Insanity and Other Discomforts

2. INSANITY AND OTHER DISCOMFORTS
A Century of Outpatient Psychiatry and Mental Health Care in the Netherlands 1900-2000

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Throughout the nineteenth century, psychiatry in the Netherlands, as in other countries, primarily developed in relation to the care of the insane in asylums. Around 1900, however, it also gained ground in clinics tied to universities, in sanatoria and other facilities for mental and neurotic patients as well as alcohol addicts, and in private practice. After the First World War, psychiatrists began to treat more and more individuals who were not institutionalised. The 1920s and 1930s saw the emergence of the mental health movement and the establishment of Pre- and Aftercare Services for the mentally ill and the mentally retarded as well as counselling centres for problem children. In the Second World War the first public facility for psychotherapy was established, followed by Centres for Family and Marriage problems.

In the nineteenth century psychiatry centred on the notion that the mentally ill could be cured by temporarily removing them from society, but in the twentieth century, the opposite view gradually won ground. It was now thought better to treat those with either serious disorders or minor psychic and behavioural problems in ways that enhanced their social functioning and allowed them to remain in their everyday environments as much as possible. In the last decades of the twentieth century, this approach gained prominence in Dutch mental health care.

In this general overview, I will map all the various extramural organisations, facilities, and practices in the Netherlands in which psychiatrists and other professional groups have played a role during the twentieth century. My discussion is chronologically divided into four periods: (1) before the Second World War, when the first outpatient facilities and the first mental health organisations were established, with specific contradictions coming to the fore from the beginning; (2) the years of the German occupation and post-war reconstruction (1940-1965), when the fairly small-scale mental health care system rapidly expanded and professional expertise was increasingly emphasised; (3) the years between the mid-1960s and early 1980s, marked by a substantial increase in scale of the mental health system as a whole, a growing involvement and funding by the government, and a striving for greater uniformity in the fragmented outpatient care sector; and finally, (4) the 1980s and 1990s, a period in which the limitations of the sector's unbridled growth became visible and the emphasis shifted from building an independent outpatient sector towards closer collaboration with institutional psychiatry. Moreover, my discussion is organised around four themes: (1) the formal and institutional development of outpatient mental health care, including its funding; (2) the professional groups that shaped it and its various groups of patients and clients; (3) the kinds of approaches and treatments adopted by the mental health facilities; and finally, (4) the larger socio-cultural context.

Germination and Fragmentation (1900-1940)

The first form of outpatient psychiatry in the Netherlands developed in private practice. At the end of the nineteenth century, 'nerve doctors' were active in this field. The growing medical attention for nervous disorders, neurasthenia in particular, and a larger social sensitivity for these complaints caused doctors, and some nurses also, to focus on this new group of patients, who were not insane and therefore not eligible for certification and institutionalisation.[1] This emerging clientele allowed Dutch psychiatrists to expand their practice beyond the confines of the mental asylums and enlarge their professional standing. It was in the psychiatric setting of private practice and sanatoria for nervous sufferers that the first forms of psychotherapy were developed. Initially, these were largely didactic in nature: the doctor's personality exerted a strong moral influence on patients in order to strengthen their will-power and self-control. In 1887, the Dutch pioneers in this field, A.W. van Renterghem and F. van Eeden, established an institute for psychotherapy in Amsterdam that was geared towards the treatment of psychosomatic and nervous as well as psychological disorders. They practised hypnosis and suggestion and, later on, influenced by psychoanalysis, also applied talking-cure.

After the First World War, when psychoanalysis began to make headway, more psychiatrists began to focus on offering psychotherapeutic treatment in private practice. Their number must have been slight, though, given that the market for private psychotherapy was extremely small: only few individuals could pay for a lengthy and expensive analysis, assuming they already saw its usefulness and possessed the proper verbal and introspective skills. As a result, psychoanalytic therapy was necessarily elitist and exclusive.[2] As a theory, psychoanalysis received favourable attention from leading Dutch psychiatrists even before the First World War, but its institutionalisation was delayed by the various internal conflicts and rivalries that plagued the Dutch Association for Psychoanalysis, established in 1917. Disagreements on the proper interpretation of theoretical aspects and questions as to whether laypersons should be allowed to practise psychoanalysis, on whether future psychoanalysts as part of their training had to undergo analysis, and on who was qualified to train new analysts caused divisions within the Association. In the 1930s and 1940s, these conflicts even led to secessions. The arrival of foreign psychoanalysts, most of them refugees from Nazi Germany, also stirred up disputes, pitting nationally and internationally orientated analysts against each other. These antagonisms were resolved only in the post-war period. The Psychoanalytic Institute, established in Amsterdam in 1946, became the leading national centre for training and professional practice.

A second extramural domain in which Dutch psychiatrists were active during the first decades of the twentieth century was the fight against alcohol addiction.[3] In the wake of the emergence of a social movement against (excessive) alcohol consumption, which emphasised the social and moral aspects, the development of a medical-psychiatric approach and the foundation of some sanatoria signalled the beginning of individualised care for alcohol addicts. In 1909, the first counselling centre for alcohol abuse was established in Amsterdam, with psychiatrist K.H. Bouman as one of its initiators. By emphasising the centre's medical character, he sought to define this new health facility in contrast to the excessively moral effort of the temperance movement. Nevertheless, the centre's regime basically consisted of a form of moral re-education, aimed at building self-discipline and promoting social re-integration, with special attention for the

surveillance and rehabilitation of convicted alcoholics. Soon, other Dutch cities would establish similar provision.

In the 1910s, some psychiatrists began to advocate the necessity of social and psychiatric support for and supervision of the insane and mentally disturbed who were not yet or no longer hospitalised. This awareness of the significance of aftercare followed in the footsteps of various Dutch philanthropic associations, which were established – some as early as the mid-nineteenth century – to offer both material and social support for discharged patients. Yet the call by psychiatrists for pre- and aftercare facilities was also closely tied to the overcrowding of asylums and the growing costs of hospitalisation. Between 1884 and 1915, the number of institutionalised patients almost tripled, from about 4.800 to over 14.000.[4] The rising costs to local governments, who were financially responsible for the institutional care of the indigent, as stipulated by the Poor Relief Law, and increasing doubts about the effectiveness of hospitalisation caused both psychiatrists and government officials to look for alternative care options. The Amsterdam psychiatrist F.S. Meijers was instrumental in the birth of psychiatric pre- and aftercare in the Netherlands when in 1916, he established the city's outpatient service. It provided help to discharged mental patients, as well as to mentally ill, mentally retarded and other disabled individuals who had not (yet) been institutionalised. He also set up an association aimed at serving their social interests and promoting his social-psychiatric approach in other parts of the nation. By the 1920s and 1930s, psychiatrists, assisted by nurses, did consultations in some twenty Dutch towns and cities.[5]

In the 1920s, mental asylums also began to organise outpatient facilities to support discharged patients and prevent (re)admission by giving consultations, paying home visits, and providing social support. Some leading psychiatrists in this field argued that mental illness in itself constituted no sufficient cause for institutionalisation and that only patients whose behaviour was intolerable or dangerous needed to be certified as insane, and indeed be hospitalised.[6] The introduction in asylums of the new approach called 'active therapy', adopted from Germany, also reflected growing confidence in the possibility of making patients more responsible for their own behaviour. This didactic approach, geared towards the social rehabilitation of the mentally ill through work, opened up new opportunities to look after patients extramurally, for example in sheltered workshops. Some psychiatrists viewed its beneficial effects as evidence of the major influence of the social environment on the behaviour of the mentally ill.

To a large extent, the growth of pre- and aftercare in the Netherlands during the 1930s, when about half of the country’s thirty-nine mental institutions established such services, was advanced by the endeavour of local and provincial governments to cut down on their expenses for psychiatric patients.[7] In a decade marked by economic depression, they were faced with tighter budgets and taking care of psychiatric patients in society was seen as a less expensive solution than institutionalisation. The small-scale outpatient facilities were supervised by psychiatrists, who held office hours, but most of the work was carried out by nurses. They mobilised social support and paid home visits. However, given the uneven geographical spread of asylums and the religion-based identities of half of them, their outpatient facilities did not always operate effectively. In contrast to institutions that only admitted patients on a regional basis, many catered to patients from their own religious constituency (Catholic, orthodox Protestant, Dutch Reformed or Jewish) and these generally came from all over the country. Because of this

spread and the distances involved, it was difficult to realise effective pre- and aftercare. For this reason, some cities and provinces began to establish facilities that operated on a local or regional basis, more or less independently of the mental institutions.[8]

In Amsterdam, A. Querido, the director of Amsterdam's public outpatient service, developed a comprehensive social-psychiatric approach: psychiatrists and nurses held office hours, offered crisis intervention, visited patients at home, provided medication, looked for alternatives to hospitalisation, and served as intermediary in case of a person's institutionalisation. Querido, who (not quite correctly) advertised himself as the pioneer of social psychiatry in the Netherlands, claimed that his approach was successful, at least in the sense that the number of admissions stabilised.[9] Some other Dutch cities followed the example of Amsterdam, but most new pre- and aftercare facilities that operated autonomously were established on the basis of private and religious initiatives, as well as longer standing home nursing services. These received subsidies from provincial and local governments, who thus tried to justify a lowering of their subsidies to mental institutions. The two largest Social-Psychiatric Services, those of Amsterdam and Rotterdam, had a clientele of some 1.500 to 2.000 each year. But all the other services were fairly small, employing just one psychiatrist and a few nurses and serving not more than a few hundred patients at most.[10]

In the 1930s, pre- and aftercare was also designated as 'social psychiatry'. However, this term had a broader meaning, referring in a general way to a psychiatric approach to mental illness that focused on its social origins and backgrounds. In this interpretation, social psychiatry was closely linked with the psycho-hygienic goal of preventing mental disorders. In 1924, K.H. Bouman, Professor of Psychiatry in Amsterdam, took the initiative towards laying the groundwork for the Dutch mental hygiene movement.[11] Those involved included doctors, but also teachers, educational experts, sociologists, psychologists, criminologists, lawyers and social workers. Concerned about the perceived increase in mental and nervous disorders in modern society, they argued for a containment of it by preventive measures, an approach that had proven effective in the fight against epidemics and contagious diseases. The professional domain they claimed stretched from the care for socially disabled, mentally retarded, psychopathic and insane individuals to the treatment of minor psychological flaws and behavioural problems of basically healthy people. It covered family-life, procreation, sexuality, education, alcoholism, crime and leisure activities. For inspiration, this movement looked in particular to eugenics and education. The theory of heredity and the interventions in the field of procreation that were based on it, supposedly offered opportunities for preventing mental defects. A new branch of medical pedagogy targeted 'abnormal' and 'retarded' children and sought to provide for early treatment and special educational programmes, so as to limit the occurrence of mental disorders among them at a later age.

The underlying reasoning of psycho-hygienists was rooted in a more broadly shared cultural pessimism about the assumed harmful effects of the modernisation process, as well as in an optimistic belief in the potential of science to solve them. In addition to heredity, they viewed society's rapid changes and mounting complexity as a major cause of the presumed increase in mental and nervous disorders. An increasing number of people would have trouble keeping up with the rapid technological advances and high-paced lifestyle of urbanised and industrialised society. From the late nineteenth

century, a wide array of problems, including illness, poverty, poor housing, unemployment, bad labour conditions, neglected children, crime, immoral conduct and educational disadvantages, had given rise to a broadly shared social activism, aimed at improving the living conditions of the lower classes and 'civilising' them. These efforts had been initiated by the liberal bourgeoisie, but since the turn of the century, they became entangled with both religious and socialist politics, aimed at furthering the social emancipation of their constituencies. As political and social democratisation progressed, it seemed all the more essential to improve the overall population morally. Responsible citizenship required self-control, a sense of duty and a sense of community.[12] With their particular understanding of 'public mental health', the leading psycho-hygienists closely aligned themselves with the paradigm of an orderly mass society that was based on the adaptation of the individual to nationally shared civil norms and values.

In addition to moral-didactic activism, professional interests equally played a role in the emergence of the mental hygiene movement. Psychiatrists, educators, and eugenicists turned to psycho-hygiene to forge a professional alliance and legitimise or enlarge their professional domains.[13] Confronted with overpopulation, financial shortages and the low improvement rates of mental asylums, psychiatrists tried to extend their professional competence by focusing on society. Experts in special education, teachers and school medical officers concerned with abnormal children used mental hygiene to promote the medical status of their new area of expertise. While advocates of eugenics considered mental hygiene a potentially helpful notion for spreading their doctrine, psychiatrists and remedial education experts referred to the significance of genetics so as to give their concern for mental hygiene a scientific outlook.

Despite their ambitions, the psycho-hygienists did not establish a strong or broad movement. It is possible to single out three major reasons for this failure.[14] First, psychiatrists who were interested in psychological approaches to mental disorders, influenced by psychoanalysis and phenomenology, mainly kept apart, because mental hygiene was defined either as a form of social psychiatry or as a branch of biomedical psychiatry, with an emphasis on heredity. Second, mental hygiene and eugenics proved hard to combine into one approach. Some eugenicists rejected the social-psychiatric objective of keeping the mentally ill as much as possible in society, because they believed the mentally ill should not procreate, and apart from sterilisation, social isolation by means of institutionalisation provided the best guarantee for this. When it came to implementing concrete measures like sterilisation and forced isolation, however, many social psychiatrists proved rather sceptical of eugenics. In both social psychiatry and in the mental hygiene movement as a whole, confidence in the possibility of reforming human beings, which in the Netherlands was strongly rooted in the tradition of moral education and social work, won out over biological determinism. Furthermore, Catholics and orthodox Protestants, whose views could not be ignored given the prominent social and political role of religious denominations in the Netherlands, also believed eugenics to be at odds with Christian principles.[15] Third, in a more general way Christian groups were hesitant about a neutral mental health movement based only on scientific principles. Its domain comprised education, marriage, family and sexuality, and, as such, was closely intertwined with core religious values. Therefore, in the early 1930s, they established their own organisations in these areas based on Catholic, Dutch Reformed

and orthodox Protestant views respectively.[16] This fully fitted the increasingly 'pillarised' structure of Dutch society, its segmentation along religious-ideological lines.

The first initiative of the neutral mental hygiene movement failed, then, mainly because of professional and religious rivalries, but it received a new impulse from outside the psychiatric world. In 1928, on the initiative of E.C. Lekkerkerker, a lawyer, the first Dutch Child Guidance Clinic, geared towards troubled children and young delinquents, was established in Amsterdam, followed by five more clinics in the 1930s. This new type of facility, although staffed by psychiatrists and psychiatric social workers, was rooted not so much in medical psychiatry but in the judicial domain, child welfare organisations and the educational system. Stressing the hygienic aim of prevention, Lekkerkerker and her associates claimed that the effort should focus in particular on maladjusted behaviour of children and that therefore, ordinary families were the main targets of intervention. They distanced themselves from the institutional care of the insane, so as to avoid scaring off parents and educators, as well as from the moralistic and repressive approach that was the prevailing pedagogical response at the time. Applying insights and methods from psychology, social work and psychiatry, the staff of the Child Guidance Clinics defined problems in psychological and especially psychoanalytic terms. Much emphasis was put on 'becoming aware' of problems and making them into a topic of discussion. Treatment applied not only to the child's mental condition, but also to its parents' attitudes.

If the first Dutch initiative in the area of psycho-hygiene was tied directly to the problems of mental asylums and largely based on eugenics and German social-psychiatric models, the Child Guidance Clinic model was adopted from the United States. The American mental hygiene movement had changed its focus from the reform of institutional psychiatry and the prevention of mental disorders with adults to the treatment of children and their families on the basis of psychological insights. Because of Lekkerkerker's input and the participation of several leading Dutch psycho-hygienists in the First International Congress on Mental hygiene in Washington in 1930, the Dutch movement increasingly tended towards the American model. This caused a much more autonomous development of mental health care, disconnected from the institutional care of the insane and, to a lesser extent, also from pre- and aftercare.[17] Psychiatrists who wanted to open up the closed asylum system by integrating institutional and social-psychiatric care into the broader field of mental health, failed to realise their goal, also because of financial policies. Whereas the mental asylums, which were not funded and administered as health care but on the basis of the poor relief system and the judicial requirements of institutionalisation, were co-ordinated by the Ministry of Domestic Affairs, mental hygiene facilities fell under the aegis of the health section of the Ministry of Social Affairs. A new umbrella organisation, the National Federation for Mental Health, was established in 1934 to maintain contacts with the health section of the Ministry of Social Affairs and distribute public health funds aimed at prevention. In part because of Lekkerkerker's influence, most funding went to the Child Guidance Clinics, while most pre-care and aftercare facilities were excluded because they were the responsibility of the Ministry of Domestic Affairs as part of its monitoring task regarding the care of the insane. Many psychiatrists felt that Lekkerkerker's concept of prevention was an overly one-sided interpretation of mental hygiene and basically left the insane out in the cold. On the eve of the Second World War, the competing views on what belonged

to psycho-hygiene and what did not caused a split between institutional psychiatry and extramural mental health care, whereas pre- and aftercare uneasily hovered in between.

Growth and Professionalisation (1940-1965)

During and after the war, the National Federation for Mental Health undertook several major efforts aimed at reorganising the fragmented Dutch mental health care system. In addition to proposing more governmental supervision and funding, some psychiatrists favoured a closer link between institutional and outpatient care as well as more collaboration among the various extramural facilities. Apart from the existing Pre- and Aftercare Services and Child Guidance Clinics, two separate Institutes for Psychotherapy and a growing number of Centres for Marriage and Family problems was set up in the 1940s.[18] Some psychiatrists strongly advocated an integrated mental health care system, in which social psychiatry would play a pivotal role as an intermediate between the mental asylums and psycho-hygienic provisions. Others, however, rejected such proposals: they favoured a strict separation between intramural psychiatry and extramural mental health care, not just because of the stigma associated with the mentally ill, but also because in their opinion, psycho-hygiene comprised much more than just medical psychiatry.

The 1948 international meeting of the World Federation of Mental Health in London, much like the 1930 Washington conference, provided a major incentive for the Dutch psycho-hygienic movement. The notion 'mental health' replaced 'mental hygiene', underscoring that not only the prevention and treatment of mental problems mattered, but also that it was important to ensure maximal health and general well-being for all citizens. The National Federation for Mental Health focused on developments in Great-Britain and America, where various psychosocial approaches were providing alternatives to the medical-psychiatric view. In extramural mental health care the biomedical perspective was now superseded by the view that education and environment (especially family life) constituted the main factors in the aetiology of psychological disorders. Even more strongly than before, emphasis was put on the need for a multidisciplinary approach by teams of various professional groups: psychiatrists, psychologists, educators, psychiatric social workers, and social-psychiatric nurses. In particular, the psychoanalytic model, which was already central in Child Guidance Clinics, became more prominent, even though the most common form of treatment in outpatient services was more akin to social casework and counselling. Although many of the post-war reform proposals proved unproductive, from the late 1940s on, mental health care provisions expanded, received more government funding and saw increased professionalisation. Worries about social disruption and moral decay in the wake of the German occupation, followed by concern about the harmful psychological effects of economic and social modernisation, gave psycho-hygienists a strong argument in support of their cause. They argued that many people were unable to cope with social pressure and change, mainly because of individual shortcomings, behavioural defects, and difficulties with personal relationships; these were treatable and could thus be prevented from degenerating into more serious mental disorders.

In 1940, just after the beginning of the German occupation, the first public facility for psychotherapy was established in Amsterdam: the Institute for Medical

Psychotherapy. It was geared towards those who were suffering mentally from exposure to the war's violence. After the war, the psychiatrists who staffed this institute described the common occurrence of neuroses and the loss of a sense of security in a rapidly changing society as reasons for legitimising psychotherapy. Among the Institute's staff, a split developed between those who favoured classical psychoanalysis, aimed at providing insight, and those who favoured shorter, didactic forms of treatment, geared towards solving concrete problems. The latter group won out, in part because of the institute's public funding, but also because the Psychoanalytic Institute, established in 1946, specialised in psychoanalytic therapy. Until the 1960s, these two Amsterdam-based facilities, together with one that was set up in Utrecht in 1954, were the only psychotherapeutic institutes in the Netherlands. Their annual number of clients rarely exceeded a few hundred.[19] The total clientele of psychotherapy did increase until the second half of the 1960s and in the 1970s, when more institutes were established in other Dutch cities. In addition to the limited funding opportunities, the public's lack of familiarity with psychotherapy curbed its growth. Initially, it was unclear to many what kind of problems these institutes actually addressed and who was eligible for treatment. Few people were familiar with the therapists' specific expectations and mode of interpretation. What is more, psychotherapy itself invited selection on the basis of rather specific personal aptitudes, such as being introspective, the ability to verbalise, and a willingness to reveal one's inner life in front of a stranger.[20]

In addition to the public's limited familiarity with psychotherapy, several concrete forms of resistance in Christian circles obstructed its spread. Catholics in particular, viewed therapy as a threat to Roman ethics. Around 1950, psychotherapy and psychoanalysis were the main issue in conflicts between clergy and conservative doctors on the one hand and some psychiatrists and psychologists on the other. These antagonisms reflected a struggle about expertise between the established moral and medical authorities and the psycho-hygienic newcomers, who began to challenge Catholicism's rigid sexual morality. The latter claimed that people's sexual health and emotional balance were better protected by psychological guidance than by the Church's moral preaching and sanctions. Despite religious resistance against psychotherapy, some priests and ministers began to be interested in psychotherapeutic insights and techniques, and they used these new views to improve their own spiritual care practice. In both Protestant and Catholic circles, study groups were established in which clergy and mental health professionals reflected together on how to bridge the gap between Christian faith and the insights of psychology and psychiatry. The gist of these discussions was that clergymen ought to have more concern for people's individual circumstances, their psychological barriers, and their personal conscience, so that religious morality became easier to live with. In this sense, psychotherapeutic insights were considered to be helpful in their work. From the late 1950s, both Protestant and Catholic clergymen began to be concerned with acquiring psychological knowledge and skills. Especially, Rogers' non-directive counselling method was seen as useful for renewing pastoral care by shifting the balance from dictating and moralising toward understanding and empathy. In this way, around 1960, some leading Catholic and Protestant psychiatrists and clergymen openly advocated a new approach to marriage, birth control, sexuality, and homosexuality, stressing acceptance, tolerance and individual responsibility. Genuine moral conduct could not be imposed from outside or above, they argued, but was a product of inner reflection and conviction.[21]

Whereas the specialised psychotherapeutic institutes remained small and limited in number until the 1970s, the Child Guidance Clinics and Centres for Family and Marriage Problems, which focused on psychosocial (especially relational and family) problems, saw a substantial growth.[22] They employed psychiatrists with psychotherapeutic expertise as well as other doctors, psychologists, educators and social workers, their approach being largely based on social work and simple psychological methods such as counselling. The psychiatric social worker gradually turned into the key figure of both organisations. Frequently she was not only responsible for managing daily affairs, but also took charge of the intake of new clients and also began to play a role in their treatment. Psychiatric social workers – all female – were social workers trained in both social casework and mental health care. The rise of this specialisation was closely linked with the professionalisation of social work, whereby new methods designed in the United States replaced older approaches that were mainly tied to the traditions of philanthropy, poor relief, and moral edification. Social casework was meant to improve not only clients' social adaptation, but also their sense of autonomy and self-reliance. The reasoning was that their proper social functioning was obstructed by their psychological shortcomings rather than by their immorality. The social worker had to approach them with an open mind and avoid a moralising stance. It was crucial to observe and listen to clients carefully, build a relationship of trust with them and encourage them to face up to the motives underlying their behaviour. The casework method relied on conversational techniques and psychological interpretation and aimed at solving clients' problems by talking about them, improving their self-knowledge and self-awareness, and bringing about changes in the way they related to their partners, children and others. As with the application of psychotherapy, mental health workers in Catholic Centres for Family and Marriage Problems met with resistance from clergy members and general practitioners, who saw this innovation as a threat to their own authority in family matters. In particular the plea of psychiatrists and psychologists for a more flexible way of dealing with birth control caused fierce polemics. The pivotal element of the new conjugal and sexual ethics they propagated in the 1950s and 1960s was the forming of healthy personal relationships. The mistrust in religious circles regarding their approach disappeared in the 1960s, mainly because many doctors and clergy members liberalised their views on marriage and sexuality. The differences between the Catholic centres and the neutral, humanist, and Protestant equivalents, where the psychological mode of treatment was accepted earlier, had basically faded. The care providers looked for the causes of marital and family problems in relational difficulties, which on the basis of psychoanalytic notions were traced back to the personality structure of those involved. To solve the problems of clients it was necessary for them to express their emotions and become aware of their behaviour, attitudes, motivations and feelings.

A psychological perspective and the use of psychotherapeutic techniques set the tone in Child Guidance Clinics, Centres for Marriage and Family Problems and Institutes for Psychotherapy. To be eligible for treatment, clients were expected to have some capacity for introspection, verbal talent, initiative and willingness to change, which automatically excluded the mentally ill and other 'troublesome' clients – such as alcohol addicts and later, drug addicts. The Pre- and Aftercare Services, which barely survived the war but were restored in the late 1940s, failed to win a solid footing in this new extramural mental health care network, although they employed more psychiatrists and

served more patients than the other facilities and almost all of them had broken away from the mental institutions. Whereas other outpatient facilities were financed by the national health care Prevention Fund, social psychiatry was dependent on support from local and provincial governments, which only provided money obtained after cutbacks in their financial contributions to the mental institutions. Not until 1961, when the pre- and aftercare facilities were officially renamed as Social-Psychiatric Services, was their funding formally regulated on a national basis.

On the other side, neither was there a close relationship between social and institutional psychiatry. Because of the uneven regional spread of mental hospitals, many of which admitted patients from their own religious constituency from all over the country, the psychiatric hospitals gradually gave up organising outpatient services themselves, although many institutional psychiatrists worked part-time for them. Nearly all Social-Psychiatric Services operated largely autonomously and their size and quality varied substantially. The public facilities in some large cities were best equipped, whereas the provincial services, found in less densely populated regions, tended to be small. Usually the latter employed just one part-time psychiatrist, not specially trained for the job, and a few full-time social psychiatric nurses.

Social psychiatry held little prestige among psychiatrists, mainly because of the high pressure of work and the irregular shifts, and also because often they were not allowed to give patients medical treatment to avoid competition with other doctors. In many ways, in fact, social psychiatry was social work rather than medicine. Because universities devoted little attention to this branch of psychiatry, it hardly attained any academic status. In actual practice, much of the work required mainly pragmatism and a talent for improvisation.[23] Psychiatrists held office hours and the social-psychiatric nurses, as the key players, either paid home visits or provided help to clients in collaboration with other care-providing facilities and social institutions. The Social-Psychiatric Services not only catered to people with serious psychiatric symptoms, but also the mentally retarded, demented elderly, epileptics, alcoholics, and 'psychopathic' delinquents on probation. For some patients, who had been discharged from the hospital but could not live on their own, halfway houses were set up. From the 1950s, the introduction of new psychopharmacological drugs, which allowed more patients to be treated at home, contributed to the growth of these services.[24] Also, in the 1960s, when psychologists began to work in this field, family and group therapy was introduced.

The Counselling Centres for Alcohol Addiction, which expanded their activities in the late 1960s to include drug addiction, played a rather marginal role in the mental health care system. Previously medical-psychiatric views had replaced socially and morally inspired approaches to alcohol addiction, at least in theory, but few services were able to put the new views into practice. Because of a shortage of psychiatrists, their lack of interest in this problem, and the centres' major role in the rehabilitation of delinquents, social workers gained the upper hand, which meant that the social aspects of addiction continued to receive most attention. The medical orientation mainly served strategic goals, associated with the facilities' recognition and acquisition of public health funds. In the 1960s, however, the medical model lost ground to psychosocial approaches.

Heyday and Integration (1965-1980)

In the view of many mental health experts, the structural changes in post-war everyday life in the Netherlands, caused by industrialisation and urbanisation, threatened both the mental stability of individuals and the overall social cohesiveness, which is why countermeasures were called for. Initially, they stressed the significance of collective morality, discipline and regenerating people's spiritual life. But in the course of the 1950s their attitude towards social-economic modernisation changed. Accepting it as inevitable, they began to underline the urgency of enhancing the resilience and psychological attitudes that people needed to function properly in a changing society. Their task was, so psycho-hygienists believed, to prepare people for the dynamic of modern life. They advocated an individualising and psychologising perspective, in which people's inner orientation became centre-stage. It was the individual's task to develop into a 'personality' and to achieve a certain measure of inner autonomy regarding the outside world. Individuals were expected to follow their own convictions, but also to do this in line with social expectations involving a morally responsible mode of life. The internalisation of social norms and values in an autonomous self was crucial. The mentally healthy were not those who uncritically subjected themselves to rules and regulations, but those who were independent, conscientious and responsible – who knew how to take decisions on their own, strove for optimal self-development and thoughtfully adapted to social change. Therefore, constant reflection on individual conduct and motivation was called for, so as to find the right balance between guidance and supervision on the one hand, and autonomy and individual freedom on the other.[25]

Although mental health experts pointed to the significance of social factors in the emergence of individual problems, they did not go so far as to claim that these were caused by society. Mental health care in the 1950s and early 1960s was geared towards individual shortcomings and it looked for a solution to them in changes in personality and psychological functioning. However, during the 1960s, mental health workers increasingly voiced self-criticism. The number of those among them with training in the behavioural sciences and sociology grew and their attention was increasingly geared towards the social wrongs that supposedly led to psychological difficulties. Fuelled by the protest movement of the sixties and anti-psychiatry, both of which rejected people's adaptation to the existing social order, the very foundation of mental health care, individual treatment, became subject to debate. It was argued that the causes of problems should not be looked for in the psyche of the individual or their defective social integration, but in the 'social structures' that caused intolerable situations.[26] People needed to be liberated from the unnecessary restrictions imposed by society, and the realisation of this objective seemed more dependent on social welfare work and political activism than on mental health care. Also, clients began to protest about what they saw as undemocratic relationships and a structural absence of their own voice in the care providing system.

The fierce debates in the 1960s about the unfavourable effects of society on individuals, which became fused with the anti-psychiatry movement's critique of the medical institutionalisation and treatment of the mentally ill, once more accentuated the contrast between intramural psychiatry and extramural mental health care. Despite the new therapeutic energy in mental hospitals after the introduction of psycho-tropic drugs and socio-therapy and the significantly enhanced quality of care as a result of more funding, institutional psychiatry's reputation hardly improved. On the contrary, the anti-

psychiatry movement caused its public image actually to deteriorate, not so much because of the absence of sufficient medical forms of treatment, which had hampered psychiatric hospitals before the 1950s, but precisely because of the dominance of the medical regime. Anti-psychiatry aimed its shots at clinical psychiatry rather than mental health care as such. It argued for its improvement, that is a de-medicalised psychiatry in the community, much in the way as in the outpatient sector, which since the 1930s had repeatedly distanced itself from medical psychiatry and since the 1950s had largely a psychosocial orientation. Mental health workers, many of whom had not a medical background but a psychological or sociological one, embraced some of anti-psychiatry's basic principles. Ultimately, the sixties' movement and anti-psychiatry led to more mental health services: supported by the expanding and generous welfare state, psychosocial and psychotherapeutic facilities increased in both size and number throughout the 1970s.[27] Furthermore, psychiatric hospitals and psychiatric departments of general hospitals also began to offer extramural treatment in a growing number of outpatient clinics. In the early 1970s, the number of clients in extramural facilities surpassed the number of admissions to psychiatric hospitals. Essentially, though, this eventful era constituted no break in the basic development of twentieth-century mental health care in the Netherlands. Dissatisfaction with psychiatry as practised in mental institutions as well as the unacknowledged impotence to treat serious and chronic mental illness prompted the expansion of extramural mental health care, which attracted new groups of clients.

While engaging in heated debates on the political implications of their work, mental health professionals widened their domain to include the welfare sector that experienced enormous growth in the 1970s. Now that the welfare state guaranteed material security, the solution to immaterial needs came into focus; consequently, mental health experts and social workers began to count on the government's approval as well as its financial support. In the course of the 1970s, a comparatively generous system of collective funding was put in place, which allowed the expansion of mental health care and promoted its accessibility. As the scale of its services grew, the number of care providers and their professional diversity increased correspondingly. In the 1940s and 1950s, psychiatrists, psychiatric social workers, and social-psychiatric nurses dominated the field. From the 1960s, they began to be confronted with a growing number of social and clinical psychologists, specialised psychotherapists, social workers, sociologists and educational experts. Both psychiatrists and other mental health experts appeared as inspired advocates of personal liberation in the areas of religion, morality, relationships, sexuality, education, work and drugs. They advocated the emancipation of women, the young, the lower classes, traumatised war victims and other disadvantaged groups such as homosexuals and ethnic minorities. Influenced by the welfare ideology, the objective of prevention received a boost and also a broader interpretation. Many mental health workers were not so much involved in the treatment of the mentally ill, but they rather focused on the improvement of people's psychosocial welfare, their self-development opportunities, social participation, and assertiveness. Their clients had to 'liberate' themselves from fixed traditions and conventions and become autonomous and emancipated.

The 1970s constituted the heyday of psychotherapy in the Netherlands. It was practised by psychiatrists, psychologists and social workers alike, and in the public mind,

constituted the *pars pro toto* of mental health care. The Dutch Association for Psychotherapy and the psychotherapeutic institutes played a crucial role in its development into a separate, interdisciplinary profession that in the middle of the 1980s achieved formal governmental recognition. Not only did the number and size of the psychotherapeutic institutes grow, but various psychotherapeutic approaches were also applied in other outpatient facilities and private practice. More and more people began to consider it appropriate to seek psychotherapeutic help for all sorts of discomforts. Simply by virtue of their engaging in therapy, both clients and therapists viewed themselves as members of a cultural avant-garde: psychotherapy would liberate individuals from unnecessary inhibitions and provide them with opportunities for self-discovery, self-confidence and personal growth. The humanist ego-psychology, which began to replace psychoanalysis, constituted a major source of inspiration. Most clients had a middle-class background and tended to be young, well-educated, non-churchgoing and either studying or professionally active in service-sectors such as health care, social work and education.[28] What drove many of them to knock on the psychotherapist's door were concerns situated on the intersection of individual experience and changing social conditions: problems with social contacts, personal relationships, and sexuality, but also complaints associated with nervousness, obsessions, feelings of fear or aggression and psychosomatic disorders. Confronted with the new and much more liberal social and personal ideals of the 1960s and 1970s, not everyone succeeded in bringing these into line with their own views, attitudes and feelings. At the individual level, more opportunities for being autonomous and independent and having more options could cause confusion and uncertainty. Problems arose especially for those who had trouble bridging the gap between the new liberties and their old ways of thinking, feeling and behaving.[29]

The strong growth of psychosocial care during the 1970s - psychotherapy in particular - reflected a 'psychologisation of everyday life' that influenced the personal lives of ever more people: a change of mentality prompted by a combination of growing individualisation, internalisation and recognition of emotions.[30] From the 1960s, individual character traits and one's self-chosen lifestyle began to replace more traditional identity-providing structures like family background, class, property, profession and religion. Fixed conventions and rules of conduct that were linked with formalised and hierarchical social relations gradually began to lose their significance. People's conduct was increasingly a reflection of personal wishes, inner motives and feelings. Yet at the same time, increased equality also forced people to reckon more with others and, paradoxically perhaps, show more restraint in social interactions. As the authority of explicit rules and formal conventions eroded and individual social conduct became less predictable, the significance of self-regulation, subtle negotiation and mutual consent grew accordingly. To find the proper balance between assertiveness and compliance, people needed social skills, empathy, self-knowledge and an inner, self-directed regulation of emotions and actions. Thus, the interactions between people and the ways in which they evaluated each other became determined more and more by psychological insight. The less coercion and interference from outside, the more they were expected to know how to guide themselves and find their own way, and the more troubled they were in the event of failing to do so. The higher the expectations regarding the individual's pursuit of self-development, the larger the disillusion if this pursuit turned out to generate few rewards or even failure.

People were given more space than before to fashion their life according to their own views and fulfil their personal wishes, without having to bother with sanctions or moral restrictions. But if they failed, they could only blame it on themselves.

Although the Social-Psychiatric Services and Counselling Centres for Alcohol and Drugs also expanded as a result of more lavish funding and a growing number and variety of professional workers, they were more or less forced on the defensive vis-à-vis other mental health care facilities. This could be seen in the prolonged debates about their merging into Regional Institutes for Ambulatory Mental Health Care (RIAGG), modelled after the American Community Mental Health Centres.[31] The serious overhaul of the Dutch extramural sector, initiated in the 1970s partly by the national government, was aimed at forging a more coherent ensemble of all the various therapies, approaches, target groups and ideologically divided facilities. However, mental health workers were deeply divided as to what course the planned system should embark on. The Institutes for Psychotherapy, the Centres for Family and Marriage Problems and the Child Guidance Clinics all distanced themselves (again) from care providing for psychiatric patients as well as alcohol and drug addicts, and emphasised their identity as welfare facilities with a psychotherapeutic orientation.[32] Workers in social psychiatry and outpatient clinics for addicts, on the other hand, feared that their patients would receive less attention in a new organisation that mainly focused on approachable and treatable clients and that kept the chronic, serious mentally ill and unmanageable addicts at bay. In their view, the new system would allow - if not cause - 'difficult' cases to slip through the net. The city-run Social-Psychiatric Services in large urban areas resisted their integration into the new system until the very end, fearing that the accessibility or public character of social and emergency psychiatry, which was their main function, would suffer. They mainly provided care to groups that were hard to approach, such as the homeless, who had physical and social problems in addition to psychiatric ones, who generally did not ask for help on their own initiative and were shut out from other forms of care, but did cause trouble and social inconvenience. Eventually, the social-psychiatric facilities, in contrast to the outpatient clinics for alcohol and drug addicts, merged into the RIAGG system, which was fully operative by 1983.[33]

The two key factors that triggered the emergence of the RIAGG were pressure from the government, which wanted to reinforce the extramural sector as a counterbalance against institutional psychiatry, and the growing need to control rising costs: the economic crisis in the second half of the 1970s put an end to the unbridled growth of the preceding years. The new system, which comprised divergent forms of care providing and mental health professions, aimed at a broad spectrum of problems, from personal existential problems to mental suffering and serious psychiatric disorders, and engaged in a range of activities – including social-psychiatric care, psychotherapeutic treatment, counselling, prevention, advice and emergency psychiatry. With almost sixty facilities the RIAGG system had a regional basis, well spread throughout the country and each covering a catchment area of between 150.000 and 300.000 residents.

Consolidation and Reorientation (1980-2000)

In spite of the crisis of the welfare state and the downsizing of social work from the late 1970s, outpatient mental health care saw further expansion in subsequent years. Three

reasons account for the fact that mental health workers kept their professional field intact, while welfare workers failed to do so. First, the mental health sector was now paid for by collective medical insurance and thus it had grown entirely independent of funding that was tied to collective social services. Second, further growth of the extramural sector was stimulated by the ongoing effort to push back institutional psychiatry and develop community care; in the 1980s and 1990s, this was a governmental priority. Third, the mental health sector managed to adapt better to changing social circumstances, notably the de-politicisation of social issues, coupled with ongoing individualisation. New cultural values like professionalism, efficiency and rationalisation took the place of the lofty ideals of the sixties movement that had defined politicised social work. Increased attention to free market forces and people's own sense of responsibility went hand in hand with the development of a more formal, legally based relationship between client and care provider, while specific rights and responsibilities were fixed into laws, rules and procedures.

In part because of cutbacks in government spending and the larger role of the market, the issue of costs and benefits began to weigh heavily in the 1980s, as well as the issue of who was eligible for care and who was not. Immediately after the RIAGG was created, in fact, several critics already argued that it was geared towards the wrong clientele, that is individuals with minor psychosocial problems and psychological disorders, a group that constituted the target group of psychotherapists. But mental health care, some claimed, had to concentrate on marginal groups that were not so pleasant to deal with, but that really were in need of care: those who suffered from serious and chronic mental disorders that were hard to treat and those with serious behavioural problems, who were troublesome and potentially aggressive. In the previous decades, these patient categories had been rather neglected by the leading outpatient facilities because they did not fit their therapeutic optimism. Now, social psychiatry, which in the Dutch extramural sector had always been sizeable but never prominent, would have to become a priority.

In the 1980s and 1990s, the government repeatedly argued the need of shifting attention away from those with minor afflictions to those with serious disorders, not only to control the increasing demand for mental health care, but also in order to reduce admissions to psychiatric hospitals. From the 1970s on, the isolation of these hospitals was broken down and their size reduced, while outpatient and halfway facilities, such as sheltered housing, expanded. Increasingly, psychiatric patients were living outside treatment facilities, so as to advance their social integration, while the number of long-term admissions significantly dropped. Only people with serious psychiatric problems who were unable to get by in society on their own without hurting others or themselves would be eligible for (temporary) hospital care. All other psychiatric patients, including those with chronic disorders, should receive the help they needed from extramural provisions, which included – apart from the RIAGG system – domiciliary care, day care, crisis intervention, mobile psychiatric task forces, outpatient psychiatric clinics and special shelter and housing projects.[34]

This policy, which prioritised social psychiatry, was (again) partly motivated by financial concerns, as outpatient care was supposed to be cheaper than hospitalisation, but it also echoed some of the ideals of the anti-psychiatry movement: the need to counter the social isolation of psychiatric patients, improve their autonomy, and respect their civil

rights. The government's mental health policies of the 1980s and 1990s, described as 'socialisation', moved away from the historically developed constellation of Dutch mental health care, which ever since the 1930s had been marked by a division between institutional psychiatry and the outpatient facilities. The socialisation of mental health care required collaboration between extra- and intramural facilities, as well as between the mental health sector and adjacent ones such as social welfare, care of drug and alcohol addicts, special housing and the justice system. In the late 1990s, to improve co-operation between psychiatric hospitals and the RIAGGs in particular, the government pressured these organisations to merge at a regional level. Both the outpatient facilities and the psychiatric hospitals were increasingly replaced as separate organisations by so-called 'care circuits' and 'multifunctional units' for specific categories of patients and 'case-management' for individuals. These would represent a coherent system of intra- and extramural as well as halfway services tuned to specific care demands. This signified the emergence of a new organisational principle in mental health care. Its basic tenet was no longer the supply of care by a number of separate institutions, but meeting the constantly changing tasks and functions that have to be performed for various client groups.

This recent change in the government's dominant mental health policy, however, should not obscure the high level of continuity in the development of the Dutch mental health care sector. First, contrary to the United States, Great Britain and Italy, large-scale, radical de-institutionalisation did not happen. Despite protests, new psychiatric hospitals, aimed at downscaling and a more even regional spread, were built. After a small reduction in the number of beds in psychiatric hospitals in the years 1975-1985, this number slightly grew in the ensuing decade.[35] Polarisation and a radical break were averted by gradually integrating new practices in existing institutional frameworks. Second, in light of the government's persistent effort to shift attention away from psychosocial problems and towards psychiatric disorders, it is questionable to what degree this shift was in fact realised. The prevailing approach of the RIAGG network basically followed the one established earlier by the Child Guidance Clinics, Centres for Family and Marriage Problems, and Institutes for Psychotherapy. They focused on psychosocial problems and psychotherapeutic treatment, which their staff seemed to value more highly than medical and social-psychiatric activities. Although the 1970s euphoria about psychotherapy diminished, while the biomedical approach gained ground, the number of people who received psychotherapeutic treatment doubled in the 1980s and 1990s, funding continued to facilitate broad accessibility, and the number of psychotherapists also increased. The RIAGGs, like the psychiatric outpatient clinics, continued to treat many individuals with more or less serious psychosocial problems.[36] Only as the 1990s evolved, did they begin to give priority to more serious psychiatric disorders and to their social-psychiatric responsibilities.

By the 1990s psychotherapy had basically lost its special appeal in the Netherlands. Its discourse had become an integral part of mainstream life, where – in its popularised form as 'psycho talk' – it influenced the actions and thinking of ever more individuals. If in the 1960s and 1970s the preoccupation with personal feelings and inner emotions was mainly found among young, urban and well-educated groups, while the articulation of these concerns was largely restricted to the therapeutic setting, by the end of the century psychotherapy's popular status was obvious. It was more common for people to talk about others or themselves in psychological terms and to refer to their

mood or feeling as a way to legitimate their behaviour. Although in mental health care medication and behavioural therapy have meanwhile become more prominent at the expense of psychological approaches, the psychotherapeutic frame of mind has permeated both private and public spheres. Promoted in mass media and self-help books and by all sorts of therapists, trainers, advisors and consultants, psychotherapeutic jargon has fully become part of everyday language – albeit in a watered-down version.

In the context of the dichotomy between minor psychosocial complaints and serious psychiatric illness, the coverage and accessibility of the mental health sector continued to be an issue of debate. In response to the pleas of politicians and some psychiatrists to discourage the growing demand for mental health care, others argued that this sector, in contrast to somatic medicine, still hardly received its due share, so a further expansion could well be justified. Either way, between 1980 and 2000 the growth of the mental health sector was explosive. The total number of individual registrations – which is not the same as the number of individual clients as some of them may register several times or at different facilities – increased from 2,66 per cent of the population in 1980 to 6,92 per cent in 1997, or from an annual total of some 380.000 to over a million. In the mid-1990s, about five per cent of the Dutch population, or between 700.000 and 750.000 people, who suffered from a wide range of serious and mild psychological disorders and complaints, came into contact with the mental health care system, while four per cent was actually accepted for treatment. The large majority of them, around eighty per cent, was treated in outpatient facilities, the RIAGGs in particular.[37]

Under the influence of the ongoing expansion of care use and prognostic data that even suggested a further acceleration, in the 1990s the concern with the social dimension of psychic disorders and their possible prevention grew, whereby a familiar cultural pessimism resurfaced. The supposed increase of mental problems was seen as effected by the high pace and intensity of social change, social atomisation, the loss of cohesive and normative frameworks, and the excessively high demands made on people in terms of their flexibility, social skills and mental resilience. The optimistic view espoused by many mental health workers in the 1970s, in which emancipated and motivated individuals would be able to solve their own problems, was replaced with concern about the loss of public morals and a sense of community. Furthermore, the positive evaluation of self-determination began to be questioned, since it allowed deranged individuals to refuse psychiatric treatment, even if they could not take care of themselves or caused social trouble. Pleas for more pressure and coercion in social-psychiatric care and for new experiments in special outreaching services for those in particular problem groups who were unwilling to co-operate or hard to reach, put earlier ideals of individual liberation and self-development into perspective.[38]

Dutch Outpatient Psychiatry and Mental Health Care: Basic Characteristics and Trends

The first forms of outpatient psychiatry in the Netherlands took shape around 1900, when nerve doctors catered to private patients who wanted to avoid any association with insanity or the asylum. By contrast, the initiatives of the 1920s in the area of pre- and aftercare were closely bound up with the mental institutions and shared their problems. This new form of care was an effort to break away from the closed-off tradition of

institutional psychiatry and renew it. In the 1930s, the psycho-hygienic movement embarked on a different course, which in time would become the dominant one. First the Child Guidance Clinic began to distance itself from institutional psychiatry by stressing that its clients had little to do with the mentally ill. After World War Two, the Child Guidance Clinics, the Centres for Family and Marriage Problems, and, from the 1960s on, the Institutes for Medical or Multidisciplinary Psychotherapy set the tone in outpatient mental health care, while social psychiatry and the Counselling Centres for Alcohol Addiction were pushed into the background. In the 1980s social psychiatry was formally integrated into the new network of RIAGGs, but the persistent critique that this system neglected psychiatric patients with serious disorders indicate that the split between hospitals and outpatient care was still a major factor. The latest developments, pressured by government policies, suggest that, finally, the public mental health sector will become fully integrated, as a result of a planned merger between the various intramural, extramural and halfway facilities.

The development of extramural mental health care in the twentieth century was motivated by professional and organisational concerns rather than by the public demand for it. The establishment and spread of the various facilities were mainly triggered by a dynamic on the supply side: the initiatives of socially concerned individuals, the aspirations of various professional groups, the rivalry among the religious-ideological pillars and, finally, funding opportunities. It is hard to ignore the impression that there has been a strong tendency in most outpatient services to keep out of its system patients with serious psychiatric disorders, especially those who might be annoying, dangerous, or frightening to others and difficult to treat. In this respect, this effort followed in a long tradition within psychiatry: the recurrent alternation and juxtaposition of therapeutic optimism and pessimism. Time and again, experts argued that the existing facilities fell short in providing adequate treatment to patients, let alone cure them. Alternative ways of organising care and establishing new facilities, they believed, would lead to successes where prior efforts had failed. Repeatedly, newly established provisions caused an expansion of psychiatry and mental health care, as well as the emergence of new groups of patients, whereby a distinction was made between those who were treatable and those who were not. This frequently implied that attention for the former led to the neglect of the latter.

Around 1900, increasing doubts were raised about the beneficial effects of a patient's stay in a closed asylum. As a result, the therapeutic optimism began to be orientated towards other institutions: the specialised sanatoria and clinics for patients with nervous disorders and alcohol addicts, private practice, and mental wards and hospitals where acute and 'neurotic' patients were admitted and treated on strictly medical grounds, without certification. From a therapeutic perspective, however, the partly open and partly closed institutions for the mentally ill continued to be a source of concern, especially given their over-crowding with chronic cases. In the 1920s, this therapeutic pessimism led to new outpatient facilities for psychiatric patients, the Pre- and Aftercare Services, and to the psycho-hygienic effort to prevent mental disorders. This second objective caused a substantial expansion of psychiatry's domain: children and youngsters with learning, educational, and developmental problems were now potentially included, as were adults with problems in the sphere of marriage, family, relationships, procreation, sexuality and work. From the 1960s, mental health expanded to comprise welfare and

individual well being as well: to a large extent psychotherapy catered to people who were basically healthy but who nevertheless were troubled by personality flaws, relational problems, existential uncertainties and their potential for self-development. Only since the mid-1980s, partly because of financial considerations, the continuing expansion of the mental health sector began to be questioned more often and attention focused again on the seriously and chronically mentally ill.

From the 1930s onward, the psycho-hygienic movement and most outpatient facilities tried to hook up with the overall health care sector, and they indeed managed to do so, which meant that they kept their distance from institutional psychiatry, closely associated as it was with poor relief and the judicial system. On the other hand, extramural services also displayed a clear affinity with the traditions of charitable aid and social work. In the Netherlands these sectors were strongly developed, both emphasising a close link between the alleviation of material want and moral or spiritual elevation. In their moral-didactic approach, they focused on the social environment and efforts to reform individuals, while the principle of social integration, rather than the principle of isolating or excluding problem groups, gained the upper hand. The eugenicist perspectives of the first psycho-hygienists lost ground, while the influence of medical psychiatry remained limited, at least until the 1990s. In the 1970s, when the number of social workers in mental health care rose sharply, it even seemed that it would soon merge into welfare work. However, in the 1980s and 1990s, mental health workers retreated into the more limited professional domain of health care and thus avoided falling prey to the government's cutbacks on welfare services.

Until the 1970s, most mental health facilities were tied to Dutch society's 'pillarised' system, which meant that religious motivations played a major role. Many services were rooted in Catholic and, albeit to a lesser degree, orthodox Protestant and Dutch Reformed doctrine; they basically served the aim of maintaining the central role of religion. But from 1950, leading psychiatrists and psychologists, as well as several reform-minded clergymen, began to question the subordination of issues associated with mental well-being to the church's norms and values. Based on psycho-hygienist views, they tried to bridge the gap between religious doctrine and modern life. That the confessional groups of the population had their own mental health facilities raised the chances of religious people coming into contact with a more psychological approach of normative issues. Religion-based mental health induced individualisation at a moral level and provided a basis for the more radical liberation of individuals from the second half of the 1960s, when a massive secularisation process took off.

The prominence of the confessional groups in the area of mental health and the wide variation in facilities were made possible in part by the Dutch government's low profile in the health care sector until the mid-1960s. Its role was restricted to control and supervision, leaving the actual provision and organisation of care to local and private initiatives. Although the national government raised its subsidies in the 1950s and 1960s, its role in non-institutional mental health basically remained restricted to regulation and inspection. Only from the mid-1960s did collective funding enable the welfare state to grow and implement large-scale policies. As the money for mental health care increasingly came out of national funds, the need for a large variety of more or less autonomous facilities began to be debated increasingly, while the government issued more and more regulations concerning the implementation and organisation of providing

care. It played an active role in the realisation of the RIAGG-network and the increasing integration of intra- and extramural care. The policies that in the 1990s promoted deregulation and the free market diminished the input of government once again, although collective funding was maintained.

The modernisation of Dutch society and the evolving views of democratic citizenship provided the socio-political context for the pursuit of mental health; either a cultural pessimism or an optimistic belief in society's progress prevailed. In this respect, it is possible to identify a radical break around 1950. At that point, defensive responses to the modernisation process and strict adherence to Christian, bourgeois morality were exchanged for a much more accommodating stance, while in the reflection on citizenship there was a shift from an unconditional adaptation to collective values and norms to individual self-development. People's inner motivations came to be centre-stage. Between 1950 and 1965, the mental health sector accommodated to rapid social change: individuals had to shape their personality, develop their autonomy and flexibility, be open for renewal, and, in a responsible way, achieve self-realisation. In the 1960s and 1970s, mental health workers embraced personal liberation, democratisation and assertiveness as core values. Subsequently, in the last two decades of the twentieth century, they have approached their clients as mature, autonomous and self-responsible citizens, whose freedom to make choices as members of a pluralist market society was perceived as self-evident. At the close of the twentieth century worries about social cohesion resurfaced and, as attention focused on groups suffering from serious mental and behavioural disorder, the emphasis on individual autonomy was brought up for discussion.[39]

Throughout the twentieth century the size of the Dutch mental health care system increased, in both absolute and relative terms. In 1900, the number of people who received psychiatric care and treatment did not exceed 0,2 per cent of the general population. At least eighty percent of those who received any care and treatment were hospitalised. Around 2000, the number of clients and patients in mental health care was about 750.000, or a little under five percent of the population; outpatient facilities catered to eighty percent of those who received mental care. The Netherlands, together with the United States, Canada and Australia, belonged to the countries with the highest number of psychiatrists and psychotherapists in proportion to the size of the population.[40] The strong growth of the extramural sector, especially after 1970, might give the impression that ever larger numbers of Dutch suffered from mental afflictions. This, however, is hard to substantiate. There are indications that no correlation exists between the incidence of mental disorders suffering in a population and the degree to which its members make use of care-providing facilities. Studies from the 1980s and 1990s reveal that about one quarter of the adult population between the age of 18 and 64 suffered from a DSM-listed psychiatric disorder or serious psychosocial problem every year. Although this number was significantly higher than that of patients who ended up in the mental health system (which increased from over two percent to almost five percent of all adults), it remained steady over the years and was similar to that of many other countries.[41] These data cast doubt on the view that the population's increasing demand for care also reflected the occurrence of a growing number of disorders and mental problems. It suggests that many people with mental problems did not look for professional help and that general practitioners only considered a portion of the complaints they identified as serious enough for referral to mental health services. It cannot be denied, however, that between

1980 and 2000, more and more individuals found their way to mental health facilities, especially in the outpatient sector: there was, in fact, more than a doubling of the number of registrations.[42]

Apart from political decisions on funding, social and cultural factors have probably had greater influence on the consumption of care than any measure of mental disorders. In the case of psychosocial problems, to which many of the outpatient facilities were geared, the definitions of disorders tend to change and expand. The way in which individuals experienced them and looked for ways of dealing with them was subject to change during the twentieth century. Individual problems are of all times, but their specific interpretation as mental health complaints has been strongly determined by the availability with specialised services, their specific treatment options and the psychological discourse used by experts. These rendered a host of tacitly experienced problems visible and identifiable, and, most importantly, offered a concrete context for talking about them. Social factors influenced what counted as a problem, which complaints were identified and discussed, and who was asked to treat them. In the psychosocial and psychotherapeutic mental health sector, the growing supply of professional care created the increasing demand for care, rather than the other way around. In contrast, institutional and social (pre- and aftercare) psychiatry focused on the core group of severely mentally ill individuals. This group remains the heart of the psychiatric domain and its relative size has remained fairly stable over time in the population at large.[43]

An extensive network of extramural mental health facilities came into being in the Netherlands over the course of the twentieth century and, especially from the 1960s, it acquired a large clientele. In this country, which in social and cultural terms used to be quite bourgeois, conservative and Christian, the cultural revolution of the 1960s was more sweeping than in others, because it coincided with rapid secularisation and de-pillarisation.[44] Once the solid, familiar moral frame began to be discussed publicly, it soon lost its relevance for many. The ensuing spiritual vacuum was partially filled by the new psychotherapeutic ethos.[45] Since the 1960s, Dutch society experienced an accelerated democratisation of public and everyday life, which replaced hierarchy, group coercion and formal power relations with self-development, emancipation and informal manners. This subsequently required self-control, subtle social regulation and psychological insight from individuals. The focus on discussion, accommodation and consensus, which has long been characteristic of Dutch political elites, became a characteristic of society as a whole. With their emphasis on self-reflection and raising sensitive issues, mental health workers articulated new values and offered a clear alternative for the outdated morality of dos and don'ts. They not only adapted their views to the continuously changing social circumstances, but, especially in the 1950s, 1960s, and 1970s, also functioned as major agents of social-cultural renewal. Talking was their preferred strategy for solving problems, which not only linked them with the Dutch culture of negotiation and consensus, but also with the practice of everyday life of many Dutch people.

Since the 1930s, the largest segment of the working population has been active in the services sector, in which communications grew increasingly central.[46] In the densely populated and highly urbanised Netherlands, therefore, proper social functioning depended greatly on personality traits associated with verbal and communicative skills, flexibility, and the subtle regulation of emotion. Finally, the strong inclination toward

psychologisation dovetailed with how the Dutch culture of consensus addresses social and ethical issues. It is a culture in which experts figure prominently because their supposedly objective professional stance, thus neutralising social conflicts over sensitive issues. In the articulation of policies on sexuality, birth control, abortion, euthanasia, drugs and disability, for example, experts such as doctors, psychiatrists, psychologists, and others had a large say. They generally contributed to formulating solutions that are both pragmatic and well-considered, while also taking into account as much as possible individual conditions, attitudes and motivations.

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[1] See the articles of J. Vijselaar, J. Slijkhuis and M. Gijswijt-Hofstra, in M. Gijswijt-Hofstra and R. Porter (eds), *Cultures of Neurasthenia. From Beard to the First World War* (Amsterdam, New York: Rodopi, 2001). See also the article of Gijswijt-Hofstra in this volume.

[2] On the history of psychotherapy and psychoanalysis in the Netherlands see W.J. de Waal, *De geschiedenis van de psychotherapie in Nederland* ('s-Hertogenbosch: De Nijvere Haas, 1992); I.N. Bulhof, *Freud en Nederland. De interpretatie en invloed van zijn ideeën* (Baarn: Ambo, 1983); C. Brinkgreve, *Psychoanalyse in Nederland. Een vestigingsstrijd* (Amsterdam: Uitgeverij De Arbeiderspers, 1984).

[3] On the history of alcoholism and its treatment see J.C. van der Stel, *Drinken, drank en dronkenschap. Vijf eeuwen drankbestrijding en alcoholhulpverlening in Nederland. Een historisch-sociologische studie* (Hilversum: Verloren, 1995).

[4] P. van der Esch, *Geschiedenis van het staatstoezicht op krankzinnigen* I (Leidschendam: Ministerie van WVC, 1975), 81-2; J.H. Schuurmans Stekhoven, *XXVste Verslag van het Staatstoezicht op krankzinnigen en krankzinnigengestichten over de jaren 1915-1929* ('s-Gravenhage: Algemeene Landsdrukkerij, 1932), 172.

[5] Nederlandsche Vereeniging voor Geestelijke Volksgezondheid, *Gids betreffende de geestelijke volksgezondheid (psychische hygiëne) in Nederland* (Amsterdam: F. van Rossen, 1936), 74-6.

[6] R. de Schepper, *De Pameijer Stichting (1926-1991): Een geschiedenis van de sociale psychiatrie en verstandelijk gehandicaptenzorg te Rotterdam* (Rotterdam: Pameijer Stichting, 1991); G. Blok en J. Vijselaar, *Terug naar Endegeest: Patiënten en hun behandeling in het psychiatrisch ziekenhuis Endegeest 1897-1997* (Nijmegen: SUN, 1998), 94-9.

[7] Nederlandsche Vereeniging voor Geestelijke Volksgezondheid, *op. cit.* (note 5), 67-74.

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[27] Nationale Federatie voor de Geestelijke Volksgezondheid, *Gids voor de Geestelijke Gezondheidszorg in Nederland* (Amsterdam: NFGV, 1965), 20-40, 59-64, 68-75, 241-52; Nationaal Centrum voor Geestelijke Volksgezondheid, *Gids Geestelijke Gezondheidszorg 1981* (Utrecht: Nederlands Centrum Geestelijke Volksgezondheid, 1981), 43-241; D. Ingleby, 'The View from the North Sea', in M. Gijswijt-Hofstra and R. Porter (eds), *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands* (Amsterdam, Atlanta: Rodopi, 1998), 295-314; C.Th. Bakker en H. van der Velden, *Geld en gekte. Verkenningen in de financiering van de GGZ in de twintigste eeuw* (Amsterdam: Universiteit van Amsterdam, 2004), 65.
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