DISORDERED MINDS AND OTHER DISCOMFORTS:
MENTAL HEALTH CARE IN 20TH-CENTURY DUTCH SOCIETY

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Introduction

My paper is part of a collective research project, in which several scholars at the universities of Amsterdam and Maastricht are involved. Its aim is to study the 20th-century history of psychiatry and mental health care in the Netherlands from a social and cultural perspective and to situate it in an international context. Specific projects are geared towards subjects like the development of the psychiatric profession, psychiatric nursing, patients in mental institutions, the influence of the anti-psychiatry movement, the funding of mental health care and the development of a commercial market for mental health care and alternative treatments.

One of the distinctive features of the history of Dutch psychiatry in the 20th century is the expansion of its domain. In this paper I focus on the development the mental health care network outside of the psychiatric institutions and clinics. Whereas the First Psychiatric Revolution of the 19th century centered on the notion that the mentally ill could be cured by temporarily removing them from society, in the 20th century the opposite view won ground. It was now thought better to treat people with psychic and behavioral problems in ways that allowed them to remain in their everyday environments as much as possible. As the 20th century progressed, this approach gained prominence in Dutch mental health care. At the same time the size of the 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 10,000. Given a total population of a little over 5 million, this was not more than 0.2 percent of all Dutch. At least 80 percent of them were hospitalized. Around 2000, when the Netherlands had approximately 16 million residents, the number of clients approached 800,000, a little under 5 percent of the population; now 80 percent of them receive outpatient mental health care. The Netherlands belongs to the countries with the highest number of mental health care professionals in proportion to the size of the population.

First I will present some more factual information about the expansion of the Dutch extramural mental health care system, as far as its facilities, the various professions that staffed it, and its patients and clients are concerned. Then I will highlight 6 basic characteristics of the Dutch mental health care system, which might throw some light on the similarities or differences between the Dutch system and extramural psychiatry in other Western countries.

Institutional expansion

Before World War One, psychotherapy, especially psychoanalysis by resident psychiatrists and a center for alcoholics were the only forms of extramural psychiatry. The 1920s and 1930s saw the emergence of the movement of mental hygiene and the establishment of the first extramural facilities for psychiatric patients: pre- and aftercare services and public health services for social and emergency psychiatry. Also from the late 1920s on, centers for problem children, the so-called Medical Pedagogical Centers modeled on the American Child Guidance Clinics, were established. In the 1940s services for marriage- and family-related problems and some public institutions for psychotherapy were added to the mental health network. From the 1960s more and more psychiatric hospitals established outpatient clinics, offering social psychiatric care to psychiatric patients but also psychotherapeutic treatments to other clients. All these facilities for social psychiatry, psychotherapy, counseling and alcohol, and later also drug-addiction expanded steadily in the 1950s and 1960s, and culminated in the 1970s. In the early 1980s most of these different facilities, were joined in approximately sixty Regional Centers for Mental Health Care (RIAGG) for which the American Community Mental Health Centers served as a model. These

Centers still exist nowadays but more and more they merge with psychiatric hospitals to form new integrated mental health organizations at a regional level.

Professional expansion

Various professional groups initiated and staffed the outpatient services. They tended to be involved in institutional psychiatry, but also in other fields, such as welfare work, probation service, child welfare, special education, church-based spiritual care, eugenics, and psychoanalysis. The first forms of extramural psychiatry in the Netherlands were developed by psychiatrists who offered treatment in private practice, who participated in the fight against alcohol addiction, or who initiated and staffed, together with psychiatric nurses, pre- and aftercare services. Psychiatrists also founded and staffed the first institutes for psychotherapy. In the centers for problem children and marriage and family issues, next to psychiatrists and other physicians, psychiatric social workers played a central role, and also clergymen, psychologists, and pedagogues got involved. As the scale of the mental health care services grew larger, the number of care providers and their professional diversity increased accordingly. In the 1940s and 1950s, psychiatrists, psychiatric-social workers, and social-psychiatric nurses still dominated the field. Since the 1960s they began to be confronted with a growing number of psychologists, social workers, pedagogues, sexologists, and others. This contributed to a widening of the ambulatory sector from medical to psycho-social care providing and, in part, welfare work as well. In the RIAGGs psychiatrists constituted a minority amidst other professions. What was a unique development from an international perspective is that psychotherapy developed as a separate, interdisciplinary profession: from the late 1960s not only doctors, but also clinical psychologists and social workers practiced psychotherapy.

Patients and clients

These outpatient mental health services, run by a variety of professionals applying several treatment methods, were geared toward an increasingly wider spectrum of patients and clients. Offering psychotherapy in private practice, psychiatrists from the first decades of the 20th century on, catered to middle and upper class patients suffering from nervous disorders. Psychotherapy, especially psychoanalysis in private practice, was elitist and confined to a small circle. In the 1920s, overpopulation and the therapeutic pessimism in the psychiatric hospitals led to new facilities for psychiatric patients, the pre-care and aftercare services for people who did no longer, or not yet, have to be hospitalized. Also, psychiatrists and other professionals geared their effort toward the prevention of mental disorders on the basis of psycho-hygienics. This objective caused a substantial expansion of psychiatry’s patient group: children and youngsters who had behavioral and learning problems were now potentially included, as were adults with problems in the sphere of marriage, family, relationships, procreation, sexuality, and work.

After World War Two the notion "mental health" replaced "mental hygiene" so as to underscore that not only prevention and treatment of psychological disorders and problems mattered, but also that it was important to improve the mental health of the population in general. From the 1960s, mental health expanded to comprise welfare and individual well being as well: psychotherapy catered to individuals who were basically healthy but who nevertheless were troubled by personality flaws or their potential for self-development. A growing number of people began to consider it more or less self-evident to seek psychotherapeutic help for all sorts of discomforts that previously were either not regarded as mental problems as such. The strong growth of psycho-social care providing during the 1970s, psychotherapy in particular, reflected a process of psychologization, a change of mentality that can be described as a combination of growing individualization and internalization. In the closing decades of the century, psychiatry and psychotherapy were confronted with new problems and afflictions while the therapeutic implications of several existing and new clinical pictures, like stress, burn-out, psycho-trauma, eating disorders, multiple personality disorder, and attention deficit hyperactivity disorder were

stretched. The RIAGGs were aimed at a broad spectrum of problems, from existential problems to mental suffering and serious psychiatric disorders. Only since the 1980s the expansion of the domain of mental health care began to be questioned. Primarily motivated by financial concerns, the government repeatedly argued the need of shifting the attention away from those with minor mental afflictions to those with serious mental disorders, not only to dam the increasingly growing demand for mental health care, but also because to keep the number of admissions to mental hospitals as low as possible.

In the rest of my paper I would like to discuss some basic characteristics of the Dutch mental health care system as it developed in the 20th century; these might be relevant from the perspective of international comparison.

1. The wide extension of outpatient mental health care

In the Netherlands mental health care was not only social psychiatry in the sense of outpatient care for psychiatric patients, but from the 1930s and 1940s on it also included various counseling centers for problem children, for marriage- and family related issues, for psychotherapy, and for alcohol- and drug addiction. Mental health care was not just medical psychiatry or psychotherapy, for a large part it also was (moral) education, pastoral care, and social work. It displayed a clear affinity with the traditions of charitable aid and welfare work, which were strongly developed in the Netherlands. This explains the strong presence of a moral-didactic approach, which focused on the social environment and the perfectibility of the individual, while the principle of social integration, rather than the principle of isolating or excluding problem groups, gained the upper hand. Also, until the mid 1960s, religious - Catholic, orthodox and Dutch Reformed Protestant - motivations played a major role in mental health care. Many facilities were set up in order to maintain the central role of religion in society. But at the same time this raised the chances of religious people coming into contact with a more psychological approach of normative issues. In a general sense mental health care was not so much medical as moral, educational and psychological in nature.

The ambulant mental health sector has successfully established itself in the Netherlands. The notion of mental health, which heaped together a host of problems in and between people, caught on and precisely because of its vagueness it fulfilled a major strategic function in linking various social domains and appealing to various groups. Mental health applied to both the individual and society, which established a connection between the private and public sphere. The notion of health care evoked associations with medicine and hygienics, while “mental”, in Dutch *geestelijk* that also means "spiritual", referred to psychic features as well as religious, moral, and cultural values. Discussions on mental health provided a context in which medical, psychiatric, and psychological diagnoses could be linked to moral, religious, and political values. Repeatedly, psycho-hygienists articulated their views about the position of human beings in modern society and they connected mental health to ideals of democratic citizenship.

2. Ideals of citizenship

The modernization of Dutch society and the evolving views of democratic citizenship provided a context for the pursuit of mental health. Before and after the Second World War, experts in mental health care linked up a sustained cultural pessimism with an optimist belief in the potential of scientific knowledge to solve the problems individuals faced as a consequence of the modernization of society. In the first half of the 20th century a defensive response to social modernization set the trend. In order to safeguard overall social stability the significance of the existing collective morality and the social adaptation of the individual were stressed. In the 1950s, however, the emphasis on collective morality as an essential belief-system was exchanged for a much more accommodating stance. In the reflection on citizenship there was a shift from unconditional adaptation to the existing system of norms and values to individual self-

development. Mental health care experts changed their attitude regarding modernization: they saw a need for more openness and for enhancing the mentality and psychological attitude that people needed to function properly in a changing society. The striving for more dynamic and flexible adaptation took the place of the generally forced attempts at upholding the standard morality. It was now believed that individuals should be granted more space to develop in responsible ways. By encouraging self-development, individual responsibility, and taking initiatives, people were expected to develop the flexible attitude that was needed to lead a modern life in a democratic society. In the 1960s and 1970s mental health care professionals, together with welfare workers, advocated personal liberation in the areas of religion, morality, relationships, sexuality, birth control, education, work, drugs, and even death (euthanasia) as well as regarding the emancipation of women, youngsters, the lower classes, and other groups like gays and ethnic minorities. People were to liberate themselves from the coercive social structures and mental health care was supposed to support its clients to become aware of their true needs, to "grow", and develop their true self. Subsequently, in the last two decades of the twentieth century, professionals approached their clients as autonomous, mature, and self-responsible citizens, whose freedom to make choices as members of a pluralist market society was perceived as self-evident.

3. The gap between institutional psychiatry and outpatient mental health care.

The initiatives of the 1920s in the field of pre- and aftercare for psychiatric patients and also of psycho-hygienics were closely tied to the problems of mental institutions and they were largely based on German social-psychiatric models and to some extend also inspired by eugenics. In this approach psychiatrists dominated the field. However, in the 1930s, when other professions became involved with mental health care, the psycho-hygienic movement and outpatient facilities embarked on a different course, which in time would become the dominant one. The leading experts began to define their role and identity by distancing themselves from institutional psychiatry and by stressing that their client groups had little to do with the mentally ill. This emphasis was motivated by the social isolation and stigmatizing effect of asylum psychiatry, closely associated as it was with the judicial system, as well as by funding arrangements: the care for institutional patients was largely paid by poor relief funds, while the new extramural counseling facilities were funded on the basis of health care. After the Second World War, the counseling centers for children and adults and later the institutes for psychotherapy set the tone. Social psychiatry in the narrow sense, although it was the largest out patient mental health care sector, and also the care facilities for addicts were more or less marginalized. There was a strong tendency in ambulant mental health care to keep patients with serious psychiatric disorders that were difficult to treat out of its system. However, in the 1980s social psychiatry was formally integrated into the new RIAGG network, but the persistent critique that it did not devote sufficient attention to psychiatric patients with serious disorders suggested that the radical split between intramural and extramural care was still a major factor. The latest developments, pressured by the government, suggest that, finally, the mental health sector will become fully integrated, as a result of a planned merger between the various intramural, semi-mural, and extramural facilities. The government’s policies of the 1980s and 1990s meant a break with the historically developed constellation of Dutch mental health, which since the 1930s had been marked by a sharp division between clinical psychiatry and the outpatient sector. In the late 1990s, to improve the cooperation between psychiatric hospitals and RIAGGs in particular, the government pressured these organizations to merge at a regional level.

4. Private initiative and collective funding

Private and especially religious-motivated initiatives played a crucial role in the development of mental health care. The prominence of the confessional groups in this field and the wide variation in facilities were made possible in part by the Dutch government’s low profile in the health care

sector. Its role was restricted to control and supervision, leaving the actual providing and organization of health care to private, often religious-motivated, organizations; only in some large cities did local government engage in organizing social-psychiatric care. However, from the late 1960s on, institutional as well as outpatient mental health care was financed by collective funding. The rapid expansion of mental health care from the 1960s on was facilitated by its embedding in the welfare state. The care for the mentally ill and people with psycho-social problems was no longer dependent on a variety of funding sources, like poor relief, social work, or local and provincial authorities. Instead, a national and compared to other countries, generous system of funding was put in place, which allowed the expansion of the mental health care sector, and enabled the improvement of its quality and its accessibility. In the years between 1965 and 1980 there was a substantial increase in the number and scale of outpatient facilities as well as in the number of clients. In early 1980s pressure from the government caused the various separate facilities to merge in the RIAGG. Although the crisis of the welfare state led to a downsizing of welfare work in the 1980s, ambulant mental health care saw further expansion in subsequent years. This was stimulated by the ongoing effort to minimize intramural psychiatry; in the 1980s and 1990s this was even a government priority. At the start of the 21st century, the Netherlands still had an extensive and differentiated supply of mental health care facilities, certainly from an international angle, while there are virtually no countries where this sector is as accessible and where as much money is spent on the basis of collective funding regulations. Although there has been an increase of more or less neglected psychiatric patients roaming in the streets or living in private boarding houses, the Dutch picture of community care is not as dismal as that of other countries, like the United States and the United Kingdom. Deinstitutionalization was not as radical in the Netherlands, because a variety of intermediary care facilities, situated between psychiatric hospitals and society, was set up.

5. Antipsychiatry and ambulant mental health care

Like in other Western countries psychiatry became harshly criticized in the Netherlands around 1970, but ironically the anti-psychiatric movement strengthened rather than weakened the expansion of mental health care in Dutch society. Anti-psychiatry aimed its shots at clinical psychiatry rather than mental health care as such. It argued for a better psychiatry, meaning a de-medicalized and de-institutionalized psychiatry, much in the way of the outpatient sector, which largely had a social-psychological orientation. The anti-psychiatry and psycho-hygienic movements found one another in their mutual dislike of clinical psychiatry, which, as they argued, basically disregarded the social influences on mental disorders. The ambulatory sector, which already since the 1930s had repeatedly distanced itself from institutional psychiatry, had few problems absorbing elements of the anti-psychiatric critique. Anti-psychiatry was more or less co-opted to strengthen out patient facilities. This was supported by the government, which in the 1980s started a policy of deinstitutialization of psychiatric patients, not so much because it embraced anti-psychiatry but more in order to cut back on expenses. Ultimately, the sixties movement and the anti-psychiatry movement led to more rather than fewer mental health care services: the facilities that offered psycho-social and psychotherapeutic treatments increased in both size and number throughout the 1970s. Psy-experts widened their professional domain to include welfare work, a sector that since 1970 experienced enormous growth. In contrast to the American Community Mental Health Centers, on which they were modeled, the so-called RIAGGs, the Dutch Community Mental Health Centers were quite successful.

6. The impact of the cultural revolution of the 1960s

It is no coincidence that from the 1960s on mental health became firmly rooted in Dutch society and that at the same time the personal lives of and the social relations between the Dutch became highly psychologized. From the 1950s on the psychological perspective grew more prominent in the various counseling centers and psychotherapeutic institutes, but only since the 1960s, when

the economic, social, and political developments enabled the definitive breakthrough of individualization, more and more people became familiar with the psychological mode of self-understanding. The explanation might be found in the cultural revolution of the 1960s which has been more pervasive and lasting in the Netherlands than in other Western countries because it coincided with rapid secularization and the downfall of the religious-based organization of political and social life. Between 1965 and 1975 the Netherlands changed from a conservative, law-abiding, and Christian nation into one of the most innovation-minded and liberated countries of the Western world. Secularization, growing prosperity and the expanding welfare state caused individuals to take a more independent stance. The control of desires and emotions and the individual's adaptation to society were no longer understood as signs of a responsible attitude, but as the repression of personal freedom and authenticity. In a relatively short span of time the familiar bourgeois and Christian moral frame lost its relevance for many people. The ensuing moral or spiritual vacuum was partially filled by the new psychotherapeutic ethos. Since the 1960s Dutch society has been confronted with a strongly developed democratization of public and everyday life, which replaced hierarchy, (group) coercion, and formal power relations with self-development, emancipation, and informal manners. This subsequently required 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 focus of society as a whole. With their emphasis on self-reflection and raising sensitive issues, mental health care professionals articulated new values and offered a clear alternative for the outdated morality of dos and don'ts. 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. Already since the 1930s the largest segment of the working population has been active in the services sector. It is a sector in which communications grew increasingly central. In the densely populated and highly urbanized Netherlands, therefore, proper social functioning highly depended on personality traits associated with verbal and communicative skills, flexibility, and subtle emotion-regulation. The strong inclination toward psychologization is also tied to the specific ways in which in the Dutch culture of consensus social and ethical issues are addressed. It is a culture in which experts figure prominently. Their expertise is frequently called in because their supposedly objective professional stance neutralizes social conflict situations in which difficult decisions play a major role. In the articulation of policies on euthanasia, abortion, drugs, and also job-related problems, experts – mainly physicians, but also other care providers – had a large say.