two decades of the nineteenth century Dutch psychiatrists increasingly linked up immoral and criminal conduct with mental disorders and argued for a psychiatric input in criminal law. They received backing from two international developments. The first was the rise of biomedical explanations of criminal behavior in general and criminal anthropology in Italy and France in particular. The second was the growing influence of the so-called modern school of criminal law (see introduction to this volume). Alongside the Amsterdam physician A. Aletrino, especially the leading psychiatrists C. Winkler and G. Jelgersma, who held chairs at the universities of Utrecht and Leiden, sought to expand psychiatric competence in criminal law. Only psychiatrists would have a reliable diagnostic toolkit at their disposal for determining which suspects were mentally disturbed and should be declared to be of unsound mind. Aside from detaining pathological criminals, Winkler and Jelgersma also advocated forced admission to and treatment in a mental asylum. They felt that protection of society against criminals and the prevention of crime both belonged to the psychiatric professional domain. Jelgersma favored psychiatric diagnosis of all suspects and forced treatment of so-called psychopaths who had not (yet) committed a crime (Draaisma, 1995; Slijkhuis, 2002).

Although Winkler and Jelgersma considered social conditions in their reflections on crime, the emphasis was on hereditary disposition: immoral behavior, like insanity, would often be indicative of degeneration. Inspired by C. Lombroso's theory, they also believed that born criminals had specific anatomic features. In the years 1894–1896 Winkler, with consent of the Dutch Minister of Justice, performed extensive skull measurements among fifty murder convicts in a prison. The results were compared with findings from two other physicians who had done similar studies among recruits and insane persons. Even though this comparison only produced marginal differences between criminals and the insane on the one hand and the general population on the other, Winkler felt this study corroborated the correctness of Lombroso's ideas (Draaisma, 1995; Winkler-Junius, 1947).

Jelgersma valued the Lombrosian approach as well, yet he also believed that a criminal predisposition only emerged after multiple consecutive generations handed down bad traits. Moreover, he felt it was important to take into account bad social influences. If inferior predisposition might be a major precondition for having a criminal streak, its expression in acts was often determined by factors related to social environment. At the third conference on criminal anthropology in Brussels (1892), Jelgersma, like the Dutch lawyer and liberal politician G.A. van Hamel, who was a prominent champion of the modern legal school, argued for a rapprochement between the Italian and French approach in criminology—that is a middle course between the biological versus the social explanation of crime (Carp, s.a.; Franke, 1990; Winkler-Junius, 1947).

Apart from the continued effects of international criminal anthropology and the theory of degeneration, around 1900 two homegrown psychological and sociological approaches of crime were developed in the Netherlands (Franke, 1990; van Weringh, 1986; cf. de Roos, 1914). At the University of Groningen the philosopher and experimental psychologist G. Heymans and the psychiatrist E.D. Wiersma designed a classification system of character types based on biographical study and the theory of 'temperaments'. Their findings and those of their students concerning 'the mind of the criminal' seemed more nuanced than those of criminal anthropology. Regarding

the causal explanation of crime they not only argued for steering a middle course between hereditary predisposition and environment, but they also denied that criminals constituted a clearly identifiable group based on shared character traits. It was possible, however, to trace back crimes to various temperaments. Heymans and Wiersma felt there was a structural link between criminal leanings and a limited power to control and channel emotions, urges, and drives (Nagel, 1966).

The more sociological approach of crime had its outspoken advocate in the Amsterdam legal scholar W.A. Bonger, who gained international recognition with his dissertation *Criminalité et conditions économiques* (Crime and economic conditions, 1905). Where criminal anthropology and the theory of temperaments looked for causes of criminal behavior mainly in the individual's physical and mental traits, Bonger pointed to social–economic relationships. In psychiatry, however, his approach had little influence. Psychiatric–forensic reports concentrated on the physical and mental characteristics as well as inherited traits of suspects, while hardly any attention was paid to the social circumstances in which they lived (Pouw, 1985).

In the 1890s psychiatry made headway in the Dutch legal system. The number of criminals declared to be of unsound mind and discharged from prosecution—who ended up in the army-guarded state mental asylum in Medemblik—grew from sixteen to 130 between the late 1880s and the early 1900s. Most were from the working class and sentenced for theft, arson, assault, and sexual abuse of minors (Franke, 1990; Pouw, 1985). The asylum in Medemblik, which also admitted mentally disturbed detainees from prisons, was soon overcrowded. The strict regime and common application of forced measures could not prevent frequent occurrence of disturbances and escapes. The opening in 1898 of a second State Asylum, one for women in the town of Grave, somewhat alleviated the capacity problems (Franke, 1990; Koenraadt, 1995; Pouw, 1985; Weijers, 2003).

The psychiatric involvement in the administration of justice was subject to debate and met with obstacles. The new Dutch Penal Code, which in 1886 replaced the French *Code Pénal*, reflected the spirit of the classic rather than that of the modern school: punishment as retribution of guilt remaining the basic principle. According to the letter of the law only offenders who because of the 'poor development or pathological disorder' of their intellectual powers were declared to be fully of unsound mind, could be discharged from prosecution (Weijers, 2003). With the authority to place them in a mental asylum for one year at most, the criminal judge obtained an instrument to remove them temporarily from society. It was not necessary, however, that physicians diagnosed a suspect's mental disorder. Judges decided whether medical expertise was called for and only they judged on an individual's responsibility. In fact the proponents of classic criminal law principles openly doubted the relevance of any psychiatric input, although such doubt was not made explicit and formal in a strict definition of legal unaccountability, such as the M'Naghten Rules did in England since 1843 (see introduction and the article by Loughnan and Ward, this volume).

The proponents of the modern legal school and forensic psychiatry countered that the existing legal practice provided insufficient opportunities for removing the risk of disturbed recidivists permanently, and thus to reduce the social burden of crime substantially. First, the strict legal distinction between full responsibility and full irresponsibility, psychiatrists felt, ignored the sizable category of the so-called 'border cases': offenders who were not insane, but who nevertheless suffered from mental disorders such as insania moralis, on account of which they had no sense of good and evil. Commonly, however, these more or less diminished responsible lawbreakers remained beyond the scope of medicine and after their prison term ended up in society again, without having undergone psychiatric treatment, which increased their chances of recidivism. It largely involved offenders who were guilty of fairly minor misdemeanors, but who because of their assumed irregular and asocial lifestyle would continue to cause social trouble: notorious alcoholics, beggars, pickpockets, imposters, pimps and such. The questions whether they primarily were either criminal or mentally disturbed and how best to deal with them triggered much discussion in legal and psychiatric circles. The growing attention for these border cases would advance the development of forensic psychiatry (Slijkhuis, 2002; Weijers, 2003; Weijers & Koenraadt, 2007).

Second, physicians and also legal experts who supported the modern school pointed to the limited possibilities to ward off the dangers posed by disturbed criminals. Although offenders diagnosed as insane and declared to be fully unsound of mind could be involuntarily placed in an asylum, it was doubtful whether this measure offered a sufficient solution. The state asylum in Medemblik excepted, mental asylums were not equipped for these patients and sooner or later they were released again, without any guarantee of their being cured. Partly for this reason, apparently, many judges exercised restraint in discharging offenders from prosecution because of insanity (Pouw, 1985). Asylum physicians put forward that the already overcrowded asylums were not suitable for the sometimes violent delinquents with behavioral disturbances: these facilities lacked adequate security and therapy for such patients. Most asylum physicians who had at that time advocated the medical model to advance psychiatry, would be glad to be rid of them because they caused problems of order, exercised a baneful moral influence on other patients and the nursing staff, and had to be constantly watched and controlled, which threatened to go at the expense of the care of calm patients (de Ridder, 1987, 1991; Slijkhuis, 2002). Around 1900 both physicians and advocates of the modern school of criminal law pushed for forced institutionalization of insane criminals and border cases that might pose a risk to society in separate facilities. The so-called *prison-asile* they advocated, a combination of prison and asylum, should not only relieve mental asylums, but also make it possible to remove mentally disturbed criminals from society longer than the legal proportionality principle permitted (Slijkhuis, 2002).

The plea for this new facility did have another background as well. From the 1850s on the cellular system and solitary confinement had been introduced in Dutch prisons, meant to reform detainees. The Penal Code of 1886 stipulated that delinquents with a penalty of five years or less were detained in a cell alone. In case of a conviction of more than five years, detainees had to spend the first five years of their penalty in solitude. One of the consequences of the new prison-system was an increasing number of detainees suffering from mental problems. For example, in prisons the inspectors of the State Supervision of the Insane and Mental Asylums (*Staatstoezicht op Krankzinnigen en Krankzinnigengestichten*) came across 'food-refusing, yelling, raging, crying, dizzy, hallucinating, and severely paranoid individuals who shattered the cell windows, soiled themselves with their feces, caused self-inflicted wounds, or tried to commit suicide' (quoted by Franke, 1990: 419). Initially physicians and prison officials did not attribute the occurrence of mental disorders among inmates directly to solitary confinement, as they believed that these disorders would mostly have been present in rudimentary form already. However, they could not deny that proportionally many more prison inmates ended up in mental asylums than individuals from the general population. Around 1870 the ratio was six times higher, a figure that around 1900 had gone up to as much as thirty (Franke, 1990; Meijer, 1899a, 1899b). Many convicts with mental disorders were repeatedly transported back and forth between prisons and the state mental asylum in Medemblik. Some physicians felt that this could largely be blamed on solitary confinement, while in the absence of medical expertise in prisons it was often wrongly assumed that detainees simulated mental disorder (Casparie, 1911; Franke, 1990; Meijer, 1899a, 1899b). At the start of the twentieth century, the psychiatric world increasingly acknowledged the possibility of a causal relationship between solitary confinement and certain delusions and hallucinations, or so-called 'prison

psychosis.' Moreover, members of parliament posed questions on the interrelationship between solitary confinement and the high frequency of insanity among detainees (Franke, 1990).

The discussion around 1900 on the possible establishment of a *prison-asile* took place against the backdrop of the problems occurring in what was still a diffuse border area between criminal law and psychiatry—a realm not only populated by a growing number of suspects declared to be of unsound mind, but also by detainees with mental disorders and dangerous insane persons (Franke, 1990; cf. Slijkhuis, 2002). The State Supervision inspectors, the Dutch Society of Psychiatry, and two commissions consisting of legal experts and physicians, argued for special measures and institutions or asylum wards for these groups. Psychiatrists also pleaded for special 'observation stations' for suspects that were thought to be mentally disturbed, an extension and intensification of psychiatric surveillance in prisons, and special facilities for 'border cases' such as state employment facilities, state reformatories, reform schools, houses of correction, and institutions for epileptics and alcoholics (Jelgersma, 1902, Jelgersma et al., 1905; Koenraadt, 1995). If the new *prison-asile* and the observation stations were not realized for the time being, around 1910 the state asylum in Medemblik was reorganized as an exclusively forensic mental asylum with room for 200 patients while measures were adopted to counter runaways, which in fact caused it to function as a *prison-asile* (Pouw, 1985). In 1918 this facility was replaced by a new state mental asylum near Eindhoven. Six years before, a special prison for mentally disturbed detainees was set up in Scheveningen, partly to meet the growing need for psychiatric diagnosis of suspects. Other penitentiaries hired physicians with knowledge of psychiatry (Weijers, 2003).

Not only legal experts but also physicians held divergent views on the relationship between law and psychiatry. Forensic psychiatry was not a product of a univocal professional urge to expand (Slijkhuis, 2002; Weijers, 2003; Weijers & Koenraadt, 2007). Initiatives were also instigated in part by reform-minded legal experts: a change in legal thinking, specifically the growing influence of the modern school vis-à-vis classic criminal law and lawyers' interest in positivist theories of crime, cleared the way for psychiatrists to play a role as forensic experts in courts. Judges who had doubts about the mental state of suspects or witnesses increasingly called upon psychiatric advice (de Ridder, 1991; Pouw, 1985). Psychiatrists embraced their new role in the administration of justice as a challenge, but at the same time they rather disliked seeing disturbed delinquents in their asylums because of the trouble they caused and because there was little medical credit to be gained regarding these patients. This is partly why the handling of border cases was a contentious issue among physicians. Before the court they were inclined to present and defend their medical diagnosis, suggesting that imprisonment was not a suitable solution, yet once these delinquents ended up in a mental asylum many physicians seemed to believe that they did not really belong there either (Slijkhuis, 2002).

By contrast with the ambitions of Winkler, Jelgersma, and others who regarded law a welcome extension of the psychiatric professional domain, some psychiatrists pointed to the problems and dilemmas implied in a forensic role and they argued for restraint (Slijkhuis, 2002; Weijers, 2003). Forensic psychiatry would trigger expectations concerning the treatment of mentally disordered criminals that might be hard to meet (de Ridder, 1987). It was doubtful whether they were eligible for treatment. Lombrosian criminal anthropology and the theory of degeneration hardly promised a cure. Admission to a mental asylum or *prison-asile* basically involved a form of detention. The question presented itself whether such compulsory incarceration could be justified from a medical perspective. Some psychiatrists considered the striving for protection of society essentially a legal and political affair that did not automatically go together with the medical task of guarding the interests of ill individuals. In this respect the question arose whether it was possible to reconcile the criminal policy of social defense advocated by proponents of the modern legal school and criminal anthropology with medical ethics. Physicians who sat in the witness stand were not only asked whether and to which degree suspects were mentally disturbed and thus could not be held accountable, but they sometimes were also expected to judge the danger of defendants and potential measures. To do so would be like walking on thin ice, as critics from within and outside the medical world argued; all too soon physicians would be tempted to formulate statements that surpassed their medical authority and belonged to the judge's competence. They had to be careful not to translate their medical diagnosis into a ready-made legal judgment. It was difficult to establish a direct causal link between mental disease and irresponsibility—let alone offer a scientific basis for such a connection, especially when the suspect was not fully insane. The border cases and the qualification of diminished responsibility continued to give rise to doubts and disputes, while forensic–psychiatric reports frequently revealed major diagnostic disparities (Pouw, 1985; Weijers, 2003).

Moreover, the already dubious social standing of psychiatrists might be weakened even further. The public upheaval following their involvement in controversial incidents such as what became known as the Papendrecht court cases, which took place in the years 1907–1910, impaired their social reputation (Oosterhuis & Slijkhuis, 2012; see also Franke, 1990). A suspect charged with fishing without a license and breaking a window in the local town-hall, publicly accused the police in the town of Papendrecht of serious maltreatment after he had turned himself in. Thereupon two country policemen instituted proceedings for contempt against the suspect, who was sentenced to a prison term of two months. With the help of a local legal advisor the suspect lodged an appeal against this sentence and this led to a series of court cases. These received nationwide attention because more complaints about the police in Papendrecht were made public and the Justice Minister, at the request of parliament, started an investigation. The Court in Arnhem, which handled the appeal, heard as many as seventy-three witnesses. This court's examining judge asked several leading psychiatrists to investigate the reliability of the witnesses. In their report the psychiatrists claimed that the main witnesses who had expressed or supported the accusations of maltreatment were not reliable: one would suffer from 'quarrel-monger insanity', another from 'imbecillitas', and yet another one was a neuropath or had a deviant, morally unreliable personality. The legal advisor who had supported the suspect was characterized as a 'quarrel-monger' who had stirred up the people of Papendrecht against the authorities. The rather one-sided forensic report—witnesses who denied the police maltreatments were not examined by psychiatrists—caused much uproar. The lawyer for the accused individual launched a fierce attack on the role played by psychiatrists in this case: credible complaints from residents about abuse of power by the police were dismissed as expressions of mental disease and the authorities were kept out of range. According to him this was justice based on class bias. Eventually the man accused was discharged from prosecution, but for quite some time this affair would linger on the minds of psychiatrists, legal experts, and politicians alike.

Despite social resistance against forensic psychiatry and differences of opinion among psychiatrists on the scope of their competence in legal matters, around the turn of the century most psychiatrists felt they should have role in fighting crime (de Ridder, 1991; Pouw, 1985; Weijers, 2003). The premise that criminal, antisocial, and immoral behavior was rooted in the personality of perpetrators and that it could be diagnosed as a symptom of mental disorder became more widely accepted. Although the division between proponents of the classic approach in criminal law and those of the modern school slowed down the development of forensic psychiatry, while as a new practice it remained contentious, in the early decades of the twentieth century the criminal law climate was clearly changing and psychiatric involvement gained more recognition.

The 1907 establishment of the Psychiatric–Juridical Society (*Psychiatrisch–Juridisch Gezelschap*) as a forum for discussion between psychiatrist and lawyers indicated that mutual distrust or misunderstanding was decreasing. Whereas lawyers who supported

the principles of the modern school were receptive to positivist theories of crime, psychiatrists who related their forensic role to the wider objectives of social hygiene, more and more emphasized the importance of social defense. Just as the modern school of criminal law, criminal anthropology in principle was not primarily geared to more legal protection and humane treatment of criminals, as protecting society came first instead. However, in the longer term, interest in born criminals and social defense would be accompanied with a milder penal climate and more attention to the rehabilitation and re-socialization of offenders (Dankers & van der Linden, 1996; de Ridder, 1987; Franke, 1990; Kelk, 2007; Mooij, 1998; Slijkhuis, 2002; Weijers, 1996). Lawyers and psychiatrists found common ground in a differentiated and individualized approach in criminal law, which was implemented in the first four decades of the twentieth century. Next to regular prison terms, other legal sanctions were introduced: suspended sentences, probation, supervision and re-education for offenders who were considered to be corrigible and prolonged detainment and medical treatment for dangerous and mentally disordered criminals.

The introduction of child protection laws in 1905 was the first step towards a differentiated and individualized assessment of offenders. These laws took into account the underlying causes of criminal conduct of minors: their age, personal traits, living environment, and the way they had been raised by their parents. The accent shifted from punishment to prevention through making the child a ward of court and re-education in reform schools, reformatories, and guardian families (Franke, 1990; Nijnatten, 1986). Ten years later the suspended sentence was enacted for adult offenders while the options for being released on parole, already introduced in 1886, were widened. Besides the general condition that a convicted person would have to serve his or her original sentence if he or she offended again within a three-year period, the judge could impose several special conditions, such as forced relocation and a banning order regarding bars, alcohol consumption, or contact with specific persons. The reasoning behind a suspended sentence or release on parole was that some offenders were capable of improvement and that the deterrent effect of a prison term together with close surveillance in society was a more effective means to bring about behavioral change than actual detention. Rehabilitation organizations were assigned to re-socialize them by enhancing their self-control and self-reliance. Soon suspended sentences and releases on parole were applied frequently. In the period 1910–1930 the prison population declined from over 3000 to nearly 2400. Around 1930 the number of detainees, at slightly more than 30 per 100,000 residents, reached a record low (Franke, 1990).

The child protection laws as well as the introduction of the suspended sentence and facilities to 're-socialize' offenders marked the growing impact of the modern, differentiated approach in the administration of criminal law (Franke, 1990; Kelk, 2007; van der Stel, 1995). This development was in line with the extending role of the state in society and growing social activism, not only to combat social wrongs and misfortunes like poverty, illness, backwardness, and exploitation, but also to achieve a virtuous life and a sense of social responsibility for every citizen. As society's democratization progressed, it was deemed all the more essential to elevate the lower orders morally and to inculcate in them a civil sense of responsibility and decency.

Psychiatrists generally approved the new criminal law practices because they stimulated a differentiated assessment of offenders, whereby their personal background was taken into account (Meijers, 1913; cf. de Roos, 1914). The efforts to socially integrate offenders perceived to be corrigible were accompanied by proposals to protect society more effectively against the presumed hard core of disturbed and frequently recidivist criminals, the so-called psychopaths. It was believed that the existing criminal laws, which offered judges the possibility to acquit perpetrators who were completely insane by declaring them to be of unsound mind and place them in a mental asylum involuntarily, were not effective enough for dealing with the much more numerous borderline cases. In 1911, 1915 and 1921 the Minister of Justice proposed bills to enable special measures against this group. These proposals also met with approval among psychiatrists and motivated their professional association to press the issue of a formal role of psychiatric diagnosis in the administration of criminal law for specific criminal categories, especially those suffering from mental disorders, such as murderers, arsonists, imposters, sex delinquents, and women who committed illicit acts during menstruation or pregnancy (de Ridder & de Vries, 1984). In 1915 three psychiatrists argued for a law on psychopaths that should not only be geared to criminal psychopaths, but also to non-criminal ones. Both groups after all consisted of 'moral degenerates' and 'anti-social retarded' and they had to be met with a coherent set of 'medical–pedagogic' and 'preventive' measures (van Deventer, Sissingh, & Postma, 1915).

3. The psychopaths laws and the placement under a special restriction order (1925–2005)

In 1925 Dutch parliament passed the so-called 'psychopaths laws', which were to be enforced three years later. These laws made it possible for judges to place both fully and partly irresponsible lawbreakers 'under a special restriction order' (*Ter Beschikking van de Regering*, or: TBR). This meant that mentally disturbed delinquents following their potential prison term could be put in an asylum for psychopaths involuntarily or, as in the case of a suspended sentence or release on parole, put under psychiatric surveillance otherwise. Every two years the judge could prolong an individual TBR, whereby his decision depended to a large extent on the assessment of the attending psychiatrist or the asylum's medical director of the delinquent's mental state and the chance of recidivism. An individual TBR could be renewed an indefinite number of times, which implied that the delinquent could be incarcerated in an asylum for the rest of his or her life. A release from TBR could be realized at the end of a TBR term if the prosecutor did not request an extension or if the judge rejected the requested extension. Formally it was the Minister of Justice who signed the release order. Also, the minister could decide to end an individual TBR before the end of the term.

The psychopaths legislation, which to a large extent represented the views advanced by the modern legal school as well as forensic psychiatry since the turn of the century, was first of all motivated by the desire to protect society against presumably incorrigible and dangerous criminals through removing them longer from society than could be legitimized on the basis of a merely legal sentence and criminal law's proportionality principle. The law stipulated that TBR could only be imposed if the judge felt that public order or safety was at stake (de Ridder & de Vries, 1984; Haffmans, 1984; cf. Kortenhorst, 1929). The TBR regulation was meant, in the words of a psychiatrist, for 'the commonly-dangerous, poorly-developed or sickly-disturbed deviants from the so-called norm, of whom it should be feared that they [will] repeat offenses, given their prior life, personality, and character' (Kortenhorst, 1929: 175).

Although TBR reflected a hardening of the administration of criminal law that was in line with the call for law and order during the economic crisis in the 1930s and the associated (fear of) social unrest, at the same time it implied a continuation of the trend in criminal law associated with child protection laws and suspended sentences, geared toward re-education and re-socialization. In this respect the new laws on psychopaths were ambiguous: despite the emphasis on the protection of society they also offered a starting-point for shifting the accent from punishment to treatment and rehabilitation (Weijers, 2003; cf. Nederlandsche Vereeniging voor Geestelijke Volksgezondheid, 1936). TBR would continue to give rise to debates among legal experts and psychiatrists on the question whether social security or individual treatment should be given priority. The psychopaths laws and their implementation can be considered as an uneasy compromise between the approach of the

modern school of criminal law and the classic principle of proportional punishment. Although the law made it possible to apply TBR without a preceding prison term, in practice this hardly happened: in general delinquents were hospitalized after a prison term.

At the same time, the new legislation increased psychiatric influence in criminal law and rehabilitation. In the context of the option to impose a suspended sentence or a TBR, the advice and reports from psychiatrists and probation officers became more important (Franke, 1990). The laws on psychopaths sealed the legal recognition of the need to seek psychiatric advice about some suspects because of their personality traits. The number of cases in which judges called in the expertise of psychiatrists went up (Tammenons Bakker, 1957). Although at the introduction of these laws the Justice Minister, partly with an eye to the limited care capacity, warned for '*überpsychiatrisierung*' (overpsychiatrization) because medical experts might foster a too broad interpretation of the notion of psychopathy, soon judges began to impose a TBR verdict on a regular basis: between 1929 and 1933 in nearly 140 cases each year on average (Haffmans, 1984; cf. Kortenhorst, 1929; Weijers, 2003).

The psychopaths laws implied the establishment of a new type of asylum: the asylum for the detention and care of TBR-convicts, who were under the authority of the Justice Ministry rather than the Public Health Department of the Ministry of Social Affairs, which supervised regular mental asylums. Between 1928 and 1933 three such asylums were established with a total of over 300 beds (Bakker, 2002; Barneveld, 1983; Koenraadt, 1991a; Kortenhorst, 1929; Nederlandsche Vereeniging voor Geestelijke Volksgezondheid, 1936; van de Uitvlugt, 1991; Weijers, 2003). Initially little actual psychiatric treatment of TBR-convicts was realized. The therapeutic repertoire comprised chiefly re-education through a strict regime with emphasis on order and regularity as well as (agricultural) labor. Cultivating self-discipline and a sense of responsibility was center-stage. The only medical intervention applied (from 1938 onwards) was castration of sex offenders. Detainees experienced their forced institutionalization not so much as treatment but as punishment, especially given the indefinite duration of the detention, which in the light of the seriousness of their offense they often viewed as unreasonable (Weijers, 2003; Weijers & Koenraadt, 2007). Partly for a lack of financial means the asylums for psychopaths functioned as prison facilities rather than therapeutic facilities (Barnhoorn, 1932; de Ridder & de Vries, 1984; Haffmans, 1984; van Bemmelen, 1957; Weijers, 1996). The 1933 psychopaths emergency act (or: 'stop act'), which aimed at limiting the number of TBR-sentences, was the direct product of cutbacks, overcrowding—by 1931 all available beds were occupied—and resistance from some legal experts, who felt that equality before the law might suffer. Offenders against property who did not use violence or physical intimidation could no longer be sentenced with TBR, which caused the share of assault delinquents and especially sex offenders in asylums for psychopaths to go up (Haffmans, 1984; Weijers, 2003; cf. van Bemmelen, 1957). The average number of TBR-sentences per year subsequently dropped to nearly 100 between 1933 and 1946 (Haffmans, 1984).

Psychiatric thinking on crime moved further along the lines staked out since the late nineteenth century. Bonger's sociological approach, supported by statistic and social demographic study of crime at the criminological institute (set up in 1934) of the University of Utrecht, had but little influence in the psychiatric world and the practice of criminal law. Among Dutch psychiatrists the ideas of criminal anthropology and psychological approaches found more support in the 1920s and 1930s. The Groningen professor of psychiatry E.D. Wiersma, a leading expert in the forensic field, started from a view of human agency in which there was only little room for free will. Because of the large influence of mental disposition and environment factors, the penal code would have to make room for more measures aimed at treating the disturbed personality of criminals. The psychiatrist H. van der Hoeven, author of a guidebook on psychiatry for lawyers (1912) and member of the Psychiatric–Juridical Society, shared this view: his motto was more and better treatment instead of punishment. In the late 1930s Van der Hoeven, psychiatrist A. Stärcke, prison physician S. van Mesdag, and the criminologist W.P.J. Pompe began to move away from the notion of the inborn criminal and to argue for a less repressive and more emphatic approach of criminals, based on psychological insights (Dankers & van der Linden, 1996; Franke, 1990; van Weringh, 1986; Weijers & Koenraadt, 2007).

These views, however, hardly made inroads in practice for the time being, whereas a more biological approach, partly in response to developments abroad in the field of eugenics, met with approval from both legal experts and physicians. In the early 1930s some advocated castration as treatment of sex delinquents assumed to be incorrigible: this intervention was seen as a 'humane' alternative for lengthy imprisonment and ought to be legally regulated (Franke, 1990; Oosterhuis, 1992; van Bemmelen, 1933; van Weringh, 1986). In the wake of several sentences in which mainly homosexual offenders received less punishment after they or their defense attorneys promised that they had themselves castrated, a debate unfolded among legal experts, psychiatrists, theologians, and politicians on the acceptability of forced castration. Against the background of Nazi Germany's introduction of sterilization and castration laws in 1933 and 1934, most participants in the debate adopted a cautious attitude regarding coercion, even though some did not exclude it as an option. In general there was great reservation regarding eugenics in Dutch society, dominated as it was by religious groups; this pertained in particular to preventing unwanted offspring through birth control, sterilization, abortion, and legal marriage impediments. Psychiatrists and also some legal experts and clergy, however, emphasized that 'therapeutic' castration was no eugenic intervention but a medical one and, as such, was acceptable (Oosterhuis, 1992; van der Scheer & Hemmes, 1936).

In 1935 the physician J. Sanders, who had ties with the Dutch Institute for Human Genetics and Race Biology (*Nederlandsch Instituut voor Erfelijkheidsonderzoek bij den Mensch en voor Rassenbiologie*), wrote a report—with help from three psychiatrists—on the therapeutic effects of castration of sex offenders. This was based on a dozen castrations performed in the Netherlands and some one hundred done elsewhere (chiefly in Germany). Most of these cases involved feebleminded men or men whose sexual behavior was punishable, notably exhibitionism and heterosexual and homosexual acts with minors. Sanders wrote that in all cases both the attending physicians and the patients were satisfied with the intervention's result. Uncontrollable and sickly sexual drives vanished or grew significantly weaker and there would hardly be any negative physical or mental side-effect. Based on foreign and domestic casuistry, Sanders felt castration to be advisable as therapeutic treatment for deviant sexual behavior, provided that the individuals themselves or, in the case of feeblemindedness, their parents or guardians consented (Sanders, 1935). Several leading psychiatrists, partly based on their own professional experience, voiced a similar view on castration (Barnhoorn et al., 1941; Carp, 1936a, 1936b; Kandou & Speyer, 1936).

In contrast to countries such as Denmark, Germany and the United States, the Netherlands did not introduce legislation on castration. Medical professionalism and ethics, thus was assumed, would offer enough guarantees to leave decisions on its application up to physicians and patients. However, castration of sex delinquents with TBR required approval from the Ministry of Justice. According to the official guidelines, the patient himself had to put in a request with the minister, while also medical advice and possibly a declaration by a clergyman were needed as confirmation of the patient's voluntary consent. Such requests were rejected until 1938, but in this year the medical-director of the largest asylum for psychopaths, A.L.C. Palies, managed to convince the Minister of Justice, a member of the Catholic Party, to give his approval (Palies, 1947). In 1941, together with a colleague, Palies reported on some thirty castrated sex delinquents, emphasizing

they themselves willingly wanted to be freed from their 'sickly sexuality' (Palies & Wuite, 1941). In 1947 he reported that 79 castrations had been carried out on TBR convicts in the asylum of which he was in charge (Palies, 1947). Palies claimed they voluntarily consented, but it is hard not to get the impression that physicians and others involved exerted pressure on unwilling detainees. A TBR-sentence meant after all that physicians had great influence on the duration of detention. As long as patients did not cooperate in their 'cure', physicians could advise the judge each time to prolong their TBR with two more years (Hartsuiker, 1947; cf. Palies, 1947). The consideration that a 'cure' raised their chances of being discharged often was a deciding factor in giving in to pressure from physicians (Hartsuiker, 1947; Palies, 1947; Palies & Wuite, 1941; Wijffels, 1954; cf. Oosterhuis, 1992).

The number of castrations peaked around 1950. In the period 1938–1968 more than 400 men who received a TBR-sentence for sex offenses—almost half of whom were sentenced based on the sections of the law that made all sexual contacts with a youth or child under the age of sixteen and homosexual acts between an adult and a minor (under 21 years) punishable—were castrated, with permission of the Dutch Ministry of Justice. In addition, an unknown number of men who received a suspended sentence underwent this surgery (Buitelaar, 1978; Koenders, 1996; Noordman, 1989). According to some psychiatrists, who in the 1940s and 1950s wrote about this treatment, its results were largely positive. Although the patients had to deal with certain disadvantageous physical or mental effects, these would pale into insignificance beside the beneficial effects. The libido's weakening would diminish chances of sex offenders becoming repeat sex offenders (Hartsuiker, 1947; Palies, 1947; Palies & Wuite, 1941; Wijffels, 1954).

After World War Two, changes in the criminal law climate and new psychosocial and behavioral approaches fostered optimism about other treatment possibilities of mentally disturbed delinquents, even though practice was not up to the ideals yet (Hamers, 1986; Kelk, 2007; Mooij, 1991; Weijers & Koenraadt, 2007). In 1945 the so-called 'stop act', introduced in 1933 to limit the number of TBR-sentences, was revoked. Four years later, parliament adopted a new Prison System Act, after a commission investigated the prison system and observed that it was lacking in psychological expertise. The new law sealed the end of the isolation cell system that was based on systematically isolating detainees, and put the striving for their re-socialization center-stage, such as through communal activities. The goal was to reintegrate criminals into society. During the German occupation members of the resistance movement had personally experienced imprisonment and this reinforced the postwar reform-mindedness in penitentiary issues (Franke, 1990). In the second half of the 1940s, to gain more insight into the personality features of detainees and to meet the increasing need for behaviorist reports for sentencing, punishing and re-socialization, the first psychologists were hired by prisons.

When in the 1950s psychiatrists gained permanent positions in some court districts, psychiatry obtained an institutionalized place in the administration of law and the prison system. Before, forensic psychiatry was practiced on a consultancy basis (Brand, 2000; Haffmans, 1983). These first formal positions evolved into forensic–psychiatric district services, which increasingly were multidisciplinary organized and which apart from providing information and advice to judges also engaged in care of inmates with mental problems and in rehabilitation activities (Haffmans, 1983; Weijers, 2003). In the mid-1960s, about seventy psychiatrists were engaged in part-time reporting for courts and some ninety were involved in rehabilitation efforts.[3]

[3] Letter of F. Hartsuiker, A.H. Roosenburg and W.A. Vaandrager to the executive board of the Nederlandse Vereniging voor Psychiatrie en Neurologie 24-5-1966, Archive of the Dutch Society of Psychiatry and Neurology.

The growing recognition of the importance of psychiatric examination and therapeutic treatment of mentally disturbed delinquents was reflected in particular in the rise of the number of TBR-sentences. Between 1947 and 1960 it averaged between 580 and 680 per year, the majority of which—between 300 and 400—consisted of suspended sentences (Haffmans, 1984). The TBR-institutions were unable to handle this strong growth, causing more and more patients—in 1948 some sixty already—to have to wait in prison before being hospitalized in an asylum in order to be treated (Weijers, 2003). In the course of the 1950s the problem grew less urgent because the forensic–psychiatric institutions saw major expansion. Between 1949 and 1965 their number increased from three to sixteen and the total number of forensic beds went up from over 300 to more than 800 (Bakker & De Goei, 2002; Haffmans, 1984; Nationale Federatie voor de Geestelijke Volksgezondheid, 1949, 1962, 1965: II; Weijers, 2003; see also Blankstein et al., 1986; Hamers, 1986; Koenraadt, 1991b; Krul-Steketee & Zeegers, 1993). With three new institutions, Utrecht evolved into the Dutch center of forensic psychiatry: the Psychiatric Observation Clinic of the Prison System (1949) for suspects who had to undergo court-authorized psychiatric examination; the Selection-Institute for TBR-Patients (1952), for diagnosing and examining those with TBR as to their suitability for a specific clinic or treatment; and the Dr. H. van der Hoevenkliniek for therapeutic treatment (1955). General mental institutions also admitted delinquents for observation and treatment (Kroft, 2005; van Emmerik, 1999). Discharged TBR-convicts and those with a suspended sentence were under surveillance of rehabilitation agencies and received psychiatric support from psychiatrists who worked for social–psychiatric services (Weijers, 2003).

In terms of its content, forensic psychiatry received a new boost especially through the work of several leading representatives of the so-called Utrecht School. Aside from the legal expert Pompe and the criminologist G.Th. Kempe, the legal expert and psychiatrist P.A.H. Baan was active in this area in particular. Among others, they worked to renew criminal law, the prison system, the care of mentally disturbed delinquents and their rehabilitation. Inspired by German phenomenological–anthropological psychiatry and French personalism, they submitted that it was not retribution, but understanding of the delinquent's personality, life history, and individual circumstances that should serve as the guideline of criminal law (Franke, 1990; Moedikdo, 1976).

Baan, who took charge of the three new forensic–psychiatric institutions in Utrecht, disassociated himself from determinist psychiatric diagnoses in terms of hereditary disposition and psychopathy. He felt that people's individual development depended on relationships and communications with other people and that crime was often a symptom of 'obstructed personality growth' resulting from a lack of love, warmth, nourishing, and security. Despite their crimes, delinquents remained approachable 'fellow humans' whose drives were comprehensible based on their individual life history. They needed help and their sense of responsibility and social bonds could be restored through a dialogue—'encounter' in personalist jargon—based on empathy and understanding and psychological and pedagogic counseling. Criminals too, it was argued, had an inkling of 'potential freedom and responsibility' which therapy should draw on (Baan, 1957: 11, 14). One should avoid that as a result of exclusion and stigmatizing they would end up in the margins of society; the Utrecht School's adage was social rehabilitation and reintegration. Like other supporters of this approach, Baan was motivated by great optimism about the possibilities to improve human beings. 'Just give me enough money,' he is supposed to have said, 'and I will cure all psychopaths' (Koenraadt, 1995: 121; cf. Dankers & van der Linden, 1996; Moedikdo, 1976; Weijers, 2003).

Baan tried to realize his ideas in the new Van der Hoevenkliniek. Its therapeutic regime was grafted onto Rogerian psychotherapy as well as socio-therapeutic approaches developed in Britain and France by M. Jones and P. Sivadon. Patients' everyday life was

devoted to treatment and they could voice their views in meetings with staff. Nurses and social workers functioned as group leader and had a pedagogical task. Besides occupational therapy, whereby the TBR-patients received merit pay to improve their self-esteem, much attention was paid to education and creative therapy, physical therapy, and leisure activities. Baan's views on individual freedom and responsibility, however, proved too optimistic. In the initial period quite a number of TBR-patients escaped from the clinic, which effected tighter rules and security (Dankers & van der Linden, 1996; cf. Cossee-Buys, Feldbrugge, & Hendriks, 1975).

For the time being the Van der Hoevenkliniek was the only forensic institution to have a strong focus on therapeutic efforts. The other TBR-institutions lacked the financial means and staff or proper expertise to apply the socio- and psychotherapeutic treatment advocated by the Utrecht School (Haffmans, 1984). Detainees in these facilities were administered psychiatric drugs, while, as we saw, the practice of castrating sex offenders continued into the 1960s. From this period, however, the Utrecht School approach began to see wider application, and socio-psychological approaches grew more influential in TBR-facilities, partly because of the increased hiring of psychologists. It is possible to identify three specific approaches: a psychoanalytic approach that focused on childhood-related traumas and disorders in personality development whereby therapy aimed at self-insight served as common method of treatment; an anthropological–phenomenological approach that centered on the disturbed relationship between the delinquent and his social environment whereby socio-therapy and family therapy offered suitable treatments; and a behaviorist approach that was geared to improper behavioral patterns and poor self-control and whereby the therapy had a behavioral–psychological and pedagogical character (Barneveld, 1991; Haffmans, 1984; van Marle & Reicher, 1987; Weijers, 1995, 1996). In one of the smaller TBR-facilities, psychotherapy and socio-therapy were combined with medication-based treatments such as carbon dioxide inhalation, Methedrine, and LSD (Snelders, 2000; Weijers, 2003).

Precisely when TBR-institutions shifted their emphasis from social protection to socio- and psychotherapeutic treatment, the TBR-system became subject to debate again. From the late 1950s judges began to question the system's therapeutic effectiveness and they doubted whether it made society safer indeed. In the 1960s the average annual number of TBR-sentences dropped to about 330, half of which were non-suspended (Haffmans, 1984; cf. Barneveld, 1991; Dankers & van der Linden, 1996; Hamers, 1986; Weijers & Koenraadt, 2007). More frequently than before these were combined with long prison sentences. That the goal of social defense still weighed heavily was expressed in the fact that TBR, when considered over a longer period, was accompanied in only fifteen percent of the cases with discharge from prosecution, meaning that eighty-five percent received both a prison sentence and TBR (Hamers, 1986; cf. Haffmans, 1984). Because of escapes and recidivism among former TBR-convicts after their release, TBR-institutions attracted negative publicity (Bakker, 2002). At the same time, however, there was more criticism of the lack of rights of those sentenced with TBR, partly after media articles and political attention for abuses in some TBR-institutions. They could be locked up indefinitely, were always uncertain about their future, and were at the mercy of the medical regime: the physician's advice was a major factor in the decision every one or two years to prolong an individual TBR-sentence (Weijers, 1996).

Between 1970 and 1980 the annual number of non-suspended TBR-sentences declined from over 160 to an average of 80 and in the 1980s it slightly rose again to just below 100. In the 1970s the number of TBR terminations surpassed the number of new sentences, causing the total number of TBR-convicts to drop from nearly 1,000 in 1970 to slightly under 400 in 1980. In the following decade it gradually increased again to more than 520 in 1990, partly as a result of the declining number of terminations and a longer average duration of the TBR-sentence: it went up from four, five years in the early 1980s to seven, eight years in the 1990s. Nearly exclusively men were involved, the number of female TBR-convicts being no larger than a dozen (van Emmerik, 1999; cf. Haffmans, 1984; Hamers, 1986; van den Boogaard & van der Graaf, 1978).

In the early 1970s delinquents who committed crimes against property constituted two thirds of the total number of TBR-convicts. The strong decrease of the total number in the ensuing decade mainly resulted from the TBR of many in this category being terminated. Changes in legal views caused TBR no longer to be applied to most property crimes or sex offenses not involving assault, such as exhibitionism. The two main criteria for imposing TBR were the seriousness, especially the violence, of an offense and the chance of recidivism. Judges increasingly imposed it in the case of a severe assault or sex offense by perpetrators with more or less serious mental disorders and/or addiction problems. In the early 1980s nearly ninety percent of those who got TBR met this profile (Barneveld, 1983; Dankers & van der Linden, 1996; Haffmans, 1984; Hamers, 1986; Koenraadt, 1995). Those with TBR and forced treatment mostly ended up in a forensic–psychiatric institution, generally after being examined in the forensic Selection-Institute in Utrecht to decide on which security and treatment was most proper in their case. Around 1970, apart from the Utrecht clinics for observation and selection, there were ten TBR-institutions with a total of some 670 beds (Esser, 1970: II; cf. Geneeskundige Hoofdinspectie voor de Geestelijke Volksgezondheid, 1987; van den Boogaard & van der Graaf, 1978). In the mid-1980s the number of TBR-facilities went down to six, with a total of over 470 beds (Haffmans, 1984; Hamers, 1986). General psychiatric hospitals also had several places for TBR-convicts and other mentally disturbed delinquents (Haffmans, 1984). The partly outdated TBR-facilities often seemed more like prisons than psychiatric institutions and they also had capacity problems. In the largest and oldest facility, Veldzicht in the eastern part of the country, until 1980 the patients slept in closed-off spaces smaller than two by two square meters, officially labeled *chambrettes*, or sleeping cubicles (Esser, 1970: II; Barneveld, 1983; Haffmans, 1984; van de Uitvlugt, 1991).

In terms of therapeutic regime, there were substantial differences among TBR-facilities. Some primarily functioned as shelter for long-term hospitalization of hard to treat delinquents. The therapeutic ambitions here were modest at best: traditionally the emphasis had been on regular (agricultural) labor and a pedagogic approach geared toward re-socialization. From the late 1960s, other methods of treatment, such as creative, socio-, and psychotherapy, were introduced, whereby psychologists fulfilled a major role (Barneveld, 1983). The patients themselves felt there was quite a gap between the ideal of treatment and actual practice. 'During the day you have to fill bags or tie together bits of paper. Sitting there together with others is called socio-therapy and the monotonous work they call occupational therapy,' one detainee held in Veldzicht explained in 1978. He felt the best way to get out was 'to play along. By and large you know what they want to hear. […] you only say things of which you think that they will go down well' (van den Boogaard & van der Graaf, 1978: 4).

Just like in general psychiatry, the accent in treatment shifted from a medical–psychiatric approach to psychosocial, educational, and behaviorist orientations (Esser, 1970: II; Haffmans, 1984; Koenraadt, 1995; Weijers, 2003). In the course of the 1960s castration was abandoned, partly because this operation was replaced by pharmaceutical libido inhibitors. In the Netherlands—in contrast to countries such as Germany, the United States and Russia—no brain surgery has ever been performed on mentally disturbed delinquents. In 1974 plans for applying it on a TBR-convict were fought at the level of the Dutch Supreme Court, which ruled against such forced treatment. In the 1970s there was no broad social backing for drastic biomedical interventions, partly because of the critical stance vis-à-vis medical psychiatry by the anti-psychiatric movement. Fierce protest also contributed to ending treatments such as electroshock therapy in Dutch psychiatric hospitals. In the media and public opinion there was strong resistance against any form of biological explanation of human behavior, as was experienced by the newly

appointed Leiden professor of criminology W. Buikhuisen. When in the late 1970s he planned to study not only social factors but also biological features of criminals, he was booed off the platform and got no chance to carry out his planned research (Haffmans, 1984; Snelders, 2000; van den Boogaard & van der Graaf, 1978; van Weringh, 1986).

Particularly the newest TBR-facilities, the Van der Hoevenkliniek and the Pompekliniek in Nijmegen, capitalized on socio- and psychotherapeutic optimism. In both facilities treatment and everyday life started from the notion of the therapeutic community. The basic premise was that one could change behavior by focusing on social relationships and self-reliance. Based on the ideas of the Van der Hoevenkliniek's founder, Baan, who put much emphasis on developing self-responsibility, the treatment program included individual psychotherapy. From the mid-1960s, however, the focus shifted to a behavior-therapeutic and system-theoretical approach, highlighting family-therapy, on-site observation and correction of behavior as well as patients' everyday social functioning in the clinic (Dankers & van der Linden, 1996). In the Pompekliniek, opened in 1967, introduction of the therapeutic community principle with democratic participation and a large degree of permissiveness led to clashes with the outside world. Runaway patients caused much public and political commotion, which in 1972 led to intervention by the Ministry of Justice to reinforce security. Although the therapeutic community's basic premises remained in place, in the following years more attention was given to order and security. The democratic relationships between staff and patients, which in practice had produced chaotic scenes and a hardly transparent distribution of responsibilities, were replaced by a professional and hierarchic organization structure (Blankstein et al., 1986; Haffmans, 1984).

Although the Dutch TBR-institutions enjoyed much international standing, staff shortages continued to linger and there were hardly any scientific data on the effectiveness of treatment (Weijers, 1995; cf. 1996). Partly in the context of a planned amendment of the psychopaths laws, in the 1960s, 1970s and 1980s, the debate on TBR centered on the dynamic of rights and treatment options of individual delinquents versus protection of society. A commission set up by the Minister of Justice that studied the effectiveness and legitimacy of the TBR-measure advised in 1967 to add more differentiation in and between TBR-institutions in terms of security and treatability of TBR-convicts. The commission also argued for smaller-scale residential facilities and the introduction of a socio-therapeutic living environment, as already realized in the Van der Hoevenkliniek and Pompekliniek. This advice constituted the basis for a memorandum of the government (1970) and a bill to amend the psychopaths laws, which the Minister of Justice submitted to parliament in 1972 (Hamers, 1986). Nevertheless, the (unenacted) bill still failed to make clear choices between social security and the relevance of individual treatment and re-socialization.

Meanwhile, partly on account of the activism of anti-psychiatry, criticism grew stronger, particularly regarding the lack of rights that accompanied a TBR-sentence and its indefinite and often long duration. Judges also paid more attention to the legal protection of TBR-convicts. Until the late 1960s a request to prolong a TBR-sentence was largely a formality and judges normally endorsed medical advice. In the course of the 1970s, however, courts increasingly began to deviate from it. Judges also weighed a crime's severity and the duration of the deprivation of liberty. Since they felt that the TBR-treatments lasted too long, the number of 'contrary terminations' of TBR-sentences increased strongly in the 1970s and 1980s. And if courts decided in favor of extension, this often applied to the limited period of one year or on the condition that a maximum duration of treatment was fixed. Psychiatrists regretted this development, feeling that the legal argument undermined the effectiveness of treatment and that decisions on termination of TBR-sentences would have to depend on treatment results (Dankers & van der Linden, 1996; Kelk, 2007).

In 1982, partly in response to the activism of the patient movement in general psychiatry, the government set up a commission to prepare a bill regulating the legal status of TBR-convicts. The basic question was to what extent they could retain specific civil rights. It was felt that the government ought to legitimate and motivate infringements on the autonomy of TBR-convicts better and that there should be more room for hearing them. Moreover, the indefinite maximal duration of a TBR-sentence—a major source of uncertainty for those involved—was disputed. In line with the effort to render criminal law more humane, the legal status of TBR-convicts was strengthened, while regulations on parole, suspended discharge, and work outside the institution were softened (Haffmans, 1984). Conversely, data on recidivism—averaging some sixty percent from the 1950s to the mid-1980s—continued to be ground for doubts about the effectiveness of therapeutic treatment. Partly as a result of the declining trust among judges and cost management concerns, in the 1980s the emphasis shifted back again toward TBR as a form of detention to protect society, and the average duration of a TBR-trajectory began to go up (Franke, 1990; Haffmans, 1984; Hamers, 1986; van den Boogaard & van der Graaf, 1978).

All in all, the developments involving TBR show conflicting tendencies. On the one hand, this sentence was increasingly limited to serious assault and sex offenses, more attention was paid to the rights of TBR-convicts, and objections to the indefinite duration of their detention grew stronger. On the other hand, judges continued to question the effectiveness of treatment and the issue of security was more emphasized, precisely because TBR became geared more toward violent delinquents. Although the anti-psychiatric movement publicly criticized psychiatry for its assumed repressive dimension, TBR received public attention mainly after incidents of escape or recidivism and it became increasingly associated with a too 'soft' approach of crime.

After a debate lasting fourteen years, the 1925 psychopaths laws were replaced with a new law adopted in 1986 and enacted in 1988. TBR, short for *Ter Beschikkingstelling van de Regering*, was changed into TBS, short for *Ter Beschikking Stelling*. Also in 1988, a legal frame for forensic reporting was instituted: at least two behavioral experts from different disciplines, including a psychiatrist, had to contribute to it. The twenty-three district forensic–psychiatric services—geared toward providing advice to courts and rehabilitation agencies and treating detainees with mental disorders—were staffed by psychiatrists (a total of some thirty-five) and psychologists (Brand, 2000; Hutschemaekers, ten Have, & Jacobs, 1995; Weijers, 2003). The new TBS-law provided disturbed delinquents more legal protection and limited the sentence to serious offenses carrying a penalty of at least four years. The latter had in fact been common practice since the 1970s: TBS largely applied to severe acts of assault and sex offenses. While before TBS had no maximum duration, the new law stipulated that as a rule it should not last more than four years. A longer TBS continued to be an option, however, if the judge, partly based on medical advice, felt that the security of society so demanded (Hamers, 1986). In fact, because of the violence of their crimes, a growing number of TBS-convicts were treated for more than four years. The new law distinguished TBS with and without forced treatment; in the latter case the convicts could be put under surveillance of a rehabilitation agency or be subjected to ambulatory or outpatient treatment (Dankers & van der Linden, 1996; Groenhuijsen, 2000). Improved legal protection was reflected in a more detailed extension procedure of TBS-sentences. The judge had to hear the TBS-convict and the latter could appeal the decision. When a request was put in to extend a TBS-sentence that already had lasted six years, the judge had to solicit advice from independent experts. Furthermore, rules were laid down regarding coercion in TBS-institutions, freedom of movement of TBS-convicts, visiting rights, the right to correspondence and so on (Dankers & van der Linden, 1996; Kelk, 2007).

The trend of imposing TBS especially on perpetrators of assault and sex offenses persisted. While around 1970 nearly 40% of the TBR-sentenced were guilty of harsh aggression and sexual violence, around 1990 this was true of 95% of the cases (Marle & Harte, 1999; Witteman, 1995). Because TBS was mainly deployed as a last resort after other measures had failed, it largely involved repeat offenders,

most of whom had previously been in contact with mental health agencies and social work. The fear of recidivism was a major reason for judges to impose TBS. While the number of women remained limited to 5% of the total, the number of TBS convicts of non-Dutch background rose from a quarter to a third in the 1990s. The average age was around thirty and the level of education was low. Most suffered from severe personality disorders while psychotic disorders and drug addiction also occurred frequently (Dankers & van der Linden, 1996; de Goei, 1990; Hamers, 1986; Hildebrand, 2004; Inspectie voor de gezondheidszorg, 2003; Mol & Stalman, 2000; Oostveen, 2003; Poll, 2005; Weijers, 2003).

In the 1980s each year the number of TBS-sentences with forced treatment approached 100 while the number of treated TBS-convicts grew from almost 400 to close to 530 (de Vogel et al., 2001; Geneeskundige Inspectie voor de Geestelijke Volksgezondheid, 1990; Hutschemaekers, ten Have & Jacobs, 1995; van Emmerik, 1999; Witteman, 1995). In the first half of the 1990s the number of TBS-sentences went up rapidly to almost 200 each year, while also the average duration increased, from four to five years in the early 1980s to over six or seven years around 2000. At the same time, the number of TBS terminations decreased. This put pressure on the institutional capacity and more and more TBS-convicts had to wait in prison for treatment in a forensic institution (de Vogel et al., 2001; Geneeskundige Hoofdinspectie voor de Geestelijke Volksgezondheid, 1988; Geneeskundige Inspectie voor de Geestelijke Volksgezondheid, 1989, 1992; Groenhuijsen, 2000; Inspectie voor de Gezondheidszorg, 1997, 2003; van Emmerik, 1999; Weijers, 2003). In addition to the existing seven TBS-facilities, four new ones were built between 1996 and 2000 (de Goei, 1990; Geneeskundige Inspectie voor de Geestelijke Volksgezondheid, 1989; Inspectie voor de Gezondheidszorg, 1997, 2003; Jansen, 2005, Ketting, Jacobs, & Bijl, 1987; cf. Mens, 2003). Despite major growth of the number of beds—going up from almost 550 to over 1300 between the mid-1990s and 2004—there continued to be a shortage: in this same period the number of TBS-convicts grew from over 1100 to over 1600 (Inspectie voor de Gezondheidszorg, 1998, 2002, 2003; Tonnaer, 2001; van Emmerik, 1999). Further increase of the number of TBS-places to 1600 in 2005 proved not enough to avoid waiting lists.

Partly in response to capacity problems, general intra- and extramural mental health care facilities also took on responsibilities in this area. In the early 1990s the government introduced the idea of forensic care circuits to stimulate the flow of delinquents from TBS-institutions to general psychiatric facilities. At that time four psychiatric hospitals set up forensic wards with a total of 120 beds. In the late 1990s 15% of the TBS-convicts stayed in regular psychiatric hospitals (Geneeskundige Hoofdinspectie voor de Geestelijke Volksgezondheid, 1987; Geneeskundige Inspectie voor de Geestelijke Volksgezondheid, 1989, 1990, 1993; Mens, 2003; Simons, 1993; van Emmerik, 1999). Apart from TBS-convicts, these wards also treated delinquents declared to be of unsound mind and discharged from prosecution whose admission for one year was court-authorized, as well as detainees with mental disorders transferred from prisons. In the 1980s and 1990s, estimates of the number of detainees with mental disorders in prisons vary from 10 to 15% of the total prison population. In 1985 the Medical Inspection for Public Mental Health established that it was harder and harder for people to accept the deprivation of liberty and the authoritarian approach associated with imprisonment. The resulting feelings of discomfort would increasingly surface as mental complaints. The Inspection also explained the increase of the number of prison inmates with mental problems by reference to problems in regular mental health care, especially de-institutionalization, which caused aggressive patients to end up in the legal circuit earlier (Geneeskundige Hoofdinspectie voor de Geestelijke Volksgezondheid, 1985; Geneeskundige Inspectie voor de Geestelijke Volksgezondheid, 1990, 1992, 1993, 1994; Inspectie voor de Gezondheidszorg, 1996, 1997; Inspectie voor de Gezondheidszorg, 2000; Staatstoezicht op de Volksgezondheid, 1983, 1984; cf. Brand, 2000; Franke, 1990; Groenhuijsen, 2000). The forensic capacity of general psychiatric hospitals remained too limited to process the flow of mentally disturbed delinquents. Furthermore, on a modest scale semi-mural and ambulatory services in the shape of supervised and protected living facilities were set up, as well as several outpatient clinics linked to TBS-facilities and other ambulatory treatment options. The preliminary results of this policy were modest; regular mental health care still showed little eagerness to treat TBS-convicts and other mentally disturbed delinquents (Dankers & van der Linden, 1996; de Vogel et al., 2001; Geneeskundige Inspectie voor de Geestelijke Volksgezondheid, 1989, 1993; Hutschemaekers, ten Have & Jacobs, 1995 Inspectie voor de Gezondheidszorg, 1996, 2003; Mol & Stalman, 2000; van Emmerik, 1999; Weijers, 2003).

While in the 1960s and 1970s forensic psychiatry was viewed as a humanitarian achievement, in the 1980s and 1990s, when the administration of criminal justice hardened, more criticisms could be heard (Kelk, 2007). The emphasis of forensic experts on the explicability of the act in the light of life history and character structure of suspects, critics felt, turned into a predictable ritual and was met with more criticism from judges and other experts as well (Heerma van Voss, 1990; cf. Hamers, 1986; Weijers & Koenraadt, 2007). Psychiatrists and psychologists increasingly doubted the possibility of curing TBS-convicts. They were treated with drugs and psycho-, behavioral- and socio-therapies, but the optimism of the 1960s and 1970s about the possibility of changing their personality had been toned down. The therapeutic objectives shifted toward regulating behavior, self-control, and learning to avoid dangerous situations (Dankers & van der Linden, 1996; de Goei, 1990). Moreover, long stay-wards were set up for TBS-convicts who for six years had been treated in vain; to the initial sixty beds more were added later on to accommodate the growing groups of patients considered as untreatable (Inspectie voor de gezondheidszorg, 2003). In 1995 the Ministry of Justice published the results of a study of the occurrence of recidivism among discharged TBS-convicts in the 1980s. More than half of them had been sentenced again for a misdemeanor and 20% were convicted of a ruthless crime. Sex offenders in particular seemed incurable (Dankers & van der Linden, 1996; Groenhuijsen, 2000; Witteman, 1995). The TBS-institutions repeatedly got bad publicity after escapes and serious crimes by delinquents on probationary release.

The focus partly shifted back from treatment to protection of society through risk assessment and risk management, teaching self-control and expansion of long stay-wards (Inspectie voor de gezondheidszorg, 2003; Kelk, 2007; Sins, 2002; Witteman, 1995). For example, the research in the Utrecht selection clinic, the F.S. Meijers-Institute, focused on assessing the risk posed by delinquents and the chance of recidivism. Moreover, in psychiatry attention focused more and more on the assumed genetic influence on criminal behavior. The label 'psychopath', which since the 1960s had vanished as a diagnostic category, became current again. C. de Ruiter, adjunct professor of Forensic Psychology at the University of Amsterdam, introduced the so-called *Psychopathology checklist*, put together by the Canadian psychologist R.D. Hare. Hare assumed that the psychopathic personality was rooted in genetic disposition and the workings of the brain and that treatment had little use. 'No difficult childhood, no re-education and new chances', so De Ruiter echoed Hare. 'Simply: this is a bad human being to the core' (Koelewijn & de Koning, 2004: 35; cf. Hildebrand, 2004). H. van Marle, who in 2003 became a professor of Forensic Psychiatry at the Erasmus University in Rotterdam, felt that TBS should only be accessible for treatable delinquents. Sufficient expertise had meanwhile been developed, he argued, to predict which TBS-convicts were treatable or not. He favored creating more room for coercion, also in therapy, while untreatable TBS-convicts were best put into long stay-wards, so that they did not take up any places of treatment (Jippes, 2004).

Also from within politics there were pleas for a more stringent dealing with TBS-convicts through swifter transfer of untreatable delinquents to (cheaper) long stay-wards and a prolonging of the maximal probation

after discharge to ten years (*NRC Handelsblad*, 8 March 2004). By the mid-2005, 220 TBS-convicts were staying in long stay-wards (*NRC Handelsblad*, 17 June 2005). Despite its plea for risk assessment and control and the expansion of long stay-facilities, the Health Care Inspection claimed in a 2003 report on TBS-clinics that some put too much emphasis on security, rules and sanctions while providing not enough therapeutic treatment. The Inspection praised the treatment climate based on therapeutic community principles in the Van der Hoevenkliniek and the Pompekliniek (Inspectie voor de gezondheidszorg, 2003). Strikingly, given the call for tougher handling of TBS-convicts, a sizable number of them—in 2003 more than 150—were living outside an institution under supervision without official parole but with the approval of the Ministry of Justice (Oostveen, 2003).

Partly on account of several widely-published escapes by TBS-convicts, which ended in a kidnap and a murder, and the ensuing call for a stricter TBS-regime, in the spring of 2006 parliament initiated commission hearings on the practice of TBS. These revealed that a growing number of untreatable delinquents were in long stay-wards, that the connection with regular mental health care left much to be desired, and that the risk of a surge of juvenile delinquents with psychiatric problems posed a new challenge. In its final report the parliamentary commission concluded that the TBS-system was clogged and that there was a lack of accommodation and treatment possibilities in regular mental health care. Besides expansion of the number of TBS-places—the number of TBS-convicts had meanwhile gone up to 1700—and a better tie-up with regular mental health care, the commission recommended prolonging psychiatric surveillance of discharged TBS-convicts (on parole) from maximal three years to nine years and in special cases even to lifetime. The government and parliament accepted these plans while the Justice Minister stressed that the basic principles of the TBS-system, treatment and social rehabilitation, should be preserved. In response to the social and political commotion that erupted every time a TBS-convict escaped he claimed that these were isolated incidents, that the risk of recidivism of TBS-convicts was lower than that of other convicts and that the number of escapes had gone down substantially, partly through a more stringent parole policy (Verlaan, 2006; *NRC Handelsblad*, 17 May 2006).

4. Conclusion

The main goal of the Dutch legislation on psychopaths was ambiguous. If it was designed to protect society against assumed dangerous criminals, at the same time they were supposed to receive psychiatric treatment to enable their return to regular social life again. These legal and medical objectives were at odds with each other and as a result discussions about collective versus individual interests, as well as about the usefulness and the effects of this legislation, kept flaring up. To this day, within the history of this legislation, punishment and social defense on the one hand and treatment and re-socialization on the other exist in constant tension. Whether at some point one or the other prevailed was largely tied to the social climate with respect to law, order, and authority, as well as to notions about democratic citizenship (See Oosterhuis, 2007a, 2007b).

Forensic psychiatry grew to full stature from the late nineteenth century until the 1920s, a period of social and political transformation in the Netherlands. The emergence of mass society and ongoing democratization—the gradual extension of the right to vote climaxed in universal suffrage in 1919—caused mounting concerns among those in society's upper echelons regarding the dominance of irrational emotions and drives, which would only generate unruliness, mental slackening, and social disintegration. Divergent behaviors—ranging from drinking, dancing, gambling, fair-going, and other forms of 'low entertainment' to idleness and money squandering, and from impulsive satisfaction of needs and sexual licentiousness to child abandonment and crime—became the target of interference and intervention by both voluntary organizations and the state. Collective social insurance and state intervention were introduced to protect the socially weak from disaster and to create such conditions that their social position might improve. What mattered was not just the resolution of social wrongs and misfortunes such as poverty, illness, backwardness, and exploitation; it was equally important to achieve a virtuous life and a sense of social responsibility for everybody. Starting in the late nineteenth century, the striving for the people's moral elevation, which had been underway since the Enlightenment in the form of the bourgeois civilization offensive, accelerated and spread more widely. The question behind it was whether all people had the necessary rational and moral qualities to meet the social responsibilities of an increasingly complex and democratic society and were able to act as responsible, political citizens. Bourgeois values took on a general significance as social glue and the civic virtues that applied to all members of society. Central notions were self-control and having a sense of responsibility: the curbing of erratic impulses and the postponement of instant satisfaction of needs was aimed at a proper balance between individual independence and community spirit, as well as at long-term personal and collective well-being. An industrious and productive existence, self-reliance, a sense of order and duty, thrift, and the family, acted as cornerstones of the democratized bourgeois ideal of citizenship.

Against the backdrop of these developments, a special regulation, the psychopaths laws, was realized for mentally disturbed offenders qualified as dangerous. Thereby the striving for protecting society carried more weight than treatment and re-socialization of these delinquents. This trend was further stimulated by the emphasis on law and order during the economic crisis in the 1930s and worries about social disruption and moral decay in the wake of the German occupation between 1940 and 1945 and the liberation by the allied forces. Various forms of misconduct and lack of ethical standards—including idleness, malingering, juvenile mischief, trading on the black market, lack of respect for authority and ownership, but also family disruptions, growing divorce rates, greater autonomy of women, and sexual license—were considered as serious threats to both the moral fiber and the nation's mental health.

In the 1950s and 1960s, against the background of the rising welfare state and growing confidence in the possibility to improve human beings, a new approach crystallized in forensic psychiatry, emphasizing the treatment and re-socialization of mentally disturbed criminals. In social policy in general the significance of a fixed collective morality and the social adaptation of the individual in order to safeguard overall social stability, made way for a more accommodating approach. More and more members of the various elites acknowledged that moral restrictions and external coercion only affected the outer behavior of people while leaving their inner self untouched. Rapid social-economic modernization brought about a new perspective in social policy: a striving for normalization and social integration, not only by offering support to people who were lagging behind, but also by enhancing the mental attitude and psychological abilities they needed to function properly in a changing society. Thus the pursuit of more dynamic and flexible adaptation took the place of frantic attempts at restoring morality and community spirit. It was now believed that new social conditions required a redirection of norms and values, and that individuals should be granted more responsibility for self-development. An individualizing and psychologizing perspective put people's inner orientation, the internalization of social norms and values in an autonomous self, on center-stage. In the 1970s the ideal of self-exploration and self-realization paved the way for an assertive individualism that together with the democratization movement rocked the foundations of Dutch society and its social policy as well. In this period the number of TBR-sentences reached a low, while there was more attention for the rights of mentally disturbed delinquents and in their treatment emphasis was put on socio- and psychotherapy.

In the 1980s, with its neoliberal politics of deregulation and privatization, liberal and Christian-democratic politicians began to shift the emphasis from the state-organized collective care facilities back to the self-reliance of citizens within communities and a focus on the market. The 1970s ideology of individual liberation and emancipation was called into question. Since the 1990s, Dutch politicians and intellectuals have been taking stock of the legacy of the 1960s and 1970s, largely evaluating it to be a negative one. The anti-authoritarian movement and the celebration of individual freedom, they argued, had degenerated into egoism, erosion of the personal sense of responsibility, an exaggerated assertiveness that was exclusively based on rights rather than duties, a coarsening of social interactions, and an increase of 'senseless' violence and other forms of crime. The welfare state had resulted in calculating behavior and improper use of social benefits. The overall toleration policy and the new taboos of political correctness had led to a lack of self-restraint, a degradation of the public domain, and social disintegration. These developments had to be countered by the restoration and revitalizing of a sense of community and civic virtue, with an emphasis on adjustment, integration, and moral regeneration. The taboo on coercion and duties began to recede, for instance regarding the integration of migrants. The hardening of the social and political climate, which intensified after the financial crisis of 2008, was reflected in a sharp rise of the number of TBS-sentences and a reduced trust in the treatability of forensic–psychiatric patients.

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