INTRODUCTION:
COMPARING NATIONAL CULTURES OF PSYCHIATRY

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When in 1905 the Budapest asylum doctor Kárlmán Pándy published his 'comparative study' of the care for the insane in Europe, he was by no means the first one to do so, nor would he be the last.[1] The history of psychiatry and mental health care offers numerous examples of cross-national inquiries by doctors and others who wished to learn about psychiatry in other parts of the Western world, and perhaps seek models to adopt in their home-country. International study trips were – and still are - a favourite way to collect information firsthand.[2] Correspondence with foreign colleagues and international conferences on psychiatry and mental health and hygiene provided other opportunities to be informed. After the Second World War, the World Health Organization (WHO) played an active part in generating information about the state of mental health care in various countries, largely in order to set international standards for it.[3] The European Community has also functioned as a framework for reporting on mental health policies in the member states.[4] The reports and publications resulting from these various, internationally orientated fact-finding and policy-orientated reports, however different in scope, depth, and method, all bear witness to attempts to learn about and from each other for practical purposes.

While mental health professionals and policymakers have time and again reported on different countries, historians of psychiatry have only hesitantly followed suit, focused as most of them were on their home-countries. An early exception was *Bürger und Irre: Zur Sozialgeschichte und Wissenschaftssoziologie der Psychiatry* (1969) by the German psychiatrist Klaus Dörner about the development of institutional psychiatry in Britain, France, and Germany in the eighteenth and nineteenth centuries. The French psychiatrist J. Postel and historian C. Quetel, in their *Nouvelle Histoire de la Psychiatrie* (1983), also followed an international perspective.[5] In recent years, other attempts have been made at comparative history. Some monographs and collections address the way in which insanity or mental problems were defined and treated in a range of different countries and societies, including a volume which brings together studies from all the continents.[6] Although not aiming to present systematic and fully-fledged comparative studies, these works reveal and also, to a certain extent, analyse and contextualise differences and similarities between national psychiatric cultures.[7] Next to Edward Shorter's *History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (1997) about the United States and several European countries, and Mark Micale's and Roy Porter's historiographic collection *Discovering the History of Psychiatry* (1994), collections have appeared - to mention some recent examples - on the 'confinement of the insane' in the nineteenth and early twentieth centuries world-wide, on the United Kingdom and some of its former colonies; on neurasthenia around 1900 in Great-Britain, Germany, and the Netherlands; on social psychiatry and psychotherapy in the twentieth century in these same three countries; and on post-war psychiatry and mental health care in Britain and the Netherlands.[8] Some conferences of the European Society for the History of Psychiatry, founded in 1993, have resulted in collections of papers about several European countries - albeit without any systematic comparison.[9] Whereas most comparative historical studies

on psychiatry are about the nineteenth and early twentieth centuries, this volume focuses on the twentieth.

Comparing national psychiatric cultures or aspects of these cultures has proved to be rewarding but also difficult, for at least two different reasons. Firstly, we are faced with the problem of the availability of historical research with a sufficiently similar focus, especially when relating to fairly recently developed research interests such as the patient's view, the role of the family, the different options for care and treatment, the way patients were admitted to and discharged from mental institutions, psychiatric nursing, psychopharmacology, social psychiatry, outpatient services, and the financial aspects of mental health care. Secondly, we are confronted with methodological problems relating to the availability of sources, and the translation and comparability of terminology and data from different countries and periods.[10] The term 'mental health care', for example, does not have the same meaning in various national cultures. In some it refers to a wide sphere of activity, including the care for the mentally handicapped and demented elderly as well as outpatient facilities and counseling centres for psychological and social problems. In others, it mainly concerns psychiatry in a narrower sense: the care and treatment of the mentally ill. The way the boundaries of the mental health domain were and are drawn as well as its relation to adjacent fields, such as poor relief, general health care, social work, pastoral care, education, and justice, vary from nation to nation. Concepts like 'social psychiatry', 'psychotherapy', and 'de-institutionalisation' may give rise to confusion. In some countries, psychotherapy and counseling were part and parcel of psychiatry and (public) mental health care, but in others they developed in the context of private practice, psychosomatic medicine, or social work. In general, comparative research seems to be most rewarding when it is problem-orientated and focuses on a particular subject.

The present volume is the result of an international workshop entitled *Cultures of Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches*, which took place in September 2003 in Amsterdam.[11] This workshop was inspired by the research project *The Disordered Mind: Theory and Practice of Mental Health Care in the Netherlands during the Twentieth Century*. That project started in 1998 under the aegis of the Huizinga Institute for Cultural History, the Netherlands Organisation for Scientific Research (NWO), the University of Amsterdam, and the University of Maastricht. The concrete goal of this project is to write a history of mental health care in the Netherlands in which its cognitive content, intervention practices, organisation, and institutional, social, and cultural settings are analysed in their mutual interconnections. The research team consisted of eight scholars doing research on patients' files in Dutch mental hospitals; the history of the psychiatric profession; the history of 'anti-psychiatry'; the history of psychiatric nursing; and the financing of mental health care. Also, other scholars working on various topics have participated in the team's meetings. In addition to monographs and articles by the participants, the directors of the project will publish a synthesis, offering a general overview of the history of psychiatry and mental health care in the Netherlands from the late nineteenth to the early twenty-first century. It will attempt to understand the development of Dutch psychiatry and mental health care from a social and cultural angle and to situate it in an international context.[12]

This volume has two aims. The first is to compare Dutch developments in psychiatry and mental health care in the twentieth century with those in some other Western countries. Which similarities and differences can be discovered? To what extent is the Dutch case exceptional? Both the Netherlands and the countries that have influenced it in this field - Germany, France, Britain, and the United States - are covered by national overviews. The second objective is to present some new approaches and promising research topics in the twentieth-century history of mental health care. For this reason, some other countries - Italy, Japan, and Sweden - have been selected. Studies on patterns of institutional admission and discharge and the practice of family care in the first two countries demand comparison with new Dutch research on the various ways mental patients were cared for. A fairly new topic of research concerns psychiatric nursing, and here Sweden is the counterpart of the Netherlands.

The essays in this volume have been organised in three parts. The first includes the national overviews of developments in psychiatry and mental health care and a comparative overview of the outpatient sector and de-institutionalisation in the Netherlands, Britain, Germany, France, Italy, and the United States. As a point of reference, this section starts with three articles on the Netherlands, the first focussing on intramural psychiatry, the second on extramural mental health care, and the third on 'anti-psychiatry' in the 1960s and 1970s. These contributions are followed by chapters on the surrounding countries and the United States, of which the former West- and East Germany are covered most extensively. In the second part, some new and promising topics and approaches are presented: the care of patients in the context of the interaction between asylums and the family in the Netherlands, Italy and Japan; psychiatric nursing in Holland and Sweden; and psychotropic drugs, mainly in the Netherlands. Two reflective reviews, one historiographic by a specialist in medical history and the other contextual and comparative by two specialists in political and cultural history, form the third and final part of the volume.

This collection of essays offers one of the first attempts in the history of psychiatry towards a more systematic comparison of national developments in a number of major Western countries during the twentieth century - a period that is only beginning to be the object of historical research. By making Dutch mental health care the point of reference and confronting it with developments abroad, the volume highlights contrasts and analogies which were partly unexpected. Like the professionals and policymakers mentioned above, historians of psychiatry, including the authors of this volume, show an increasing eagerness to learn about and from each other. Though practical purposes may not be their primary concern, the search for historical knowledge and understanding certainly is.

General trends, themes, and issues

To ensure that the overviews of the various countries would more or less cover a similar range of topics, the authors were invited to deal with crucial trends and developments, major features and turning points, as well as significant discussions and controversies in their home-countries. Other points of special interest that we suggested were: the external and internal boundaries of mental health care domains; the organisation and funding of care (public or voluntary; centralised or on a regional or local basis); legislation and policies in this field; the role of various professions (doctors, nurses, psychologists, social

workers, etc.) and the demarcation of their fields of work; the broader social and cultural context, the impact of two World Wars and, in some countries, of totalitarian regimes. Last but not least, we asked questions about patients: their profile, complaints, and the diagnoses of their mental disorders; their differentiation into new categories of care (such as in- and outpatients, chronic and acute, the mentally handicapped and demented elderly); self-organisation and influence of patients, and patients' rights. The authors were thus confronted with an ambitious list of queries and issues as a heuristic framework. For the individual author, it was impossible to answer all of these, simply because of lack of space or of relevant research. Covering a whole century and the whole range of intramural and outpatient mental health care is quite a challenge. The Dutch authors had the advantage of participating in the running research project *The Disordered Mind*. Yet, as will become clear, both the national overviews and the contributions on special topics are very helpful in understanding the way in which Dutch psychiatry and mental health care resembled and differed from those in other countries.

Some common trends in twentieth-century psychiatry and mental health care can be hypothesised. As far as intramural psychiatry is concerned, this period witnessed a gradual transformation of more or less closed asylums, where patients were admitted only or mainly with legal certification and more often than not for social rather than medical reasons, into more open mental hospitals,with increasing numbers admitted on a voluntary basis and according to medical criteria. This is not to say that in the past asylums were by definition institutions of social control and that there was something like a great confinement. Such a view, propagated by revisionist authors, has been convincingly refuted.[13] Some of the contributions in this volume, focusing on actual patients, show how complicated and divergent patterns of care and of institutional admission and discharge actually were. However, the revisionists were to some extent right in that medical criteria were often less crucial than social, political, administrative, and financial considerations as well as family interests and gender and class relations.

It was only in the course of the twentieth century that the main function of mental institutions shifted from shelter and care to treatment and cure. Distant, isolated mental institutions were to an increasing extent considered outdated, the more so if they were huge, overcrowded and in bad state. In many countries, the 1950s appear to mark a turning point: more and more patients were actually being treated instead of just sheltered and cared for; from then on, the average time-periods in which they were hospitalised steadily decreased. At the same time, patients were differentiated and segregated according to medical criteria: mentally handicapped and psycho-geriatric people, for example, moved to specialised institutions, thus leaving behind those with 'pure' psychiatric disorders. Of crucial importance were the changes in the way mental institutions were financed and administered. Until far into the twentieth century, they were largely dependent in many countries on poor relief, while their social and medical status was low. Sooner or later, in the context of a welfare state, collective medical insurance and social security schemes replaced poor relief. More money and the growing involvement of national governments often contributed to the improvement of the quality of care and living conditions for the mentally ill. Also, the accessibility of care, both in terms of legal or financial regulations and of geographical distance, was considerably broadened.

Probably the most drastic changes concern the expansion of the psychiatric domain and, closely connected to that, the development of mental health care outside mental institutions. Whereas in the nineteenth century psychiatry was predominantly confined to asylums, and in certainplaces, sanatoria and spas, in the course of the twentieth, it also gained ground in newly established facilities such as psychiatric wards in general hospitals, outpatient clinics, private practice, social-psychiatric services, and counseling centres. Psychiatry became part of the more-embracing field of mental health care and mental hygiene. Its expansion was accompanied by a growing number of professionals and an increasing professional diversity. Until the 1950s, psychiatrists and nurses or attendants still dominated the field. Afterwards, they began to be confronted with growing numbers of psychologists, social workers, and other, often new professions. This institutional and professional expansion and diversification reflected an increasingly wider spectrum of patients and clients. The development of the psychiatric domain since the late nineteenth century, appears to have been driven by an internal dynamic to include new groups: in addition to the insane, feeble-minded, and neurological patients, this included a diversity of nervous sufferers, psychosomatic patients, psychopathological criminals, sexual perverts, alcoholics, problem children, traumatised war victims, and others. Some psychiatrists began to present themselves as social-hygiene experts, focusing on the mental health of society at large. Not only mental illnesses, but also an increasing variety of milder nervous, psychosomatic and psychological disorders and complaints, personality problems, and a diversity of more or less common problems in modern life became part of the mental health system's sphere of action.[14]

The idea that psychiatric patients should preferably be discharged from a mental institution as soon as possible, or even that it was better to keep them as much as possible outside it, can be traced back to the late nineteenth and early twentieth centuries. Officially sanctioned family-care was then practised on a small scale in most Western countries, and on a larger scale in some, like Belgium (Gheel), Italy, Norway, and Japan.[15] Also, the first social-psychiatric facilities, outpatient clinics, and prevention-orientated counseling centres were set up before the Second World War. The two World Wars, especially the last, promoted a number of psychiatric innovations in the Anglo-Saxon World: new principles of in- and outpatient treatment along social and psychological lines, like brief psychotherapy, group-therapy, and the therapeutic community were then picked up by innovative psychiatrists in other Western countries. In most, however, it was not until the 1960s and 1970s that the role of extramural mental health care really grew more prominent and that the scope of outpatient facilities was enlarged. This was largely a consequence of the policy of de-institutionalisation, implemented in all Western countries, although its form, scale, and timing varied substantially. Outpatient facilities were no longer conceived as merely complementing psychiatric hospitals, but as replacing them to a large extent. The shift from intra- to extramural care was advanced by a diversity of factors which included practical considerations or necessities as well as ideological and ethical principles. These included: the introduction of psychotropic drugs from the 1950s; nationally designed plans to integrate psychiatry into the overall health and social care-providing system of the welfare state; the anti-psychiatric criticism of institutional and medical psychiatry; the striving for humanistic reform of the care and treatment of psychiatric patients and

enhancement of their social integration and civil rights; and last but not least, financial and political considerations.

The dynamic of modern psychiatry suggests that to some extent supply increasingly created demand. However, next to this push factor, some external pull factors such as social developments in modern society, should be taken into account to explain the expansion of mental health care. The Western world in the twentieth century witnessed a growing dependence of laypeople on scientific knowledge. According to the British sociologist Anthony Giddens, this is part of the 'reflexivity of modernity': the regularised use of expert knowledge, often in popularised forms, about personal and social life as a constitutive element in its organisation and transformation.[16] In this connection, the Dutch sociologist Abraham de Swaan has coined the term 'proto-professionalisation' to indicate the growing tendency of laypeople to adopt professional language and modes of interpretation.[17] Rising levels of education and heightened communication among the general population play an important role in this process. To a much lesser extent than in the past, people in Western societies are willing to accept individual shortcomings or unhappiness as an inevitable part of life, as God's will, or simply a matter of bad luck. Rising expectations of people about their ability to treat and solve personal problems, to fashion their individual lives by free choice, and to create or recreate their self have furthered the demand for mental health services, although their expansion and organisation - public or private - differ substantially between countries.

The strong growth of mental health care, especially in the second half of the last century, reflected a more general process of psychologisation - a change of mentality combining a combination of growing individualisation, internalisation, and self-guidance, related to changing social manners and relationships. The psychological interpretation of the self and of other people's motives and behaviour can be traced back to the late eighteenth century, but until far into the twentieth it was largely restricted to intellectual and bourgeois circles and mental health professionals themselves. In general, it was not until the 1950s and 1960s, when economic, social and political developments enabled the definitive breakthrough of individualisation on a massive scale and with a focus on authenticity, self-determination, and self-expression, that the psychological way of thinking gradually spread among the populations of Western societies.[18]

Political developments should also be taken into account. From the late eighteenth century, psychiatry, as a product of the bourgeois society that emerged during the era of the Enlightenment and the French Revolution, had developed in a dynamic between humanisation and disciplining, emancipation and coercion, social integration and exclusion, and between democratic citizenry and political control.[19] Until far into the twentieth century, institutional psychiatry fulfilled two functions: a medical one (care and cure), which gave priority to the interests of the individual patients or their relatives, and a social-political one (segregation), which was geared toward freeing society of the nuisance, danger, or harmful influence associated with the insane. How these two functions related to each other and which was most prominent varied in time and from place to place, and was also closely linked with a country’s political constellation. In countries where a liberal constitutional state was realised, there were constraints on the possibility of admitting people involuntarily to a mental asylum. From around 1840, various West-European countries and American states adopted measures to regulate the institutionalisation of the insane. Within the margins of the constitutional state, these

regulations served to protect citizens against the random deprivation of freedom and to allow effective admission procedures to ensure timely medical treatment for those who needed it, as well as the security of public order. The basic tenet of this regulation was that the insane – within and**,** on occasion, outside institutions – fell under a special jurisdiction and state supervision, based on their mental incapacitation. This meant that their civil rights were suspended for either a shorter or longer period of time. To this extent, mental illness was at odds with citizenship, as articulated on the ideals of freedom and equality since the American and French Revolutions.

Despite the constitutional state's juridical safeguards built into this arrangement, in the course of the last two centuries, it was not uncommon that these safeguards and the medical-humanitarian motives lost out against the view of mental disease as a social order, public health, or financial-economic problem. This happened in part on account of larger historical processes, notably growth in size, bureaucratisation, and increasing state intervention. Collective and state interests thereby might outweigh the well-being of the individual patient, while the boundaries of acceptable coercion became stretched little by little These trends were at work in many countries, albeit in different degrees, but went furthest in Germany. There, since about 1900, eugenics gained more following among psychiatrists, who let themselves be used as a tool by the Nazi regime in large-scale, mandatory sterilisation and euthanasia programmes. In liberal-democratic countries, psychiatry was also involved in social-hygienic policies, which subordinated individual civil rights to what was regarded as public health and national strength. For example, several American states and social-democratic Scandinavian countries enforced eugenic intervention. This was almost entirely for mental retardation. In the Soviet Union, psychiatry was used to confine dissidents and subject them to medical treatment for their 'mental disorders' in order to discredit their political opposition.[20]

In the nineteenth and early twentieth centuries, the relationship between institutional psychiatry and citizenship was 'negative' or 'exclusive' in the sense that hospitalisation in an asylum – apart from the voluntary admission that was made possible in many countries – generally implied legal certification and therefore the potentially serious infringement of basic civil rights. Later, however, a more 'positive' or 'inclusive' connection between psychiatry and liberal-democratic citizenship was established in two ways. Firstly, from about 1970, there was a growing attention to and recognition of the civil rights of the mentally ill. In many Western countries, the legislation on insanity was amended, reflecting a shift from values associated with maintaining law and order and protecting citizens against arbitrary detention or the insane against themselves, for their own benefit, to values associated with patients' autonomy, responsibility, and consent, as well as their right to adequate care and treatment.[21] Secondly, from the early years of the twentieth century, in psychiatry as well as in the broader field of mental hygiene and mental health care, socio-psychological definitions of citizenship were advanced. Expressing views about the position of individuals in modern society and their possibilities for self-development, psychiatrists, psycho-hygienists, and other mental health workers connected mental health to ideals of democratic citizenship and civic virtue. Thus, they were clearly involved in the modern liberal-democratic project of promoting not only virtuous, productive, responsible, and adaptive citizens, but also autonomous, self-conscious, assertive, and emancipated individuals as members of an open society.[22]

Whilst the history of psychiatry and mental health care can only be understood in their social, political, economic, and cultural contexts, it was not possible to cover these systematically in this volume. The format of the chapters hardly allowed that - although many authors refer or allude to these contexts. One of the other important topics discussed during our workshop was to what extent continuity and discontinuity, ruptures or watersheds can be discerned in the different countries in the course of the twentieth century. If, for example, the 1950s were to be characterised as a watershed, what exactly would this refer to? To the introduction of new psychotropic drugs, referred to by some as the 'psychopharmacological revolution'?[23] Or to the more or less gradual realisation of more differentiated options for treatment and care, both within and outside mental hospitals? Or to both, the first creating the conditions that were favourable for the second? And to what extent could these developments in the 1950s be considered as the foreboding for what was presented as 'anti-psychiatry' in the late 1960s and after? Or should that period itself, rather than the 1950s, be marked as a watershed? If so, in which respects was it important: in rejecting the 'medical model'; in setting a different 'moral agenda'; in 'emancipating' both patients and psychiatric nurses; or in enhancing the accessibility of mental health care? [24] How did these developments relate to what came to be called 'de-institutionalisation'?[25] Perhaps the clearest, yet at the same time much more localised example of a rupture is presented by Nazi psychiatry and their 'euthanasia' programme.[26]

Another issue raised during the workshop concerned the assessment of the quality of institutional or other types of care of the mentally ill, as they developed in the course of the twentieth century. On the one hand, everybody seemed to agree that it is quite legitimate or even imperative for an historian to look into the quality of care according to the standards of the period itself and of the different parties concerned.[27] On the other hand, there was less consensus about whether or not historians should themselves attempt to strike a balance and make evaluative judgements, eg. in terms of the degree of 'humanity' or therapeutic effectiveness of psychiatric cultures or regimes over time. The risk of finding oneself on the slippery slope of Whiggish thinking in terms of 'progress' is indeed far from imaginary.[28] Yet this risk can be considerably contained. First, by making explicit how and according to which criteria the quality of mental health care is being assessed. And second, by making a clear distinction between the quality of mental health care as it was actually realised, and the way in which this came about - whether or not it was planned or intended as such is but one important aspect of this question. Both issues will be discussed at some length in the final chapter of this volume.

Contributions to this volume

The first part of this volume, the national overviews, opens with three Dutch contributions. The first one, by Marijke Gijswijt-Hofstra, provides an overview of Dutch institutional psychiatry between the late nineteenth century and 2000. The central themes in her overview include: the development from closed asylums to their gradual opening up from around the 1920s, and the recent integration and mergers of mental hospitals with half-way or community care facilities; the development of private, voluntary, or charitable versus public involvement in institutional care of the mentally ill; processes of differentiation of mental institutions, both internally through allocating separate wards for different kinds of patients, and externally by building separate institutions for mentally

handicapped, epileptic, alcoholic, or psycho-geriatric patients; the development of hospital versus asylum functions, including the tension between medical aspirations and what was actually realised; and, finally, the development of the quality of care. Interesting results include the relatively early opening up of asylum wards for 'voluntary', uncertified admissions, and the relatively late and cautious introduction of 'socialisation', as the Dutch variant of de-institutionalisation was called.

The second chapter, by Harry Oosterhuis, maps the various Dutch extramural organisations, facilities, and practices in which psychiatrists and other professional groups have played a role during the twentieth century. He discusses the institutional development of outpatient mental health care, the professional groups that shaped it and the approaches and treatments they adopted, their various groups of patients and clients, and, finally, the larger socio-cultural context. Especially notable is that the Netherlands acquired an extensive network of extramural services in the course of the twentieth century, ranging from pre- and aftercare for the core group of severely mentally ill people to a broad psychosocial and psychotherapeutic mental health sector that, particularly from the 1960s, attracted a large clientele. It is emphasised that the growing supply of professional care created, as it were, its own demand. It is also suggested that the cultural revolution of the 1960s, in combination with rapid secularisation and the erosion of 'pillarisation' – the far-reaching Dutch social and political compartmentalisation along denominational and ideological lines – resulted in a spiritual vacuum that was partially filled by 'the new psychotherapeutic ethos'.

The third chapter on the Netherlands, by Gemma Blok, is about the impact of anti-psychiatry on the actual practice of clinical psychiatry during the 1970s. She attempts to explain its popularity in the context of the situation in clinical psychiatry at that time, as well as of broader cultural changes. Interestingly, it was not the abolition of psychiatry as such, but rather an intensification of psychiatric treatment - especially in the form of psychotherapy, the therapeutic community, or family therapy - that Dutch critical psychiatry stood for. Much was expected from the new 'social model' - in fact a psychotherapeutic model - with its emphasis on self-determination and the personal responsibility of the 'clients'.

From the Netherlands we cross the North Sea. The central theme of Hugh Freeman's overview of British psychiatry is the relationship between the state and the care of the mentally ill. Before the establishment of the National Health Service (NHS) in 1948 – a watershed according to Freeman - the mainly public British asylum system was, like in many countries, closely intertwined with poor relief. The NHS placed the 'mental hospitals' together with general hospitals in one nationalised system of health care. From the late 1950s onwards, the emphasis of British psychiatry gradually shifted from mental hospitals to 'community care'. It was only from the mid-1970s onwards, however, that de-institutionalisation was officially stated as government policy, although financial support was inadequate. Indeed, financial limitations and dictates cropped up time and again, especially during the Thatcher regime, when the NHS withdrew from providing long-term care, and the social security system began to pay for transferring patients with chronic mental illness to privately run nursing homes.

Gerald Grob's chapter on the United States focuses on the origins, goals, and outcomes of de-institutionalisation, including the different meanings of this term over time, and the reasons why it did not benefit all patients. The emergence of de-

institutionalisation was facilitated by the growing role of the federal government in social welfare and health policies soon after the war, together with the impaired authority of state governments that were responsible for the public mental hospitals. With the Community Mental Health Centres Act of 1963, the federal government advanced a radically new policy. Community Mental Health Centres (CMHCs) were meant to facilitate social support for mental patients as well as early identification of symptoms and preventive treatments, and thereby make (long-term) hospitalisation superfluous. However, the outcome did not meet expectations. Due to the financial incentive of the enactment of Medicare and Medicaid in 1965, long-term, primarily elderly patients were moved from state mental hospitals to nursing homes, resulting in trans-institutionalisation rather than de-institutionalisation. Also, it soon become clear that the CMHCs attracted a clientele with less serious problems, rather than assuming responsibility for the aftercare and rehabilitation of chronic patients with serious mental disorders.

Germany is discussed in the next three chapters. Volker Roelcke questions the conventional tripartite periodisation of twentieth-century German psychiatry, parallel to German political history, with the Third Reich as the obvious second period. He does so by considering three dimensions of psychiatry from the early twentieth century up to the 1970s: the professional policies, the organisation of mental health care, and scientific research. Apart from notable discontinuities, Roelcke signals considerable continuities extending from 1933 to 1945. The Weimar period, for example, already contained strong eugenicist tendencies. Without denying that the ruthless way the Nazis put eugenics and racial hygiene into practice was unparalleled in history, Roelcke argues that Hitler's regime represented not so much a rupture as continuity. Moreover, he points out that, certainly as far as personnel and the strong medical focus were concerned, 1945 represented no clear break, although eugenically inspired genetic research programmes almost disappeared. If all three dimensions of psychiatric activity are taken into consideration, it was only much later, around 1970, that we can speak of a clear rupture. There was then a shift away from large-scale mental hospitals, other professional groups, such as psychologists and social workers, were integrated into mental health care settings, and a more open attitude emerged towards social psychiatry and psychotherapy.

Greg Eghigian's contribution is about the German Democratic Republic (GDR) and he focuses on the role there of politics. Was there something particularly ‘communist’ about East German psychiatry? Or, more generally, do totalitarian or authoritarian regimes necessarily imply that psychiatry is also repressive? He argues that the connection between politics and psychiatry is by no means straightforward, and that liberal, fascist, and communist societies alike have tended to give mental health care an increasingly important role in the management of (ab)normality. With respect to the regime of the GDR, Eghigian demonstrates how, after an initial period of reticence, party officials and the government increasingly accepted psychiatric expertise. From the 1960s onwards, during the period of de-stalinisation, psychiatrists and psychologists played a prominent role in certain social reform projects. In the 1970s and 1980s, East German psychiatry experienced a phase of ‘openness’, including more international professional contacts.

Focussing on the federal state of North Rhine-Westphalia, Franz-Werner Kersting examines asylum psychiatry from 1940 to 1975. More particularly, he explores how the acknowledgement of the fate of psychiatric patients in the Third Reich affected the

reform process of German psychiatry. For the West German reform movement in psychiatry, advocating a shift from a medical to a social approach, the Nazi past served as a warning example to show that an exclusive biomedical and institutional focus easily entailed the danger of an inhuman, repressive psychiatry, possibly with deadly consequences. The reform effort started in the 1950s as an internal debate in the psychiatric world. It was the interaction between the aims of innovative psychiatrists and those of the broader protest movement of the 1960s that made it into a public issue, resulting in the Psychiatry Commission of the German parliament in the early 1970s. There was reason enough for Kersting to conclude that '1968' was a turning point, thereby agreeing with Roelcke.

From Germany, we cross the Rhine to arrive in France. Jean-Christophe Coffin outlines the development of the French public mental health care system between 1920 and 1980, paying special attention to the debates that inspired its transformation. Coffin examines the innovative ideas of a group of psychiatrists around Henri Ey in Paris, who were active after the Second World War. They pleaded for radical innovation in psychiatric thinking and practice: hospitalisation should only be the ultimate solution in a whole range of options to be made available for mental patients, such as open care services, social re-adaptation facilities and care at home. However, reform-plans launched by the government in the early 1950s and 1960s failed to materialise, although local experiments with 'therapeutic communities' and outpatient projects, were indeed started around 1950. It was only in the 1970s that the sector model was finally implemented, meaning the integration of various in- and outpatient mental health provisions within geographical districts so as to make them more accessible to the population. However, at the same time, psychiatry was strongly criticised so that Ey and his colleagues concluded that the more radical reform of psychiatry - its demedicalisation and a push back of mental hospitals - which they advocated, had not been realised.

The national overviews, most of which focus especially on institutional psychiatry, are followed by a comparative essay in which Harry Oosterhuis explores the development of outpatient mental health care and de-institutionalisation in the five countries discussed in the previous chapters, as well as Italy. He shows that there is no simple relation between the growth of outpatient services and community care on the one hand and de-institutionalisation on the other, in the sense that more or less de-institutionalisation was paralleled by the creation of more or less outpatient services. In countries with relatively highly developed outpatient facilities and community services - France and the Netherlands - de-institutionalisation was introduced rather late and cautiously, compared to other nations. Germany, with considerably fewer outpatient services, likewise pursued de-institutionalisation in a gradual and moderate way. In Italy, the United States, and the United Kingdom, on the other hand, de-institutionalisation was implemented earlier and more drastically, whereas outpatient facilities or community care lagged behind.

The second part of the volume include six chapters in which some recent and promising approaches and research topics are discussed: the history of the psychiatric patient, of psychiatric nursing, and of psychotropic drugs. The three chapters on patients demonstrate in different ways what can be gained by analysing medical records and other written sources on the practice of psychiatric care. 'Doing medical history from below' fixes attention not only on the patient, but also on their relatives and, perhaps, their

friends and neighbours.[29] How were the mentally ill cared for? What were the options and which options were successively used and why? What was the role of the family in this whole process? Joost Vijselaar's chapter is about the patterns of admission and discharge in three Dutch mental institutions between 1890 and 1950. His detailed study of patients' records sheds light on a number of the social mechanisms that surrounded admission and discharge, in particular the interaction between asylum and family. Vijselaar demonstrates, on the one hand, that for families with a relative suffering from mental illness, the asylum was often far from being the first option, and on the other hand, that asylums were not bent on keeping patients hospitalised at all costs and, depending on the social situation, rather encouraged their (early) return to society.

The next chapter, by Akihito Suzuki, explains the excess – between three-fifths and two-thirds - of male patients in the Japanese asylum population: numbers that were not equalled in the Western world, before the Second World War. Against the background of the mental health care system in Japan, which was characterised by relatively few asylums and widespread family care, and focussing on the diagnosis of schizophrenia, Suzuki explores the reasons for the over-representation of men in asylums. Analysing statistical materials and patients' records, Suzuki concludes that since psychiatric beds were rather scarce, priority was given to the hospitalisation of male patients, because their symptoms were perceived to be of a more public nature and more threatening to others. Female patients were more frequently cared for at home, while their symptoms tended to be regarded as more private and more directed against themselves, while the traditional extended family was able to 'absorb privately troublesome cases'.

Patrizia Guarnieri's contribution on subsidised home care of mental patients by their relatives in Italy in the early twentieth century focuses on the province of Florence, where the provincial administration bore the costs of asylum-care for the poor. In 1866, the province started a family-care programme, which was cheaper and alleviated the overcrowding of the asylums. Initially, home-care was only subsidised for those patients who had first been admitted to an asylum. Soon, however, support was extended to patients who had not been institutionalised before and who were already cared for by their indigent families. In the last two decades of the nineteenth century, the number of mentally ill people entrusted to family care rose from around 200 to 700. Guarnieri examines the different roles and often conflicting interests of provincial and local authorities, the attitude of psychiatrists, and finally, what actually went on in the small homes of the families concerned. It appears that relatives did not keep their patients at home for the money – the subsidy was much too low for that - but that they often preferred to care for them and 'did what they could, even with love'.

The history of psychiatric nursing is also a promising, yet relatively unexplored field of research. Analysing a series of Dutch textbooks for student psychiatric nurses from 1897, Cecile aan de Stegge sheds light on changing attitudes towards the use of restraint in mental institutions in the twentieth century. Although reliable data on the actual use of restraint are lacking or scarce, she shows that from the beginning, both the textbooks and the requirements of the State Inspectors reflected rejection of the use of mechanical restraint – at least of those means of restraint that had to be registered, such as straitjackets. On the whole, both textbook authors and Inspectors 'felt uneasy with mechanical measures that hampered the freedom of bodily movement'. However, as far as other techniques to restrain patients and the isolation of patients were concerned, they

appeared to be more flexible and less consistent. Aan de Stegge highlights a fundamental change between the mid-1920s and the mid-1950s, when short-term 'educational seclusion' in the context of occupational therapy was considered 'appropriate'. After the introduction of psychotropic drugs, a diminishing tolerance for 'unnecessary' restriction can be detected, but should seclusion nevertheless be used, nurses were expected to be able to motivate this intervention in writing.

The other chapter on psychiatric nursing, by Gunnel Svedberg, is about Sweden and covers the period from the mid-nineteenth until the end of the twentieth century. Her focus is on professional identity, including the role of gender and class. The Swedish case is rather special in that psychiatric nursing was not established as a separate, autonomous, and asylum-based branch of training, like, for instance, in the Netherlands, Britain, or Germany. As in the United States, all Swedish nurses received both general training and supplementary training in a special field, such as psychiatric nursing. Whereas in other countries males worked as psychiatric nurses, in Sweden this profession was, until the early 1950s, an exclusively female affair. In daily practice, qualified female nurses were appointed as head-nurses on both female and male asylum wards, whereas a much larger group of female and male attendants, with much less training, performed most of the nursing work. Male attendants especially were increasingly dissatisfied with this situation, which would only change when training for attendants was improved, and nursing colleges finally opened their doors to male students in 1950.

In their chapter about the 'hidden history' of psychiatric drugs, Toine Pieters and Stephen Snelders, on the basis of two case studies, examine the continuities and discontinuities with regard to the use and meaning of medication in mental institutions. The first case study concerns the European career paths of the new drug hyoscine (scopolamine) in the late nineteenth century. The second, based on Dutch professional and popular publications as well as interviews with expert witnesses, focuses on the career paths of chlorpromazine in the 1950s and 1960s, primarily in the Netherlands. Pieters and Snelders conclude that in both cases, continuity rather than discontinuity should be stressed. In both cases, a recurring cycle of therapeutic optimism, and subsequent re-evaluation and disappointment can be discerned.

The third and final part of the volume contains two chapters with reflections on the previous contributions and has the twofold goal of comparing Dutch developments with those in other countries and presenting some new approaches and promising research topics. Frank Huisman elaborates historiographic issues and offers suggestions on how to write (comparative) history of psychiatry, while Ido de Haan and James Kennedy, in their joint contribution, present some general and concluding reflections.

Psychiatric cultures compared: results and remaining problems

This collection, of course, can by no means offer a final comparative history of psychiatry and mental health care. We have only made a start and this volume illustrates some of the difficulties in attempting international comparison. An exhaustive comparison of national psychiatric cultures requires not only a certain structuring of themes that are considered worth comparing, but also thorough research on common topics. As far as the organisation and provision of mental health care and the treatments offered is concerned, we are fairly well informed - although historical research of outpatient care still leaves much to be desired. However, this is much less true, for

example, of issues that are essential from the perspective of the 'history from below': the need among the population for mental health care, the way people experienced mental disorders and articulated their needs and demands, and the available options they did or did not use. These issues are covered in the three chapter on patients and their families, but they do not go beyond the first half of the twentieth century, nor do they cover Britain, France, Germany, and the United States - the major countries with which the Netherlands are compared. The patient's perspective should receive more attention, including the role of the family and patient's 'careers'. Also, the perspective of psychiatric nurses or attendants, the professional group that is the most intensively involved with care for psychiatric patients, appears to be a promising topic for future research. At another level, more research into the politics and funding of mental health care may lead to new insights. In this way, this volume generates new questions, though we have certainly learned a lot from this undertaking. So far as the general trends highlighted earlier in this introduction are concerned, we are able to qualify some of them and to specify in what way Dutch mental health care in the twentieth century might be different or even unique from an international perspective.

It appears to be crucial to distinguish between ideas or ideals, rhetoric, norms, intentions, and plans with respect to mental health care on the one hand, and what was actually realised on the other. It is also useful to distinguish between reporting what happened at both these levels and the extent to which the one corresponded with or diverged from the other, as well as attempting to explain why things happened as they did, or failed to happen. The reform of mental health care through de-institutionalisation and the promotion of community care in particular were frequently accompanied with high expectations and much enthusiasm, but nearly everywhere, this commitment met with financial, political, organisational, or professional obstacles. The chapters in this volume contain numerous examples of outcomes that fell short of or deviated from the original intentions and expectations. To answer the question why this happened and how we should explain the unexpected results requires a more detailed comparative analysis than can be offered here. It is beyond doubt that the growing involvement of national governments, the development of welfare states, and the impact of financial considerations were important. However, they do not in themselves account for the various policies that were implemented and the different ways in which new systems of mental health care materialised.

The shift from mental institutions to other psychiatric provision, including 'community care', is usually seen as one of the most drastic changes in twentieth-century mental health care. The way and the extent in which complementary or alternative facilities were realised, however, differed considerably, both in timing and cross-nationally, and even regionally within the larger nations. Moreover, the term usually used to characterise this development, 'de-institutionalisation', may be inaccurate or even misleading. What often happened was in fact 'de-mental-hospitalisation', the reduction of (long-term) hospitalisation in mental hospitals. If, in a more literal sense, de-institutionalisation is understood to mean the reduction of institutional care as such, then the care provided by, for instance, the inpatient psychiatric departments of general hospitals, institutions for the mentally handicapped, and nursing homes for demented elderly people should also be included. In such a perspective, the shift from mental hospital to alternative types of residential care should perhaps not be called de-

institutionalisation, but rather, as Grob suggests, 'trans-institutionalisation'.[30] Certainly, for many patients suffering from severe and chronic mental illnesses the range and (financial as well as geographical) accessibility of mental health services was broadened, especially in the form of outpatient or community care facilities. Although the expansion of public community care facilities was orientated towards psychiatric patients in the majority of the countries concerned, this appears to have been only partly the case in the United States and the Netherlands where, as Oosterhuis shows, a broader clientele with minor mental complaints and psychosocial problems was also included. To what extent this also happened in other countries has yet to be clarified.

To what extent can we answer the question whether or not the Netherlands presented a special case? The contributions by Gijswijt-Hofstra and Oosterhuis as well as the concluding chapter by De Haan and Kennedy refer to this in some detail, though a relatively limited number of (large) countries has been included in our comparison. I futuer considerations, it would be worth while to expand the scope, and also include, for instance, some smaller countries like Belgium, the Scandinavian nations, Switzerland, and Austria.

With respect to Dutch institutional psychiatry, it may be noted that until the last decades of the nineteenth century, most asylums were old – sometimes centuries old – and small, and were situated in towns. Most remained relatively small-scale, seldom more than 800-900 beds. The Netherlands was among the first countries to introduce an insanity law emphasising that the insane were to be treated and cured, and imposing state supervision on asylums to maintain good standards of care and treatment. The Netherlands was also among the first countries that opened asylum wards for uncertified admissions. In the context of the 'pillarisation' of Dutch society from the late nineteenth century onwards, voluntary, religiously inspired initiatives (orthodox Calvinist, Roman Catholic, Jewish, Dutch Reformed) played, next to public initiatives, a prominent role in the building and administration of mental institutions. As the Netherlands is a small country, geographical distance between the different parts of the country could be fairly easily bridged. Thus, some Roman Catholic patients from Amsterdam were sent to a relatively cheap denominational mental institution in the south of the country. It should be mentioned, however, that the Netherlands was by no means the only country where religious organisations played an important role in institutional psychiatry: this was also the case in Belgium and Germany. As in other social sectors, there has always been a delicate balance in Dutch mental health care between voluntary organisation and administration on the one hand, and public financing and government supervision on the other. If and to what extent this public/voluntary mix was specific to the Netherlands remains a question for future research.

With respect to the therapeutic regime, Dutch asylum doctors tended to follow international medical developments. However, the very prominent role of 'more active therapy' (in German: *aktivere Therapie*) in the Netherlands, from the 1920s until the 1960s, is striking. Although this form of occupational therapy - a social and didactic rather than medical approach to mental illness - originated in Germany, it seems to have been especially popular and lasting in the Netherlands. Why this would have been the case, has not become sufficiently clear. Obviously, Nazi Germany went its own way. In Britain, France and the United States this form of occupational therapy was either not introduced at all, or it did not nearly become as popular as in the Netherlands – and, for

that matter, initially in Germany itself. Future research may shed more light on this. It seems quite probable that, certainly if compared to the large British, French, and American mental institutions, the overall small scale of Dutch asylums, many of them built according to the pavilion or cottage system, offered a relatively favourable environment for the introduction of active therapy. In addition, it may well be that this therapy fitted in with a more general preference for moral, didactic, and social approaches that can also be found in Dutch outpatient mental health care. Compared to their colleagues in other European countries, Germany in particular, Dutch psychiatrists were somewhat more reserved towards somatic treatments; in general, their approach was eclectic and pragmatic, and many of them had an open mind towards psychoanalysis as well as social, phenomenological, and anthropological psychiatry. In contrast with pre-war Germany, the United States, and some Nordic countries, eugenics never caught on in Dutch psychiatry.

Psychiatric nursing appears to have some specific Dutch features. The Netherlands is one of the few countries where this specialty developed apart from general nursing in somatic medicine and where there has been a separate training system for psychiatric nurses – both female and male - from the late nineteenth century onwards. In the Dutch training system psychological, didactic, and social approaches were allotted an increasingly important place, whereas in Sweden, for instance, nursing was much more medically orientated. Other countries that, at one time or another, developed a training system for psychiatric nurses that was completely separate from general nursing, were Britain, Ireland, and Switzerland.[31]

With respect to Dutch extramural mental health care, public outpatient facilities were founded early (from the 1920s) and showed a stronger degree of continuity than anywhere else. This was partly caused by the influence of the Dutch pillarised social system, which facilitated more or less stable organisational structures on the basis of voluntary initiatives, and later by the generous collective funding in the Dutch welfare state. Otherwise, the role of the Dutch government remained rather passive, at least until the 1970s, when it began to formulate and implement its own policies. When, from the 1980s onwards, 'socialisation', being the Dutch variant of de-institutionalisation, began to be pursued - later than in the Anglo-Saxon countries and Italy - an extensive and multifaceted network of outpatient facilities was already in place. Another striking element of the Dutch outpatient mental health care sector was its wide boundaries. From early on, it not only offered pre- and aftercare for psychiatric patients and the mentally handicapped, but also included counseling centres for problem children, for marriage- and family-related issues, for psychotherapy, and for alcohol and drug addiction. Outpatient mental health care, partly organised on a religious basis, was not just medical psychiatry or psychotherapy, to a large extent it also (moral) education, pastoral care, and social work. Moral-didactic and psychosocial approaches rather than medical treatment gained the upper hand in this respect.

The broad orientation and accessibility of Dutch extramural mental health care can also be explained by its fairly early and generally strict differentiation from institutional and clinical psychiatry. There was a strong tendency in the outpatient sector to keep patients with serious psychiatric disorders, who were difficult to treat, out of its system. In Britain, France, and Germany, the public mental health sectors were more exclusively geared toward the mentally ill, while there was also a closer link with clinical

psychiatry. The major role of psychotherapists – psychiatrists as well as psychologists and social workers – in Dutch outpatient mental health care, especially since the 1960s, sets the Netherlands apart from other European countries, where psychotherapy largely remained limited to the more or less elitist private practice of psychiatrists. In this respect, the developments in the Netherlands were more similar to those in the United States. In both countries, the emphasis on a multidisciplinary approach in post-war mental health care ultimately resulted in both the expansion of its domain and a strong psychological orientation.

What is perhaps most striking in Dutch psychiatry and mental health care is their openness towards various foreign examples. Before the Second World War, social psychiatry, active therapy, psychoanalysis and other forms of psychotherapy, phenomenological and anthropological approaches, and experimental and clinical psychology were adopted from Germany, Austria, and, to a lesser extent, France. Whereas these innovations largely came to an end in central Europe in the 1930s, they proved enduring in the Netherlands. The same was true of the counseling centres for alcoholism and family and marriage problems, established around 1910 and 1940 respectively. Before and after the Second World War, Dutch psychiatry also followed models from the United States and Britain: the mental hygiene movement, child guidance clinics, psychiatric social work, counseling methods and new forms of psychotherapy, and the therapeutic community. Again, some of these were longer lasting in Holland than in the countries in which they originated.

Notes

[*] We are indebted to our co-editor Joost Vijselaar for his comments on earlier drafts of this introduction and to Hugh Freeman for correcting the English.

[1] Pándy's study appeared in Hungarian (1905) and in German: K. Pándy, *Die Irrenfürsorge in Europa. Eine vergleichende Studie* (Berlin: Georg Reimer, 1908).

[2] See, for instance, F. de Haen (ed.), *Mental Health Care in Some European Countries. Policy, Organization and Financing of Mental Health Care in Belgium, France, England, Wales, Denmark and Switzerland* (Utrecht: National Hospital Institute of the Netherlands, 1989).

[3] For instance: H.L. Freeman, T. Fryers & J.H. Henderson, *Mental Health Services in Europe: 10 years on* (Kopenhagen: WHO, 1985).

[4] See Steen P. Mangen (ed.), *Mental Health in the European Community* (Beckenham: Croom Helm, 1985) and *Acta Psychiatrica Scandinavica*, 104 (Suppl. 410) (2001); T. Becker and J.L.Vázquez-Barquero, 'The European Perspective of Psychiatric Reform', in *Ibid.*, 8-14.

[5] Klaus Dörner, *Bürger und Irre: Zur Sozialgeschichte und Wissenschaftssoziologie der Psychiatry* (Franfurt am Main: Europäische Verlagsanstalt, 1969); English translation: *Madmen and the Bourgeoisie: A Social History of Insanity and Psychiatry* (Oxford: Basil Blackwell, 1981); J. Postel and C. Quetel (eds), *Nouvelle Histoire de la Psychiatrie* (Toulouse: Editions Privat, 1983).

[6] Roy Porter and David Wright (eds), *The Confinement of the Insane. International Perspectives, 1800-1965* (Cambridge: Cambridge University Press, 2003.

[7] By psychiatric cultures we understand 'distinct worlds of meaning' with respect to how mental illness and mental problems were/are defined, named, interpreted, and treated or prevented. See: William H. Sewell, 'The Concept(s) of Culture', in Victoria E. Bonnell and Lynn Hunt (eds), *Beyond the Cultural Turn. New Directions in the Study of Society and Culture* (Berkeley etc.: University of California Press, 1999), 35-61: 52, 57-58. See also: Marijke Gijswijt-Hofstra, 'Introduction: Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands', in *idem* and Roy Porter (eds), *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands* (Amsterdam & Atlanta: Rodopi, 1998) 1-7: 1-2.

[8] Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York etc.: John Wiley & Sons, 1997); Michael Micale and Roy Porter, *Discovering the History of Psychiatry* (New York etc.: Oxford University Press, 1994); Porter and Wright (eds), *op. cit.* (note 6); Gijswijt-Hofstra and Porter (eds), *op. cit.* (note 7). Joseph Melling and Bill Forsythe (eds), *Insanity, Institutions and Society, 1800-1914. A Social History of Madness in Comparative Perspective* (London & New York: Routledge, 1999); Marijke Gijswijt-Hofstra and Roy Porter (eds), *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam & New York, NY: Rodopi 2001); Michael Neve and Harry Oosterhuis (eds), *Social Psychiatry and Psychotherapy in the Twentieth Century: Anglo-Dutch-German Perspectives*, special issue *Medical History*, 48, 4 (2004).

[9] Leonie de Goei and Joost Vijselaar (eds), *Proceedings of the 1st. European Congress on the History of Psychiatry and Mental Health Care* (Rotterdam: Erasmus Publishing, 1993); F. Fuentenebro, R. Huertas, and C. Valiente (eds), *Historia de la psiquiatría en Europa: Temas y tendencias* (Madrid: Frenia, 2003).

[10] See also Steen Mangen, 'Psychiatric Policies: Developments and Constraints', in: *idem* (ed.), *op. cit.* (note 4), 1-33: 4.

[11] Most contributions in this collection are based on a selection of the pre-circulated papers presented at the workshop, mediated by the contributions of the invited commentators and participants.

[12] Directors of the project are Marijke Gijswijt-Hofstra and Harry Oosterhuis. The other participants are, in the sequence of the projects mentioned: Joost Vijselaar, Ido Weijers (assisted by Peter van Drunen), Gemma Blok, Cecile aan de Stegge, and, for the project on financing, Karin Bakker and Henk van der Velden. Up until January 2005 two individual projects have resulted in book publications: Gemma Blok, *Baas in eigen brein. 'Antipsychiatrie' in Nederland, 1965-1985* (Amsterdam: Uitgeverij Nieuwezijds, 2004); Ruud Abma and Ido Weijers, *Met gezag en deskundigheid. De historie van het beroep psychiater in Nederland* (Amsterdam: SWP, 2005).

[13] See Michel Foucault, *Madness and Civilization. A History of Insanity in the Age of Reason* (London: Tavistock, 1971); Robert Castel, *The Regulation of Madness. The Origins of Incarceration in France*

(Cambridge: Polity Press, 1988); Andrew Scull, *Museums of Madness. The Social Organization of Insanity in Nineteenth Century England* (London: St. Martin's Press, 1979); D.J. Rothman, *The Discovery of the Asylum. Social Order and Disorder in the New Republic* (Boston, Mass; Toronto: Little, Brown, 1971).

[14] See, for instance, Robert Nye, *Crime, Madness, and Politics in Modern France. The Medical Concept of National Decline* (Princeton: Princeton University Press, 1984); Ruth Harris, *Murders and Madness. Medicine, Law, and Society in the fin de siècle* (Oxford: Oxford University Press, 1989; Edward Shorter, *From Paralysis to Fatigue. The History of Psychosomatic Illness in the Modern Era* (New York: Free Press, 1992); Joachim Radkau, *Das Zeitalter der Nervosität. Deutschland zwischen Bismarck und Hitler* (Munich & Vienna: Carl Hanser Verlag, 1998); Harry Oosterhuis, *Stepchildren of Nature. Krafft-Ebing, Psychiatry, and the Making of Sexual Identity* (Chicago: The University of Chicago Press, 2000); B. Shepherd, *A War of Nerves, Soldiers and Psychiatrists 1914-1994* (London: Jonathan Cape, 2000); Gijswijt-Hofstra and Porter (eds), *op. cit.* (note 8: *Cultures of Neurasthenia*); Eric J. Engstrom, *Clinical Psychiatry in Imperial Germany. A History of Psychiatric Practice* (Ithaca & London: Cornell University Press, 2003); Paul Lerner, *Hysterical Men. War, Psychiatry, and the Politics of Trauma in Germany, 1890-1930* (Ithaca and London: Cornell University Press, 2003); R. Castel, F. Castel and A. Lovell, *The Psychiatric Society* (New York: Columbia University Press, 1982); Andrew Scull, 'Psychiatry and Social Control in the Nineteenth and Twentieth Centuries', *History of Psychiatry*, 2 (1991), 149-69; J.C. Pols, *Managing the Mind. The Culture of American Hygiene, 1910-1950* (University of Pennsylvania, 1997); Leonie de Goei, *De psychohygiënisten. Psychiatrie, cultuurkritiek en de beweging voor geestelijke gezondheid in Nederland 1924-1970* (Nijmegen: SUN, 2001).

[15] See, for instance, P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum. The History of Care in the Community 1750-2000* (London: Athlone Press, 1999).

[16] Anthony Giddens, *The Consequences of Modernity* (Cambridge: Polity Press, 1990).

[17] Abraham de Swaan, R. van Gelderen and V. Kense, *Het spreekuur als opgave. Sociologie van de psychotherapie 2* (Utrecht & Antwerpen: Het Spectrum, 1979), 28-34.

[18] See C. Taylor, *Sources of the Self. The Making of Modern Identity* (Cambridge: Cambridge University Press, 1994); Mark Micale (ed.), *The Mind of Modernism: Medicine, Psychology, and the Cultural Arts in Europe and America, 1880-1940* (Stanford: Stanford University Press, 2004); R.H. Turner, 'The Real Self: From Institution to Impulse', *American Journal of Sociology*, 81 (1976), 989-1016; M.L. Gross, *The Psychological Society* (New York: Touchstone, 1978); R. D. Rosen, *Psychobabble. Fast Talk and Quick Cure in the Era of Feeling* (New York: Avon Books, 1979); N. Rose, *Governing the Soul. The Shaping of the Private Self* (London: Routledge, 1990); N. Rose, *Inventing our Selves: Psychology, Power, and Personhood* (Cambridge: CUP, 1996); Anthony Giddens, *Modernity and Self-Identity. Self and Society in the Late Modern Age* (Cambridge: Polity Press, 1991); E.S. Moskowitz, *In Therapy We Trust. America's Obsession with Self-Fulfillment* (Baltimore: Johns Hopkins University Press, 2001).

[19] Dörner, *op. cit.* (note 5); Doris Kaufmann, *Aufklärung, bürgerliche Selbsterfahrung und die 'Erfindung' der Psychiatrie in Deutschland 1770-1850* (Göttingen: Vandenhoeck & Ruprecht, 1995); M. Gaudet and G. Swain, *Madness and Democracy. The Modern Psychiatric Universe* (Princeton NJ: Princeton University Press, 1999).

[20] B. Müller-Hill, *Tödliche Wissenschaft. Die Aussonderung von Juden, Zigeunern und Geisteskranken 1933-1945* (Reinbek bei Hamburg: Rowohlt, 1985); E. Stover, E. and E.O. Nightingale (eds), *The Breaking of Bodies and Minds. Torture, Psychiatric Abuse, and the Health Professions* (New York: W.H. Freeman and Company, 1985); Paul J. Weindling, *Health, Race and German Politics between National Unification and Nazism, 1870-1945* (Cambridge: Cambridge University Press, 1989); Ian R. Dowbiggin, *Keeping America Sane. Psychiatry and Eugenics in the United States and Canada 1880-1940* (Ithaca and London: Cornell University Press, 1997).

[21] Mangen, *op. cit.* (note 4), 27-8.

[22] Matthew Thomson, 'Before Anti-Psychiatry: "Mental Health" in Wartime Britain', in Gijswijt-Hofstra and Porter (eds), *op. cit.* (note 7), 43-59; *idem*, 'Constituting Citizenship: Mental Deficiency, Mental Health and Human Rights in Inter-war Britain', in Chr. Lawrence and A.-K. Mayer (eds), *Regenerating England: Science, Medicine and Culture in Inter-war Britain* (Amsterdam, Atlanta: Rodopi, 2000), 231-50; Harry Oosterhuis, 'Self-development and Civic Virtue. Psychiatry, Mental Health, and Citizenship in the Netherlands, 1870-2005', in G. Eghigian, A. Killen and C. Leuenberger (eds), *The Self as Scientific and Political Project* (Chicago: The University of Chicago Press: forthcoming 2007).

[23] Shorter, *op. cit.* (note 9); David Healy, *The Antidepressant Era* (Cambridge MA & London: Harvard University Press, 1997). See also the contributions by Toine Pieters & Stephen Snelders, Marijke Gijswijt-Hofstra, and Hugh Freeman.
[24] See the contribution by Gemma Blok, and also by Volker Roelcke.
[25] See chapter 10 by Harry Oosterhuis, and also the contributions by Marijke Gijswijt-Hofstra, Hugh Freeman, Gerald Grob, and Franz-Werner Kersting.
[26] See the contribution by Volker Roelcke.
[27] See the concluding remarks in the contribution by Marijke Gijswijt-Hofstra.
[28] See the contribution by Ido de Haan & James Kennedy.
[29] Roy Porter, 'The patient's view: Doing medical history from below', *Theory and Society*, 14 (1985), 175-198.
[30] See the contribution by Gerald Grob, and also chapter 10 by Harry Oosterhuis.
[31] See Peter Nolan, *A History of Mental Health Nursing* (Cheltenham: Stanley Thornes Publishers Ltd, 1993); Jérôme Pedroletti, *La formation des infirmiers en psychiatrie. Histoire de l'école Cantonale vaudoise d'infirmières et d'infirmiers en psychiatrie 1961-1996 (ECVIP)* (Genève: George éditeurs, 2004). With thanks to Cecile aan de Stegge.