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Psychiatric nursing in the Netherlands and Great Britain: class, status and gender in the making of a profession

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ABSTRACT

In most Western countries psychiatric nursing, from the late nineteenth century onwards, developed as a specialization under medical supervision and within one general training scheme for all nurses. In the Netherlands as well as in the United Kingdom (UK), this occupation, initiated by psychiatrists, more or less distanced itself from somatic nursing. A comparison of the twentieth-century development of psychiatric nursing in these two countries shows similarities in its basic conditions and some of the problems it faced, but also some remarkable differences, which are largely of a social nature. We argue that Dutch mental health nurses, in cooperation with asylum doctors rather than in opposition to them, succeeded in establishing a stronger professional identity than their British colleagues: earlier in time and to a greater extent they had opportunities to voice their views on their work and to define the social and didactic nature of their vocation. Our explanation of these national contrasts focuses on gender, class and social status, which had dissimilar effects in the two countries because of some fundamental differences in the hierarchies and religious affiliations of institutional psychiatry as well as in the more general class structure of the Netherlands and the UK.

KEYWORDS

Psychiatric nursing; comparison; The Netherlands; the United Kingdom; professional development; class; gender; twentieth century

Historical studies of psychiatry have shed insufficient light on the crucial role of nurses in the care of the insane. Since the late nineteenth century they constituted by far the largest group among the staff in mental institutions. Because of their close and daily involvement with the mentally ill – in contrast to the usually limited direct contact of doctors with patients – nurses played a crucial role in the practice of care. However, their work was often undervalued and their voices are sporadic in the history of psychiatry, although there are exceptions, as we will show in this article on the similarities and differences in the twentieth century history of psychiatric nursing in the Netherlands and the United Kingdom.

The silence of psychiatric nurses is closely related to the way their vocation, from around 1890, was shaped by medical superintendents and

asylum doctors. Until far into the twentieth century, lunatic asylums had a poor reputation all over the Western world. They were largely populated by the lower class insane and funded by poor relief. Admission to these institutions was associated with incarceration because it often implied legal procedures and loss of civil rights. Until the late nineteenth century the involvement of physicians in these closed institutions was limited and nursing care, as we now understand it, was rare. The main task of the largely unschooled ‘attendants’, ‘servants’ and, in religious institutions, also Catholic brothers and sisters, was guarding and controlling the inmates’ disruptive behaviour. Although the English asylum doctor John Conolly considered the attendants ‘his most important medicine’, and made a plea for non-restraint as early as 1856, coercion, mechanical restraints and solitary confinement continued to be applied, and maltreatment of patients was no exception.¹ Low salaries and bad working and living conditions deflated the quality of this personnel and caused a high staff turnover, in the Netherlands as well as in the UK.

In the wake of legal reforms, which installed state supervision of asylum care and aimed for a more humane and therapeutic approach, from the 1860s and 1870s onwards, some physicians in Western Europe became more active in their ambition to transform lunatic asylums into *medical* facilities. For them, the incompetent and ‘uncivilized’ attendants were a major problem. The insane should be nursed on the basis of hygienic guidelines, medical instructions, middle-class standards of behaviour, and humanitarian attitudes: compassion, patience and helpfulness. This aspiration of doctors to replace the ill-equipped attendants by motivated and trained nurses, was boosted by the rise of nursing in general hospitals as a vocation for unmarried middle-class women. Nursing was framed as a typically female occupation, reflecting women’s supposedly natural proclivity for ‘tender loving care’ and role in family life.² The dominant gender ideology was reproduced in the subordination of female nurses to male physicians.

¹J. Conolly, *The Treatment of the Insane without Mechanical Restraints* (London, 1856); C. aan de Stegge, *Gekkenwerk. De ontwikkeling van het beroep psychiatrisch verpleegkundige in Nederland 1830–1980 [That’s Madness. The development of psychiatric nursing as a profession in the Netherlands 1830–1980]* (Maastricht, 2012), 66–69.

²The first translation of Florence Nightingale’s book *Notes on Nursing* (1859) had a warm reception among Dutch medical doctors in 1862. See the foreword by G.E. Voorhelm Schneevoogt in F. Nightingale, *Over ziekenverpleging. Wat men, om de herstelling te bevorderen, te doen en te vermijden heeft. [On Nursing the Sick. What one must do and avoid when one intends to be beneficial for health]*, Amsterdam, 1862, XIII–XIV. Voorhelm Schneevoogt recommended Nightingale’s book to all women who wanted to become a nurse, to mothers of families, to teachers in nursing and, finally, to all citizens. Meanwhile, the most important reformer in Dutch psychiatry J.L.C. Schroeder van der Kolk, had urged for a translation of the American *Manual for Attendants in Hospitals for the Insane* by the Philadelphian doctor J. Curwen. One of Schroeders alumni took up this wish, interweaving the Dutch version of the American Manual with texts from German handbooks and accentuating some of his own advice. He published this Dutch Manual half a year before the translation of Nightingale appeared.

When, around 1890, asylum doctors initiated the vocational training of psychiatric nurses, they tended to follow the model of general health care. In most Western countries psychiatric nursing developed as a specialization within one general training scheme for all nurses. In the Netherlands as well as in Great Britain, however, this occupation would evolve separately from somatic nursing.³ A comparison of the twentieth-century development of psychiatric nursing in these two countries is interesting because, apart from similarities in its basic conditions and some of the problems it faced, outcomes were different. We focus on its advance in the Netherlands and compare this with developments in Britain.

We argue that Dutch psychiatric nurses succeeded in establishing a stronger professional identity than their British colleagues: earlier in time they had possibilities to voice their views on their work and to define the nature of their vocation. Our explanation focuses on gender and class, which had dissimilar effects in the two countries because of some fundamental differences in institutional psychiatry as well as in the more general class structure. In the Netherlands both were aligned to ‘pillarization’; the compartmentalization of society along religious and ideological lines, which crossed and mitigated class divisions.

Apart from other sources (teaching material for nurses; the minutes of exam committees; practical report books; documents of professional associations, trade unions and supervisory and government agencies; chronicles and statistical surveys), we have especially used material in which the voices of psychiatric nurses can be clearly heard: essays written by and interviews with them, their professional journals, working papers and training guides written by leading nurses.

The emergence of psychiatric nursing as an occupation (1890–1925)

From the 1870s on doctors, supported by their professional organization, the Dutch Association of Psychiatry and Neurology (DAPN), increasingly

³B. Abel-Smith, *A History of the Nursing Profession* (London, 1960); M. Arton, ‘The Professionalisation of Mental Nursing in Great Britain 1980–1963’ (PhD dissertation [History of Medicine], London, 1998); C. Chatterton, ‘Training mental health nurses in the United Kingdom: a historical overview. Part one: pre 1948’, *The Bulletin of the UK Association for the History of Nursing*, 3 (2014), 22–33; C. Chatterton, ‘Training mental health nurses in the United Kingdom: a historical overview. Part two: 1948 onwards’, *The Bulletin of the UK Association for the History of Nursing*, 3 (2015), 5–14; O.M. Church, ‘That Noble Reform. The emergence of psychiatric nursing in the United States, 1882–1963’ (PhD dissertation, Chicago, 1982); O.M. Church, ‘From custody to community in psychiatric nursing’ *Nursing Research*, 36, (1987), 48–55; R. Dingwall, A.M. Rafferty and C. Webster, *An Introduction to the Social History of Nursing* (London, 1988), 132, 137, 143; D. Falkenstein, (2000) ‘Ein guter Wärter ist das vorzüglichste Heilmittel ...’ *Zur Entwicklung der Irrenpflege vom Durchgangs- zum Ausbildungsberuf [...]* (Frankfurt am Main, 2000); P. Nolan, *A History of Mental Health Nursing* (Cheltenham, 1993), 50, 64, 79; A.J. Sheridan, ‘An analysis of the activities of psychiatric nurses practising in Ireland from 1950 to 2000’ (PhD dissertation, Birmingham, 2003); C. aan de Stegge, *Gekkenwerk*; G. Svedberg, ‘Nurses in Swedish Psychiatric Care’, in M. Gijswijt-Hofstra et al. (eds), *Psychiatric Cultures Compared. Psychiatry and mental health care in the twentieth century. Comparisons and approaches* (Amsterdam, 2005), 359–78; A. Walk, ‘The history of mental nursing’, *Journal of Mental Science*, 107 (1961), 1–17.

established control over the operation of asylums in general and the management of the attending staff in particular. In the 1880s and 1890s several new mental institutions were built, providing more room for therapeutic facilities such as moral treatment and occupational therapy as well as bed care and prolonged baths, while curtailing the need for mechanical restraints.⁴ Some asylum doctors began to copy the nursing course for the attendant staff in an Amsterdam asylum, which had been set up in the early 1880s by its medical director and one of the first certified nurses in the Netherlands. The DAPN praised this ‘in-service training model’ as a wholesome substitution of ‘harshness and coarseness’ for ‘the impact of the civilized woman’.⁵ Between 1891 and 1903 three nationwide training courses for nurses, one administered by the DAPN, the others by an orthodox Protestant psychiatric organization and by the Dutch government for its forensic asylums, were implemented in mental institutions. In 1925 a distinct Catholic training scheme would be added to attract Catholic lay nurses, although the Catholic brothers and sisters already followed nursing courses of the DAPN from 1905 on. The two-year (from 1894 onwards, three-year) curriculum was taught by senior doctors, and the student nurses were employed and housed in the asylum. To be admitted to the programme they should be at least 18 years old and show aptitude, decent behaviour and robust health. Apart from knowledge of biology, medicine, hygiene, mental disorders and the legal aspects of asylum hospitalization, they learned practical skills in the field of somatic nursing as well as observation and treatment of the mentally ill. ‘Civilized’ manners and housekeeping skills were considered as a plus.⁶

Leading asylum doctors in the DAPN proclaimed that psychiatric nursing, like its somatic counterpart, was primarily an occupation for ‘young ladies of rank’, because of, as one of them put it, their ‘sensitivity, tact, helpfulness’ and ‘civilizing and educational talent’.⁷ Their attempts to recruit middle-class women with a secondary education, however, largely failed, because such candidates generally preferred to enrol in nurse

⁴H. Oosterhuis and M.F. Gijswijt-Hofstra, *Verward van geest en ander ongerief. Psychiatrie en geestelijke gezondheidszorg in Nederland (1870–2005)* [*Mentally Confused and Other Hardships. Psychiatry and mental health care in the Netherlands (1870–2005)*] (Houten, 2008), 70–185; C. aan de Stegge, ‘Changing attitudes towards “non-restraint” in Dutch psychiatric nursing 1897–1994’, in Gijswijt-Hofstra et al, *op. cit.*, 331–58.

⁵J.N. Ramaer, ‘De ontwikkeling van het Krankzinnigengesticht in onze tijd’ [‘The development of the asylum in our age’] *Nederlands Tijdschrift voor Geneeskunde* (subsequently *NTvG*) [*Dutch Journal of Medicine*], 22: vol. II (1886), 365–89; J. van Deventer, ‘Eenige opmerkingen over de psychische behandeling van krankzinnigen’ [‘Some remarks on the psychological treatment of the insane’], *Psychiatrische Bladen* (subsequently *PB*) [*Psychiatric Papers*], 6 (1888), 20–31; A.O.H. Tellegen, ‘Verleden heden en toekomst van de krankzinnigenverpleging in Nederland’ [‘Past, present and future of nursing the insane in the Netherlands’] *PB*, 8 (1890), 146, 189–96.

⁶Van Deventer, ‘Eenige opmerkingen’ [1888], *op. cit.*; J. van Deventer, ‘Eenige beschouwingen over krankzinnigenverpleging’ [‘Some thoughts on nursing the insane’], *PB*, 10 (1892), 232–51; J. van Deventer, W.P. Ruysch and A.O.H. Tellegen, ‘De verbetering van het verplegend personeel in de Nederlandsche Krankzinnigengestichten’ [‘The improvement of the nursing staff in Dutch asylums’], *PB*, 8 (1890), 226–9.

⁷W.H. Cox, ‘De verpleegsters-kwestie’ [‘The female nurses’ issue’], *PNB*, 2 (1898), 234–42.

training in general hospitals rather than in asylums. The stigma associated with the insane, their disorderly and possibly violent conduct, the low wages and the mandatory internship in asylums, situated in more isolated locations than general hospitals, were disincentives for choosing psychiatric nursing. Therefore, asylums largely depended on young women, as well as men, from the lower-middle and working class, who had only passed primary schooling. Apart from the religious staff in Catholic asylums and, to some extent, the nurses in orthodox-Calvinist institutions, for whom this work was part of a religious calling, most psychiatric nurses considered their job primarily as a way to make a living. For several of them, however, it also offered an opportunity to rise on the social ladder. Asylum doctors took pains to remedy their lack of secondary education by offering them extra schooling during a preliminary year and requiring an entrance examination, which half of the candidates passed.⁸ Successful passing of the complete programme, while working in the asylum up to 15 hours a day, demanded motivation and perseverance. Of the 13,000 candidates who applied for the DAPN-training scheme between 1892 and 1925, around 9,400 were admitted and about 3,100 eventually passed the final exam.⁹ The recruitment of middle-class women was given up, but the requirements of the training course warranted a fairly rigorous selection process.

Although Dutch asylum doctors were divided along religious lines, their involvement with nursing served their joint ambition to raise the level of asylums to the status of modern hospitals and with it their own (disputed) standing in medicine and in society at large. Leading nurses played a crucial role as practical instructors and daily supervisors, but, until the middle of the twentieth century, psychiatric nursing was embedded in a professional and also a social hierarchy of middle and upper-class physicians versus predominantly lower-class nurses. To a large extent, like in general medicine, there was also a gender hierarchy, since even leading female nurses were subordinated to male physicians. Nurses themselves had little say in the contents of their training. The doctors considered them as assistants, who should follow their guidelines. Yet, in the course of the twentieth century, as we will see, nurses increasingly gained influence on the profile of their occupation.

Asylum doctors and physicians in general hospitals shared basic interests and views with regard to nursing, but attempts to establish a common framework for somatic and psychiatric nursing, around 1900 and again in the 1920s, failed because some of their aspirations collided. The last group, doubting psychiatry's scientific rigour and curative power, sought to

⁸Aan de Stegge, *Gekkenwerk*, *op. cit.*, 222–3.

⁹*ibid.*, 213.

standardize the training of nurses and to raise the qualifications for the diploma by prioritizing experience in somatic health care and the related medical and technical skills. In their view asylums, as charitable and custodial institutions, did not fully meet these demands; therefore, all students should follow internships in general hospitals. Since the physicians in general hospitals did not require a comparable internship in a mental asylum of general nursing students, a double standard seemed to be applied. The refusal of general hospitals to acknowledge the diplomas issued in mental asylums displeased asylum doctors. They rightly feared that prospective middle-class candidates with a secondary school education would be discouraged from psychiatric nursing, thus turning it into a second-rate job.¹⁰ This was confirmed by the fact that in the mid-1920s only 25% of the total Dutch psychiatric nursing staff was certified, while in Dutch general hospitals this had risen to 40%.¹¹

The tensions resulted in the separation of general and psychiatric nursing. Their distinctive character was officially confirmed by the Legal Protection of the Nursing Diploma Act, ratified by the Dutch parliament in 1921. The training schemes of somatic and psychiatric nursing were supervised by the national government and the names of certified nurses were registered on two national lists, one for general nurses under the supervision of the Health Department at the Ministry of Social Affairs and the other for psychiatric nurses under the authority of the Poor Relief Department at the Ministry of Internal Affairs.¹² This exceptional position of psychiatric nursing, reflecting that the asylums were not administered as health care, was reinforced in 1925, when the Dutch National Federation of Nurses applied for membership of the International Council of Nurses. This Council stipulated that all voting members of its affiliated national organizations were obliged to have a diploma in general nursing. Thereupon Dutch psychiatric nurses were denied the right to vote in the Dutch Federation and excluded from international representation.¹³ Since psychiatrists and psychiatric nurses felt this as unfair, they now tended to follow their own course.

This early development of Dutch psychiatric nursing showed some basic similarities with that of mental nursing in the UK. After the publication of the first *Handbook for the Instruction of the Attendants on the Insane* in 1885, the professional organization of asylum doctors, the Medico-

¹⁰W.P. Ruysch, A.O.H. Tellegen, and J. van Deventer, 'Verslag der conferentie van 19 februari 1898, ten één ure "Keizershof" Buitenhof, Den Haag ['Minutes of the Conference of 19 February 1898, at one p.m. in "Keizershof" Buitenhof, The Hague]', *Psychiatric and Neurological Papers*(subsequently *PNB*), 3 (1898): 248–63.

¹¹Aan de Stegge, *Gekkenwerk*, *op. cit.*, 1010.

¹²P.J.M. Aalberse and Ch. Ruijs de Beerenbrouck, 'Wet tot wettelijke bescherming van het diploma voor ziekenverpleging' ['Legal protection of Nursing Certification Act'], *Staatsblad* [*State Bulletin*; subsequently *SB*], 21 May 1921, Decree 702: 253; Aan de Stegge, *Gekkenwerk*, *op. cit.*, 309–36.

¹³Aan de Stegge, *Gekkenwerk*, *op. cit.*, 365–82.

Psychological Association, initiated a training scheme admitting women as well as men. The first 35 candidates passed exams in 1891 and the number of issued certificates soon grew to 600 per year, amounting to a total of more than 17,000 by 1924. British historians of mental nursing, however, use a variety of sources to establish the size of mental nursing staff. Claire Chatterton's count of 4,047 certified nurses (2,263 males and 1,784 females) in 1921 covers the entire UK.¹⁴ The numbers presented by Peter Nolan (2,743 certified nurses, not more than 17% of the complete attending staff of around 17,000) only cover the asylums of England and Wales.¹⁵ Together these data suggest that the turnover of certified nursing staff must have been very high, in particular that of women, who were outnumbered by men who constituted 55% (against 45% women). As in the Netherlands, the main objective of British asylum doctors was to boost the medical prestige of psychiatry, but at the same time they faced disapproval in general hospitals. Of the two existing organizations for general nursing, the College of Nurses (founded in 1916, later to become the Royal College of Nursing) and the Royal British Nurses Association, it was especially the last one that, on the basis of middle-class values, distanced itself from its psychiatric counterpart, in particular from the (working-class) men working in this field. In both countries general medicine and institutional psychiatry competed over scarce well-educated middle-class women. Even more than Dutch mental institutions, British ones had trouble retaining certified female nurses because they preferred working in general hospitals, while at the same time they could not attract skilled and career-oriented men because salaries were low.¹⁶

The second-rate standing of psychiatric nursing in Britain was reflected in the Nurses Registration Act and its administrative body, the General Nursing Council (GNC), which around 1919 realized official recognition of nursing as a certified occupation. Psychiatry was underrepresented and mental nurses as well as all male nurses were registered in separate, supplementary registers. At the same time the GNC, while keeping the Medico-Psychological Association out, introduced its own examination in psychiatric nursing. Also, it pushed forward a 'one portal' system of entry, implying that all nurses would pass a 'generic' (but in fact somatically

¹⁴Chatterton, 'Training mental health nurses in the UK ... Part one', *op. cit.*, 28; see also Dingwall, Rafferty and Webster, *op. cit.*, 129; In emails to Cecile aan de Stegge dated 13 February 2018 and 1 June 1 2018 Claire Chatterton explained the differences in numbers of mental nursing staff in England between her own publications of 2014 and 2015 and those given by Peter Nolan in his book of 1993. Chatterton bases her numbers on the so-called 'Cobb report' of 1922 on England, Wales, Ireland and Scotland, while Peter Nolan (1993) bases his on the 1924 Report 'Nursing in County and Borough Mental Hospitals'. The latter report is about nursing staff in the asylums of England and Wales, which explains why his numbers are lower than those mentioned by Chatterton. Because only Nolan also gives a number for the total quantity of beds, his numbers enable comparison of patient ratios between the Netherlands and England and Wales.

¹⁵Nolan, *op. cit.*, 85.

¹⁶Dingwall, Rafferty and Webster, *op. cit.*, 132, 137; Nolan, *op. cit.*, 50, 64, 69, 84; Walk, *op. cit.*, 11.

oriented) preliminary examination. The GNC disputed the continuation of the separate mental nursing training scheme because in the view of leading general nurses it did not meet the medical standards of nursing. This stance caused resentment among psychiatrists as well as the large majority of psychiatric nurses, in particular the men among them. The National Asylum Workers Union accused the GNC of ‘snobbish attitudes’ which resulted in ‘an unbridgeable gulf between the mental and the general nurse’. The vast majority of certified mental nurses (around 95%) followed the Medico-Psychological Association’s training scheme instead of the GNC’s one.¹⁷

Until 1951 these two separate training schemes qualified for certification as mental nurse, but only the GNC’s scheme provided *registration* as nurse in Britain, while the relation between the two supervising organizations reached an impasse. Much more than in the Netherlands, psychiatry was pushed into the defensive because of the persistent agenda of the GNC to integrate mental nursing into general nursing and to bring it into line with hospital medicine.¹⁸ This impeded reflection about the distinct nature of mental nursing. Another difference was that the tension between the two branches of nursing in the UK was much more affected by class and gender antagonisms than in the Netherlands: the middle-class women who controlled the GNC looked down on working-class mental nurses and in particular on the substantial number of male nurses – the share of these so-called ‘attendants’ amounted to 45% of all nursing personnel and almost 60% of all certified mental nurses.¹⁹ Whereas class and gender stereotypes hampered the development of mental nursing in Britain, the working class background of Dutch psychiatric nurses and the large numbers of certified males among them – although their share was somewhat lower than in Britain – challenged Dutch psychiatrists as well as male nurses to articulate the distinctive, partly non-medical profile of the occupation.

The situation of Dutch psychiatric nurses differed in some fundamental ways from that of their British colleagues. Dutch asylum psychiatry – like the rest of health care and other sectors of society – was organized along religious and ideological lines. Apart from neutral or public asylums, many institutions arose from voluntary, religion inspired initiatives: orthodox-Calvinist, Roman Catholic, Dutch Reformed and Jewish. This differentiation entailed that Dutch asylums were generally smaller than the public institutions in Britain, where religious organizations did not play an important role in psychiatry. Whereas the average number of beds in

¹⁷Chatterton, ‘Training mental health nurses in the UK ... Part one’, *op. cit.*, 27–28.

¹⁸E. R D. Bendall and E. Raybould, *A History of the General Nursing Council for England and Wales 1919–1969* (London, 1969).

¹⁹Nolan, *op. cit.*, 81, 84–85; Dingwall, Rafferty and Webster, *op. cit.*, 132; C. Chatterton, ‘“Caught in the Middle?” Mental Nurse Training in England, 1919–1951’, *Journal of Psychiatric and Mental Health Nursing*, 11 (2004), 33; Abel-Smith, *op. cit.*, 255.

British public mental institutions was over a thousand and the largest one amounted to around 2,800, in the Netherlands asylums surpassing 1000 beds were exceptional. Dutch psychiatrists strongly opposed the ‘warehousing’ of patients.²⁰ The care-system for the insane in Britain was even more closely intertwined with public poor relief and also organized in a more hierarchical way than in the Netherlands. Not only were all residents of asylums, except for a few private patients, classified as ‘paupers’, but also many of the insane were hospitalized in workhouse-affiliated infirmaries.²¹ Moreover, the share of certified nurses among the attending staff as well as the nurse–patient ratio in Dutch and British asylums increasingly diverged in the period between the World Wars. In the early 1920s the average number of patients for each psychiatric nurse was 4.7 in Dutch asylums and 5.5 in the institutions in England and Wales. As far as certified nurses were concerned the gap between nurse–patient ratios was ever larger: in Dutch asylums the average number of patients for each certified nurse was 19 and in English and Welsh institutions it was 39, less than half of the Dutch ratio.²² British superintendents and other administrators in the field of institutional psychiatry did not support a better educated nursing staff, because they feared an undermining of their authority.²³ Not only the more advantageous nurse–patient ratio in Dutch asylums, but also their smaller scale – many of them were built according to the pavilion or cottage system – offered a more favourable environment for the introduction of diverse methods of care and treatment, and for an active involvement of psychiatric nurses. Dutch asylum doctors and later also psychiatric nurses themselves would succeed in bending their isolated and second-class position into an asset. More than its British counterpart, Dutch psychiatric nursing would actively detach itself from general nursing and develop into a more or less autonomous occupation with a distinct profile that combined the medical approach with broader – including moral, didactic and social – views on the treatment of the mentally ill.

Although Dutch asylum doctors regretted the separation between somatic and psychiatric nursing because of the negative effect on the class background and educational level of the candidates they could recruit, at the same time, in contrast to their British colleagues, they succeeded in taking advantage of this state of affairs. Their exclusive control over the training of psychiatric nurses, without the need to conform to all standards in somatic health care, enabled them to profile the distinctiveness of psychiatric nursing. Apart from teaching basic medical

²⁰S. Goodwin, *Comparative Mental Health Policy. From institutional to community care* (London, 1997), 9; Nolan, *op. cit.*, 84; Aan de Stegge, *Gekkenwerk, op. cit.*, 720, note 158; H. Freeman, ‘Psychiatry and the State in Britain’, in Gijswijt-Hofstra et al, *op. cit.*, 135.

²¹Freeman, *op. Cit.*, 118–19.

²²Aan de Stegge, *Gekkenwerk, op. cit.*, 1010; Nolan, *op. cit.*, 84–85.

²³Chatterton, ‘Training mental health nurses in the UK ...Part one’, *op. cit.*, 28.

and hygienic knowledge and skills, the instructors highlighted other aptitudes: relating to the mentally ill in a patient and empathic manner; observing and describing their conduct and symptoms; dealing with their disorderly and agitated behaviour in a reticent and tactical way. In their nursing textbooks doctors explained that patients needed daily pursuits in order to distract their disturbed minds and that nurses should associate and cooperate with them. Social and didactic competences and, in orthodox-Protestant and Catholic asylums, also moral and religious values were considered to be crucial.²⁴

Against this background, asylum doctors, in particular orthodox Calvinist ones, reconsidered their ambition to recruit middle-class women as student nurses and geared their staffing policy to the realities of the labour market. In their view patients, most of whom came from the lower classes, should be cared for by nurses with the same social and religious background since they spent a lot of time together on the wards, worked together in household chores and occupational therapy, and shared leisure activities. Moral calibre and character traits such as calmness, patience and tact were more important, they argued, than intellectual education or bourgeois standards of behaviour. Moreover, the value of occupational therapy, for economic as well as therapeutic reasons, implied that also men, in particular those skilled in crafts, could play a useful role as nurses – apart from their mobilization on wards with male patients who showed disorderly (sexual or aggressive) behaviour. Around 1910 more than a third of all (certified and non-certified as well as religious) nurses in Dutch asylums were men, while their share in the total nursing staff of general hospitals was at the very most 10%.²⁵ During the twentieth century the share of Dutch male psychiatric nurses would fluctuate between 30 and 40% of the total (certified and student) nursing staff, but it amounted to 40 and 55% of all *certified* nurses in psychiatric institutions.²⁶ Whereas female nurses were entitled to work on wards for female and male patients – which was not the case in strictly sex-segregated British institutions, nor in Dutch Catholic ones – their male colleagues were only allowed to work with male patients.

²⁴J. van Deventer, *Handboek der Krankzinnigenverpleging [Manual on Nursing the Insane]* (Amsterdam, 1897); B. van Delden, *Onze krankzinnigen en hunne verpleging [Our Insane and How to Nurse Them]* (Utrecht, 1897); D. Schermers, *Handleiding bij het verplegen van krankzinnigen [Manual for Nursing the Insane]* (Leiden, 1898); J.C. Th. Scheffer, *Voorlezingen over zenuwzieken en krankzinnigen en hunne verpleging [Lectures on Nervous Sufferers, the Insane and How to Nurse Them]* (Haarlem, 1906); P.H.M. Travaglino, *Gids ter voorbereiding op het examen in krankzinnigenverpleging [Guide for Preparing the Final Exam on Nursing the Insane]* (Amsterdam, 1910); J.G. Schnitzler, *Krankzinnigen en hunne verpleging [Nursing the Insane]* (Amsterdam, 1915).

²⁵G. Boschma, *The Rise of Mental Health Nursing. A history of psychiatric care in Dutch asylums 1890–1920* (Amsterdam, 2003), 188; Aan de Stegge, *Gekkenwerk*, *op. cit.*, 1010.

²⁶E. Borgesius, J. de Lange and P. Meurs, *Verpleegkundigen zonder Uniform [Nurses without Uniform]* (Utrecht, 1988) 191; W. van der Windt et al., *Feiten over verpleegkundige en verzorgende beroepen in Nederland 2002 [Facts and Figures about Nurses and Other Care Professions in the Netherlands 2002]* (Utrecht, 2002), 54.

The turnover of Dutch female psychiatric nurses, although showing a declining line, was higher than that of men. Not only did marriage imply dismissal of women between 1924 and 1957; many of them also left the asylum sooner or later after their certification, in order to continue their career in a general hospital, nursing home or in social psychiatry, which offered better and sometimes more independent working conditions.²⁷ In asylums, however, male nurses, to some extent, enjoyed better terms of employment, although they could obtain the position of head nurse only in male Catholic institutions. Married men were not dismissed and they even received a higher salary as breadwinners, and more private and spacious housing. This is why male nurses on average were longer employed in mental institutions than most women.²⁸ Also, because of their gender and distinct skills in crafts, their subordination to doctors was not as complete as that of their female colleagues. On the basis of their longer experience and their central role in occupational therapy, some male nurses started to reflect on their work and advanced its social and pedagogical orientation.

In 1916 and 1917, for example, the periodical of the Dutch Association for Male Nurses, founded in 1906, published a remarkable series of articles, written by Henri van den Bor, a psychiatric nurse in his early 30s from Amsterdam.²⁹ He argued that the nursing guides authored by psychiatrists did not devote sufficient attention to what in his view should be the core of psychiatric nursing: how to associate in a respectful and considerate way with disturbed persons who often behaved in erratic ways. Empathy, insight into human nature, communicative skills, self-control and patience were essential. Nurses should try to understand the experience and feelings of patients, while at the same time being able to keep some professional distance. Van den Bor strongly believed that being a good nurse was more than just fulfilling formal qualifications: subjective attitudes and experiences mattered even more. Because of such involvement in their work and their longer careers compared to those of women, male psychiatric nurses such as Van den Bor played a crucial role in the first labour unions and professional organizations for nurses, which fought for better labour conditions and official recognition of their qualifications. Their activism contributed to the emancipation and professionalization of nursing in general.

Apparently, the attitudes of Dutch psychiatrists and the small-scale and 'pillarized' mental institutions provided certified male as well as female

²⁷G. J. C. aan de Stegge, 'Honderdtwintig jaar psychiatrische verpleegopleiding in Nederland' ['120 years Psychiatric Nursing Course in The Netherlands'], *Gewina, Tijdschrift voor geschiedenis der Geneeskunde, Natuurwetenschappen, Wiskunde en Techniek* [Gewina, Magazine for the History of Medical and Natural Sciences, Mathematics and Physics] 27 (2004), 78–99.

²⁸Boschma, *op. cit.*, 199–204; Aan de Stegge, *Gekkenwerk, op. cit.*, 240–1.

²⁹H. van den Bor, 'Iets over de verpleging van krankzinnigen', Deel I–VI' ['Some notes on nursing the mentally ill, Part I–VI'], *Maandblad van de Nederlandsche Verplegers Vakvereniging* [Dutch Professional Male Nurses Association Monthly], 10 (1916), 153–8; 193–5; 213–19; 233–6; 11 (1917), 70–74; 144–50.

nurses with more possibilities for an engaged dedication to their work. In general, Dutch psychiatric nurses were more satisfied with their occupation because some of their aspirations dovetailed with those of psychiatrists. Compared to their colleagues in other European countries, including the UK, Dutch psychiatrists were somewhat more reserved towards biological explanations and somatic treatments. In general, their approach was eclectic and pragmatic, and many of them had an open mind towards moral, didactic and social perspectives as well as psychoanalysis and phenomenological and anthropological psychiatry.

In contrast, mental nursing in the UK was more 'caught in the middle', as Chatterton has characterized its uncertain and continuously disputed position between psychiatry and medically oriented general nursing.³⁰ Although most mental nurses preferred to be trained by psychiatrists rather than by leading general nurses, the GNC again and again questioned the authority of psychiatrists in nurse training. Most psychiatrists responded with a tendency to stick to the medical model, which was reflected in the contents of the training course for mental nurses in the UK: the first phase focused on medical-somatic knowledge, while psychiatric aspects were only treated in the last year. The basic training did not match well with nurses' daily work in mental institutions. The medical character of mental nursing was also fed by the leading 'matrons', nurses with a background in somatic health care, who took general hospitals as their model and downplayed the specific features of mental nursing. Contrary to Dutch psychiatrists, their British colleagues hardly disputed this orientation.³¹ Male mental nurses on the other hand – like their Dutch male counterparts – showed their discontent about this and aspired to more say about the contents of their work. In 1910, four years after their Dutch colleagues did so, they organized themselves in the National Asylum Workers Union, which addressed working conditions as well as the quality of care for patients. Between 1918 and 1923 there were significant strikes of mental nurses in the UK. Such strikes did not occur in the Netherlands.

Psychiatric nursing as a social-didactic occupation (1925–1965)

From the First World War on, the requirements of the Dutch psychiatric nursing exam were raised with respect to knowledge of mental pathology; pedagogical, communicative and observational skills; writing diagnostic reports, and responsibilities in occupational therapy, whereas the student nurses' progress during their training period was more rigorously monitored. The new stipulations were triggered by changes in the patient

³⁰Chatterton, 'Caught in the middle?', *op. cit.*

³¹Walk, *op. cit.*, 13; Chatterton, 'Training mental health nurses in the UK ... Part one', *op. cit.*, 29–30.

population and in the therapeutic regime of asylums, as well as by the development of social psychiatry.

Firstly, from 1916 on, in addition to the existing court sanctioned admission, uncertified hospitalization of patients suffering from nervous disorders, psychosomatic complaints or mild psychosis was made possible in open or sanatorium wards of mental institutions. These patients showed greater awareness of their condition and were generally more approachable and communicative, but also more demanding than many of the insane. Psychiatric nurses were supposed to serve as a confidential intermediary between these articulate patients and their physician, and this required empathic and communicative aptitudes.³² The Netherlands was among the first countries that opened asylum wards for voluntary admissions according to medical criteria, initiating a gradual transformation of rather closed asylums, where patients were hospitalized only or mainly for custodial reasons, into more open mental hospitals. In the UK a similar development started later: in 1930 the Mental Treatment Act enabled open wards, but this did not have any repercussions for nurse-training.

Secondly, for female nurses, and later also for males, a promising career opportunity emerged with the development of social psychiatry. From the early 1920s onwards, psychiatric institutions organized before and after-care services arranging help to not yet hospitalized or discharged patients in order to prevent their (re)admission. These outpatient facilities were supervised by psychiatrists, but experienced psychiatric nurses had to play a crucial and largely independent role: they mobilized social support and paid home visits. As a consequence, in 1937 the DAPN launched a new training course geared to a diploma in 'extramural aftercare', in which senior nurses, for the first time, served as teachers. This course, which until 1965 was open to women only (the diploma was linked to the general 'district nursing' course which included obstetrics), proved a great success, culminating in 1973 in an officially recognized registration and title: 'social-psychiatric nurse'.³³ From that moment on male nurses would take on many leading positions in this field. With this specialization in psychiatric nursing, the Netherlands was ahead of other Western countries. In Great Britain the practice of community mental health nursing did not develop until the late 1960s and formal training not until 1974.³⁴

Thirdly, from the late 1920s the so-called 'more active therapy', introduced from Germany, was applied in many Dutch mental institutions, and it would remain a standard method well into the 1960s. Occupational

³²Aan de Stegge, *Gekkenwerk*, *op. cit.*, 188–92.

³³I. van der Padt, *Hoopvol bezorgd, sociaal psychiatrische verpleegkunde van de 20^e naar de 21^e eeuw* [*Hopeful Care. Community mental health nursing from the 20th to the 21st century*] Eindhoven, 1999), 150.

³⁴N. Brimblecombe, 'The changing relationship between mental health nurses and psychiatrists in the United Kingdom', *Journal of Advanced Nursing*, 49 (2005): 344–53; Freeman, *op. cit.*, 131–2.

therapy, which had been widely practised since the nineteenth century for economic reasons and as part of moral treatment, was redefined as a didactic method for stimulating patients' latent abilities, social behaviour and sense of responsibility. Some leading asylum doctors focused on the behaviourist and corrective facets of active therapy, conditioning patients through a stimulating institutional environment and the systematic rewarding and discouraging of adjusted and undesirable behaviour. Other psychiatrists, in particular those who favoured psychological and psychoanalytic approaches, used active therapy as a psychosocial framework for intensive involvement and communication between nurses and patients, not only through 'working' together, but also by participating in their daily routines and by organizing recreational activities. In Britain 'more active therapy', arriving via the Netherlands, was only adopted for a minority of mental hospital patients and mental nurses were not as involved in it as their Dutch colleagues.³⁵ It must have been for this reason that the Indian government adopted the advice of the World Health Organization in 1953. A female *Dutch* psychiatric nurse, C.A.M. (Kitty) Verbeek, was invited in this former British colony to develop a specialist course in 'mental health nursing' for the nurses who worked in the All India Institute of Mental Health in Bangalore (see [Figure 1](#)). This course was officially acknowledged by the British Royal College of Nursing in 1958.³⁶

That such innovations appealed to Dutch nurses and changed their daily work can be gathered from the essays which 84 of them submitted on the occasion of a writing contest organized by the DAPN in 1941.³⁷ These essays are remarkable, not only because nurses expressed themselves frankly about their experiences and motives, but even more because some of them showed a self-confident attitude and a pronounced view on their occupation, as Van den Bor had done earlier. Many authors referred to their role in active therapy and reported improvement of living conditions in the asylums and, to their own surprise, in the behaviour of many previously apathetic or agitated patients. The need to apply restraints or isolation had dwindled. They had come closer to patients, in particular through joint relaxation after work as well as festivities, games and sports. The stimulating approach of

³⁵A. Stärcke, 'Moderne behandeling van geesteszieken' ['Modern treatment of the mentally ill'], *Nederlandsch Maandschrift voor Geneeskunde* [Dutch Monthly of Medicine], 17 (1931), 313–67; W.M. van der Scheer, *Nieuwere inzichten in de behandeling van geesteszieken* [Newer Insights into the Treatment of the Mentally Ill] (Groningen/The Hague/Batavia, 1933); F.S. Meijers, 'Beschouwingen van een buitenstaander over onze moderne gestichtsverpleging' ['An outsider's thoughts on our modern asylum nursing'], *PNB*, 40 (1936), 221–9; 228; C. aan de Stegge and H. Oosterhuis, 'Geen dressuur maar opvoeding. August Stärcke en de actievare therapie' ['No conditioning, but education. August Stärcke and the more active therapy'], *Maandblad Geestelijke Volksgezondheid*, [Monthly for Mental Health], 55 (2010), 271–84; Freeman, *op. cit.*, 132–3.

³⁶Interview, Cecile aan de Stegge with the nurse involved, C.A.M. Verbeek, 27 September 2000.

³⁷C. aan de Stegge and J.C. Hoogeveen, *Geduld en toewijding; Verplegers en verpleegsters in de psychiatrie van 1941 over hun contact met patiënten* [Patience and Dedication. Dutch psychiatric nurses of 1941 about their contact with patients] (Utrecht/Bunnik, 2010).



Figure 1. Dutch psychiatric nurse C.A.M. (Kitty) Verbeek (middle, first row, wearing a dress with a chain of flowers) when she left Bangalore in 1960. Source: author's private collection.

active therapy put high demands upon psychiatric nurses because their increased responsibility for the patients' behaviour required continuous and intensive attention, vigilance and tact. All of this stirred their professional self-awareness in general and their interest in the social, psychological and ethical dimension of their work in particular.

They also began to display a critical attitude, for example with respect to their assistance of doctors who applied drastic somatic treatments such as malaria fever, insulin coma or electroshock therapy.³⁸ Male nurse Jac Clay (see also [Figure 2](#)), noted about the insulin coma therapy:

My impression is that this method leads us to a dark way of trial and error, full of shadows ... The support nurses have to give is far from simple, yet full of responsibility. One single moment of inattention can lead to the patient's death. We already experienced such a black day, as if it were a warning.³⁹

Male nurse Frederik Boon showed his dislike of somatic therapies because they reintroduced bed rest, which – like in the old days – had made patients 'passive and weak'. After 30 years of nursing experience in an asylum, he would rather put his cards on 'labour' as the most effective therapy.⁴⁰ Other male nurses described how they had come closer to patients through their joint participation in music clubs, sports and organized walking tours.⁴¹ The author of the prize-

³⁸*ibid.*, 55–73, 149–59.

³⁹J. Clay, 'Geduld en Toewijding' [Patience and dedication], in Aan de Stegge and Hoogeveen, *op. cit.*, 149–59, 158.

⁴⁰F. Boon, 'In Depressie', in Aan de Stegge and Hoogeveen, *op. cit.*, 55–61: 60–61.

⁴¹The first two essays can be found in the Archive of the Dutch Association for Psychiatry and Neurology, Box 6, Exam Committee, nrs 57 and 60, in the Noord-Hollands Archief [Archive of the Province of Northern Holland], Haarlem. The essay by Van Stigt is published in Aan de Stegge and Hoogeveen, *op. cit.*, 187–90.



Figure 2. Male nurse Jac Clay (left, front row), was a good violin player and helped with revues in the psychiatric hospital of Santpoort, photographed here on 30 January 1928. Source: author's private collection.

winning essay described a nocturnal discussion between a young student and an older certified male nurse, in which the latter seemed to refer to what was happening to mentally disabled persons in Nazi Germany:

'Can you really accept the hopeless suffering you witness every day on this ward?', the student asked. 'O yes', the older nurse answered firmly . . . 'Sure. Even more than accepting it, I truly believe we have to respect nature, just as we should admire the whole of creation.'⁴²

Critical attitudes were advanced by the rising educational level of students, which was triggered by the economic crisis in the 1930s, hitting asylums harder than general hospitals. High unemployment rates entailed an over-supply of candidates, which enabled psychiatric institutions to raise their admission requirements. In this period, from 1925 to 1940, 6000 of the approximately 13,000 youths who started the training course between 1926 and 1940 passed the exam.⁴³ Yet, whereas the qualifications of nurses improved, their working conditions were under great pressure. The recession entailed cuts in government funding of mental institutions, whereby the nurses' wages, which had gone up in the 1920s, stagnated or even went

⁴²C.A. Dardenne Andringa, 'Eerbied voor het leven' ['Respect for every living creature'], in *Tijdschrift voor Ziekenverpleging* 52 [Dutch Magazine for Nursing], 52 (1942), 116–18, 129–34 and 152–5; also in: Aan de Stegge and Hoogveen, *op. cit.*, 129–45.

⁴³Aan de Stegge, *Gekkenwerk*, *op. cit.*, 526–38, 991.

down. While for employees in other sectors a 48-hour working week and an 8.5-hour workday were introduced in the early 1920s, psychiatric nurses would work 55 hours or more per week. A standard 48-hour working week was realized in 1957.⁴⁴

In the 1940s psychiatric nursing became an even more strenuous job. The Second World War took a heavy toll on Dutch mental institutions: damaged and confiscated buildings; forced evacuations and hence overcrowding, deportations of about 1450 Jewish patients; shortages of food, fuel and medicines; unhygienic conditions, the outbreak of contagious illnesses and, as a consequence, the premature death of more than 7300 patients (see Figure 3).⁴⁵ On top of this, the German occupation regime had introduced a collective health insurance scheme in 1941, which financially eased admissions to general hospitals and prompted their rapid expansion. As a consequence, each year mental institutions lost many freshly educated nurses to general hospitals. Psychiatric institutions thus faced a changing labour market for nurses, whereby the oversupply of qualified candidates during the 1930s turned into a shortage of 20–30%, which lasted until the 1960s. Moreover, Catholic institutions were affected by a falling number of people who joined religious congregations, so that fewer brothers and sisters were available for nursing. Once again, institutional psychiatry with its inferior social standing, the burden of stigma and unfavourable labour conditions was at a disadvantage vis-à-vis general health care, although the first post-war Dutch government granted psychiatric nurses a higher salary than general nurses.⁴⁶

A similar development occurred in the UK, where institutional psychiatry was included in the National Health Service (NHS) in 1948, providing free and comprehensive care for all patients. In the two decades after the end of the war, the total number of admissions to mental hospitals, most of them of voluntary and acute patients, increased nearly tenfold. This happened while practically all accommodation dated from before 1910 and hardly any new facilities were built in the 1950s, because public housing and schools were prioritized. The NHS did not result in a substantial increase in spending on mental hospitals;

⁴⁴Inspectie van het Staatstoezicht op Krankzinnigen en Krankzinnigengestichten [State Inspectorate on the Insane and the Asylums], *Verslag van het Staatstoezicht op Krankzinnigen en Krankzinnigen gestichten over het Jaar 1931* [Annual Report on 1931] (The Hague, 1933), 9–11.

⁴⁵During 1940–1945 official numbers show that 16,781 patients died in Dutch psychiatric institutions, which was 7337 persons more than during the years 1934–1939 when 9444 patients had died. About 1440 deported Jewish ‘patients’ were not included in this count: see G.J.C. aan de Stegge, ‘Geneesheer-directeur van een gesticht in bezettingstijd. Endegeest als case-study’ [‘On being medical director of an asylum during the German Occupation: Endegeest as case-study’], in *Leids Jaarboekje* [Leiden’s Almanac] (Leiden, 2006), 165–200; G.J.C. aan de Stegge, ‘Terugggevonden: het oorlogsdagboek van zenuwarts Marius J ten Raa’ [‘Rediscovered: war-diary of psychiatrist Marius J. ten Raa’], *NHA nieuws*, nummer 4 oktober 2006 [North-Holland Archival News, number 4, October 2006], 5–10; Oosterhuis and Gijswijt-Hofstra, *op. cit.*, 437, 465–513; Cecile aan de Stegge, ‘Excess mortality and causes of death in Dutch psychiatric institutions 1940–45’, lecture for the International Conference ‘Mass Murder of People with Disabilities and the Holocaust’, organized by the International Holocaust Remembrance Alliance, the Pädagogische Hochschule Bern and the Federal Department of Foreign Affairs of Switzerland (FDFA), 26 November 2017, Hochschulzentrum von Roll, Bern [in press under responsibility of the IHRA, 2019].

⁴⁶Aan de Stegge, *Gekkenwerk*, *op. cit.*, 398.



Figure 3. Nurses at the mental institution, Warnsveld, undertook all washing by hand using cold water and sun between October 1944 and May 1945. No working laundry was left as a result of damage sustained during the Second World War. Source: Museum GGNet Warnsveld.

in the 1950s direct public expenditure on mental health amounted to less than 0.2% of the Gross National Product. Although the NHS was relatively cheap, the government feared escalating demand, and again and again stressed the need to contain its costs. The working conditions in the massive and overcrowded British mental institutions were far from attractive; the ensuing shortage of nursing staff was intensified because it was relatively easy for candidates to find alternative and better paid jobs. In the mid-1950s the shortage amounted to 20% in wards for male patients and 35% in wards for females – numbers which were comparable with the Dutch ones at that time.⁴⁷

Again, Dutch psychiatric nurses were able to recover from the setbacks in the 1930s and 1940s, more than their British counterparts. To make psychiatric nursing more attractive for youngsters, from the late 1940s an information service was put into operation in order to foster the general public's understanding of mental illness. Also, growing government regulation of health care in the emerging welfare state advanced the gradual increase of wages and improvement of working terms as well as the effort to bridge the gap between institutional psychiatry and general health care.⁴⁸ Mental patients were increasingly differentiated according to

⁴⁷Freeman, *op. cit.*, 122–5; A. Querido and E.I. Weyland, 'Rapport uitgebracht door de Werkgroep Verpleegsterkort, dd. 13 juni 1962' [Report, issued by the Task Force Shortage of Nursing Personnel, 13 June 1962': printed in 1964], in *Verslagen en mededelingen betreffende de Volksgezondheid 1964, nr. 5* [in *Minutes and Messages concerning Public Health, Number 5*] (Leidschendam: Ministerie van Sociale Zaken en Volksgezondheid) [Leidschendam: Ministry of Social Affairs and Public Health], 726–75.

medical criteria: the ‘mentally retarded’ and ‘demented elderly’ moved to separate care facilities, thus leaving behind a more homogeneous population in mental institutions, suffering from psychotic, neurotic and mood disorders. More and more of them were treated instead of just sheltered and cared for.⁴⁹ Therapeutic facilities gradually expanded and diversified, not only within mental institutions, but also in psychiatric wards and outpatient clinics of general hospitals. The introduction of psychotropic drugs in the early 1950s, suppressing psychotic symptoms, cleared the way for efforts to remedy the attitude and social functioning of the mentally ill through socio-therapy and community therapy. ‘Patients became persons’, as a nurse noticed when he took them out for a holiday trip.⁵⁰

These innovations triggered the need to modernize psychiatric nurse training by focusing on social skills and psychological insight. Psychiatrists asserted that the new medication and psychosocial therapies required that nurses could systematically observe and report about patients’ behaviour.⁵¹ Also, they should develop social skills as well as ‘self-knowledge’ and ‘personality’ in order to be able to support ‘the creation of a therapeutic atmosphere’ aimed at the ‘positive encouragement’ of the mentally ill towards more autonomy.⁵² Around 1960 also some nurses themselves articulated such views. As the authors of a new course reader, some leading Catholic brothers in particular appealed to nurses to end their subordination to doctors and show more initiative and responsibility.⁵³ The core nursing task should be pedagogical instead of custodial: ‘the creation of a good atmosphere’ which would encourage patients to change their behaviour, recover their ‘personality’ and enlarge their independence.⁵⁴

That Catholic brothers in particular voiced these views about psychiatric nursing can be explained by the fact that they were less dependent on medical doctors than lay nurses, because they were supposed to be guided by their religious superiors. Moreover, as mentioned earlier, male nurses generally were longer employed and therefore more experienced and involved than most women. Also, in the Catholic sex-segregated

⁴⁸Aan de Stegge, *Gekkenwerk*, op. cit., 643–7.

⁴⁹F. Meyboom, ‘De taak van de verplegenden in een psychiatrische inrichting’ [‘The Task of Nurses in Psychiatric Hospitals’], *Maandblad Geestelijke Volksgezondheid*[*Monthly on Mental Hygiene*], 7 (1952), 25–29.

⁵⁰Oosterhuis and Gijswijf-Hofstra, op. cit., 533–75; A. Zondag, *Naar Franeker gaan, Herinneringen en reflecties van een oud-hoofdverpleegkundige* [Going to Franeker. Memories and reflections of a former leading nurse] (Franeker, 1995), 95.

⁵¹A.P. Timmer, *Leerboek voor verplegenden van zenuwzieken en krankzinnigen*. [Textbook for Nurses of Nervous Sufferers and the Mentally Ill], 5th edn (Haarlem, 1957), 341–2, 345, 347; cf. B. Chr. Hamer and F.J. Tolsma (eds), *Algemeen Leerboek voor het verplegen van geestes- and zenuwzieken, 9de compleet gewijzigde herdruk van Schermers’ Leerboek* [General Textbook for Nursing Mental and Nervous Patients, 9th Completely Revised Edition of Schermers’ Textbook] (Leiden, 1956), 438–9, 595–6.

⁵²A. P. Timmer, *Leerboek voor verplegenden van zenuwzieken en krankzinnigen* [Textbook for Nurses of Nervous Sufferers and Mentally Ill], 4th edition (Haarlem, 1952), 322.

⁵³P. Stevens, J. Pepping and A.P. Lammens, *Psychiatrische Verpleegkunde (1, 2, 3)* [Psychiatric Nursing (vols 1, 2, 3)] (Heiloo, 1960–63).

⁵⁴W.A. van den Hurk, *Bewaken wordt begeleiden. Moderne psychiatrische verpleging*. [Guarding Turns into Coaching. Modern psychiatric nursing] (Amsterdam, 1966).

institutions for male patients, religious brothers held leading positions, which in mixed non-Catholic institutions were reserved for women until 1962. Anyway, the Catholic brothers and psychiatrists agreed about the need to foster a professional, self-reflective attitude among nurses and give them a more independent role.⁵⁵ More and more (student) nurses indeed began to express their own opinions about the treatment of patients. Thus, some of them criticized the monotony of occupational therapy, which they considered as humiliating for patients and without therapeutic benefit. Although many nurses considered psychotropic drugs generally as a blessing, which reduced unpleasant interventions such as restraints and isolation, some of them, interviewed in 2005, also pointed to the allergic reactions and apathy that the new medication induced in patients.⁵⁶

Heyday of psychiatric nursing (1965–1985)

In the early 1960s, skills in socio-therapy, psychomotor and creative therapy, as well as in group discussions and in coaching patients, were added to the training course. Psychiatric nurses were supposed to associate with them in an empathic way and thereby to reflect critically on their own attitude and behaviour.⁵⁷ Although ideals and realities in mental institutions differed widely, nursing tasks began to shift from household chores, which were gradually taken over by lower educated domestic helps, to therapeutic and recreational activities with patients. Hence, the interaction between doctors and nurses and between nurses and patients became less hierarchical and more informal than before.⁵⁸ The official adoption in 1978 of the title '*verpleegkundige*' (a term stressing expertise and in fact current since the mid-1960s), and with an ethical and disciplinary code including confidentiality about patients, showed that nurses had gained professional status.⁵⁹

Under the influence of critical attention in society at large for the fate of the mentally ill, the previously isolated mental institutions opened up. Developments in Dutch psychiatric nursing were not so much affected

⁵⁵Aan de Stegge, '120 years', *op. cit.*, 92; Van den Hurk, *op. cit.*; F. Kramer, *Psychiatrische verpleegkunde* [Psychiatric Nursing] (Lochem, 1968).

⁵⁶Aan de Stegge, *Gekkenwerk*, *op. cit.*, 771–2, 794, 802, 609–16.

⁵⁷Van den Hurk, *op. cit.*; Aan de Stegge, *Gekkenwerk*, *op. cit.*, 647–63; H. van der Drift, 'Hoofdstuk IV. Verpleging en behandeling van geestes- en zenuwzieken' ['Chapter IV. Nursing and medical treatment of the mentally and the nervously ill'], in Dr. B. Chr. Hamer en Dr. F.J. Tolsma, *Algemeen Leerboek voor het verplegen van geestes- en zenuwzieken* [General Textbook for the nursing of the mentally and the nervously ill], 9th edition, (Leiden, 1956), 431–578: 463–504.

⁵⁸G. Blok, *Baas in eigen brein* [In Charge of One's Own Brain] (Amsterdam, 2004); Aan de Stegge, '120 years', *op. cit.*, 39; Aan de Stegge, *Gekkenwerk*, *op. cit.*, 774, 793–4, 1040–1.

⁵⁹Juliana, 'Wet van 8 juni 1977, houdende wijziging van de Wet van 2 mei 1921, Staatsblad 702, tot wettelijke bescherming van het diploma voor ziekenverpleging' ['Law of June 8 1977, meaning to change the Law of May 2 1921, Bulletin 702, in order to lawfully protect the certificate in Nursing'], Staatsblad van het Koninkrijk der Nederlanden nummer 397, 1977, [Bulletin of Acts and Decrees of the Kingdom of The Netherlands, 1977, number 397], 1.

by de-institutionalization – which in the Netherlands started later under the label of ‘socialization’ and in a much more moderate way than in the UK – as by the 1960s protest movement and a wave of social democratization. Medical psychiatry was under fire, but at the same time more patients than ever before were hospitalized and treated, owing to widening collective health insurance schemes. Alternative treatments – individual or family psychotherapy and the therapeutic community – were intensified. Much was expected of the ‘social model’ with its emphasis on self-activation and self-determination of the ‘clients’.⁶⁰ The participation of nurses in such therapies increased and some of them, in particular those involved in therapeutic communities, joined the therapeutic staff.

In this way psychiatric nursing became more attractive and even popular among youngsters. Between 1965 and 1985 around 23,000 student nurses were certified, almost the same number as in the entire period between 1892 and 1965.⁶¹ The share of certified nurses among the total nursing staff went up to more than a half, whereas their number in social psychiatry rose from around 200 in 1970 to nearly 900 in the mid-1980s. In 1958 a new training programme had started for nursing in facilities for the mentally handicapped, which was legally sanctioned in 1978–1979, when more than 1500 students passed the exam.⁶² In psychiatry, from 1970 on, the minimal requirement for being admitted to the training course was raised to secondary education, but also more and more candidates with higher schooling applied.⁶³ Increasing numbers of better educated nurses were employed since growing budgets for mental health care facilitated the expansion of psychiatric hospitals, whereas the size of wards was scaled down and the ratio of the total nursing staff and patients halved between 1965 and 1975 from 1 to 4.5 to around 1 to 2.⁶⁴

Psychiatric nursing by now provided interesting career opportunities for well-educated youths, who pursued self-liberation and involved themselves in emotional debates about (anti-)psychiatry and patient’s rights. Many young psychiatric nurses were critical but also exceptionally motivated. They organized themselves and voiced their views in the media, decrying not only

⁶⁰Blok, *op. cit.*

⁶¹A.J. Gerritse and W. van der Windt, *Van verloop naar loopbaan, een arbeidsmarktverkenning verpleging en verzorging in de negentiger jaren* [From Turnover to Career. A job market assessment of the care and nursing sector in the 1990s], Report 91724 (Utrecht, 1991), 87.

⁶²Nationale Ziekenhuisraad [National Council of Hospitals], *De arbeidsmarkt voor inservice-leerlingen. Een onderzoek naar de stand van zaken en toekomstige ontwikkelingen* [The Labour Market for Vocational Nurses. A study of the state of affairs and future developments] (Utrecht, 1985), 6; Aan de Stegge, *Gekkenwerk, op. cit.*, 994.

⁶³P.C.J. van Loon, Eindrapport van de Commissie Hogere Beroepsopleiding Verplegenden [‘Final Report from the Commission on Academic Professional Education for Nurses’], *Verslagen en Mededelingen Volksgezondheid van het Ministerie van Volksgezondheid en Milieuhygiëne nr 24* [Reports and Communications on Public Health of the Ministry of Health and the Environment nr. 24] (Leidschendam, 1969), 49, 59, 71.

⁶⁴C.Th. Bakker, *Geld voor GGz. De financiering van de geestelijke gezondheidszorg en de invloed van geld op de zorgpraktijk (1884–1984)* [Money for Mental Health. Funding mental health care and the influence of money on the practice of care, 1884–1984] (Amsterdam, 2009).

‘authoritarian’ psychiatrists, but also older nurses, who would show too little understanding and respect for patients. In the early 1970s the noisy and playful Action Group *Willem*, a group of student nurses who were trained in a psychiatric hospital near Utrecht, spawned a lot of media coverage (see Figure 4). They criticized their curriculum as outdated and demanded its radical renewal by including more sociology, pedagogy and psychology, as well as training in conversation techniques and reflective and writing skills. This protest group, initiated by a female student but led by her male colleagues, was supported by nurses, some psychiatrists, policymakers, politicians and patients. Such activism, however, also caused conflict with older colleagues who felt that the psychotherapeutic ethos of the youngsters resulted in a neglect of their more down-to-earth caring responsibilities for chronic patients.⁶⁵

From the mid-1960s, various advisory boards, study commissions, supervisory agencies and professional associations endlessly tackled the question of what psychiatric nursing should be about.⁶⁶ Leading nurses enlarged their role in these discussions, which generated the feeling that psychiatric nursing was an occupation in itself and that its main expertise was communicating with, guiding, stimulating and rehabilitating the mentally ill. Therefore professional training should cover the fields of pedagogy, psychology, psychotherapy and sociology, while social and communicative skills should reinforce the therapeutic effect of nurses’ daily interactions with patients.⁶⁷ Soon numerous books by psychiatrists, psychologists, pedagogues, sociologists and lawyers appeared, in which they explained how insights from their own field could be used in psychiatric nursing.⁶⁸ A silent revolution took place in 1971 when senior psychiatric nurses began to

⁶⁵Interviews conducted by Aan de Stegge with former nurses E. Verkerk, 2004, M. van de Siep kamp-de Vries, 2004 and T. van der Donk, 2004; Internationaal Instituut voor Sociale Geschiedenis (1969, Archief Nieuw Dennendal, 1969–1974, inventarisnummer 38) [International Institute of Social History, 1969, Archive Nieuw Dennendal, number 38].

⁶⁶Nederlandse Vereniging voor Psychiatrie and Neurologie, Vereniging voor Katholieke gestichtsartsen and Vereniging tot Christelijke verzorging van geestes- en zenuwzieken, *De opleiding in de verpleegkunde* [Training Course in Nursing] (Utrecht, 1966); Van Loon, *op. cit.*; A.J.H. Thiadens and M.J. Smulders-Aghina (eds), *De verpleegkundige die ons toe-komt* [The Nurse We Are Entitled to] (Deventer, 1971); Nationale Raad voor de Volksgezondheid [National Public Health Council], *Rapport in het kader van de specialisaties in de verpleegkunde betreffende ‘De verpleegkundige belast met specifieke taken in de geestelijke gezondheidszorg met name in de psychiatrische hulpverlening’* [Report in the Context of Nursing Specializations Concerning ‘The Nurse in Charge of Specific Tasks in Mental Health, in Particular in Psychiatric Care’] (Rijswijk, 1983).

⁶⁷Van den Hurk, *op. cit.*; Kramer, *op. cit.*; Van Loon, *op. cit.*; C.J.M. Nieland, L. van der Laan and P.F. Rooyackers, *Verpleegkundige lessen voor de opleiding tot het diploma B [Nursing Lessons for the Psychiatric Nurse Degree]* (Leiden, 1969); J.A.M. Kerstens, *Grondkaders voor een leerplan psychiatrische verpleegkunde* [Basic Principles for a Curriculum in Psychiatric Nursing] (Lochem, 1974).

⁶⁸P. Bierenbroodspot, *De therapeutische gemeenschap en het traditionele psychiatrische ziekenhuis* [The Therapeutic Community and the Traditional Psychiatric Hospital] (Meppel, 1969). J. Foudraïne, *Wie is van hout... een gang door de psychiatrie* [Not Made of Wood? A Psychiatrist Discovers His Own Profession] (Baarn, 1971); A.A.A. Terruwe, *Geef mij je hand; Over bevestiging, sleutel van menselijk geluk* [Give Me Your Hand. On acknowledgement, key to human happiness] (Lochem, 1972); P.C. Kuiper, *Hoofdsom der Psychiatrie* [Main Chapters of Psychiatry] (Utrecht, 1973); A. Frid, P. Ippel and P. Laurs, *Jij liever dan ik, De psychiatrische patiënt: wat heeft hij te vertellen?* [Rather You Than Me. The psychiatric patient, what has he got to tell us?] (The Hague, 1980).



Figure 4. Action Group *Willem* travelled round Dutch mental hospitals (shown here in Apeldoorn) in February 1970 in order to raise awareness of the need for curriculum reform among their colleagues. Source: CODA/Archive Apeldoorn, with thanks to P. Arends.

replace psychiatrists as examination supervisors, and some of them even published course books. Substantial changes in the training scheme soon followed: psychological and socio-cultural subject matters were added to the curriculum and training in reporting and writing was extended, in particular to engender a self-reflective attitude in their ‘therapeutic relationship’ with patients.⁶⁹

Whereas the educational level and professional profile of Dutch psychiatric nursing improved in the 1960s and 1970s, its British counterpart was under pressure – although British psychiatry in general gained an international reputation for breaking the barriers between mental institutions on the one hand and somatic medicine and society on the other. In 1951 the training programme of the Medico-Psychological Association had come to an end, which entailed that the education of mental nurses now completely fell under the authority of the General Nursing Council. Attention for psychological and social skills in nurse training increased,

⁶⁹Interview, Cecile aan de Stegge with C.J.M. Nieland, 20 August 2001; *Nederlandse Staatscourant* [Dutch State Bulletin], 78 (1971); Kramer, *op. cit.*; Nieland, Van der Laan and Rooijackers, *op. cit.*; Werkgroep Rechtspositie Patiënten in Psychiatrische Ziekenhuizen [Working Group Legal Position Patients in Psychiatric Hospitals], *Resultaten Enquête en Eindrapport* [Results Survey and Final Report] (The Hague, 1979); Commissie, ingesteld door de Staatssecretaris van Volksgezondheid and Milieuhygiëne [Commission, set up by the Deputy Minister of Public Health and the Environment], *Sociotherapie in de psychiatrische hulpverlening*. [Socio-therapy in Psychiatric Care] (Leidschendam, 1981).

to be true, but this advance was undercut by the growing employment, for financial reasons, of low-educated ‘enrolled nurses’ or ‘nursing assistants’ in psychiatric hospitals. Protests of certified nurses did not prevent the massive hiring of less qualified personnel: in the early 1970s nearly half of the nursing staff in psychiatric hospitals were enrolled nurses and nursing assistants.⁷⁰

Moreover, British mental nursing faced the consequences of an ever more radical de-institutionalization. From the late 1950s onwards, the emphasis in British psychiatry shifted from mental hospitals to alternative clinical and outpatient facilities in general health care as well as in ‘community care’. From the mid-1970s onwards de-institutionalization was officially stated as government policy, which was implemented in a more radical way than in any other European country, apart from Italy.⁷¹ This was the main impetus for shifting the focus of mental nurse training from the medical model to social and also counselling skills – an innovation which had been realized in the Netherlands at least two decades earlier – which caused confusion among British mental nurses whose training had mainly been geared to hospital care.⁷² At the same time, however, funding was inadequate for substituting psychiatric beds with alternative provisions and outpatient support by community mental health nurses, whose limited number – 2000 in 1980 – could not fulfil needs.⁷³ The Thatcher government not only cut public health budgets, but also excluded long-term care from the NHS. Many mentally disabled and chronic psychiatric patients in nursing homes and other dwellings came to depend on the social security system and what was deemed social care, which undermined their right to provision of NHS nursing care.

The waning of psychiatric nursing (1985–2005)

From the early 1980s on, Dutch psychiatric nursing faced developments in psychiatry which changed and to some extent jeopardized its strong, in particular socio-psychological, profile. A new generation of psychotropic drugs bolstered biological psychiatry, which enhanced the medical authority of psychiatrists. At the same time, the government’s mental health policy of ‘socialization’, which aimed to prevent hospitalization as much as possible and to move chronic patients to

⁷⁰Dingwall, Rafferty and Webster, *op. cit.*, 139; Nolan, *op. cit.*, 102–4; Chatterton, ‘Training mental health nurses in the United Kingdom ... Part two’, *op. cit.*, 7; *The Bulletin of the UK Association of the History of Nursing*, 4 (2015), 5–14.

⁷¹H. Oosterhuis, ‘Outpatient psychiatry and mental health care in the twentieth century: international perspectives’, in Gijswijt-Hofstra et al., *op. cit.*, 248–74.

⁷²Chatterton, ‘Training mental health nurses in the United Kingdom ... Part two’, *op. cit.*, 7–8.

⁷³Dingwall, Rafferty and Webster, *op. cit.*, 140.

sheltered residences in order to make them more independent in their daily lives, brought about a shift of focus in the training programme of nursing care from a socio- and psychotherapeutic approach to practical social-psychiatric guidance, coping strategies, symptom relief and social support for and rehabilitation of chronic patients.⁷⁴ Another trend was the emphasis on working and reporting in a 'methodical' way, which, on the one hand, reflected the scientification of nursing, but, on the other hand, also the growing impact of technocratic, managerial and budget considerations in mental health care. The last trend, implying increasing administrative responsibilities, raised more and more complaints about 'office nursing' and the related workload.⁷⁵

Meanwhile the labour conditions of Dutch nurses deteriorated. In the late 1980s their discontent led to massive demonstrations, which eventually resulted in wage increases and several social-scientific investigations about their daily work.⁷⁶ Although the number of certified psychiatric nurses employed in mental health care had gone up from around 10,000 in 1985 to more than 17,000 by 2005, this growth had not kept pace with the increasing workload which was caused by the rising number of patient admissions and re-admissions and the growing needs of more or less severely disordered chronic patients who had been moved from psychiatric hospitals to sheltered homes or other dwellings. Not only did the enthusiasm of youngsters for a career in psychiatric nursing wane, also more and more nurses worked part-time. As a result, the quality of care suffered.⁷⁷

Moreover, the independent position of psychiatric nurses vis-à-vis general nursing was undermined by developments in educational and health policies. In the course of the 1970s more and more regular secondary and higher vocational schools as well as a university faculty provided an education in nursing, which drew an increasing number of students.⁷⁸

⁷⁴B. Holman, *De Beschut Wonen begeleider. Een onderzoek naar de motivatie en de manier van werken van begeleiders in een beschutte woonvorm in het Algemene Psychiatrisch Ziekenhuis* [Care Workers in Sheltered Living. A study of the motivation and working method of care workers in sheltered living projects in general psychiatric hospitals] (Noordwijkerhout, 1986); H.J. Meillo, 'Verpleegkundigen veranderen. Van ordebewaker in Santpoort tot casemanager' ['Nurses are changing: from guardian in santpoort to case manager'], *MMH*, 46 (1991), 483–97; P.K. Meurs and H.J. Meillo, 'Verpleegkundigen verdienen meer. Een pleidooi voor functiedifferentiatie' ['Nurses deserve better pay. a plea for job differentiation'], *MMH*, 49 (1994), 159–73.

⁷⁵M.F. Ward, *Het verpleegkundig proces in de geestelijke gezondheidszorg. Een leerboek voor verpleegkundigen in opleiding en nascholing (voor Nederland bewerkt door A. Eliëns en H. Vermaas)* [The Nursing Process in Mental Health Care. A textbook for nurses in training and in continuing education (edited for the Netherlands by A. Eliëns and H. Vermaas)] (Nijkerk, 1986); M.C. Townsend, *Verpleegkundige diagnostiek in de psychiatrie* [Nursing Diagnostics in Psychiatry] (Lochem, 1990).

⁷⁶J.F.M. Werner, *In hoger beroep. Perspectief voor de verplegende and verzorgende beroepen* [Moving Up Professionally. Perspectives for nursing and care professions] (Rijswijk, 1991).

⁷⁷Oosterhuis and Gijswijt-Hofstra, *op. cit.*, 1135–54.

⁷⁸J. Von Nordheim, 'Nota uitgebracht door de Commissie von Nordheim' ['Paper Issued by the Von Nordheim Committee'], *Verslagen and Mededelingen Volksgezondheid* 6 [Minutes and Messages concerning Public Health, 6] (The Hague, 1971), 115–28; J.J. von Nordheim and M.E.M. Schreurs, *Anders opleiden en verplegen? Liever niet... of well! Een serie rapporten over de eigentijdse vormen van de verpleging and de opleiding daartoe* [Training and

Yet, in the schools, which belonged to the system of general education and were outside the control of mental health officials or the in-service instructors, priority was given to somatic nursing. Psychiatry was at a disadvantage, despite the fact that general nursing – in its turn – had incorporated social and didactic elements of psychiatric nursing. The basic training for nursing in vocational schools involved work experiences in various sectors of health care, a requirement which could be met by general hospitals with psychiatric wards, but which could not be realized by psychiatric hospitals without general wards. As a result, the number of graduates from vocational schools who opted for a psychiatric career dwindled: on average only 8% of them opted for employment in mental health care.⁷⁹ At the same time the higher vocational schools, gaining weight in the training of health professionals, also educated new mental health workers such as social-pedagogical coaches, whose rapidly increasing numbers and overlapping competences forced psychiatric nurses onto the defensive.⁸⁰

All of this was in line with the reorganization of mental health care which the Dutch government initiated in the 1990s. Psychiatric hospitals merged with outpatient and sheltered housing provisions and these new comprehensive organizations were supposed to co-operate with general health care and social work. As a consequence, the flexibility of nurses to work in different sectors was prioritized. The need to adopt European standards and a uniform legal registration system for health professionals added to the final decision to break with the differentiation between general and psychiatric nursing. In 1997 the separate Dutch in-service training and the professional title of psychiatric nurse, in existence since 1892 and legally sanctioned since 1921, came to an end. Henceforth only the general title ‘nurse’ was acknowledged, no matter whether one was employed in general or mental health care or in facilities for the mentally handicapped. The primary distinction made now was the (secondary, higher or academic) educational level of nurses, while the practical need to gear care to different (somatic, psychiatric or mentally handicapped) patients was only recognized in optional specializations after a general

Nursing Differently? Do it ... or rather not do it. A series of reports on contemporary forms of nursing and its training] (Amsterdam, 1972).

⁷⁹ Staatstoezicht op de Volksgezondheid, *Verslag over de jaren 1969–1974 van de Geneeskundige (Hoofd-)inspectie voor de Geestelijke volksgezondheid* [Report on the Year 1969–1974 by the Medical (Chief)Inspectorate for Mental Health Care] (The Hague, 1976), 79.

⁸⁰ L. Neijmeijer et al., *Beroep: psychiatrisch verpleegkundige, een verkennend onderzoek naar persoon, werk en werkplek van verpleegkundigen in de geestelijke gezondheidszorg*. [Profession: Psychiatric nurse. An exploratory study of person, work and work location of nurses in mental health care] (Utrecht, 1997), 215, 319; N. Van Tol, G. Boonekamp and P. Winkelaar, ‘Sociaal-pedagogisch hulpverleners. Kompanen of concurrenten’ [Social-pedagogical care providers: cronies or competitors?], *MMH*, 54 (1999), 376–79; W. van der Windt and H. Talma, *De arbeidsmarkt voor verpleegkundigen, verzorgenden en sociaal-pedagogen in de zorgsector 2004–2008. Een verkenning met Regio Marge* [The Job Market for Nurses, Care Workers and Social-Pedagogues in the Care Sector. An exploration based on region margins] (Utrecht, 2005), 11.

basic training. The basic theoretical training was provided by vocational schools, while various health care institutions were charged with the practical part in the form of internships or training-employment contracts.⁸¹ The result was that most new nurses entering the mental health sector lacked a thorough training in psychiatric knowledge and skills.

Leading psychiatric nurses, organized in new professional associations, strongly defended the continuation of psychiatric nursing as a separate field, but their efforts with regard to basic training failed: their influence on policymaking with regard to their own profession appeared to be limited after all. The rank and file at the bedside lost hold on their daily working conditions in the large-scale and complex mental health conglomerates, which were increasingly administered by technocratic managers.⁸² At the same time, however, a new and promising career opportunity was created for nurses with five years of practical experience in psychiatry: on the basis of advanced training at a higher vocational school or university, they could become a certified 'specialist nurse in mental health care'. These highly qualified specialist nurses would fulfil central roles as treatment coordinators, indicators, coaches and consultants in the new multifarious mental health organizations. Their number gradually increased from less than 100 in 2004 to more than 1000 in 2018.⁸³

All in all in the Netherlands the demise of psychiatric nursing, whereby the relation between somatic and mental health care – once again – played a crucial role, was partly an unintended effect of its strength. The growing significance of theoretical education in vocational schools, including social-pedagogical perspectives, raised the quality of somatic nurses according to standards which had been realized much earlier in the in-service nurse training for psychiatry. Paradoxically, somatic nursing was again elevated as 'the' model for nursing in general, precisely after it had modified its medical character by adopting psycho-social elements from psychiatric nursing.

⁸¹Minutes of a meeting of 29 November 1983 at the Commission on the course in psychiatric nursing; R.T.J.D. Janssen and J.C.H.M. Langerak, *Opleiden: binnen of buiten het huis? Financiële gevolgen van een overgang van het inservice-onderwijs voor verplegende beroepen naar dagonderwijs* [Training: In-service or external? Financial Consequences of Transition of In-service Training for Nursing Professions to Daytime Education] (The Hague, 1989), 17; J. Heitink and K. Teluy, *Het lopend vuur. Ontwerp samenhangend opleidingsstelsel voor verplegende, verzorgende en assisterende, helpende beroepen. Eindrapportage Pro6* [Running Fire. Draft Shared Curriculum for Professions in Care, Nursing and Aid. Final Report Pro6] (Leiden, 1995), 24.

⁸²Oosterhuis and Gijswijt-Hofstra, *op. cit.*, 1135–54; J.K. van Dijk et al., 'Management participatie in de praktijk. De resultaten van het NZi project' ['Management Participation in Practice. Results of the NZi Project'], in J.K. van Dijk and T.A.J. Oostrom (eds), *Perspectief op verandering. Managementparticipatie van verpleegkundigen en verzorgenden in zorginstellingen* [Perspective on Change. Management participation of nurses and care workers in care institutions] (Maarssen/Utrecht, 1998), 21–55.

⁸³E-mail, 1 August 2007, from Eline Schut to Cecile aan de Stegge, with data on all graduated specialists in mental health nursing by 2004; Information from the director of this education, 6 February 2018; <https://vregister.venvn.nl/over-het-register>.

Similar developments took place in the UK. The GNC introduced a new mental nursing syllabus in 1982, composed without input from the Royal College of Psychiatrists, emphasizing a combination of scientific theory and practical skills, and geared to individualized care. However, this syllabus had no lasting impact. Firstly, many old asylums were closed down in the 1980s and 1990s, a process that led to a serious identity crisis among mental nurses in the UK. Secondly, in 1983 the GNC itself was replaced by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) with separate boards for England, Scotland, Wales and Northern Ireland. The UK Council took the lead in monitoring all nurse training schemes along similar lines as in the Netherlands. Not surprisingly, this centralized policy was heavily criticized by ‘mental health nurses’, as they were now called, for not enabling students to fully develop essential mental health skills.⁸⁴ In 1992 the Ministry of Health responded by establishing a Mental Health Nursing Review Team. As a consequence, the UKCC set up a new Commission that published yet another report and repaired some of the earlier flaws. In 2002, the UKCC and its four sub-boards was replaced by a new Nursing and Midwifery Council. However, all of this did not end the identity crisis of mental health nursing and debates continue about its proper role.⁸⁵

Conclusion

Apart from wider trends in Dutch society – economic and labour market fluctuations; professionalization; class relations; social emancipation; the influence of religion; the welfare state – the most important factors that shaped psychiatric nursing in the Netherlands have been class, gender and the difference in social status between general health care and institutional psychiatry. This occupation was initiated, as in the UK, under the medical authority of asylum doctors and psychiatrists, and defined as a typically female (and middle-class) occupation. When it turned out that psychiatric nursing did not attract sufficient numbers of middle-class women, Dutch asylum doctors, in particular orthodox-Protestant and Catholic ones, were pragmatic enough to adapt their objective: they geared the training courses to lower-class young women and men without secondary education. Their considerable effort to educate student nurses enabled the latter to improve themselves and climb the social ladder, not only through a career in mental institutions and later in social psychiatry as well, but also by moving on to general hospitals, which had the means to employ a large number of certified psychiatric nurses. This also happened in the UK, where large-scale mental institutions had even more trouble in keeping certified nurses,

⁸⁴Chatterton, ‘Training mental health nurses in the United Kingdom ... Part two’, *op. cit.*, 9.

⁸⁵*ibid.*, 7–12.

thus undermining the quality of mental nursing even more than in the Netherlands.

The more small-scale and differentiated organization of Dutch institutional psychiatry, as well as the influence of religion, added to the exceptional development of psychiatric nursing in the Netherlands and its distinct profile. Unlike their British colleagues, Dutch psychiatrists accentuated the distinct character of psychiatric nursing by introducing and highlighting moral, social-didactic and social-psychological approaches. The strong presence of male nurses in psychiatric nursing, not only in numbers (which hardly differed from the British ones) but also with regard to their outspoken views and their engagement for the improvement of working conditions, furthered the non-medical profile of the occupation, which eventually enhanced the professional identity of female nurses as well. After the Second World War the educational level of certified nurses was further raised and between the mid-1960s and mid-1980s psychiatric nursing was a popular job among well-educated and increasingly numerous middle-class youths. The official acknowledgement of the particular expertise of psychiatric nurses reinforced their enhanced professional status.

Yet, at the very moment in the mid-1980s that Dutch psychiatric nursing attracted greater numbers and better educated candidates than ever before, its demise as a distinct occupation set in. This was a consequence of government policies in the field of (mental) health care as well as of education, which both prioritized general nursing. Psychiatric nurses were forced onto the defensive and they lost their autonomous position vis-à-vis general nursing. Their professional organizations were not able to reverse this, in part because the control over nursing training schemes shifted from decision-makers in the mental health sector, who since the 1960s included leading psychiatric nurses, to officials in the field of general education. The priorities of general nursing, which were supported by developments in nursing science, now overwhelmed mental health nursing, the very tendency which from the late nineteenth century on had been prevented, first by psychiatrists and later by leading psychiatric nurses as well. They had shaped psychiatric nursing as a unique combination of medical, social, didactic and psychological elements that proved its worth and vitality for over a century. The ease and speed with which this exceptional model came to an end in the Netherlands was striking, the more so because in the UK the debate about the separate status of mental nursing is still going on, although its distinct knowledge base and professional profile had never been as developed as that of Dutch psychiatric nursing.

Disclosure statement

No potential conflict of interest was reported by the authors.