TREATMENT AS PUNISHMENT
FORENSIC PSYCHIATRY IN THE NETHERLANDS (1870-2005)

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My paper provides an overview of the development of forensic psychiatry in the Netherlands from the late nineteenth to the early twenty-first century. I focus on two issues: first, the way forensic psychiatry established itself between 1870 and 1925; second, the so-called psychopath law under which terms forensic psychiatry was practiced from 1925 until this day. At the end of my paper I will briefly connect developments in forensic psychiatry with the wider sociopolitical context.

From the 1870s Dutch psychiatrists tried to advance their role in the administration of criminal justice as part of a more general effort **to expand their professional domain**. In order to break their isolation in mental asylums, they aligned themselves with social hygiene that aimed at the possible prevention of mental disorders as well as crime. However, forensic psychiatry developed later in the Netherlands than in, for example, France and Britain, where from the mid-19th century, psychiatrists, using diagnostic categories like monomania, insania moralis, and psychopathy, managed kept with mental disorders from being prosecuted. Until the late 19th century, Dutch legal practice rarely invoked medical expertise to determine whether suspects were mentally ill. The emerging field of psychiatry made little impression on the judicial establishment and **the then prevailing legal views offered little room for forensic expertise**. The *Code Pénal*, introduced under Napoleon, was based on the classic criminal law principle that suspects be judged only on their actions and not on their personality. Only suspects who were undeniably insane were eligible for discharge from prosecution. The *Code Pénal* only allowed the qualification of individuals as either fully responsible or fully irresponsible, and judges apparently felt no need for medical advice. Discharge from prosecution because of insanity was rare. The new Dutch Penal Code, which in 1886 replaced the *Code Pénal*, also reflected the spirit of the classic school: punishment as retribution of guilt remaining the basic principle. According to the letter of the law only offenders who because of the 'poor development or pathological disorder' of their mental powers were declared to be fully irresponsible, could be discharged from prosecution and placed in a mental asylum. It was not necessary, however, that physicians diagnosed a suspect's mental disorder. Judges decided whether medical expertise was called for and only they judged on an individual's responsibility.

Psychiatric involvement in the administration of justice was subject to debate between lawyers and physicians and it also met with **other obstacles**. Forensic psychiatry was **not a product of a univocal professional urge to expand**: physicians held divergent views on the relationship between law and psychiatry. Some psychiatrists pointed to **the problems and dilemmas implied in a forensic role**, and they argued for restraint. Psychiatrists aspired after a role in legal affairs, but at the same time they would rather not admit disturbed delinquents in their already overcrowded asylums. Asylum physicians, who tried to promote psychiatry as part of medical science, put forward that,

as medical institutions, asylums lacked adequate security and therapy for such patients. There was little medical credit to be gained regarding these patients who might be violent and cause problems of order, and therefore had to be constantly watched and controlled. Before the court psychiatrists were inclined to present and defend their medical diagnosis, suggesting that imprisonment of disturbed delinquents was not a suitable solution, yet once these criminals ended up in a mental asylum many physicians felt that they did not really belong there. Compulsory admission to a mental asylum basically involved a form of detention and the question presented itself whether this could be justified from a medical perspective. Some psychiatrists considered the striving for protection of society essentially a legal and political affair that did not automatically go together with their medical task of guarding the interests of ill individuals. Also, some critics argued that as forensic experts, psychiatrists would be tempted to formulate statements that surpassed their medical authority. They should be careful not to translate their medical diagnosis into a ready-made legal judgment. It was difficult to establish a direct causal link between mental disease and irresponsibility – let alone offer a scientific basis for such a connection, especially when the suspect suffered from mental disorder, but was not fully insane. Such considerations were reinforced by controversial incidents: some court cases, in which psychiatrists were involved as forensic experts, caused much public and political uproar.

Despite legal and social resistance against forensic psychiatry and differences of opinion among psychiatrists themselves, **from the 1890s on psychiatry made headway in the Dutch legal system**. The premise that criminal, antisocial, and immoral behavior was rooted in the personality of perpetrators and that it could be diagnosed as symptom of mental disorder became more widely accepted. More and more, judges afforded psychiatry an advisory role in legal practice. Around 1900, the number of criminals declared to be of unsound mind and discharged from prosecution and who were sent to a mental asylum, went up. Most were from the working class and sentenced for theft, arson, assault, and sexual abuse of minors.

Forensic psychiatry in the Netherlands received backing from **two international developments**. The first involved **the rise of criminal anthropology** in Italy and France since the late 1870s. Although leading Dutch psychiatrists emphasized the impact of heredity and degeneration in their reflections on crime, and some of them performed extensive anatomic measurements among convicts, they also considered social conditions and psychological characteristics. Dutch psychiatrists and other criminal experts tended to argue for a rapprochement between the Italian and French schools. In fact, pragmatic as they were, they combined the biological approach with social and psychological factors to various degrees. Psychiatric-forensic reports, however, focused on the physical and mental characteristics of suspects, while hardly any attention was paid to the social-economic circumstances in which they lived.

The second international development that provided a stimulus to forensic psychiatry in the Netherlands was **the rise of the so-called New Direction** in legal thinking from the 1880s on. While traditional criminal law emphasizes proportional retribution of committed crimes, the New Direction gave priority to the protection of society against

criminal behavior by preventing it. By focusing on suspects' personality and motives it would be possible to identify dangerous criminals and repeated offenders, as well as to eliminate the risks they posed through special protective measures such as long-term isolation, possibly under psychiatric supervision. In the early decades of the 20th century **the Dutch criminal law climate changed**. The introduction of the Child Protection Laws in 1905 as well as of the suspended sentence and release on parole in 1916, both of which represented a major impetus for a differentiated approach in criminal law, marked the growing impact of the New Direction. The Child Protection took into account the underlying causes of criminal conduct of minors: their age, personal traits, and living environment. The accent shifted from punishment to prevention and re-education. The reasoning behind a suspended sentence or release on parole was that some delinquents were capable of improvement and that the deterrent effect of a prison term together with close surveillance in society was a more effective means to bring about behavioral change than actual detention. Rehabilitation organizations were assigned to re-socialize them by enhancing their self-control and self-reliance. Soon this new criminal law measure was applied frequently.

Psychiatrists, who increasingly linked up immoral and criminal conduct with psychopathy, generally approved these new criminal law practices because they stimulated **a differentiated assessment of offenders**, whereby their personal characteristics were taken into account. The efforts to socially integrate offenders perceived to be corrigible were accompanied by proposals to protect society more effectively against the presumed hard core of disturbed and recidivist criminals, the so-called **psychopaths**. It was believed that the existing criminal laws, which offered judges the possibility to acquit perpetrators who were completely insane by declaring them irresponsible and place them in a mental asylum, were not effective enough for dealing with the much more numerous so-called border cases. These were offenders who were not insane, but who nevertheless suffered from mental disorders such as insania moralis, on account of which they had no sense of good and evil. It largely involved offenders who were guilty of fairly minor misdemeanors, but who because of their assumed irregular and asocial lifestyle would continue to cause social trouble. The questions whether they primarily were either criminal or mentally disturbed and how best to deal with them triggered much discussion in legal and psychiatric circles. **The growing attention for these border cases in the first decades of the twentieth century advanced the development of forensic psychiatry.** Both physicians and advocates of the New Direction pushed for forced institutionalization of mentally disturbed criminals that might pose a risk to social security in separate facilities. The so-called *prison-asile* they advocated, a combination of prison and asylum, should not only relieve regular mental asylums, but also make it possible to remove mentally disturbed criminals from society longer than the classic legal proportionality principle permitted.

This aim was realized in 1925 when Dutch parliament adopted the so-called **psychopath law**. This law made it possible for judges to place both fully and partly irresponsible convicts under a special restriction order, in Dutch *Ter Beschikking van de Regering*, or abbreviated: TBR. This meant that mentally disturbed delinquents following their potential prison term could be put in a special asylum for psychopaths involuntarily.

Every two years the judge could prolong a TBR-sentence, whereby his decision depended to a large extent on the attending psychiatrist's assessment of the delinquent's mental state and the chance of recidivism. This legislation was first of all motivated by the desire **to protect society** against presumably incorrigible and dangerous criminals through removing them longer from society than could be legitimized on the basis of a merely legal sentence and criminal law's proportionality principle. However, at the same time the psychopath law implied a continuation of the trend in criminal law associated with the Child Protection Laws and the suspended sentence, geared toward **re-education en re-socialization**. In this respect the TBR proceeding was **ambiguous**: despite the emphasis on the **protection of society** it also offered a starting-point for shifting the accent from punishing to **treatment and rehabilitation**. Time and again it would give rise to debates on the question whether social protection or individual treatment should be given priority.

The psychopath law sealed the legal recognition of the need to seek psychiatric advice about some suspects because of their personality traits. Judges called in the expertise of psychiatrists more frequently. Also, TBR implied the establishment of **a new type of asylum** for the detention and care of psychopaths. Between 1928 and 1933 three such asylums were realized and after the Second World War these forensic institutions saw major expansion. However, until the 1950s or 1960s little actual **psychiatric treatment of TBR-convicts** was realized. The therapeutic repertoire comprised chiefly re-education through a disciplinary regime as well as (land) labor. The only medical intervention applied was **castration** of sex delinquents. In the 1940s and 1950s up to some 400 men who received a TBR-sentence for various sex offenses, especially homosexual ones, were castrated. Apart from this drastic medical treatment, until the 1950s or 1960s the asylums for psychopaths functioned as prison facilities rather than therapeutic facilities. Detainees experienced their forced institutionalization not so much as treatment but as punishment, especially given the indefinite duration of the detention, which in the light of the seriousness of their offense they often viewed as unreasonable.

In the 1930s some psychiatrists and criminologists began to move away from the notion of the inborn criminal and to argue for a less repressive and more emphatic approach of criminals based on psychological insights. Only after World War II such ideas would begin to carry weight. In the 1950s changes in the criminal law climate and new psychosocial and behavioral approaches fostered **optimism about treatment possibilities** of mentally disturbed delinquents, even though practice was not always up to the ideals. The growing recognition of the importance re-socialization of convicts as well as of psychiatric examination and therapeutic treatment of mentally disturbed delinquents was reflected in the rise of the number of TBR-sentences. Forensic psychiatry received a new boost especially through the work of some leading representatives of the so-called Utrecht School. Inspired by German phenomenological-anthropological psychiatry and French personalism, they submitted that not retribution should serve as guideline of criminal law, but understanding of the delinquent's personality, life history, individual circumstances, and his relationships and communications with other people. In this way forensic experts disassociated themselves from determinist psychiatric diagnoses in terms of hereditary disposition and psychopathy. Despite their crimes, delinquents remained approachable 'fellow human-

beings' who needed help. Their sense of social responsibility could be restored through a treatment based on empathy and understanding. The Utrecht School's adage was social rehabilitation and reintegration and it displayed great optimism about the possibilities to improve human beings.

In the 1950s, 1960s and 1970s psychiatrists tried to realize these ideas in several asylums for psychopaths. In addition the administration of psychiatric drugs and occupational and creative therapies, **various forms of socio-, psycho- and behavioral therapies were introduced**, whereby psychologists fulfilled a major role. Also, in line with reforms in mental health care in general in the 1970s, the regime in these institutions more or less loosened. In the course of the 1960s castration was abandoned. In the Netherlands – in contrast to countries such as Germany, the United States and Russia – no brain surgery has ever been performed on mentally disturbed delinquents. In the 1970s there was no broad social and political backing for drastic biomedical interventions, partly because of the critical stance vis-à-vis medical psychiatry by the anti-psychiatric movement. In the media and public opinion there was strong resistance against any form of biological explanation of human behavior.

However, precisely when TBR-institutions shifted their emphasis from social protection to socio- and psychotherapeutic treatment, the **TBR-system became subject to debate**. From the late 1950s judges began to question the system's therapeutic effectiveness and they doubted whether it made society safer indeed. There were hardly any scientific data on the effectiveness of treatment. In the 1960s the number of TBR-sentences dropped and more frequently than before these were combined with long prison sentences. Because of escapes and recidivism among TBR-convicts after their release, TBR-institutions gave cause to negative publicity as well as public and political commotion.

At the same time there was more **criticism of the lack of rights** of those sentenced with TBR, partly after media articles and political attention for abuses in some TBR-institutions as well as on account of anti-psychiatric activism and that of the patients' movement. These convicts could be locked up indefinitely, were always uncertain about their future, and were at the mercy of the medical regime: the physician's advice was a major factor in the decision every one or two years to prolong an individual TBR-sentence. Judges began to pay more attention to the legal protection of TBR-convicts and they increasingly began to deviate from medical advice to extend a TBR-sentence. Psychiatrists regretted this development, feeling that the legal argument undermined the effectiveness of treatment and that decisions on termination of TBR-sentences would have to depend on treatment results. In the 1980s, the legal rights of TBR-convicts were strengthened. Also, rules were laid down regarding coercion in TBS-institutions, freedom of movement, visiting rights, the right to correspondence and such. After a debate lasting fourteen years, the psychopath law was replaced with **a new law** adopted in 1986 and enacted in 1988. The new law provided disturbed delinquents more legal protection and limited the sentence to serious offenses. While before TBR, after a prison-term, had no maximum duration, the new law stipulated that as a rule it should not last more than four years. A longer TBR-term continued to be an option, however, if the judge felt that the security of society so demanded. In fact, because of the violence of their crimes, a

growing number of TBR-convicts was treated for more than four years. Already since the 1970s TBR largely applied to **severe acts of assault and sex offenses**. While around 1970 nearly 40 percent of the TBR-sentenced was guilty of harsh aggression and sexual violence, around 1990 this was true of 95 percent of the cases. TBR was no longer applied to most property crimes or sex offenses without assault. TBR was increasingly imposed violent crimes by repeated offenders with more or less serious mental disorders and/or (drug) addiction problems. The great majority of them were young males and a substantial portion of them was of non-Dutch background.

Between 1970 and the mid-1980s the annual number of TBR-sentences declined, but in the past twenty years it **increased to an unprecedented level**. Also as a result of a longer average duration of TBR-sentences, the forensic-psychiatric institutions expanded. Conversely, data on recidivism – averaging some sixty percent from the 1950s to the mid-1980s – continued to be ground for doubts about the effectiveness of therapeutic treatment. Partly as a result of the declining trust among judges and cost management concerns, in the late 1980s the emphasis shifted back again toward TBR as a form of detention in order to protect society. The fear of recidivism was a major reason for judges to impose this sentence.

While in the 1960s and 1970s forensic psychiatry was viewed as a humanitarian achievement, in the 1980s and 1990s, when the administration of criminal justice hardened, **skepticism grew**. The emphasis of forensic experts on the explicability of the act in the light of life history and character structure of suspects, was met with increasing criticism from judges and other experts as well. Therapists increasingly doubted on the possibility of curing TBS-convicts. They were still treated with drugs and psycho-, behavioral- and socio-therapies, but the optimism of the 1960s and 1970s about the possibility of changing their personality had been toned down. The therapeutic objectives shifted toward regulating behavior, self-control, and learning to avoid dangerous situations. Moreover, ***long stay*-departments** were set up for TBS-convicts who for six years had been treated in vain and who were considered as untreatable. Many sex offenders in particular seemed incurable. The TBS-institutions repeatedly got bad publicity after serious crimes by patients who were on probationary release or who had escaped. The focus partly shifted back from treatment to protection of society through risk calculation and management. Moreover, in psychiatry attention focussed more and more on the assumed genetic influence on criminal behavior and the deviant brain of criminals. The label ‘psychopath’, which since the 1960s had vanished as diagnostic category, became current again.

Also, more and more politicians advocated **a stricter TBS-regime** through swifter transfer of untreatable delinquents to *long stay*-wards and a prolonging of the maximal probation after discharge. Partly as a consequence of several widely-published escapes and serious crimes by TBS-convicts, in the spring of 2006 parliament initiated hearings on the practice of TBS. Besides expansion of the number of TBS-places, the parliamentary commission recommended to prolong psychiatric surveillance of discharged TBS-convicts (on parole) from maximal three years to nine years and in special cases even to lifetime. The government consented to these plans, although the

Justice Minister stressed that treatment and social rehabilitation should be preserved as essential elements of TBR.

All in all, the developments involving TBR during the last five decades show **conflicting tendencies**. On the one hand, this sentence was increasingly limited to serious violent crimes, more attention was paid to the rights of TBR-convicts, and the objections against the unfixed duration of their detention grew stronger. On the other hand, judges continued to question the effectiveness of treatment and the issue of security was more emphasized, precisely because TBR became geared more toward violent and dangerous delinquents. Whereas the anti-psychiatric movement publicly criticized psychiatry for its assumed repressive dimension, TBR received public attention mainly after incidental cases of escape or recidivism and it became increasingly associated with a too 'soft' approach of crime. Also, the new TBR-bill still failed to make clear choices between the protection of society and the relevance of individual treatment and re-socialization. These legal and medical objectives were at odds with each other and as a result discussions about collective versus individual interests as well as about the usefulness and the effects of this legislation kept flaring up. To this day the history of TBR is characterized by the tension between punishment and security on the one hand and treatment and re-socialization on the other. Whether one or the other prevailed, was largely tied to the social climate with respect to law, order, and authority, as well as to notions about democratic citizenship.

Forensic psychiatry developed from the late nineteenth century until the 1920s, **a period of social and political transformation in the Netherlands**. The emergence of mass society and ongoing democratization caused mounting concerns among the upper echelons of society regarding the dominance of irrational emotions and drives, which would only generate unruliness and social disintegration. Divergent behaviors that were considered as immoral and irresponsible, became the target of interference and intervention by both voluntary organizations and the state. Starting in the late nineteenth century, the striving for the people's moral elevation, which had been underway since the Enlightenment in the form of the bourgeois civilization offensive, spread more widely. The question behind it was whether all people had the necessary rational and moral qualities to meet the social responsibilities of an increasingly complex and democratic society. Would they be able to act as responsible, political citizens? With the gradual extension of the right to vote, climaxing in universal suffrage in 1919, bourgeois values were emphasized as crucial civic virtues. Central notions were self-control and having a sense of social responsibility. An industrious and productive existence and a sense of order and duty acted as cornerstones of the democratized bourgeois ideal of citizenship. Against the backdrop of these developments, the psychopath law was introduced for mentally disturbed offenders qualified as dangerous. Thereby the striving for protecting society carried more weight than treatment and re-socialization of these delinquents. This trend was further stimulated by the emphasis on law and order during the economic crisis in the 1930s and worries about social disruption and moral decay in the wake of the German occupation and the liberation by the allied forces.

In **the 1950s and 1960s a new approach crystallized** in forensic psychiatry, emphasizing the possibility of treating and thus re-socializing mentally disturbed

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

In the 1980s, with its politics of deregulation and privatization, liberal and Christian-democratic politicians began to shift the emphasis from the state-organized collective care facilities to the self-reliance of citizens in communities and on the market. **The 1970s ideology of individual liberation and emancipation was called into question.** Since the 1990s, Dutch politicians and intellectuals have been taking stock of the legacy of the 1960s and 1970s, largely evaluating it to be a negative one. The anti-authoritarian movement and the celebration of individual freedom, they argued, had degenerated into egoism, erosion of social responsibility, a coarsening of social interactions, and an increase of crime. The overall toleration policy and the new taboos of political correctness had led to a lack of self-restraint, a degradation of the public domain, and social disintegration. These developments had to be countered by the restoration and revitalizing of a sense of community and civic virtue, with an emphasis on adjustment and moral regeneration. The taboo on coercion and duties began to recede, for instance regarding the integration of migrants. This hardening of the social and political climate was reflected in a sharp rise of the number of TBR-sentences and a reduced trust in the treatment of forensic-psychiatric patients.